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Integrating Art Therapy and Eye Movement Desensitization and Reprocessing to Treat Post Traumatic Stress

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INTEGRATING ART THERAPY AND EYE MOVEMENT DESENSITIZATION AND
REPROCESSING TO TREAT POST TRAUMATIC STRESS

by

Holland Breed

A research paper presented to the

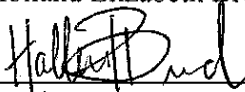
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MARITAL AND FAMILY THERAPY
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In partial fulfillment of the
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MASTER OF ARTS

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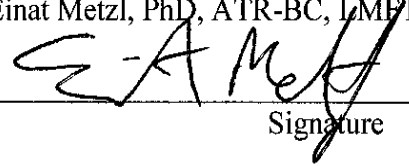


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Abstract

This research study explored the integration of Art Therapy and Eye Movement Desensitization and Reprocessing (EMDR) to treat clients with Posttraumatic Stress Disorder (PTSD). The study explored how art therapy and EMDR can be combined effectively. First, a literature review investigated previous research connecting trauma and its neurological impact, as well as the subsequent causes, symptoms and criteria for PTSD, as well as the connection between neurobiology to art therapy and EMDR. Second, an in-depth interview with a licensed MFT and registered art therapist who is also a certified EMDR practitioner portrays the ways combining art therapy and EMDR to treat clients with PTSD can be done, and how a therapist experienced effectiveness of this treatment, its purpose, techniques, as well as the benefits and challenges of integrating these two treatment can inform others. Information gathered from the interview was transcribed, systematically categorized, and analyzed, resulting in three overarching themes; incorporating the body and mind, combining techniques of Art Therapy and EMDR and populations treated with this integrative modality. Third, a discussion of findings within the context of the larger literature review expanded the meaning of these findings, offering considerations for future clinical applications and research in the young field of integrative trauma treatment.

Keywords: Art Therapy, Eye Movement Desensitization and Reprocessing, Post Traumatic Stress Disorder, Integrative, trauma

Disclaimer

In this study all client information has been disguised, or presented in an unidentifiable manner. The interviewee chose to be identified by her full name Theresa Dausch, as she was speaking from her professional identity. Before collecting any data, a Human Subject Review Board (HSRB / IRB) approval for this research, titled *Integrating Art Therapy and Eye Movement Desensitization and Reprocessing to Treat Post Traumatic Stress Disorder* was obtained (see appendix for full IRB submission).

Dedication

I would like to dedicate this research to Denise Schenk LPC CAC III LLC and Melinda Jameson LPC, for inspiring me to research the integration of Art Therapy and EMDR, to treat PTSD. Denise, you showed me how deep, swift and effective trauma treatment can be when addressed with EMDR. Your treatment provided a safe environment to process extremely intimidating and activating memories. Mel, you exhibited art's powerful processing and ability to express and explore repressed and difficult emotions. Your ability to empower victims of trauma to conquer, survive and thrive inspired me to become a therapist. My gratitude to you both is immeasurable and everlasting.

Acknowledgements

I would like to acknowledge Theresa Dausch for participating in this study. Her willingness to partake in my in-depth and vulnerable interview process made my data gathering possible. She provided me with valuable and inspiring clinical experiences that have the power to spark further research in the field of integrative trauma treatment.

Additionally, I would like to acknowledge Eiant Metzl for guiding and supporting me through this entire research process. Her countless hours spent educating me on the research process, critiquing drafts and lending me emotional guidance and support, made this study possible. Her drive to promote further research in the field of Art Therapy is necessary and motivational.

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Introduction

The Study Topic

This research study explored the integration of Art Therapy and EMDR to treat PTSD, through interviewing an experienced professional that integrated art therapy and EMDR, to treat clients with PTSD. The following literature review explored trauma and its neurological impact, as well as the subsequent causes, symptoms and criteria for PTSD. It additionally attempted to shed light on the connection between neurobiology to art therapy and EMDR. This study aimed to integrate these two treatment modalities; through an exploration of the relevant techniques, interventions, benefits and challenges, when working with clients suffering from PTSD.

My interest in this topic is both professional and personal. As an adolescent I suffered from PTSD, due to a childhood trauma. At sixteen, I had been in verbal therapy for several months and my therapist introduced me to art as a form of expression. I was already a passionate artist and gravitated to releasing my frustration and pain through art. Through the use of play therapy and art I was able to express myself and begin the process of recovery. Despite the accomplishments made in my first year of therapy, my continual re-experiencing of the trauma, or flashbacks, had increased. The danger caused by the flashbacks concerned my therapist and family and I was referred to see a clinician for EMDR. For a year I gradually processed increasingly severe and threatening memories of the trauma in EMDR. I would further process the material explored in EMDR through art and play, with my verbal therapist. By the time I terminated treatment I had seen art's powerful ability to express and process somatic memories and emotional challenges. I also knew that I wanted to pursue a career in Art Therapy. Now that I am completing my training in Art Therapy, I wanted to explore more in depth the combination of EMDR and art processing, as it had been so powerful in treating my PTSD.

In the professional aspect of this interest, researchers and clinicians have been experimenting with integrative, innovative treatments that are effective for reducing trauma disturbances. EMDR has been established as a central Evidence Based Practice (EBP) for trauma treatment; although I was surprised to find that very little research had been done integrating Art Therapy and EMDR. Due to EMDR's lack of imagination development and non-verbal exploration of the affective trauma memory, Lahad, Farhi, Leykin and Kaplansky (2010) and Talwar (2007) advocated for the integration of art therapy, to address these deficiencies and utilize the healing effects of the art process. This thesis allowed me to study the prior research that linked the two treatment modalities, explore their therapeutic benefits and challenges; as well as add my own data to the increasingly vital field of integrative trauma therapy.

Significance of the Study

Experiencing a traumatic event(s) and the subsequent stress disorders that may follow, including PTSD, can disturb one's well being and ability to effectively function. The American Psychiatric Association (2000) point to several predominant symptoms, including extreme helplessness, fear or horror; continual re-experiencing of the traumatic event, continual avoidance of stimuli related with the trauma; numbing and / or continual symptoms of increased arousal. In order to be diagnosed with PTSD these disturbances must cause clinically significant distress or impairment in occupational, social or other important areas of functioning.

Researchers and clinicians have been experimenting with integrative, innovative treatments that are effective for reducing trauma disturbances, and EMDR which had been established as an EBP for trauma treatment seem to be a central piece. However, EMDR does not overtly refer to the development of imagination and subsequently does not utilize its healing effects as art engagement inherently does (Lahad et al. 2010). Similarly, according to Talwar

(2007), to treat trauma successfully, therapists are required to progress beyond spoken language to incorporate the emotional, cognitive and affective memory of the trauma; current EMDR practices lack this non-verbal exploration. The current art therapy practices that attempt to treat the symptoms of trauma and PTSD are not EBPs and therefore lack research and evidence of their treatment outcomes. Although the field of art therapy lacks in published controlled studies, copious benefits of the creative art therapies have been accounted for in therapeutic settings. The use of art therapy and its ability to incorporate the emotional, cognitive and affective memory of trauma has increased when verbal psychotherapy falls short of helping clients (Talwar, 2007).

Talwar (2007) shed light on the impact the progression in psychotherapy and neurobiology have had on the advancement of art therapy. The connection between art therapy and neurobiology has sparked an increasing interest for therapists and researchers in the field of art therapy. An innovative trauma treatment has promoted integrating art therapy and EMDR; in order to provide thorough treatment that addresses what each modality alone is lacking. This research study was therefore intended to add an infield exploration to the innovative research exploring the integration of art therapy and EMDR to treat PTSD, by interviewing therapists that integrate both modalities. Although only one such therapist was ultimately interviewed, the study offers a consideration of clinical criteria, interventions, benefits and challenges of incorporating art therapy and EMDR in trauma treatment.

Background of the Study Topic

The following section will focus on research studies, within the last decade, that integrate methods of art therapy and EMDR to treat trauma. Talwar's (2007) ATTP art therapy protocol concentrates on "the non-verbal, somatic memory of traumatized clients using right and left brain methods based in a positive adaptive functioning model" (p.26). The ATTP protocol integrates

the physiological, cognitive and emotional levels of trauma using elements of McNamee's (2003) bilateral art, Michelle Cassou's method of painting and Shapiro's (2001) EMDR. Talwar's (2010) underpinning of EMDR lies in Shapiro's (2001) adaptive information processing system (AIPS), which suggests that individuals have the inherent capability to create adaptive resolutions to negative experiences and to incorporate negative and positive emotional schemata. According to Talwar (2007), what represents target memory is the major difference between ATTP and basic EMDR protocol. In EMDR treatment, the target memory must be a life event that the client is required to verbally recall. Talwar (2007) argues that art therapy clients can more clearly and comfortably express their target memory through visual images that capture their somatic memory of the event. Talwar's (2007) clinical practice and art therapy training informs her in the method of painting with the dominant and non-dominant hand and use of cognitive links.

Similar to Talwar (2007), Tripp (2007) incorporates heightened somatic awareness into her art-based treatment protocol. Her research promotes a trauma related short-term narrative art therapy approach. This approach uses an adapted EMDR protocol with "alternating tactile and auditory bilateral stimulation," through which somatic and sensory-based "associations are rapidly brought to conscious awareness and expressed in a series" of consecutive drawings. By simultaneously focusing on the art making and somatic sensations in the present, a safe therapeutic environment is established and the client can experience relaxation while rapidly accessing levels of unresolved material from the past. "As new information is accessed, affective material is metabolized and integrated, leading to the transformation of traumatic memory and an adaptive resolution of the trauma" (p.176).

Like Tripp (2007), Brown (2010) also purposed an effective short-term interdisciplinary protocol. Brown's (2010) PTSD treatment protocol combines grounding techniques, elements of EMDR, bilateral stimulation and art therapy interventions. The protocol was administered over six sessions; which contained "trauma processing, reframing maladaptive cognitions and behaviors, discussions of participant strengths, personal relationships, and the importance of self-care." (p.96).

Most recently, Lahad et al. (2010) established a new protocol for treating PTSD; integrating methodologies that have been found to be clinically effective. Like Talwar (2007) and Tripp (2007), Lahad et al. (2010) combined aspects of the somatic experience, as well as fantastic reality and CBT to establish SEE FAR CBT. This protocol stresses the task of fantastic reality and the use of imaginal e-narration of the traumatic event with the use of artistic cards to externalize the trauma and allow the client a sense of control over the event. Lahad et al. (2010) incorporates EMDR using the releasing mechanism of the traumatic memory by moving to and from resourced areas in the body, or between therapeutic cards. This research of SEE FAR CBT is an effort to assess the efficacy of an arts form of PTSD treatment protocol evaluated against an evidence based treatment (EBT) such as EMDR.

Benefits of These Integrative Approaches

Participants in Brown's (2010), Lahad's et al. (2010), Talwar's (2007) and Tripp's (2007) research experienced some kind of alleviation of their trauma symptoms. According to Lahad et al. (2010) SEE FAR CBT and EMDR were correlated with statistically significant decreases in the participant's trauma symptoms over time, but showed no difference in treatment efficacy throughout the assessments. Similarly in Brown's (2010) research, the two participants who completed the treatment protocol experienced lessening of their PTSD symptoms and an

enhancement in their functioning; reflected by the progression in their art created during the research; although, both participants concluded the study with requirements that reached beyond the scope of the study. Tripp (2007) also found that her integration of EMDR's bi-lateral stimulation and art therapy showed a quick and remarkable shift in consciousness and cognition connected to the original negatively held somatic memory. Similar to Brown (2010), Tripp's (2007) positive shift was monitored through the participant's art imagery. Tripp's (2010) protocol offered an adaptive resolution for single event and complex trauma.

According to Talwar (2007) ATTP gives the client tools to construct sensory awareness, which establishes emotional and affect regulation. Through the art process, the client is able to monitor their feelings and actions, while becoming conscious of the sensorimotor experience, promoting proprioception. Similar to Brown's (2010), Lahad's et al. (2010) and Tripp's (2007); Talwar's (2007) protocol promotes bi-lateral stimulation. Specifically, the left and right brain are stimulated from the process of walking back and forth. Creating the art image, deciding between brushes, colors and sequential decisions via analytical thinking, uses left brain processes that alternate with right brain processes; triggering the spatial, visual, motor, emotion and sensory regions. Meanwhile, the mediating limbic structures, hippocampus and amygdala are constructing a series of events and assigning the events their emotional meaning. The incorporating and preparing functions of the prefrontal cortex are engaged by bilateral art process, as the hippocampus allocates the traumatic memory a narrative of beginning, middle and end, using left brain function.

Lastly, Brown (2010), Tripp (2007) and Talwar (2007) conducted their art-based research under their ATR license; which allows them to be informed and effective in the art process, although some may say this limits these integrative treatments to solely be administered by Art

Therapists. Tripp (2007) argues that her integrative protocol has the ability to stimulate strong sensory responses and associations in the client and must not be administered unless the therapist has training and experience in trauma related disorders, art therapy and EMDR. On the other hand, Lahad's et al. (2010) method was administered by clinical social workers, clinical psychologists and creative arts therapists.

With the context of this body of research as a background, the purpose of my study was to integrate Art Therapy and EMDR through interviewing a clinician who applied both techniques. I specifically interviewed a therapist who treats clients with PTSD and explored her experiences and perceived effectiveness of this treatment, as well as the purpose, techniques, benefits and challenges of integrating these two treatment modalities. This integrative treatment is an innovative and young concept, with minimal understanding and research and it is my hope that this study will bridge some of this gap.

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Literature Review

Experiencing a traumatic event and the subsequent stress disorders that often follow, including PTSD, can disturb one's well being and ability to effectively function. The current art therapy practices that attempt to treat symptoms of trauma and PTSD are not EBPs and therefore lack research and evidence in their PTSD treatment outcomes. Yet the field of art therapy continues to advance; Talwar (2007) shed light on the impact the progression of psychotherapy and neurobiology have had on advancements in Art Therapy. The connection between Art Therapy and neurobiology has sparked an increasing interest for therapists and researchers in the field.

Lahad et al. (2010) states multiple reasons for the development of new trauma treatment modalities. First, previous findings have established there are key brain configurations and pathways linked with "retaining the traumatic incident process" (p.391). Therefore the reactivation of these pathways through imaginal exposure techniques is a vital element of the healing process. Although EMDR, is an EBP for treating PTSD, it does not overtly refer to this development of imagination and subsequently does not utilize its healing effects (Lahad et al. 2010). According to Talwar (2007), to treat trauma successfully, therapists are required to progress beyond spoken language to incorporate the emotional, cognitive and affective memory of the trauma; current EMDR practices lack this non-verbal exploration. Innovative trauma treatments have promoted integrating art therapy and EMDR; in order to provide thorough treatment that addresses what each treatment alone is lacking.

