

Trauma Finds Expression Through Art Therapy

BY PATRICK J. MORRISSEY, AT-R, LCPC

A small group of veterans in a nondescript room at the Jesse Brown VA Medical Center in Chicago gets to work on an assignment to draw an image of their choice, using color as the primary method of relating a thought or story. One patient — to respect his privacy, we'll call him Baker — uses an oil crayon to shade a piece of paper light blue and sets what look like ghostly eyes in the upper half of the composition. He then adds blood-red droplets that look like tears all along the top, streaking down into the blue expanse. With its aptly placed eyes, the picture seems to symbolize a face.

To most people, that image would be unremarkable, primitive, certainly no work of art. To Baker's art therapist, it's a breakthrough. The drawing reveals more about Baker's body and soul than has emerged during months of behavioral therapy. Baker calls the drawing a "sea of pain." With it, Baker, a homeless man with traumatic brain injury (TBI), has acknowledged his plight while proving an ability to think and communicate — something that has been in question until now.

This is but one striking example of how the tactile and tactical techniques of art therapy can draw out thoughts, emotions and experiences in nonverbal ways, uniquely advancing and supplementing efforts to lead people out of trauma that grips their lives long after events that they can barely talk about.

For veterans who are trained to be in control, to "carry on," art therapy can allow them to access a neglected, non-language part of the brain where the traumatic experience might actually reside — and bring it out in a safe, supportive, nonjudgmental setting without necessarily having to take own-

ership of those experiences in words. They create something that is just a drawing, a collage, a sculpture — until it can be more personally attributed to the veteran's own past actions or life-altering events and emotional triggers.

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In 1945, the Winter VA Hospital in Topeka, Kan., was the first U.S. Department of Veterans Affairs (VA) facility to specifically offer art therapy among its psychiatric services, according to the American Art Therapy Association. At Jesse Brown, it has been part

of the clinical treatment mix since 2010.

Art in general has been long recognized and employed in behavioral treatment as a source of comfort, a way of quieting intrusive thoughts and inducing enough calm to get through activities of daily living. A veteran with terrible insomnia from post-traumatic stress disorder (PTSD), for example, might build elaborate custom model cars late into the evening as a way of distancing himself from his triggering inner thoughts. Such diversional arts and crafts fall under the umbrella of therapeutic art-making, but a clinical role for art therapy has gained visibility and value as part of an interdisciplinary approach with social workers, nurse practitioners, psychologists, psychiatrists and music and dance/movement therapists.

As a relatively recent clinical discipline, art therapy does not have voluminous evidence of quantifiable impact — but it is slowly building. "In comparison to many scientific fields, the body of studies in art therapy that has accumulated since its inception is minimal," said a recent review of outcome studies. But in findings of the 35 studies conducted between 1999 and 2007, including 11 trials with random assignment of patients, art therapy was "shown to be statistically significant in improving a variety of symptoms for a variety of people with different ages."¹



In addition to being effective in addressing behaviors, art therapy “accesses sensory and affective process on basic levels that are not available for verbal processing,” according to a study on implications for brain functions. As such it can be effective

in “stimulating the brain structures involved in processing information.”²

BREAKING THROUGH

VA health care facilities are huge places, organized around specialty clinics of all sorts, from acute inpatient

and intensive outpatient treatment to clinics specific to certain sub-groups: PTSD, addiction, chronic psychosis, dual diagnosis and a dedicated unit for veterans of recent Middle East conflicts.

Individuals who arrive in crisis at the VA medical center are continually prompted to voice their trauma, describe the symptoms it causes and talk about the overall effect on their lives. As the veteran receives various kinds of care in assorted clinics, as he or she improves or relapses during succeeding weeks or months, the repetition continues. After it is recounted for the umpteenth time, a veteran’s story can become flat, rehearsed — a script rather than a felt experience. Art therapy is a way to re-engage the veteran because it calls for visual rather than narrative expression, thus it accesses different parts of the brain that have been dormant. In so doing, the story becomes fresh and vital. Some veterans have burst into tears at a stick-figure drawing involving far less detail than a written or verbal narrative, because it’s like they’re seeing their source of trauma again for the first time.

There’s also a neurological component to the harboring of trauma. Visually witnessing or hearing sounds when a battle buddy is killed by a roadside bomb — those are sensory assaults. The phrase, “I can’t talk about it” may not necessarily be a form of resistance or reluctance to talk about a traumatic incident, it may be a neurological fact: “I can’t access it, that part of my brain has gone dark.”

Even when describable, the reasons for nightmares, guilt and emotional numbing are difficult to own up to. Telling someone about accidentally killing a civilian, or switching assignments with a battle buddy who then is killed by an improvised explosive device, or the survival decisions that bring shame — these traumas in a raw narrative are extremely painful. Such distress or terror can only be treated in a safe, trusting environment, but establishing that trust can be hindered



“You can’t know what killing has made me. You don’t know who I am now.”

or even prevented by constantly having to revisit the trauma in conversations with different clinical professionals in various therapy sites.

TRANSITIONAL ARENA

If you have an enormous psychological wound, and you can't look at it, and you can't dress it, you can't begin the healing process. With a drawing, collage or sculpture about the experience, the veteran doesn't have to take ownership of it until he or she is ready. A drawing can be just a drawing for as long as it needs to be: "This is a girl who was killed." "This is a person dying." "This is a soldier shooting his gun." For the veteran, the information is out there in a form that can be locked away in a drawer, taken out and re-examined.

For the treatment team, it's much easier to discuss an image than to directly question a person. The course of the conversation also can add or resurrect information that otherwise might not have surfaced. This technique often teases out sensory information: it was hot; it was cold; it was loud; there was a smell.