The following literature review assembles research on the subjects of trauma, the development of PTSD and the subsequent treatments utilizing art therapy and EMDR. A brief synopsis of traumatic events, various categorizations of trauma and trauma's connection to

neurobiology will be explored. Additionally, the causes, criteria, and symptoms of PTSD will be stated. A discussion of the use of art therapy interventions for PTSD and art therapy's connection to neurobiology will be provided. In order to support the efficacy of the addition of art therapy interventions, previous studies and research using art therapy interventions to treat trauma must be reviewed. Although various researches support the effectiveness of art therapy's treatment with children, this literature review will solely focus on treatment with adults. A discussion of the use of EMDR to treat trauma and PTSD and its connection to neurobiology will be provided. Finally, a review of various innovative trauma treatments integrating art therapy and EMDR protocols will be presented.

Trauma

According to Solomon and Heide (1999) psychological trauma is defined as the psychological effects of an event(s) that cause extreme fear and defenselessness, that overpower one's normal coping and defense mechanisms.

Types of trauma.

The American Psychiatric Association (2000) lists the following as directly experienced potential traumatic events: severe car accidents, being diagnosed with a terminal illness, violent personal attacks (mugging, robbery, physical and sexual assault) being kidnapped, taken hostage or tortured, military combat, imprisonment in a concentration camp or as a prisoner of war, violent terrorist attack and manmade or natural disaster. Potential witnessed traumatic events include: witnessing severe injury or abnormal death of a victim of assault, seeing a dead body or body parts without warning, war and disasters. Hearing about the following events can produce trauma: a severe accident, the violent personal assault of another, the severe injury of a close friend or family member or one's child being diagnosed with a terminal disease. The American

Psychiatric Association (2000) lists specific traumatic events for children, but this literature review will solely focus on trauma experienced by adults. This following material will review two methods of categorizing trauma; simple and complex and type I, II and III.

Simple trauma refers to a solitary traumatic event and is most likely to cause PTSD (Virginia Commission on Youth). Complex trauma is caused by one's experience of numerous or extended traumatic events that impact the development of a person (National Child Traumatic Stress Network, 2003). This type of trauma normally transpires in settings where the victim cannot escape and is controlled by the perpetrator. Victims of domestic violence are at high risk for developing complex trauma. Exposure to complex trauma can result in emotional deregulation, loss of safety, direction and the capability to identify or react to threats. Victims of complex trauma are likely to expose themselves to trauma repeatedly throughout their lives (National Child Traumatic Stress Network, 2003).

Similar to simple trauma, Solomon and Heide (1997) suggest that a solitary event, like rape, assault, observing a murder, natural disasters, motor vehicle accidents, fires, explosions, bombings and robbery can cause Type I trauma. If the traumatic event is experienced when a person is at least three years of age, the survivor normally preserves full memory of the event. The survivors of these traumas struggle to understand why the trauma happened and can experience perceptual disturbances like time distortions or visual hallucinations. Type II trauma is an outcome of a single incident with repetitive exposure, or multiple incidents of exposure to severe external traumatic events (Solomon and Heide, 1997). Incidents causing Type II trauma can include; chronic illness, nuclear accidents, toxic spills, combat, abuse and battered syndrome. Survivors normally have at least some recollection and can separate their traumatic incidents. Type II trauma can cause anxiety, impairing some functioning, but survivors are still

able to access resiliency. The third and final type of trauma happens when a person experiences numerous, invasive, violent events, starting at a young age and enduring for an extensive period of time (Solomon & Heide, 1997). This trauma type exposes the victim to simultaneous or chronological incidents of child abuse, neglect and domestic violence that usually take place within the primary care system. The diagnostic criteria for type III trauma consists of key developmental deficits, a disjointed sense of person, a central idea that one is incurably damaged and lacks the right to be alive, a sense of despair and disgrace, no perception of the future, a lack of trust that hinders relationships, emotional numbing, shifts in consciousness and memory and dissociation.

Trauma's neurobiological impact.

A growing body of research, including Talwar (2007) uses the limbic system to understand memory and emotions connected to trauma. The limbic system guides the emotions and responses essential for self-preservation and survival. Within the limbic system are the hippocampus and amygdala, which are central to the storage and recovery of memory. The amygdala evaluates the emotional significance connected to extreme emotional memories like terror and remains active during the re-experiencing and remembering of the traumatic event. The hippocampus cognitively maps experiences into a sequential time line in one's memory. Traumatic memories are more often recorded in implicit memory. This causes the highly stimulated and incomplete memory to be locked in the body as a biological response to threats. Traumatic memories do not inhabit in the verbal analytical areas of the brain but affect the limbic system and non-verbal area of the brain. When the traumatic event is not able to reside in its proper place in one's timeline, it continues to attack the present cognitive state, upsetting the incorporation of the experience and memory.

According to Talwar (2007), when the traumatic event(s) is re-experienced, the frontal lobes become damaged and cause the person to struggle with thinking and speaking. The somatic experiences, images and emotions connected to a traumatic event can profoundly imprint on an individual's mind and be re-experienced without appropriate transformation. This malfunction in transforming these traumatic sensory imprints holds individuals in an elevated cognitive state that prohibits them from feeling safe; this state is otherwise known as hyper-vigilance.

Post Traumatic Stress Disorder

According to the American Psychiatric Association (2000), when a person is directly exposed to a severe traumatic event that entails actual or threatened death or serious injury, or danger to one's physical integrity; or observing an incident that entails injury, death or danger to the physical integrity of another person; or learning about an unanticipated or violent death, severe injury, or threat of death or harm experienced by a family member or other close associate they are susceptible of developing Post Traumatic Stress Disorder (PTSD). The American Psychiatric Association (2000) states several symptom criteria for an individual experiencing PTSD. First, one must respond to the stressor with extreme helplessness, fear or horror. Second, the distinguishing symptoms resulting from the exposure to the severe stressor include; continual re-experiencing of the traumatic event, continual avoidance of stimuli related to the trauma and numbing of universal sensitivity and continual symptoms of increased arousal. These disturbances must cause clinically significant distress or impairment in occupational, social or other important areas of functioning. If the traumatic event is purposely inflicted by another person, (torture, rape) the symptoms can be particularly severe or extensive. The chance of

developing PTSD is amplified by the victim's physical closeness to the traumatic event (American Psychiatric Association, 2000).

PTSD Treatment Modalities

Art Therapy

Art therapy's connection to neurobiology.

According to Hass-Cohen (2008) fear and anxiety, stimulated by traumatic memories and triggers, are adjusted and controlled by the middle prefrontal cortex and neighboring areas.

PTSD symptoms have been correlated with medial prefrontal cortex breakdowns, causing the extinction of fear conditioning in the amygdala. The anterior cingulate cortex's failure to aid in reducing the limbic reactions while re-experiencing the trauma has been connected with continual emotional processing of the trauma. Hass-Cohen (2008) presents a case study using art directives that may aid in repairing the limbic functions by reducing reactions from chronically experiencing flashbacks and nightmares. Due to trauma's effect on the brain, when the traumatic event is re-experienced the frontal lobes become damaged and cause the person to struggle with thinking and speaking (Talwar, 2007). Gantt and Tinnin (2009) also suggest the notion that trauma is largely a nonverbal disturbance. They support this idea with three lines of research, including the evolutionary survival responses, brain imagery studies of human responses to trauma cues and the relation of alexithymia to posttraumatic dissociation.

Hass-Cohen (2008) placed the neurobiology of the stress response as central in understanding the process of dissociation. When traumatic stress is experienced, inadequate levels of cortisol have been implicated in hippocampal malfunction and inability to control fragmented sensory and emotional memories, resulting in symptoms of dissociation. The largely non-verbal, situational accessible memory system (SAM-DRT) corresponds to this fragmented

visual-spatial sensory information, set during the trauma. Buk (2009) provides psychoanalytically informed art therapy interventions; supported by research in the areas of cognitive science, infant development and neurobiology. This research centers on the continuum of dissociation as a survival response to an overpowering trauma, the connection of this process to implicit memory, the mirror neuron system and embodied simulation.

According to Talwar (2007), in trauma treatment, the non-verbal memory of the disjointed sensory and emotional elements of the trauma is more important than the verbal account. To treat trauma successfully, therapists are required to progress beyond spoken language to incorporate the emotional, cognitive and affective memory of the trauma. According to Talwar (2009), art therapy has long been recognized as a treatment modality that comprises a major process that connects with the non-verbal realm of imagery. Gantt and Tinnin (2009) provide research that takes a neurobiological analysis of psychological trauma that supports art therapy as a key means of treating symptoms of PTSD. Hass-Cohen (2008) considers art therapy directives that are uncomplicated and repetitive like cutting paper into shapes, stringing beads together or kneading a piece of plasticine while verbalizing difficult memories may decrease the disturbance caused by fragmented sensory and emotional memories.

Talwar (2007) cites research that provides positive implications for art therapy being a connection between the brain and creativity. Although this connection is not yet fully definite, Talwar (2007) assumes it is likely that creativity engages multiple areas of the brain. Talwar (2007) believes, in light of current research on trauma, creativity and neurobiology, it is probable that the brain's hemispheres are involved by the art process in accessing memories and processing emotions. According to McNamee (2005), the process of creating narrative, analytical thinking, sequential processing, language and speech are responsibilities of the left

hemisphere. While in the process of art therapy, the left hemisphere offers a clarification to the right hemispheric output in the structure of a created image. Emotions, intuition, sensory, automatic skills, visual motor activities and the procedures implicated in creativity, are all responsibilities of the right hemisphere (Bogousslavsky, 2005). The non-verbal creative facets of this hemisphere are induced in the process of drawing, while in art therapy. This process stimulates the amygdala in the limbic system, which connects the social emotional input with the prefrontal cortex for integrating and planning. This in turn, stimulates the physiological, emotional and cognitive processes (Klorer, 2005). Hass-Cohen (2008) also links verbalization and the art process to left and right hemispheric integration; specifically the art therapy process of simultaneously tilting the head and discussing the art. Talwar (2007) sums up this process, by stating that art therapy can combine right and left brain functions, which combine experiences on a non-verbal level.

This art therapy process, allows the traumatized client to sublimate unspeakable terror into an art product. According to Hass-Cohen (2008), this process initiates experiences that diverge from anything formerly related with the trauma. She states this therapeutic method can assist in lessening implicit, automatic responses and enhance flexible, adaptive, logical and stable mental states. Hass-Cohen's (2008) research demonstrates how clients can practice combining emotion, thoughts, feelings, bodily sensations and images into one art product. With the art therapist, the client can enhance interpersonal capacity through re-examining, discussing and tilting the art; presenting enhanced opportunities for narrative coherency and mental flexibility. Hass-Cohen (2008) suggests uncomplicated media, like markers to reduce the risk of automatic threat responses during this process.

Trauma focused art therapy interventions.

According to Rankin and Taucher (2003), various art therapists who treat survivors of trauma present minimal guidelines, so their clients may create their own art processes and themes. On the other hand, they found additional art therapists provide more structured formats to increase the possibility for cognitive, affective and behavioral adaptation to trauma. A vigilantly selected combination of narrative, expressive, explorative, management and integrative art interventions are proposed by Rankin and Taucher (2003), to attend to six fundamental trauma-focused tasks: safety planning, self-management, telling the trauma story, grieving losses, self-concept and worldview revision and self- and relational-development.

In 2007, Gantt and Tinnin questioned if it was feasible to effectively treat clients with PTSD with a brief, 1 to 2 week outpatient program. Their intensive outpatient program utilized art therapy, hypnosis and video therapy. Collie, Backos, Malchiodi, Spiegel (2006) also studied art therapy within the context of additional PTSD treatments. Their research provides theoretical rationale for using art therapy and additional PTSD treatments, to treat combat-related PTSD. They proposed group treatment in three phases and advise that art therapists who work with these veterans have specialized training in trauma intervention and PTSD theory.

Although various research such as Mallay and Neily (2002) and Lyshak-Stelzer, Singer, Patricia, Claude (2007), find art psychotherapy a fitting treatment for children and adolescents with PTSD, this literature review focuses on PTSD treatment modalities studied with adults. Collie et al. (2006) focused their research on treating combat-related PTSD. They found that although there is minimal research, art therapy has the capability of treating and providing insight on difficult combat-related PTSD symptoms, such as emotional numbing and avoidance. Separately, Spring's (2004) thirty year study found that in art therapy, sexual abuse victims

create an artistic language not created by non victims. Additionally, Buk (2009) utilized sessions with an extremely traumatized woman as a foundation for her research on mutative actions of psychoanalytically informed art therapy interventions.

Benefits and limitations of art therapy.

According to Pizarro and Judith (2003), traumatic stress negatively affects overall health and well-being. Their research explored the difference in effectiveness between art therapy and writing therapy on psychological and health outcomes. Their participants, who received art therapy, reported increased enjoyment in therapy and were more prone to continue and recommend the treatment. Hass-Cohen (2008) presents a PTSD treatment case study that supports art therapy as a playful activity; where handling of the media inspires play states, which in the company of a supportive art therapist can be a reparative emotional experience. Additionally, Gantt and Tinnin (2007) found that brief intensive outpatient trauma treatment, including art therapy, showed to be an effective treatment for posttraumatic disorders. In their naturalistic study, they collected pre- and post-test data on 72 patients. The improvement in their patients was statistically significant, with 45% of the participants meeting the criteria for recovery, 44% showing improvement, 8% were unchanged and 3% worse following treatment.

The field of art therapy research is minimal and lacking quantitative studies to strongly establish art therapy as a standard treatment for PTSD. The field of psychotherapy in general is moving toward an EBP model. Art therapy treatment interventions are lacking in these EBP treatments.

Eye Movement Desensitization and Reprocessing.

Connection to neurobiology.

According to Van der Kolk (2000) traumatic memories are mainly imprinted in emotional and sensory forms; although a semantic image of the trauma may coexist with sensory flashbacks. When triggered by stimuli, the trauma can be vividly re-experienced with instantaneous sensory and emotional force. Van der Kolk (2000) presents findings linking reduced dorso-lateral frontal cortex activation with partial consciousness when re-experiencing trauma. These flashbacks are experienced as cut off motoric, emotional and sensory imprints of the trauma, lacking a clear storyline. The sensory elements of the trauma continue to be re-experienced, causing the trauma memory to be fragmented and un-integrated with one's overall sense of self. When these fragmented memories are re-experienced they cause excessive emotional arousal, leading to an inability of the central nervous system to fuse the trauma sensations into an integrated whole. This extreme emotional arousal also obstructs hippocampal functions and further inhibits appropriate integration of the traumatic sensory imprints. Van der Kolk (2000) believes these states of excessive arousal also cause malfunction in the left hemisphere, causing the de-realization and depersonalization symptoms of PTSD. Van der Kolk (2000) presents a pilot study depicting participants' improved activation of the dorso-lateral prefrontal cortex, following EMDR treatment.

The right hemisphere is also impacted by the re-experiencing of trauma. According to PTSD neuroimaging studies reviewed by Van der Kolk (2000), the Broca's area functioning is reduced when exposed to the trauma script, while the activation in the right hemisphere is amplified. These changes make it hard for traumatized clients to verbalize their experiences during states of emotional arousal. Van der Kolk (2000) supports EMDR as the best treatment to

desensitize clients with PTSD, devoid of requiring them to entirely engage in verbal recall of the traumatic incident.

Current neuroimaging research also shows a constant decline in thalamic activity, due to PTSD's effect on the brain (Bergmann, 2008). This research considers the thalamus to be centrally involved in the assimilation of cognitive, perceptual, memorial and somatosensory processes. Van der Kolk (2000) states that somatization entails sensations of symptoms on a somatic level; which cannot be medically explained. Bergmann (2008) suggests that dual-attention stimulation and bilateral stimulation are EMDR methods that activate the thalamus. This activation may assist the restoration and assimilation of cognitive, somatosensory, memorial, frontal lobe and synchronized hemispheric tasks disturbed in PTSD. According to research presented by Shapiro (2001), an innovative understanding of neurotransmitters, SPECT scans and fMRI, support positive biological changes following EMDR processing.

EMDR interventions

Shapiro (2001) formulated EMDR to specifically treat PTSD. This approach combined psychodynamic, behavioral (including operant and classical conditioning) and cognitive behavioral approaches (including stress management techniques, cognitive interventions, coping skills and exposure). The image, negative and positive cognitions, emotions and their level of disturbance and physical sensations caused by the re-experiencing of the traumatic memory are the fundamental components of EMDR. The treatment targets a disturbing memory and works to decrease the validity of the surrounding negative images, beliefs and emotions. These images, beliefs and emotions are rationalized and the client discovers what is essential and helpful from the trauma and the memory is re-established in an adaptive, vigorous, non-distressing form. Throughout treatment the client becomes more desensitized to upsetting triggers. This process

entails following eight sequential segments; client history and treatment planning, preparation, assessment, desensitization and reprocessing, instillation of positive cognition, body scan, closure and reassessment. Shapiro (2001) states the intention of this treatment is to liberate the client from the past into a vigorous and productive present.

According to Solomon and Heide (1997), EMDR frequently can be used to promptly and effectively resolve type I trauma. Specifically, Jayatunge (2008) used EMDR to treat three children and 2 adults suffering PTSD symptoms following the 2004 tsunami in Sri Lanka. Separately, Maxfield (2008) collected information on using EMDR, following situations of severe turmoil, disaster, violence and war. Maxfield (2008) provided an eclectic international perspective with research from Italy, the United States, Israel, Mexico, the United Kingdom, Palestine and Sri Lanka. One of the unique variations Maxfield (2008) provided was EMDR-IGTP. Using bilateral stimulation, it was developed to treat large groups impacted by extensive serious events. Similar to Maxfield (2008), Sondergaard and Elofsson (2008) studied the effects of eye movements throughout EMDR sessions with refugees exposed to war and torture, resulting in chronic PTSD. Additionally, Albright and Thyer (2010) studied populations exposed to war and violence, but specifically military combat veterans who suffered from PTSD.

Benefits and limitations of EMDR.

Lahad, Farhi, Leykin, and Leykin (2010) and Sondergaard and Elofsson (2008) found that EMDR is one of the most effective therapies cited in the treatments for PTSD literature. Shapiro (2001) states the efficacy of EMDR is established in its capacity to produce fast change and encourage continual reassessment of therapeutic interventions. Numerous strictly controlled, published studies of EMDR support its efficacy and allowed the practical guidelines of the International Society for Traumatic Stress Studies to elect EMDR as an effective treatment for

PTSD. According to Maxfield (2008), significant evidence for the efficacy of EMDR treatment of PTSD has resulted in copious practice guidelines like the U.S. Veterans Affairs and Defense departments (2004) and the American Psychiatric Association (2004). Specifically EMDR-IGTP; has been found effective in some field trials and has been used for thousands of global disaster survivors (Maxfield, 2008). In Jayatunge's (2008) research, following 3 to 8 sessions of EMDR his client's PTSD symptoms were eliminated and feelings of depression and anxiety, disturbances and nightmares were decreased. These clients were able to go on to function sufficiently and lead productive lives.

In 2010, Albright and Thyer presented an analysis of published outcome studies from 1987 to 2008, which studied the particular effects of EMDR and PTSD among military veterans. According to Albright and Thyer (2010), the evidence sustaining the treatment of EMDR for combat veterans with PTSD is thin and ambiguous; causing EMDR to be below the threshold of classifying the treatment as empirically supported. Their findings illustrate that it is hasty to integrate EMDR into custom care for veterans with combat-related PTSD, without a stronger evidentiary foundation.

Trauma treatments integrating art therapy and EMDR.

The need for integrative trauma treatments.

Talwar (2007) shed light on the impact the progression in psychotherapy and neurobiology have had on the advancement of art therapy. The use of art therapy has increased when verbal psychotherapy falls short of helping clients. Although the field of art therapy lacks in published controlled studies, copious benefits of the creative art therapies have been accounted for in therapeutic settings. The connection between art therapy and neurobiology has sparked an increasing interest for therapists and researchers in the field of art therapy. Lahad et al. (2010)

states multiple reasons for the development of new trauma treatment modalities. First, previous findings have established there are key brain configurations and pathways linked with “retaining the traumatic incident process” (p.391). Therefore the reactivation of these pathways through imaginal exposure’ techniques is a vital element of the healing process. According to Lahad et al. (2010) EMDR alone does not overtly refer to this development of imagination and subsequently does not utilize its healing effects.

Additionally, Brown (2010) establishes that trauma symptoms are presently being treated with art therapy protocols that are too severe or long-lasting. These lengthy treatments protocols and increasing reduction of insurance coverage and managed care subject the trauma victim to high costs of treatment. Brown (2010) suggests her research “oriented towards the development of a successful art-based, interdisciplinary trauma protocol” could be executed as a brief-therapy model (p.xi).

Integrating treatment modalities.

This section of the literature review will focus on research studies, within the last decade, that integrate methods of art therapy and EMDR to treat trauma. Talwar’s (2007) ATTP art therapy protocol concentrates on “the non-verbal, somatic memory of traumatized clients using right and left brain methods based in a positive adaptive functioning model” (p.26). The ATTP protocol integrates the physiological, cognitive and emotional levels of trauma using elements of McNamee’s (2003) bilateral art, Michelle Cassou’s method of painting and Shapiro’s (2001) EMDR. McNamee (2003) states her Bilateral Art engages both left and right brain functions and combines both verbal and non-verbal processes in an attempt to stimulate memories that dwell bi-laterally in the brain. Talwar’s (2010) underpinning of EMDR lies in Shapiro’s (2001) adaptive information processing system (AIPS), which suggests that individuals have the

inherent capability to create adaptive resolutions to negative experiences and to incorporate negative and positive emotional schemata. According to Talwar (2007) what represents target memory is the major difference between ATTP and basic EMDR protocol. In EMDR treatment, the target memory must be a life event that the client is required to verbally recall. Talwar (2007) argues that art therapy clients can more clearly and comfortably express their target memory through visual images that capture their somatic memory of the event. Talwar's (2007) clinical practice and art therapy training informs her in the method of painting with the dominant and non-dominant hand and use of cognitive links.

Similar to Talwar (2007) Tripp (2007) incorporates heightened somatic awareness into her art-based treatment protocol. Her research promotes a trauma related short-term narrative art therapy approach. This approach uses an adapted EMDR protocol with "alternating tactile and auditory bilateral stimulation," through which somatic and sensory-based "associations are rapidly brought to conscious awareness and expressed in a series" of consecutive drawings. By simultaneously focusing on the art making and somatic sensations in the present, a safe therapeutic environment is established and the client can experience relaxation while rapidly accessing levels of unresolved material from the past. "As new information is accessed, affective material is metabolized and integrated, leading to the transformation of traumatic memory and an adaptive resolution of the trauma" (p.176).

Like Tripp (2007), Brown (2010) also purposed an effective short-term interdisciplinary protocol. Brown's (2010) PTSD treatment protocol combines grounding techniques, elements of EMDR, bilateral stimulation and art therapy interventions. The protocol was administered over six sessions; which contained "trauma processing, reframing maladaptive cognitions and

behaviors, discussions of participant strengths, personal relationships, and the importance of self-care.” (p. 96).

Most recently, Lahad et al. (2010) established a new protocol for treating PTSD; integrating methodologies that have been found to be clinically effective. Like Talwar (2007) and Tripp (2007), Lahad et al. (2010) combined aspects of the somatic experience, as well as fantastic reality and CBT to establish SEE FAR CBT. This protocol stresses the task of fantastic reality and the use of imaginal re-narration of the traumatic event with the use of artistic cards to externalize the trauma and allow the client a sense of control over the event. These metaphoric cards symbolize a “safe place and the re-narrating process of the traumatic story” (p. 394). The element of fantastic reality allows the client to access the “as if space;” where all the Ifs are achievable and the unfeasible becomes achievable. This sense of attainability and control empowers and allows the client to play. Lahad et al. (2010) incorporates EMDR using the releasing mechanism of the traumatic memory by moving to and from resourced areas in the body, or between therapeutic cards. This research of SEE FAR CBT is an effort to assess the efficacy of an arts form of PTSD treatment protocol evaluated against an EBT such as EMDR.

Figure A presents the stages of treatment for each integrative protocol previously discussed, in comparison to Shapiro’s (2001) eight stages of EMDR.

Figure A: Stages of Treatment in Integrative PTSD Protocols

<u>Stages of Treatment</u>	Shapiro (2001) EMDR	Tripp (2007) Short Term Art Therapy and Bilateral Stimulation	Talwar (2007) ATTP	Brown (2010) Short-Term Art Therapy Trauma Protocol	Lahad et al. (2010) SEE FAR CBT
<u>Stage 1</u>	Client history and treatment planning		Detailed evaluation of the client's history	Inventory of experiences	A detailed intake interview/assessment and PTSD diagnosis
<u>Stage 2</u>	Preparation	Bring somatic and sensory-based images to conscious awareness.	The client explores ways of problem-solving specific to him or her; leading to an understanding of their affective responses and accessing images of safety.	Development of a safe place	Psycho-education about PTSD, common responses, approaches to therapy, SE, in vivo exposure, re-narration in the FR and cognitive processing.
<u>Stage 3</u>	Assessment			Instillation of grounding techniques.	A mutual decision that therapy is necessary.
<u>Stage 4</u>	Desensitization and reprocessing	Create multiple, consecutive images in conjunction with ongoing bilateral tactile and auditory stimulation.	The creative painting process encourages bilateral stimulation.	Debriefing to the traumatic experience.	Clarifying the objectives of the therapy.
<u>Stage 5</u>	Instillation of positive cognition	Distressing memories are transformed with new associations to adaptive and positive information.	The client develops an understanding of the underlying negative feelings and self-perceptions, and the affective responses evoked by these	Application of positive and negative cognitions to the traumatic experience.	Relaxation, creating a safe place and anchoring the sensations in the body.

			emotions. Promote cognitive functioning while lowering the client's distress.		
<u>Stage 6</u>	Body scan	Client focuses on body during the creative process	Painting process activates the body and mind	Rating cognitions	Examining avoidances and building an in vivo exposure hierarchy, practicing in vivo exposure, desensitization, practicing exposure in the FR
<u>Stage 7</u>	Closure			Bilateral stimulation	Re-narration in the fantastic reality using cards; practicing in vivo exposure
<u>Stage 8</u>	Reassessment			Assigning a distinct ending to the traumatic event.	Processing "hot spots" (i.e. high levels in the subjective units of distress) that surfaced in the re- narration in the FR using cards; practicing in vivo exposure
<u>Stage 9</u>					Summary and evaluation of results

Brown (2010), Lahad et al. (2010), Talwar (2007) and Tripp (2007) all focused their research on trauma treatment with adults. Both Talwar (2007) and Tripp (2007) used single case studies on middle aged women. Talwar (2007) studied the case of a mental health worker who experienced early reoccurring childhood trauma. Tripp's (2007) participant was sexually abused as a minor and experienced reoccurring familial hostility. Brown (2010) had a slightly larger population, with three Caucasian female participants at a university counseling center; two

whom experienced sexual assaults and one who experienced a physical and sexual assault.

Lahad (2010) had a more sufficient population with 106 adult clients that were attained from a psycho-trauma treatment unit at the Community Stress Prevention Center in northern Israel. The self-referred participants were from metropolitan and collective populations exposed to warfare for 33 days during the Second Lebanon War in the summer of 2006. These clients were divided into EMDR and SEE FAR CBT treatment groups and evaluated for traumatic symptoms at pre-treatment, post-treatment and a 1 year follow up.

Benefits and limitations of these integrative approaches

Participants in Brown's (2010), Lahad's et al., (2010), Talwar's (2007) and Tripp's (2007) research experienced some kind of alleviation of their trauma symptoms. According to Lahad et al., (2010) SEE FAR CBT and EMDR were correlated with statistically significant decreases in the participant's trauma symptoms over time, but showed no difference in treatment efficacy throughout the assessments. Similarly in Brown's (2010) research, the two participants who completed the treatment protocol experienced lessening of their PTSD symptoms and an enhancement in their functioning; reflected by the progression in their art created during the research. Although, both participants concluded the study with requirements that reached beyond the scope of the study. Tripp (2007) also found that her integration of EMDR's bi-lateral stimulation and art therapy showed a quick and remarkable shift in consciousness and cognition connected to the original negatively held somatic memory. Similar to Brown (2010), Tripp's (2007) positive shift was monitored through the participant's art imagery. Tripp's (2010) protocol offered an adaptive resolution for single event and complex trauma.

According to Talwar (2007) ATTP gives the client tools to construct sensory awareness, which establishes emotional and affect regulation. Through the art process, the client is able to

monitor their feelings and actions, while becoming conscious of the sensorimotor experience, promoting proprioception. Similar to Brown's (2010), Lahad's et al., (2010) and Tripp's (2007); Talwar's (2007) protocol promotes bi-lateral stimulation. Specifically, the left and right brain are stimulated from the process of walking back and forth. Creating the art image, deciding between brushes, colors and sequential decisions via analytical thinking, uses left brain processes that alternate with right brain processes; triggering the spatial, visual, motor, emotion and sensory regions. Meanwhile, the mediating limbic structures, hippocampus and amygdala are constructing a series of events and assigning the events their emotional meaning. The incorporating and preparing functions of the prefrontal cortex are engaged by bilateral art process, as the hippocampus allocates the traumatic memory a narrative of beginning, middle and end, using left brain function.