The art also helps preserve the observations and responses that otherwise would have to be fully captured in clinical notes. It's not realistic to expect a traumatized veteran to remember everything previously spoken, and pressing for recollection may lead to a veteran's denying what was said before, either from lack of memory or refusal to face the revelations. With images, ther-

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apy builds upon itself, providing a sequence and continuum that can be revisited again and again.

One technique I use to allow safe access to a veteran's inner turmoil is called "your life as a container." Vets draw a jar — a finite amount of space — and are told to fill it by drawing in their stressors: depression, addiction, PTSD and so on. But they have to give "weight" to the stressors by drawing them as stones, pebbles or sand. Because the artwork is concrete and visual, it helps vets grasp the ideas better than if they were just words floating in their heads. Big stressors take up a lot of room and displace available space; their size,

color and shape in the drawing actually add information helpful to therapists. It also puts feelings in context for vets: "It felt like a stone, but in comparison to these other things, it's actually like a pebble."

Other techniques turn imagery into inner reflection and help vets deal with things like loss of that control they prized so highly as soldiers. One way is to create an image using colored paper and adhesives alone — no scissors, markers or pencils. The only way to create is to tear paper and layer it. Paper tears the way it wants to, so the outcome is not within a vet's total control. But they "soldier through" and adapt to the lack of control, and limitations even spark creativity — a pleasant surprise.

Such art projects allow the clinician to make some key observations not just from the end product itself, but in the creating of it. The way a vet follows instructions, or gets frustrated or annoyed — or elated — provides great clues in terms of how to address additional cognitive or emotional issues. You don't get to see this in a psychotherapy session.

PICTURE OF A VETERAN

In the case of Baker, observing not only what he drew but how he went about it made all the difference in helping him. Disheveled and disorganized, just released from jail, Baker had come to the Jesse Brown VA Medical Center asking for an evaluation he needed in order to be re-admitted to a homeless shelter. He denied any psychiatric, drug or alcohol history — rather complete denial of his circumstances, in sum — though the clinic was able to research his case and found Baker suffered from TBI as a result of crashing through the windshield of a troop transport truck. Now in his early 50s, Baker showed a minimal ability to navigate his surroundings.

Just how minimal became evident in his first art therapy session. By the time he started a drawing project, he had forgotten the instructions. Knowing he was supposed to draw something, though, he depicted a horse and an apple, a source of comfort for him. He explained that when you give a horse an apple, he'll be your friend — it turns out Baker grew up on a farm. Observation: Write down instructions for Baker so he doesn't have to rely on memory, because his ability to retain short-term information is fleeting.



The next art exercise called for the patient to just pour paint on paper, fold it, and open it back up, creating an abstract design or perhaps a more recognizable image. Part of what makes this process successful or engaging is bilateral symmetry which characterizes most human and animal shapes. The brain decodes that kind of visual information into meaning — the design looks like a flying bird, it looks like a face. Nothing doing for Baker, the TBI patient: He ignored the larger design and went straight to a small sub-image in the middle. To him, it looked like a coat. He wasn't abstract-thinking at all, but focusing on bare basics of his predicament — he was robbed of his coat at the homeless shelter.

With the paper-tearing exercise, it was back to the comforting picture of horses on the farm. Besides supporting continued equine therapy and reinforcing other parts of his interdisciplinary treatment, the results of Baker's paper-tearing exercise showed that when the activity is clearly described, or if he can see others around him also doing it, he "gets it" and can produce an image within the limits of the material. He's not incapable of helping himself.

That brings us to the "sea of pain." Here, contrary to all previous perception, we saw someone now able to understand and use an abstract way of thinking and of presenting himself — right down to the damaged right eye, which is where he says his migraine headaches cluster. So now we know he has more ability to work with than he previously had shown.

Since then, Baker has progressed further: He is functioning, he has a sense of self, identity and limitations. Compare that with, "I need an assessment so I can go back to my homeless shelter."

UNIQUE OUTCOMES

Baker's needs were addressed in a group session, the typical setting for services in a medical center with so many patients. In such a setting, art therapy can provide more attention to each vet in the limited available time. Normally in a half-hour talking session with 15 people, that leaves two minutes per person to talk. In art therapy, everyone has the same amount of time to work on their project, so they all can be "heard" whether or not they

speak. The artwork has permanence, it remains available, so if it isn't looked at during that session, it can be examined when the group meets again or looked at individually, either with the art therapist or another treatment team member.

This kind of therapy also helps with treatment efficiency in an interdisciplinary model. In time-limited sessions, not all issues can be addressed. But themes emanating from art therapy can be ported to individual therapy. To have an art therapist on the team is to make the machinery run more efficiently and smoothly.

But even more important is how creating artwork opens up avenues for veterans to find their way back to a more normal life. I have worked with vets who tell me that even though they had been in therapy for years, in different settings and with various clinicians, art therapy provided their first ability to address a particular issue related to trauma. They have said things like, "It is impossible for me to talk about this; I can make imagery about it."

Veterans keep their art images, and in looking at them they can actually witness their progression — advancing a nonverbal narrative and becoming ever more open about what drove them down. That's the contribution of art therapy to a veteran's overall treatment mix: helping to create a lasting, clear picture of just what needs to be made better, and providing some of the tools to help address it.

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NOTES

1. Sarah C. Slayton, Jeanne D'Archer and Frances Kaplan, "Outcome Studies on the Efficacy of Art Therapy: A Review of Findings," *Journal of the American Art Therapy Association* 27, no. 3 (2010): 108-118.
2. Vija B. Lusebrink, "Assessment and Therapeutic Application of the Expressive Therapies Continuum: Implications for Brain Structures and Functions," *Journal of the American Art Therapy Association* 27, no. 4 (2010): 168-177.

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