Lastly, Brown (2010), Tripp (2007) and Talwar (2007) conducted their art-based research under their ATR license; which allows them to be informed and effective in the art process, although some may say this limits these integrative treatments to solely be administered by Art Therapists. Tripp (2007) argues that her integrative protocol has the ability to stimulate strong sensory responses and associations in the client and must not be administered unless the therapist has training and experience in trauma related disorders, art therapy and EMDR. On the other hand, Lahad's et al., (2012) method was administered by clinical social workers, clinical psychologists and creative arts therapists.

As stated previously, Talwar (2007), Tripp (2007) and Brown (2010) had small sample sizes. According to Brown (2010), the multiple similarities within her sample produced results that could not be generalized to the larger population. In order to make this generalization, Brown (2010) would need to gather a larger multicultural pool of participants who have

experienced different types of trauma. Both Tripp's (2007) and Brown's (2010) protocol were based on brief-therapy models. According to Brown (2010), clients with a history of complex trauma, would need a more long term and intensive form of therapy.

Conclusion

This literature review assembled research on the subjects of trauma, the effects of PTSD and the subsequent treatments utilizing art therapy and EMDR. First, a brief synopsis of traumatic events, categorizations of trauma, neurobiological impact, causes, criteria and symptoms of PTSD were explored. Secondly, a discussion of art therapy and the benefits and limitations using art therapy interventions to treat PTSD were provided. Third, a dialogue of the benefits and limitations using EMDR to treat trauma and PTSD were provided, comparing and contrasting different models of this common modality for trauma treatment. Lastly, a review of various innovative trauma treatments integrating art therapy and EMDR protocols were presented. These included Tripp's (2007) Short Term Art Therapy and Bilateral Stimulation, Talwar's (2007) ATTP, Brown's (2010) Short-Term Art Therapy Trauma Protocol and Lahad's et al. (2010) SEE FAR CBT, which all combined elements of art therapy and EMDR to ideally provide stronger more effective treatment protocols than art therapy and EMDR alone. Although promising for the future of trauma and PTSD treatment, without supporting research these protocols will likely remain limited in how widely they are used and with unknown limitations and benefits for clients seeking treatment.

This literature review provided background information on trauma, PTSD, Art Therapy and EMDR interventions as the knowledge basis for Data Presentation, Analysis and Discussion of Findings and Meanings sections. Therefore, it provided a context in which the study's

participant, Theresa Dausch's innovative trauma protocol of integrating EMDR and Art Therapy can be understood.

Research Approach

I conceptualized this study, the integration of art therapy and EMDR to treat clients with PTSD, within a social constructivist worldview. According to Creswell (2009) this particular worldview embraces the theory that people search for understanding of the environment they inhabit; developing various meanings from their experiences. When developing my research study, I wanted to generate or inductively develop a pattern of meaning, rather than starting with a theory. I was interested in addressing the process of this integrative treatment, focusing on therapists that were using it in the field. This worldview led me to look for the intricacy of views on integrating art therapy and EMDR; rather than reducing information into a few groupings or ideas. My research goal was to rely solely on my interviewed professional's views of this innovative treatment. Using Martin's (2008) concept of ethnography based interviews, my interview questions were broadly structured, so the therapist could build the meaning of the treatment.

According to Creswell (2009), the social constructivist worldview is normally seen as an approach to qualitative research. Using qualitative research, I planned to investigate and understand the meaning therapists ascribed to treating clients with PTSD, rather than testing it. Using Martin's (2008) concept of qualitative research, I planned to use descriptive data, including the approaches and beliefs of the therapist. I began my research process with emerging questions, collected data based on the participant's experience, analyzed this data constructing from common themes and finally made understandings of the meaning of that data. Using Kapitan's (2010) conceptualization of qualitative research, my analysis used inductive methods

that shifted from the specifics of the therapist's experiences to broader understandings plausibly revealed by the information gathered. I allowed for change to accommodate new understanding from the data collected.

Under the umbrella of qualitative research, my strategy of inquiry developed from a phenomenological perspective. I identified the essence of the interviewed therapist's experiences integrating art therapy and EMDR. Using ideas promoted by Creswell (2009), I interviewed a therapist to develop patterns and relationships of meaning, to understand her experience using the integrative treatment. Correlating with Kapitan's (2010) idea of phenomenological research, the insights that emerge presented a fresh perspective of direct and infield experiences. Using Kapitan's (2010) qualitative structure, I used this small sample size to produce holistic understanding. Throughout the research process, I set aside my own experiences to understand those of the therapists in my study.

Methods

Definition of Terms

Psychological trauma: According to Solomon and Heide (1999) psychological trauma is defined as the psychological effects of an event(s) that cause extreme fear and defenselessness that overpower one's normal coping and defense mechanisms.

Simple trauma: Simple trauma refers to a solitary traumatic event and is most likely to cause posttraumatic stress disorder (PTSD) (Virginia Commission on Youth).

Complex trauma: Complex trauma is caused by one's experience of numerous or extended traumatic events that impact the development of a person (National Child Traumatic Stress Network, 2003).

Type I Trauma: Solomon and Heide (1997) suggest that a solitary event, like rape or observing a murder causes Type I trauma.

Type II trauma: Type II trauma is an outcome of repetitive exposure to severe external traumatic events (Solomon and Heide, 1997).

Type III Trauma: Type III trauma happens when a person experiences numerous, invasive, violent events, starting at a young age and enduring for an extensive period of time (Solomon and Heide, 1997). The diagnostic criteria consists of key developmental deficits, a disjointed sense of person, a central idea that one is incurably damaged and lacks the right to be alive, a sense of despair and disgrace, no perception of the future, a lack of trust that hinders relationships, emotional numbing, shifts in consciousness and memory and dissociation.

Posttraumatic Stress Disorder: According to the American Psychiatric Association (2000), when a person is directly exposed to a severe traumatic event that entails actual or threatened death or serious injury, or danger to one's physical integrity; or observing an incident that entails injury, death or danger to the physical integrity of another person; or learning about an unanticipated or violent death, severe injury, or threat of death or harm experienced by a family member or other close associate they are susceptible of developing Post Traumatic Stress Disorder (PTSD). The American Psychiatric Association (2000) states several symptom criteria for an individual experiencing PTSD. First, one must respond to the stressor with extreme helplessness, fear or horror. Second, the distinguishing symptoms resulting from the exposure to the severe stressor include; continual re-experiencing of the traumatic event, continual avoidance of stimuli related with the trauma and numbing of universal sensitivity and continual symptoms of increased arousal. These disturbances must cause clinically significant distress or impairment in occupational, social or other important areas of functioning.

Eye Movement Desensitization and Reprocessing: Shapiro (2001) formulated the eye movement desensitization and reprocessing (EMDR) modality, as a way to specifically treat traumatic memories, using eye movements, alternating tones, and taps while recalling traumatic memories. This approach combines psychodynamic, behavioral (including operant and classical conditioning) and cognitive behavioral approaches (including stress management techniques, cognitive interventions, coping skills and exposure). The image recalled, negative and positive cognitions, emotions and their level of disturbance and physical sensations caused by the re-experiencing of the traumatic memory are the fundamental components of EMDR. This process entails following eight sequential segments; client history and treatment planning, preparation, assessment, desensitization and reprocessing, instillation of positive cognition, body scan, closure and reassessment.

Art therapy: According to the American Art Therapy Association (2012), art therapy is a treatment modality that utilizes the creative process of art making to progress and develop the emotional, mental and physical health of clients. Art therapy incorporates the fields of human development, visual art (drawing, painting, sculpture, etc...), and the creative process with theories of psychotherapy. Art therapy is practiced with children, adolescents, adults, older adults, groups, and families.

Bilateral stimulation: Bilateral stimulation in the therapeutic context refers to the stimulation of the left and right brain hemispheres in order to attain equilibrium and integration. For example, McNamee's (2003) bi lateral art combines art and bilateral stimulation by activating both hands in an art directive. In the context of EMDR, bilateral stimulation refers to the stimulation of the left and right brain hemispheres during eye movements, alternating touch, or alternating tones (Shapiro, 2001).

Design of Study

This study included an in-depth interview of a licensed MFT and registered art therapist who also has EMDR certification and combines art therapy and EMDR to treat clients with PTSD. The semi-structured interview (see interview guide in the appendix) inquired about her experiences integrating art therapy and EMDR. Later, information gathered from the interview was transcribed, categorized, and analyzed, resulting in three overarching reoccurring themes; these are discussed in the Data Presentation and the Findings sections. Lastly, the findings were discussed within the context of the literature review and created considerations for future clinical applications and research.

Sampling.

My intended sample was to include three licensed Art Therapists that additionally had their EMDR certification. The research criteria required that they treat clients with PTSD, using Art Therapy and EMDR treatment modalities combined, of any gender, age, or therapeutic style, as long as they meet the criteria above. I intended to choose the first three therapists that could meet with me within the time frame of this research, from a pool of three to five therapists meeting these criteria. I attempted to contact five participants via phone or email, based on recommendations from my research sponsor. However, when I explained the purpose of my research; the nature of the interview and what I plan do with my results, only one therapist, out of the five contacted, was willing and able to participate. Once the participant indicated her interested, we met and first went over the full informed consent, in which the therapist was formally asked if she was still interested in being interviewed about her therapeutic process integrating Art Therapy and EMDR to treat clients with PTSD and participate in this research as it was designed.

Gathering of data.

Out of five eligible participants, only one agreed to participate in this study within the time constraints I had and after I explained the purpose of my research, the nature of the interview and what I planned to do with my results. One of the participants agreed to be interviewed about their therapeutic process. I sent a follow up email to this therapist, including the informed consent and arranged to meet individually at her office. During this meeting I conducted a 1hr to 1.5hr long interview inquiring about her experiences integrating Art Therapy and EMDR to treat clients with PTSD. I reminded the participant before, during and after the interview that she only had to share information she felt comfortable with and at any point until the research was complete she could ask to exclude any information. The interview was audio recorded and the tape was stored in secure and private place until it was transcribed. My participant was only required to meet with me once. Once the interview was complete I transcribed the information and stored it in a secure and private electronic file. After the transcription process was complete the tape was destroyed. The transcription was stored until a year after the research was complete.

I allowed the participant to choose how they wish to be identified as there may be a benefit by having their professional identity and expertise affiliated with an innovative field level study. My participant had the ability to review the transcribed interview and make sure the information was correct. Her individual clients were not identifiable in the interviewing process or results section. If the participant chose to speak about her clients in the interviewing process, she could use a fake name.

Analysis of Data.

I qualitatively analyzed the transcribed interview looking for reoccurring themes which would answer the research question. First, I organized the data into categories. There were eight

pre-determine categories included, which were based on interview questions; as well as one emergent category reflecting topics presented in the interview narrative that seemed pertinent to understanding how integrating art therapy and EMDR took place. These categories were then contrasted and three overarching themes were developed, that responded to and illustrated my research question. The three themes included; incorporating the body and mind, combining techniques of Art Therapy and EMDR and populations treated with this integrative modality. I then integrated these themes with the literature review; contextualizing these findings with the body of knowledge regarding the topic. I finally, discussed the meaning of my findings and potential application for clinical work and future research (see Discussion section).

In the context of qualitative research methodology, this process began with emerging questions and collected data based on the participant's experience. The following Results Section analyzed this data, constructing from common themes and lastly made understandings of the meaning of that data. My analysis used inductive methods that shifted from the specifics of Dausch's experience to broader understandings, plausibly revealed by the information gathered. I allowed for change to accommodate new understanding from the data collected.

Results

Presentation of Data

My intended method of collecting data was to include a sample of three licensed Art Therapists that additionally had their EMDR certification. It was required that they treat clients with PTSD, using Art Therapy and EMDR treatment modalities combined. The initial contact with my participants, based on recommendations from my research sponsor, was made via phone or email. However, when I explained the purpose of my research; the nature of the interview and what I plan do with my results, only Dausch was willing and able to participate. I sent a follow

up email to Dausch, including the informed consent and arranged to meet with her, at her office. During this meeting I conducted a 1hr to 1.5hr long interview inquiring about her experiences integrating Art Therapy and EMDR to treat clients with PTSD.

Introduction of interviewee: Theresa Dausch.

Theresa Dausch is a Licensed Marital and Family Therapist and registered Art Therapist. She has received extensive training in EMDR and will have her certification by the end of the year. She graduated from an MFT program, which specializes in Art Therapy, at Loyola Marymount University (LMU). Influenced by the LMU program, she began as a psychodynamic and family clinician. She currently combines EMDR, art therapy and attachment theory with many of her clients. Dausch affirmed that she feels like integrating Art Therapy, EMDR and attachment theory currently matches her therapy style.

As for the four other clinicians that I attempted to interview, a couple of them may have not been able to participate due to the research timeframe, two others specifically named a discomfort with being interviewed as they perceived either EMDR or Art Therapy as a training they have but no longer utilize or integrate very much. This lack of willingness to be interviewed may be a reflection on the small population using this integrative treatment modality, as well as the novelty of the modality and possible discomfort discussing it in a formal research setting.

Interview categories.

The interview with Dausch was audio recorded, transcribed and categorized. Categories included eight pre-determined categories, which were based on interview questions (see appendix), as well as one emergent category, reflecting topics presented in the interview narrative that seemed pertinent to understanding how integrating art therapy and EMDR took place. This data presentation displays the categories in the following order: Art Therapy and

EMDR initial combination process, EMDR training process and circumstances when Art Therapy and EMDR are combined. The next category depicts therapeutic tools and techniques used with traumatized clients and includes two case examples illustrating desensitization and reprocessing techniques and instillation of positive cognitions, from Dausch's experience with specific clients. This section is followed by the benefits and challenges of incorporating EMDR, benefits and challenges of Art Therapy and the benefits of combining the two treatment modalities, including another case example. The final category describes how Dausch's clients experienced this integrative treatment, followed by a case example reflective of a specific client's experience.

How Art Therapy and EMDR were initially combined in Dausch's work.

As a trained Art Therapist, Dausch always relied on the art and the process. She stated, "I had years to use the art in a way that fit with me and my clients. Then I learned about attachment and how vital the knowledge about the attachment process is and about how impairments happen and how to repair them." She was given the opportunity to become trained in EMDR through her employer, the Kinship Center (Orange County, CA). Once her EMDR training began it was a natural progression to combine it with the art. Dausch expressed that "EMDR brought to the table the importance of our bodies; they are vital in the healing process. We store it all in our bodies; before we even understand cognitively what's happening. Sometimes we never really understand cognitively what's happening and we feel it in our bodies." She initially understood that art could be a physical experience but didn't understand how important the body was in the healing process until being trained in EMDR. Dausch reflects; "I didn't understand what I was doing as a therapist until it was condensed into a one

hour session through EMDR.” She affirmed that incorporating EMDR has been remarkable and “feels effective.”

EMDR training process.

Dausch’s EMDR training experiencing started with three weekends of training and after six months continued with another three weekends of training. Therapists can then continue on to get their EMDR certification by gaining twenty hours with a certified consultant. Dausch explained the training process; “you have fifteen minute segments, where you’re processing and you have no control.” Trainees were either open to participating in the EMDR process and it worked on them or they were not open to doing it in a public setting. She processed feelings with a partner, while doing the eye movements, with fifteen other pairs of people in a round room. Dausch recalls a moment where she cried and could literally feel pain hop around her body, until it disappeared and she was relieved. After that experience she felt she could really understand how the body functions and is involved in a process with no cognitions or images, just pain.

Circumstances when Art Therapy and EMDR are combined.

Dausch names the process of combining Art Therapy and EMDR as “instinctual.” She combines the two modalities when it is apparent the client has trauma in their history, such as experiences of neglect, physical abuse and emotional abuse. When working with traumatized clients she reported that “there hasn’t been one singular event” of trauma in their life and normally “it’s very complex trauma” that she works with. She treated children who had been adopted through the foster care system, as well as international adoptions; at the Kinship Center adoption agency. Most of her client’s have impaired attachments. When working with this type of population she stated “it helps to shift their internal working model all together.”

Therapeutic tools and techniques used with traumatized clients.

Case example: desensitization and reprocessing techniques.

Dausch had an adult male client that came in because he struggled with addiction for a long time but had been sober for about four years. He wanted to do EMDR specifically because there was one traumatic event that happened to him as an adolescent and he was re-experiencing auditory, visual and physical memories of the trauma. She used all types of physical stimulation; eye movements, taps and headphones with tones. Dausch went through all aspects of the trauma: “What about any smells? What about any tastes in your mouth? Can you remember eating anything around that time?” She suggests that it’s important to get all the sensory input that might trigger the client back to the trauma. Dausch stated that the more you can use the method of bi-lateral stimulation that matches the sensory input, the more productive the treatment is going to be.

Case example: instillation of a positive cognition.

Dausch worked with a six year old female that had been living in her adoptive home for three years and officially adopted for a year. The client was creating a realistic painting. She would draw it, become frustrated with the outcome, erase it and do it over again. This painting process was externalizing her perfectionism and high expectations. Dausch would use EMDR to change and shift the client’s internal negative cognitions; “I’m stupid, I’m bad, I can’t do this, I’ll never get it right.” Dausch used the EMDR tapping technique to assist with the client’s deep breathing, relaxation and problem solving skills and eventually, in order to complete the painting after several sessions. The client’s mother stepped into the treatment as a positive support, but without doing the art for her. They were then able to talk about when and how the client can ask for help. Dausch inquired, “What does it mean to ask for help? How did the client learn not to

ask for help when she was younger? How and why is it ok to ask for help now?” Throughout this process, Dausch used bi-lateral stimulation to help the client create new information. The client was extremely proud of the finished product. Dausch then integrated the tapping technique and instilled positive cognitions; “I can do this. I can be successful if I don’t give up. I can ask for help when I need it. Look what I can do with Mom. Look what can happen in my relationships when I collaborate.” The client wanted to show her product to Dausch’s office colleagues. As they shared the client’s piece with the colleagues and received positive feedback, her mom would tap her shoulders. This collaboration process with the client and her mother also supported their attachment.

Benefits and challenges of incorporating EMDR.

Dausch believes EMDR is versatile. She tends towards EMDR with adults, because it can help them work through memories, emotions and experiences in a visceral way. When working with children, Dausch believes incorporating EMDR can be challenging “you have to know your client and you have to know the process a lot better.”

Benefits and challenges of Art Therapy.

Dausch deems the art process as more nebulous at times; she attempts to embrace this in the therapeutic process. Dausch stated the art process works well when it can be done at the beginning, end or in-between sessions. She feels that “having the art as a part of the experience helps when working with children” because it slows the process down and helps the clients stay focused on interventions like, creating a safe place. In this process, she asks her clients to imagine a place real or made up in their imagination. “When you get there I want you to tell me what you see, what you hear, what you feel.” Children can get distracted in this procedure easily; the art process assists the client in sitting in that safe place and staying focused on it. Not

only does the art process “slow things down but it actually helps them embellish their vision of their safe place and really get involved in a sensational way with their body, as well as their imagination.”

Benefits of combining these treatment modalities.

The process of EMDR happens in the brain quickly. Images go by, emotions surface and shifts and sensations happen in the body rapidly; this process can be overwhelming to the client. When the client can no longer tolerate this rapid pace it’s a good moment to integrate the art; which slows down the process.

Both EMDR and Art Therapy are body approaches. Dausch asks her clients to feel what’s going on in their body. Using EMDR techniques and the art process also promotes indirect and benign visceral experiencing. Both approaches can be individualized, so they go well together. Dausch believes “you can be very flexible with them and dance with your client in the necessary manner.” However, Dausch expressed that “sometimes the benefits can be the challenges too.”

Challenges of combining these treatment modalities.

Dausch experiences challenges when the therapeutic processing is slowed down too much, from a client’s over-involvement in the art process. The art process then becomes an avoidant defense instead of a processing technique. This is informative though; if Dausch feels a client needs to avoid or slow things down, she’s comfortable with that. Although, she will push her clients to get over humps, if she feels they will leave her office in a more stable and healthy state of mind. It’s a balance, sometimes she guides the clients and other times lets them lead. Balancing speed is Dausch’s biggest challenge.

She has a hard time combining the art process with adults, because she does not want it to stop the fast process of EMDR. Sometimes, with adults the modality speeds just don't match; she then turns to solely EMDR.

Case example illustrating the challenges of combining these treatment modalities.

In one of Dausch's first safe place interventions, she had a five year old client create a safe place, without her caregiver in the session. The client visualized that her safe was in her caregiver's arms, it was unclear if it was her biological mom or adoptive mom. The client's cognitions quickly turned into mom is trying to kill me. This caused Dausch to be resistant to doing a safe place with a child, without their caregiver in the office. She believes it's safer to have the caregiver and client draw together, because it slows down the process.

How do clients experience this integrative treatment?

Dausch states that "I never had more referrals than at this point in my career. All her client's appear satisfied. They're all requesting that I use these modalities to help them, because it's been so effective for their friend, their sister" (the clients who referred them.)

Dausch describes the fluid innovative process; "it's a very individual experience. It's as unique as the art piece that's sitting in front of you." You can try and make the "same piece every minute, every hour and it will turn out different each time because it's a record of who you are and what you are right then and there and EMDR is the same way." With some clients the process is remarkable and speedy and with others it's much slower and complicated. Dausch believes "it's like you're weaving a lot of things into the process, like creating a coping box. I have one client creating this coping box and painting the box and then we move into some processing and then we'll come back to the box. It's a dance and if something comes up and triggers a client I address that."

One of Dausch's clients reported; "I did years worth of therapy tonight." Dausch got to see "a year's worth of therapy condensed as you would do each cycle of EMDR." She could see the grieving process, or the feelings of guilt turn into feelings of anger that turn into feelings of sadness, that turn into feelings of compassion for the abuser. She saw how we as humans move from a place of pain and trauma to compassion. Dausch explained, if you just get out of the way, it's this incredible process to watch, to experience, to witness, in and out.

Dausch stated "I always tell my clients that it's an experiment, let's just see what happens, let's see what your body does. It helps with the mindfulness piece, when you can take away the internal criticism; then if this doesn't work then you're freer to tell me because you don't think that I have some vested interest. You're not trying to please me and then you're not critical for not doing it right for some reason." She then explores with the client, "Is this helpful or unhelpful? We have to be really communicative and talk through it and be partners."

Dausch always has the child client's parent(s) in session. The parent is actively involved and psycho-educated about the EMDR process. Dausch tries to schedule sessions so both adoptive parents can attend, but it's typically just the mother.

Case example illustrating how clients experience this integrative treatment?

Dausch has one adult that makes art outside of therapy, to process between sessions. The client brings in the art "it's a way to maintain connection, it's a way to express, and it's a way to inform me of what she's been going through. It's a way to contain, when she's there in that moment, without me; because she's alone and isolated." Dausch believes this type of art processing has been helpful for this client. This client suffers from complex trauma, but Dausch found that she was "progressing in incredible ways; it's like magic." Seven months after treatment started the client is independent in ways that she's never been before, and continually

gets stronger. “She’s pretty remarkable, she’s one of the most courageous people I’ve ever worked with,” noted Dausch.

The above categories discussed in this Data Presentation include the following eight categories representing questions asked in the interview guide; Art Therapy and EMDR initial combination process, circumstances when Art Therapy and EMDR are combined, therapeutic tools and techniques used with traumatized clients, benefits and challenges of incorporating EMDR, benefits and challenges of Art Therapy, benefits of combining these treatment modalities, challenges of combining these treatment modalities and how clients experience this integrative treatment. From the data collected in the interview one emergent theme was created illustrating Dausch’s EMDR training process. The following Analysis section will organize these nine categories into three overarching themes that reflect Dausch’s most significant experiences using this integrative treatment.

Analysis of Data: Creating Overarching Themes

From interviewing Dausch, I hoped to collect data representing the clinical experience of integrating Art Therapy and EMDR interventions, to treat clients with trauma. In the previous Data Presentation, I organized the material collected from the interview into nine categories. In this analysis section I integrate these categories into three overarching themes. Each theme pulls aspects from many of the categories to support its significance. The first theme, incorporating the body and mind, emphasizes the importance of Art Therapy and EMDR’s combined ability to treat trauma emotionally, cognitively and physiologically. The second theme, combining the techniques of Art Therapy and EMDR, uses a table to organize Dausch’s interventions and techniques into six stages of treatment. This theme also discusses the benefits and challenges of

using these two treatment modalities. The last theme, populations treated with this integrative modality, includes sections illustrating treatment with children, trauma and adults.

Incorporating the body and mind.

Throughout the interview, Dausch stressed the important connection that EMDR and Art Therapy create between the client's mind and body. Both EMDR and Art Therapy are body approaches. Through EMDR, Dausch promotes mindfulness and encourages her clients to experience their own body. The art process similarly supports visceral experiencing, incorporating the body and imagination in an indirect, gentle and enjoyable manner. While Dausch has always understood this physical aspect of art making, she did not fully understand the vital role the client's body played in their healing process, until she began her EMDR certification.

She now understands that trauma is stored in the client's body; and its physical ramifications can be felt before its effects on the client's cognitions are clear. In Dausch's EMDR training she sat in the role of the client and practiced processing; using eye movements with a partner. She experienced firsthand the body's ability to store psychological pain, and recalls a moment where she was crying and could feel physical pain hop around her body. This moment seemed to have transformed her understanding of how the body can re-experience psychological pain, without images or cognitions.

With her clients, Dausch uses bi-lateral stimulation to process trauma that has been physically stored in their bodies and is connected to negative cognitive beliefs. She used EMDR techniques to change these negative cognitions and create new information. Dausch integrated the EMDR tapping technique to help clients cope with negative cognitions and instill positive ones.

She also noted that the more the method of bi-lateral stimulation that matches the sensory input is used, the more effective the treatment will be. For example, Dausch worked with a client who had experienced a single incident of trauma and was re-experiencing visual, physical and auditory memories. With this client, Dausch used eye movements, taps and tones as stimulation to process all aspects of the trauma. She stated the importance of processing all the sensory input that might trigger the client back to the trauma.

Combining techniques of Art Therapy and EMDR.

In the interview process, Dausch presented six stages of treatment that are organized within interventions similar to the eight stages of EMDR (see Figure A). These six stages combine elements of EMDR and art therapy to address the symptoms and challenges presented by clients suffering from trauma. The six steps in the chart below; client history, building coping skills and internal resources, preparation for bi-lateral stimulation, bi-lateral stimulation and grounding techniques, instillation of positive cognitions and externalization techniques and containment, are outlined with Dausch's techniques and interventions.

Figure B: Stages of Treatment in Dausch's Integrative Protocol

<u>Dausch's Phases of Treatment</u>	<u>Integrating Art Therapy and EMDR</u>
<u>Client History</u>	Incorporates art to take a client's history, by having them draw a timeline of their life.
<u>Building Coping Skills and Internal Resources</u>	<ul style="list-style-type: none"> - Initially uses EMDR's resource building technique to help client's build coping skills and internal resources. - Then has the client artistically create a two or three dimension safe place.
<u>Preparation for Bi-Lateral Stimulation</u>	<ul style="list-style-type: none"> - Before each session starts, clients play with the stimulation buzzies and communicate about their needs and readiness for processing trauma; which requires a quicker bi-lateral pace. - When working with children, she teaches their parents to create stimulation from standing behind them and tapping their shoulders throughout the processing. - When the therapeutic work is centered around attachment, Dausch will often physically tap the child (after creating a strong rapport.)
<u>Bi-Lateral Stimulation and</u>	- Dausch uses headphones with alternating tones, buzzies and physical tapping , based on clients' needs.

<u>Grounding Techniques</u>	Dissociation: - Some children use the art process to dissociate and some use it to come back into their bodies. - When a child starts dissociating, it's grounding to have a parental figure sit in front of them, work with the buzzies and alternate squeezing their hands or have the client sit in their lap and rock them side to side. If the physical tapping is too activating for a child, Dausch will solely rely on the buzzies.
<u>Instillation of Positive Cognitions and Externalization Techniques</u>	- Clients make a "life book;" by artistically organizing their life and creating a strength-based narrative. Throughout this process, she uses EMDR to shift negative beliefs and cognitions that come from abusive situations they previously experienced. - Clients can also externalize difficult feelings (anger, perfectionism) by artistically creating a feeling character and its environment. Throughout this externalization process, she uses buzzies or tapping to assist in processing, as a coping mechanism and to create new information.
<u>Containment</u>	She uses art for containment at the end of the session.

Benefits and challenges of combining these treatment modalities.

When the client can no longer tolerate the rapid reprocessing pace of EMDR it's a good moment to integrate the art; which slows down the process and makes it less overwhelming. Consequently, Dausch experiences challenges when a client's over-involvement in the art, slows down the therapeutic process too drastically. Making it difficult to overcome challenges and move through the six steps presented in the chart above. The art process can then become an avoidant defense instead of a processing technique. Finding an effective reprocessing speed is a challenging balance for Dausch, sometimes she feels she guides the clients and other times lets them lead.

Populations Treated with this Integrative Modality.

Children.

With children, physical bi-lateral stimulation like art or play (sand tray) is used more than with adults. Dausch incorporates physical stimulation by simultaneously having the child's parent behind them tapping their shoulders or holding their child and rocking side to side or if physical tapping is too activating for the client Dausch places the buzzies in the child's pockets.

When the therapeutic work is centered on attachment, Dausch will sometimes be the one physically tapping the child. Dausch promotes a strength-based narrative and healthy attachment with her adopted clients by having them and their adoptive parent create a life book together. Throughout this process, Dausch incorporates EMDR techniques to shift negative cognitions that stem from the client's previous abusive experiences. Dausch understands that the EMDR process can be challenging and risky with children "you have to know your client and you have to know the process a lot better." It's important to make sure clients have the internal resources for this treatment modality, because children's neural network is not very convoluted and processing happens quickly.

Dausch believes that incorporating the art process helps when working with children, as it slows down the fast process of EMDR which might otherwise be too overwhelming and helps the clients stay focused on interventions, such as creating a safe place. While identifying and creating a safe place children can get distracted easily; the art process helps them sit in that safe place and allows them to embellish and experience it in a sensational way with their body and imagination.

Trauma.

Dausch integrates EMDR and Art Therapy when a client has a history of trauma; neglect, physical abuse, sexual abuse and/or emotional abuse. She reported working with only a couple clients that presented with a single traumatic incident; it is usually complex trauma. She matches the type of physical stimulation with the type of triggers the client is re-experiencing. For auditory triggers, she uses the tones, for physical triggers she uses the buzzies or tapping and for visual triggers she uses eye movements. When a client has experienced and is prone to

dissociation, Dausch incorporates physical bi-lateral stimulation, or the art process as a grounding technique.

Adults.

It is a challenge for Dausch to combine the art process with adults, because she's hesitant to slow the fast process of EMDR, which she feels is beneficial with them. She reported one case in which she had a client make art outside of therapy, to process in between sessions. The client would bring the artwork into session. Dausch added, "it's a way to maintain connection, it's a way to express, it's a way to inform me of what she's been going through, she's pretty alone and isolated." When the speeds of EMDR and Art Therapy don't match up, Dausch solely treats her adult clients using EMDR. EMDR techniques assist these clients through memories, emotions and experiences in a visceral manner.

The nine categories in the Data Presentation were organized into and illustrated in the three themes above. These themes represent Dausch's most significant experiences and beliefs stated in the interview. In the following Discussion of Findings and Meanings, these themes will be contextualized within the body of knowledge in the previous literature review. The connections between Dausch's experiences and the previous research will allow for future clinical and research applications to be made.

Discussion of Findings and Meanings

This study allowed me to investigate the clinical experience of integrating Art Therapy and EMDR, to treat clients with PTSD. The data collected from Dausch's interview proposed three significant and overarching themes; incorporating the body and mind, combining techniques of Art Therapy and EMDR and the populations treated with this integrative modality.

This section will discuss, contextualize and suggest future applications; by introducing these three themes into the body of previous research explored in the literature review.

Understanding EMDR and Art Therapy's connection to the body and mind.

Dausch stated that EMDR and Art Therapy are both approaches that have somatic processing at their core. Through EMDR, Dausch promotes mindfulness and encourages her clients to experience what's going on in their body; the art process also supports visceral experiencing, incorporating the body and imagination in an indirect, gentle and enjoyable manner. Art integrates motor activities, with visual, emotional, intuitive, sensory and automatic skills. The procedures implicated in creativity are all responsibilities of the right hemisphere (Bogousslavsky, 2005). The art process therefore stimulates the amygdala in the limbic system, which connects the social emotional input with the prefrontal cortex for integrating and planning. This in turn, stimulates physiological, emotional and cognitive processes (Klorer, 2005).

This study further supports the body of literature suggesting the multiple benefits of art making. For example, Hass-Cohen's (2008) research demonstrates how clients can practice combining emotion, thoughts, feelings, bodily sensations and images into one art product. With the art therapist, the client can enhance interpersonal capacity through re-examining, discussing and tilting the art; presenting enhanced opportunities for narrative coherency and mental flexibility. Dausch described a similar process, with a client that kept re-visiting a painting. This painting process combined with bi-lateral stimulation techniques allowed the client to externalize difficult emotions, shift internal negative cognitions and create new information. Dausch used bi-lateral stimulation as a mechanism to help the client cope with her frustration; allowing her to calm down, problem solve and eventually complete the painting after several sessions.

Trauma's affect on the body and mind.

Dausch also focused on the importance of trauma stored in a client's mind and body and how they affect one another. With her clients, Dausch uses bi-lateral stimulation to process trauma that has been physically stored in their bodies and is connected to negative cognitive beliefs. She used EMDR techniques to change these negative cognitions and create new information. Dausch integrated the EMDR tapping technique to help client's cope with negative cognitions and instill positive ones.

Talwar (2007) uses processes in the limbic system to provide a greater understanding of memories and emotions connected to trauma. The limbic system guides the emotions and responses essential for self-preservation and survival. Within the limbic system are the hippocampus and amygdala, which are central to the storage and recovery of memory. The amygdala evaluates the emotional significance connected to extreme emotional memories like terror and remains active during the re-experiencing and remembering of the traumatic event. The hippocampus cognitively maps experiences into a sequential time line in one's memory. Traumatic memories are more often recorded in implicit memory. This causes the highly stimulated and incomplete memory to be locked in the body as a biological response to threats. Dausch agreed that trauma stored in the body can cause physical affects to be felt before affects on the client's cognitions are clear. When the traumatic event is not able to reside in its proper place in one's timeline, it continues to attack the present cognitive state, upsetting the incorporation of the experience and memory. The anterior cingulate cortex's failure to aid in reducing the limbic reactions while re-experiencing the trauma has been connected with continual emotional, somatic and visual processing of the trauma.

According to Van der Kolk (2000) these traumatic memories are mainly imprinted in emotional and sensory forms; although a semantic image of the trauma may coexist with sensory flashbacks. When triggered by stimuli, the trauma can be vividly re-experienced with instantaneous sensory and emotional force. These flashbacks are experienced as cut off motoric, emotional and sensory imprints of the trauma, lacking a clear storyline. When these fragmented memories are re-experienced they cause excessive emotional arousal, leading to an inability of the central nervous system to fuse the trauma sensations into an integrated whole. Dausch depicts treating different types of re-experienced traumatic memories and the stimuli that trigger them. In her work with a rape victim that was re-experiencing physical and auditory memories; she simultaneously used tones and buzzies to process these memories. Additionally she worked with a client who was re-experiencing visual, physical and auditory memories. With this client, Dausch used eye movements, taps and tones as stimulation to process all aspects of the trauma. She stated the importance of processing all sensory input that might trigger the client to re-experience the trauma. Adding, the more the method of bi-lateral stimulation that matches the sensory input is used, the more effective the treatment will be.

Understanding EMDR and Art Therapy interventions.

According to Rankin and Taucher (2003), various art therapists who treat survivors of trauma present minimal guidelines, so their clients may create their own art processes and themes. On the other hand, they found additional art therapists provide more structured formats to increase the possibility for cognitive, affective and behavioral adaptation to trauma. With the incorporation of EMDR into her treatment, Dausch began to provide a more structured format and her therapeutic process became more effective. Using this integrative method also allowed Dausch to utilize the quick processing of EMDR to speed up treatment when necessary.

Dausch's ability to provide structure and acceleration, through this integrative treatment, could address Brown's (2010) concern that trauma symptoms are presently being treated with art therapy protocols that are too severe or long-lasting. Brown believes, these lengthy treatment protocols and increasing reduction of insurance coverage and managed care subject the trauma victim to high costs of treatment. Brown (2010) suggests her research "oriented towards the development of a successful art-based, interdisciplinary trauma protocol" could be executed as a brief-therapy model (p.xi).

The following chart compares Dausch's six stage integrative modality to two short-term specific protocols, Tripp (2007) and Brown (2010). Tripp's (2007) research promotes a trauma related short-term narrative art therapy approach. This approach uses an adapted EMDR protocol with "alternating tactile and auditory bilateral stimulation," through which somatic and sensory-based "associations are rapidly brought to conscious awareness and expressed in a series" of consecutive drawings. By simultaneously focusing on the art making and somatic sensations in the present, a safe therapeutic environment is established and the client can experience relaxation while rapidly accessing levels of unresolved material from the past. "As new information is accessed, affective material is metabolized and integrated, leading to the transformation of traumatic memory and an adaptive resolution of the trauma" (p.176). Brown (2010) also purposed an effective short-term interdisciplinary protocol. Brown's (2010) PTSD treatment protocol combines grounding techniques, elements of EMDR, bilateral stimulation and art therapy interventions. The protocol was administered over six sessions; which contained "trauma processing, reframing maladaptive cognitions and behaviors, discussions of participant strengths, personal relationships, and the importance of self-care." (Brown, 2010, p. 96).

The chart also compares Talwar (2007) and Lahad's et al. (2010) integrative protocols. Talwar's (2007) ATTP art therapy protocol concentrates on "the non-verbal, somatic memory of traumatized clients using right and left brain methods based in a positive adaptive functioning model" (p. 26). The ATTP protocol integrates the physiological, cognitive and emotional levels of trauma using elements of McNamee's (2003) bilateral art, Michelle Cassou's method of painting and Shapiro's (2001) EMDR. Also presented in the chart, Lahad et al. (2010), establishes a new protocol for treating PTSD; integrating methodologies that have been found to be clinically effective. Like Talwar (2007) and Tripp (2007), Lahad et al. (2010) combined aspects of the somatic experience, as well as fantastic reality and CBT to establish SEE FAR CBT. This protocol stresses the task of fantastic reality and the use of imaginal re-narration of the traumatic event with the use of artistic cards to externalize the trauma and allow the client a sense of control over the event. These metaphoric cards symbolize a "safe place and the re-narrating process of the traumatic story" (p. 394). Lahad et al. (2010) incorporates EMDR using the releasing mechanism of the traumatic memory by moving to and from resourced areas in the body, or between therapeutic cards. This research of SEE FAR CBT is an effort to assess the efficacy of an arts form of PTSD treatment protocol evaluated against an EBT such as EMDR.

Dausch's integrative modality is compared with these four integrative trauma treatments and contextualized within the structure of Shapiro's (2001) eight stages of EMDR, in the following chart.

Figure C: Stages of Treatment in Integrative PTSD Protocols

<u>Stages of Treatment</u>	Shaprio (2001) EMDR	Tripp (2007) Short Term Art Therapy and Bilateral Stimulation	Talwar (2007) ATTP	Brown (2010) Short-Term Art Therapy Trauma Protocol	Lahad et al. (2010) SEE FAR CBT	Dausch Integrative EMDR and Art Therapy Treatment
<u>Stage 1</u>	<u>Client history and treatment planning:</u> Targets a disturbing memory.		Detailed evaluation of the client's history	Inventory of experiences	A detailed intake interview/assessment and PTSD diagnosis	<u>Client History:</u> Client draws a timeline of their life.
<u>Stage 2</u>	<u>Preparation</u>	Bring somatic and sensory-based images to conscious awareness.	The client explores ways of problem-solving specific to him or her; leading to an understanding of their affective responses and accessing images of safety.	Development of a safe place	Psycho-education about PTSD, common responses, approaches to therapy, SE, in vivo exposure, re-narration in the FR and cognitive processing.	<u>Building Coping Skills and Internal Resources:</u> Client builds coping skills and internal resources. The client artistically creates a safe place.
<u>Stage 3</u>	<u>Assessment</u>			Instillation of grounding techniques.	A mutual decision that therapy is necessary.	<u>Preparation for Bi-Lateral Stimulation:</u> Before each session starts, the client plays with the stimulation buzzies and communicates /assesses containment, relaxation or readiness for processing. The client and their parent are psycho-educated on the treatment process and bi-laterally stimulation
<u>Stage 4</u>	<u>Desensitization</u>	Create	The creative	Debriefing to	Clarifying the	<u>Bi-Lateral</u>

	<p><u>and reprocessing:</u> Decreases the validity of the surrounding negative images, beliefs and emotions; allowing the client to become desensitized to triggers.</p>	<p>multiple, consecutive images in conjunction with ongoing bilateral tactile and auditory stimulation.</p>	<p>painting process encourages bilateral stimulation, concentrating on the non-verbal, somatic memory of traumatized clients.</p>	<p>the traumatic experience.</p>	<p>objectives of the therapy.</p>	<p><u>Stimulation and Grounding Techniques:</u> Matches the bilateral stimulation with the type of sensory input. Dissociation: If a child starts dissociating, have a parental figure sit in front of them, work with the buzzies and alternate squeezing their hands or have the child sit in their lap rocking them from side to side.</p>
<p><u>Stage 5</u></p>	<p><u>Instillation of positive cognition:</u> Images, beliefs and emotions are rationalized and the client discovers what is essential and helpful from the trauma and the memory is re-established in an adaptive, vigorous, non-distressing form.</p>	<p>Distressing memories are transformed with new associations to adaptive and positive information.</p>	<p>The client develops an understanding of the underlying negative feelings and self-perceptions, and the affective responses evoked by these emotions. Promote cognitive functioning while lowering the client's distress.</p>	<p>Application of positive and negative cognitions to the traumatic experience.</p>	<p>Relaxation, creating a safe place and anchoring the sensations in the body.</p>	<p><u>Instillation of Positive Cognitions and Externalization Techniques:</u> Adopted clients make a life book creation; Throughout this process, she uses EMDR to shift negative cognitions Also, assists a child with externalizing a feeling by creating a feeling character and its environment, while using bilateral stimulation.</p>
<p><u>Stage 6</u></p>	<p><u>Body scan</u></p>	<p>Client focuses on body during the creative process</p>	<p>Painting process activates the body and mind</p>	<p>Rating cognitions</p>	<p>Examining avoidances and building an in vivo exposure hierarchy, practicing in vivo exposure,</p>	<p><u>Containment:</u> She uses art of the end of the session for containment.</p>

					desensitization , practicing exposure in the FR	
<u>Stage 7</u>	<u>Closure</u>			Bilateral stimulation	Re-narration in the fantastic reality using cards; practicing in vivo exposure	
<u>Stage 8</u>	<u>Reassessment</u>			Assigning a distinct ending to the traumatic event.	Processing “hot spots” (i.e. high levels in the subjective units of distress) that surfaced in the re-narration in the FR using cards; practicing in vivo exposure	
<u>Stage 9</u>					Summary and evaluation of results	

The chart above promotes multiple similarities between Dausch’s treatment and the four other integrative trauma protocols. Talwar (2007), Brown (2010), Lahad et al. (2010) and Dausch all initially assess the client’s history. Brown (2010), Lahad (2010) and Dausch’s treatments promote instillation of grounding techniques as well as the development of a safe place. All the treatments incorporate some type of bi-lateral stimulation, in order to assist the desensitization and reprocessing of the client’s trauma narrative. Finally, Tripp (2007), Talwar (2007), Brown (2010) and Dausch explore the client’s cognitions linked to their trauma and endorse instillation of positive cognitions. These overlaps between treatments highlight interventions and stages of treatment that have shown consistent effectiveness when treating trauma.

Populations treated with this integrative modality.

Children.

The published literature seemed to predominantly focus on trauma treatment with adults, and much research speaks to the evidence of EMDR treatment is conducted with simple versus complex or chronic traumas. However, interestingly, Dausch's experience is quite different – she finds the integrative approach of art therapy and EMDR particularly useful for children, and those with complex trauma. Dausch's application of her integrative modality with children is supported by various researchers such as Mallay and Neily (2002) and Lyshak-Stelzer, Singer, Patricia, Claude (2007), who find art psychotherapy a fitting treatment for children and adolescents with PTSD. With children, Dausch relies heavily on the art process and mostly incorporates physical bi-lateral stimulation like art or play (sand tray). She believes that incorporating the art process helps when working with children, because it slows down the fast process of EMDR and helps the clients stay focused on interventions, such as creating a safe place. While identifying and creating a safe place children can get distracted easily; the art process helps them sit in that safe place and allows them to embellish and experience it in a sensational way with their body and imagination. Although, Dausch also incorporates EMDR physical stimulation techniques, such as tapping or the buzzies; she understands that the EMDR process can be challenging and risky with children “you have to know your client and you have to know the process a lot better.” It's important to make sure clients have the internal resources for this treatment modality, because children's neural network is not very convoluted and processing happens quickly.

Adults.

When working with adults Dausch embraced the quick processing speed of EMDR. Shapiro's (2001) research supports her tactics stating the efficacy of EMDR is established in its capacity to produce fast change and encourage continual reassessment of therapeutic

interventions. When the fast speed of EMDR and slower speed of Art Therapy do not match up, Dausch solely treats her adult clients using EMDR. EMDR techniques assist these clients through memories, emotions and experiences in a visceral manner. Although challenging for Dausch, Brown (2010), Lahad et al. (2010), Talwar (2007) and Tripp (2007) focused their integrative Art Therapy and EMDR trauma treatment with adults. A solution executed by Dausch was to have a client create art in between sessions and process it in session; “it’s a way to maintain connection, it’s a way to express, it’s a way to inform me of what the clients been going through, it’s a way to contain, when they are there in that moment.”

Trauma.

Dausch integrates EMDR and Art Therapy when a client has a history of trauma; neglect, physical abuse, sexual abuse and emotional abuse. She reported working with only a couple clients that presented with simple trauma; defined by the (Virginia Commission on Youth) as a solitary traumatic event and is most likely to cause PTSD. The survivors of these traumas struggle to understand why the trauma happened and can experience perceptual disturbances like time distortions or visual hallucinations. According to Solomon and Heide (1997), EMDR frequently can be used to promptly and effectively resolve type I trauma. Specifically, Jayatunge (2008) used EMDR to treat three children and 2 adults suffering PTSD symptoms following the 2004 tsunami in Sri Lanka. Brown (2010) treated a slightly larger population, using her integrative method with three Caucasian female participants at a university counseling center; two whom experienced sexual assaults and one who experienced a physical and sexual assault.

Dausch’s adopted clients, who had experienced the foster care system and most likely some type of reoccurring abuse in their home, usually presented with complex trauma. Complex trauma is caused by one’s experience of numerous or extended traumatic events that impact the

development of a person (National Child Traumatic Stress Network, 2003). This type of trauma normally transpires in settings where the victim cannot escape and is controlled by the perpetrator. Victims of domestic violence are at high risk for developing complex trauma. Exposure to complex trauma can result in emotional deregulation, loss of safety, direction and the capability to identify or react to threats. Victims of complex trauma are likely to expose themselves to trauma repeatedly throughout their lives; increasing the necessity for them to receive effective treatment (National Child Traumatic Stress Network, 2003). Talwar (2007) studied the case of a mental health worker who experienced early reoccurring childhood trauma. Like Dausch's treatment modality, Tripp's (2010) protocol offered an adaptive resolution for simple and complex trauma.

Potential meanings for future trauma treatment

Talwar (2007) shed light on the impact the progression in psychotherapy and neurobiology have had on the advancement of art therapy. The use of art therapy has increased when solely using verbal psychotherapy falls short of helping clients. The connection between art therapy and neurobiology has sparked an increasing interest for therapists and researchers in the field of art therapy. The integrative trauma treatments presented above including; Tripp's (2007) Short Term Art Therapy and Bilateral Stimulation, Talwar's (2007) ATTP, Brown's (2010) Short-Term Art Therapy Trauma Protocol, Lahad's et al. (2010) SEE FAR CBT and Dausch's EMDR and Art Therapy integrative modality, all combined elements of art therapy and EMDR to ideally provide stronger more effective treatment protocols than art therapy and EMDR alone. Although, without further supporting research these treatments will remain as non EBPs; decreasing their ability to be widely used and benefit clients in the mental health community.

Within these integrative modalities, Brown (2010), Tripp (2007) and Talwar (2007) and Dausch conducted their art-based research under their ATR license; which allows them to be informed and effective in the art process, although some may say this limits these treatments to solely be administered by Art Therapists. Tripp (2007) argues that her integrative protocol has the ability to stimulate strong sensory responses and associations in the client and must not be administered unless the therapist has training and experience in trauma related disorders, art therapy and EMDR. On the other hand, Lahad's et al., (2012) method was administered by clinical social workers, clinical psychologists and creative arts therapists, making treatment more accessible to victims of trauma.

These protocols inspire a promising future for the field of trauma and PTSD treatment. Due to the limited number of therapist's willing or able to participate in this study, I hope to make this study more valid in the future by increasing the participant sample size. It is possible that as this integrative modality becomes more widely used when treating trauma, that therapists will be more confident and comfortable discussing their experiences in an interview format. Never the less, this study's positive integrative aspects have motivated me to seek EMDR training later in my career and combine it with my Art Therapy background. Treating client's with trauma in a similar fashion as Dausch's protocol and one day possibly adding my own experiences to the discussion of integrative trauma treatment.

Conclusion

This research explored the integration of Art Therapy and EMDR to treat PTSD, through an in-depth interview of a licensed MFT and registered art therapist, who also has EMDR certification and combines art therapy and EMDR to treat clients with PTSD. This study aimed

to integrate EMDR and Art Therapy; through an exploration of the relevant techniques, interventions, benefits and challenges, when working with clients suffering from PTSD.

The initial literature review presented a body of knowledge related to trauma and its neurological impact, as well as the subsequent causes, symptoms and criteria for PTSD. It additionally attempted to shed light on neurobiology's connection to art therapy and EMDR. In order to support the efficacy of the addition of art therapy interventions, previous studies and research using art therapy interventions to treat trauma were reviewed. A discussion of the use of EMDR as an EBP to treat trauma and PTSD was provided. Finally, a review of various innovative trauma protocols integrating art therapy and EMDR were presented. These included Tripp's (2007) Short Term Art Therapy and Bilateral Stimulation, Talwar's (2007) ATTP, Brown's (2010) Short-Term Art Therapy Trauma Protocol and Lahad's et al. (2010) SEE FAR CBT, which all combined elements of art therapy and EMDR to ideally provide stronger more effective treatment protocols than art therapy and EMDR alone.

To collect my own data I used a qualitative research method; investigating and exploring the meaning Dausch ascribed to treating clients with PTSD. I began this research process with emerging questions and then used a semi-structured interview, exploring Dausch's experiences and perceived effectiveness of this treatment, as well as the purpose, techniques, benefits and challenges of integrating these two treatment modalities. I then analyzed the data constructing from three common themes including; incorporating the body and mind, combining techniques of Art Therapy and EMDR and populations treated with this integrative modality.

Lastly, I made understandings of the meaning of the data and discussed them within the context of the literature review and created considerations for future clinical applications and research in the young field of integrative trauma treatment. The integrative protocols and in-

field exploration presented inspire a promising future for the field of trauma and PTSD treatment. Although, without further supporting research these treatments will remain as non EBPs; decreasing their ability to be widely used and benefit clients in the mental health community.

References

- Albright, D. L., & Thyer, B. (2010). Does EMDR reduce post-traumatic stress disorder symptomatology in combat veterans?. *Behavioral Interventions*, 25(1), 1-19.
- American Art Therapy Association. (2012). *Defining art therapy*. Retrieved from <http://www.americanarttherapyassociation.org/aata-history-background.html>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2004). *Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder*. Arlington, VA: American Psychiatric Association Practice Guidelines.
- Bergmann, U. (2008). The neurobiology of EMDR: Exploring the thalamus and neural integration. *Journal of EMDR Practice and Research*, 2(4), 300-314. doi:10.1891/1933-3196.2.4.300
- Bogousslavsky, J. (2005). Artistic creativity, style and brain disorder. *European Neurology*, 54, 103–111.
- Brown, L. E. (2010). *Developing a Short-Term Art Therapy Protocol for a University Counseling Center to Address Trauma* (Electronic Theses, Treatises and Dissertations, Florida State University). Retrieved from <http://diginole.lib.fsu.edu/cgi/viewcontent.cgi?article=3297&context=etd>

- Buk, A. (2009). The mirror neuron system and embodied simulation: Clinical implications for art therapists working with trauma survivors. *The Arts in Psychotherapy, 36*(2), 61-74.
doi:10.1016/j.aip.2009.01.008
- Collie, K., Backos, A., Malchiodi, C., & Spiegel, D. (2006). Art Therapy for Combat-Related PTSD: Recommendations for Research and Practice. *Art Therapy, 23*(4), 157-164.
doi:10.1080/07421656.2006.10129335
- Creswell, J.A. (2009). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. California, United States: SAGE Publications.
- Fox, J., & Pease, B. (2012). Military deployment, masculinity and trauma: Reviewing the connections. *The Journal Of Men's Studies, 20*(1), 16-31. doi:10.3149/jms.2001.16
- Gantt, L., & Tinnin, L. W. (2007). Intensive trauma therapy of PTSD and dissociation: An outcome study. *The Arts In Psychotherapy, 34*(1), 69-80. doi:10.1016/j.aip.2006.09.007
- Gantt, L., & Tinnin, L. W. (2009). Support for a neurobiological view of trauma with implications for art therapy. *The Arts In Psychotherapy, 36*(3), 148-153.
doi:10.1016/j.aip.2008.12.005
- Hass-Cohen , N. (2008). *Art Therapy and Clinical Neuroscience*. London, UK: Jessica Kingsley Publisher.
- Jayatunge, R. M. (2008). Combating tsunami disaster through EMDR. *Journal Of EMDR Practice And Research, 2*(2), 140-145. doi:10.1891/1933-3196.2.2.140
- Kapitan, L. (2010). *Introduction to Art Therapy Research*. New York: Routledge.

- Klorer, G. P. (2005). Expressive therapy with severely maltreated children: Neuroscience contributions. *Art Therapy: Journal of the American Art Therapy Association*, 22(4), 213–220.
- Lahad, M., Farhi, M., Leykin, D., & Kaplansky, N. (2010). Preliminary study of a new integrative approach in treating post-traumatic stress disorder: SEE FAR CBT. *The Arts In Psychotherapy*, 37(5), 391-399. doi:10.1016/j.aip.2010.07.003
- Lyshak-Stelzer, F., Singer, P., St. John, P., & Chemtob, C. M. (2007). Art therapy for adolescents with posttraumatic stress disorder symptoms: A pilot study. *Art Therapy*, 24(4), 163-169. doi:10.1080/07421656.2007.10129474
- Mallay, J. (2002). Art therapy, an effective outreach intervention with traumatized children with suspected acquired brain injury. *The Arts In Psychotherapy*, 29(3), 159-172. doi:10.1016/S0197-4556(02)00147-8
- Maxfield, L. (2008). EMDR treatment of recent events and community disasters. *Journal Of EMDR Practice And Research*, 2(2), 74-78. doi:10.1891/1933-3196.2.2.74
- McNamee, C. M. (2003). Bilateral art: Facilitating systemic integration and balance. *The Arts In Psychotherapy*, 30(5), 283-292. doi:10.1016/j.aip.2003.08.005
- McNamee, C. (2005). Bilateral Art: Integrating Art Therapy, Family Therapy, and Neuroscience. *Contemporary Family Therapy*, 27(4), 545-557.
- National Child Traumatic Stress Network. (2003). *Complex trauma in children and adolescents*. Retrieved from: <http://www.ncetsnet.org/nccts/asset.do?id=478>.

- Pizarro, J. (2004). The Efficacy of Art and Writing Therapy: Increasing Positive Mental Health Outcomes and Participant Retention After Exposure to Traumatic Experience. *Art Therapy, 21*(1), 5-12.
- Rankin, A. B., & Taucher, L. C. (2003). A task-oriented approach to art therapy in trauma treatment. *Art Therapy, 20*(3), 138-147. doi:10.1080/07421656.2003.10129570
- Shapiro, F. (2001). Trauma and adaptive information-processing: EMDR's dynamic and behavioral interface. In M. F. Solomon, R. J. Neborsky, L. McCullough, M. Alpert, F. Shapiro, D. Malan (Eds.) , *Short-term therapy for long-term change* (pp. 112-129). New York, NY US: W W Norton & Co.
- Solomon, E. P., & Heide, K. M. (1999). Type III trauma: Toward a more effective conceptualization of psychological trauma. *International Journal Of Offender Therapy And Comparative Criminology, 43*(2), 202-210. doi:10.1177/0306624X99432007
- Söndergaard, H., & Elofsson, U. (2008). Psychophysiological studies of EMDR. *Journal Of EMDR Practice And Research, 2*(4), 282-288. doi:10.1891/1933-3196.2.4.282
- Spring, D. (2004). Thirty-Year Study Links Neuroscience, Specific Trauma, PTSD, Image Conversion, and Language Translation. *Art Therapy, 21*(4), 200-209. doi:10.1080/07421656.2004.10129690
- Talwar, Savneet. 2007. "Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP)." *The Arts In Psychotherapy 34*(1), 22-35. doi:10.1016/j.aip.2006.09.001

Tobin, B. (2006). Art Therapy Meets EMDR: Processing the Paper-Based Image with Eye Movement. *Canadian Art Therapy Association Journal*, 19(2), 27-38.

Tripp, T. (2007). A short term therapy approach to processing trauma: Art therapy and bilateral stimulation. *Art Therapy*, 24(4), 178-183. doi:10.1080/07421656.2007.10129476

U.S. Department of Veterans Affairs & Department of Defense. (2004). *VA/DoD clinical practice guideline for the management of post-traumatic stress*. Washington, DC: Veterans Health Administration, Department of Veterans Affairs and Health Affairs, Department of Defense. Office of Quality and Performance Publication 10Q-CPG/PTSD-04.

Van der Kolk, B. (2000). Posttraumatic stress disorder and the nature of trauma. *Dialogues Clin Neurosci*, 2(1), 7-22.

Virginia Commission on Youth. *Trauma*. http://vcoy.virginia.gov/documents/collection/Trauma_0.pdf

Appendices

IRB Approval

Dear Ms. Breed,

Thank you for submitting your IRB application titled *Integrating Art Therapy and Eye Movement Desensitization and Reprocessing to Treat Post Traumatic Stress Disorder*. All documents have been received and reviewed, and I am pleased to inform you that your project has been approved.

The effective date of your approval is **November 27, 2013 to November 26, 2013**. If you wish to continue your project beyond the effective period, you must submit a renewal application to the IRB prior to **October 1, 2013**. In addition, if there are any changes to your protocol, you are required to submit an addendum application.

For any further communication regarding your approved study, please reference your new protocol number: **LMU IRB 2012 FA 33**.

Best wishes for a successful research project.

Sincerely,

Julie Paterson

Julie Paterson | IRB Coordinator | Loyola Marymount University | 1 LMU Drive | U-Hall #1718

| Los Angeles, CA 90045 | (310) 258-5465 | jpaterso@lmu.edu

IRB Application Cover Sheet

Received _____

LOYOLA MARYMOUNT UNIVERSITY

Human Subjects Research

APPLICATION TO THE LMU INSTITUTIONAL REVIEW BOARD (IRB)Principal Investigator
(P.I.):**Holland Breed**Title of Project: **Integrating Art Therapy and Eye Movement Desensitization and Reprocessing to Treat Post Traumatic Stress Disorder**P.I. Type: (check one)
 Faculty Graduate Undergraduate OtherDepartment: **Marital and Family Therapy**

Campus

Address: **One LMU Drive, Los Angeles, CA 90045**Telephone: **(310) 338-4562** E-mail: **hebreed@gmail.com**Faculty Sponsor (if applicable): **Einat Metzl**Submission: New Renewal Addendum Staff Other Previous IRB No.

For evaluation of your project, indicate involvement of any of the following:

- | | |
|---|---|
| <input checked="" type="checkbox"/> Audio recording of subjects | <input type="checkbox"/> Non-English speaking subjects |
| <input type="checkbox"/> Charges incurred by subjects | <input checked="" type="checkbox"/> Non-patient volunteers |
| <input type="checkbox"/> Deception | <input type="checkbox"/> Patients as subjects |
| <input type="checkbox"/> Elderly Subject (over 65) | <input type="checkbox"/> Placebos |
| <input type="checkbox"/> Establishment of a cell line | <input type="checkbox"/> Psychology Subject Pool |
| <input type="checkbox"/> Experimental devices | <input checked="" type="checkbox"/> Questionnaires |
| <input type="checkbox"/> Experimental drugs | <input type="checkbox"/> Sensitive Topics |
| <input type="checkbox"/> Fetal tissue | <input checked="" type="checkbox"/> Subjects studied off campus |
| <input type="checkbox"/> Mentally disabled subjects | <input type="checkbox"/> Subjects to be paid |

- Minor subjects (younger than 18)
- Approved drugs for “Non-FDA” approved conditions
- Charges incurred by third party carriers
- Data banks, data archives, and/or medical records
- Filming, photographing, and/or video recording of subjects
- Pregnant women, human fetuses, and neonates
- Prisoners, parolees, or incarcerated subjects
- Subjects in Armed Services (Active Duty)
- Surgical pathology tissue

The principal investigator assures the Committee that all procedures performed under the project will be conducted by individuals legally and responsibly entitled to do so and that any deviation from the project (e.g., change in principal investigatorship, subject recruitment procedures, drug dosage, research methodology, etc.) will be submitted to the review committee for approval **prior** to its implementation.

What do you plan to do with the results? Please provide a brief summary statement below:

The information I gather from interviewing three Art Therapists will be transcribed and constructed into the results section of my research paper. My results section will be exploring the how these therapists integrate Art Therapy and Eye Movement Desensitization and Reprocessing to treat clients with Post Traumatic Stress Disorder. I will be exploring the benefits and challenges of combining these two treatment modalities when specifically working with traumatized clients.

NOTE: Applications and any additional material requested by the IRB will not be processed unless **signed personally** by the principal investigator.

Date	Signature of Principal Investigator (Required)	Holland Breed Name (printed)
Date	Signature of Faculty Sponsor (Required)	Einat Metzl Name (printed)

		Debra Linesch
Date	Signature of Department Chair or Dean (Required)	Name (printed)

For ORSP Dept. Use Only

Date	IRB Approval (Signature)	Name (printed)
	IRB Approval Number	

Please deliver to: Julie Paterson, IRB Coordinator, University Hall, Suite 1718 or jpaterso@lmu.edu.

IRB Questionnaire

LOYOLA MARYMOUNT UNIVERSITY

IRB Application Questionnaire

1. RESEARCH BACKGROUND

Talwar (2007) shed light on the impact the progression in psychotherapy and neurobiology have had on the advancement of art therapy. The use of art therapy has increased when verbal psychotherapy falls short of helping clients. Although the field of art therapy lacks in published controlled studies, copious benefits of the creative art therapies have been accounted for in therapeutic settings. The connection between art therapy and neurobiology has sparked an increasing interest for therapists and researchers in the field of art therapy. Lahad et al. (2012) states multiple reasons for the development of new trauma treatment modalities; previous findings have established there are key brain configurations and pathways linked with “retaining the traumatic incident process” (p.391). Therefore the reactivation of these pathways through imaginal exposure techniques is a vital element of the healing process. According to Lahad et al. (2012) EMDR alone does not overtly refer to this development of imagination and subsequently does not utilize its healing effects.

Therefore, the purpose of my research is to ask three Art Therapists that integrate Art Therapy and Eye Movement Desensitization and Reprocessing (EMDR) to treat clients with Post Traumatic Stress Disorder (PTSD), about their experiences and perceived effectiveness of this treatment. I will use this information to discuss the purpose, techniques, benefits and challenges of integrating these two treatment modalities. This integrative treatment is an innovative and young concept, with minimal understanding and research.

2. SUBJECT RECRUITMENT

My subjects will be three licensed Art Therapists that additionally have their EMDR certification. It is required that they treat clients with PTSD, using Art Therapy and EMDR treatment modalities combined. These therapists may be male or female, with no particular age range, as long as they meet the criteria above. I will choose the first three therapists that can meet with me, from a pool of three to five recommended by my faculty sponsor, who is an Art Therapist. I will make the initial contact with my subjects via phone or email. I will explain to them the purpose of my research; the nature of the interview and what I plan to do with my results. Once the subjects have all the necessary information, I will ask if they are interested in being interviewed about their therapeutic process integrating Art Therapy and EMDR to treat clients with PTSD. If I have more than three subjects that are willing to be interviewed I will select the first three that can meet with me. Once I have my three selected therapists I will send them a follow up email including the informed consent and discuss a convenient time, date and place for the interview to be held.

3. PROCEDURES

Initially a pool of three to five eligible subjects will be contacted via phone or email. I will explain to them the purpose of my research, the nature of the interview and what I plan to do with my results. From the subjects that agree to be interviewed about their therapeutic process I will select the first three that are able to meet for an interview. I will send a follow up email to the three selected therapists including the informed consent and will arrange to meet individually at the therapist's office or Loyola Marymount University. During this meeting I will conduct a 1hr to 1.5hr long interview inquiring about their experiences integrating Art Therapy and EMDR to treat their clients with PTSD. I will remind the subjects before, during and after the interview that they only have to share information they feel comfortable with and at any point until the research is complete they can ask to exclude any information. The three interviews will be audio recorded and the tapes stored in secure and private place until they are transcribed. My three subjects will only be required to meet with me once. Once the interviews are complete I will transcribe the information and store it in a secure and private electronic file. After the transcription process is complete the tapes will be destroyed. The transcriptions will be stored until a year after the research is complete. I will qualitatively analyze the transcription material looking for themes and categories and explore them in my results section.

4. RISKS / BENEFITS

My subjects may have discomfort or nervousness sharing their therapeutic process with me. They may be uncomfortable disclosing their therapeutic experiences, fearing that they will be judged or copied. To minimize their discomfort I will initially and continually assure them that I will not be inquiring about the names or any identifying information about their clients. I will continue to remind them they can choose to not share or exclude any information, until the research is complete.

My subjects may experience benefits by choosing to share their knowledge about integrating art therapy and EMDR, with me. The interview process may allow them to reflect on and express their therapeutic experiences. Their participation in this research may allow them to be a part of an innovative field level study.

5. CONFIDENTIALITY

Due to the benefit that my three subjects may receive by having their professional identity and expertise affiliated with an innovative field level study, they will have the choice to be identifiable; as their information will be an important part of the greater field of research, integrating Art Therapy and EMDR to treat PTSD. I will notify the subjects of their choice to be identifiable in the initial contacts. My three selected subjects will have the choice (and ability to change their choice) to be identifiable before, during and after the interview, until the research is complete. The data collected from interviewing the subjects will be transcribed and explored in the results section of my research. In my results section I will describe, compare and contrast the subjects' method of integrating the two treatment modalities. The tape recordings of the interviews will be stored in a secure and private place and destroyed once my transcriptions are complete. The coded transcriptions will be stored electronically in a secure and private setting and destroyed a year after the study is complete. My subjects' individual clients will not be identifiable in the interviewing process or results section. If the subjects choose to speak about their client's in the interviewing process, they may use a fake name.

6. INFORMED CONSENT

See attached

7. STUDENT RESEARCH

See faculty sponsor signature on IRB Application Cover Sheet

8. RENEWAL APPLICATIONS

N/A

9. PAYMENTS

N/A

10. PSYCHOLOGY SUBJECT POOL

N/A

11. QUALIFICATIONS AND TRAINING

I have taken Psychological Research Methods, as a Psychology major at Fort Lewis College and Research Methods as a graduate student at Loyola Marymount University. I will meet weekly with my faculty sponsor during the research process.

12. RANDOMIZATION

N/A

13. USE OF DECEPTION

N/A

14. QUESTIONNAIRES AND SURVEYS

See attached

15. PHYSICIAN INTERACTIONS

N/A

16. SUBJECT SAFETY

The material I am collecting from my subjects is pertaining to their professional expertise and is not sensitive. I will not collect any identifying information about the subjects' clients during the interview process. I will accurately portray information collected from the interviews in my results section.

17. REDUNDANCY

N/A

18. COUNSELING

The material I am collecting from my subjects is pertaining to their professional expertise and is not considered sensitive. Furthermore, since the subjects are licensed therapists, it is assumed that they will have the training to appropriately process uncomfortable feelings and if need be have their own access to counseling services.

19. SAFEGUARDING IDENTITY

N/A

20. ADVERTISEMENTS

N/A

21. FOREIGN RESEARCH

N/A

22. EXEMPTION CATEGORIES (45 CFR 46.101(b) 1-6)

N/A

Please deliver to: Julie Paterson, IRB Coordinator, University Hall, Suite 1718 or jpaterso@lmu.edu.

Experimental Subjects Bill of Rights**LOYOLA MARYMOUNT UNIVERSITY**

Experimental Subjects Bill of Rights

Pursuant to California Health and Safety Code §24172, I understand that I have the following rights as a participant in a research study:

1. I will be informed of the nature and purpose of the experiment.
2. I will be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.
3. I will be given a description of any attendant discomforts and risks to be reasonably expected from the study.
4. I will be given an explanation of any benefits to be expected from the study, if applicable.
5. I will be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous and their relative risks and benefits.
6. I will be informed of the avenues of medical treatment, if any, available after the study is completed if complications should arise.
7. I will be given an opportunity to ask any questions concerning the study or the procedures involved.
8. I will be instructed that consent to participate in the research study may be withdrawn at any time and that I may discontinue participation in the study without prejudice to me.
9. I will be given a copy of the signed and dated written consent form.
- 10.** I will be given the opportunity to decide to consent or not to consent to the study without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on my decision.

Informed Consent

LOYOLA MARYMOUNT UNIVERSITY
Informed Consent Form

11/12/2012

Loyola Marymount University

Integrating Art Therapy and Eye Movement Desensitization and Reprocessing to Treat Post
Traumatic Stress Disorder

1) I hereby authorize Holland Breed BA to include me in the following research study:

Integrating Art Therapy and Eye Movement and Desensitization and Reprocessing to Treat Post
Traumatic Stress Disorder.

2) I have been asked to participate on a research project which is designed to gather information about my therapeutic experiences integrating Art Therapy and Eye Movement and Desensitization and Reprocessing (EMDR) to treat clients with Post Traumatic Stress Disorder (PTSD); which will last for approximately four months.

3) It has been explained to me that the reason for my inclusion in this project is that I am a licensed Art Therapist with a certification in EMDR and I combine both treatment modalities to treat my clients with PTSD.

4) I understand that if I am a subject, I will consent to being interviewed by the investigator about my therapeutic experiences integrating Art Therapy and EMDR including my interventions, benefits and challenges. I have the choice to be identified in the results section of the investigator's research, discussing my integration of Art Therapy and EMDR. These procedures have been explained to me by Holland Breed, a graduate student at Loyola Marymount University.

5) I understand that I will be audio taped in the process of these research procedures. It has been explained to me that this tape will be transcribed and the information used in the investigator's research, in which I have the choice to be identified. I have been assured that the tape will be destroyed after it is transcribed and the transcription will be destroyed a year after the research is complete. I understand that I have the right to review the tape made as part of the study to determine whether it should be edited or erased in whole or in part.

6) I understand that the study described above may involve the benefit of affiliating my professional identity with the innovative integrative treatment of Art Therapy and EMDR, in the investigator's results section of her research. I understand that I may also experience discomfort or nervousness sharing my therapeutic process.

7) I understand that Holland Breed, who can be reached at hebreed@gmail.com or (970)749-3639, will answer any questions I may have at any time concerning details of the procedures performed as part of this study.

8) If the study design or the use of the information is to be changed, I will be so informed and my consent re-obtained.

9) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time.

12) I understand that circumstances may arise which might cause the investigator to terminate my participation before the completion of the study.

13) I understand that I have the right to refuse to answer any question that I may not wish to answer.

14) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Hardy, Ph.D. Chair, Institutional Review

Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659
(310) 258-5465, david.hardy@lmu.edu.

23) In signing this consent form, I acknowledge receipt of a copy of the form, and a copy of the “Subject’s Bill of Rights”.

Subject’s Signature _____ Date _____

Witness _____ Date _____

Interview Guide

Semi-Structured Interview Guide

- 1) What are your name, profession and qualifications?
- 2) How did you come to combine art therapy and EMDR?
- 3) Why and when do you integrate art therapy and EMDR?
- 4) What are the tools and techniques you have used from art therapy and EMDR, when treating traumatized clients?
- 5) What are the benefits and challenges of integrating these two treatments?
- 6) What types of trauma have you treated using this integrative treatment modality?
- 7) How do you think your clients with PTSD experience this integrative treatment?
- 8) Is there anything else you think is important that I have not asked?