Art Therapy for Combat Related PTSD

A Literature Review

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements

For the Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By:

Leah C. Donnelly

September 24, 2013

William Premo, PhD, Chair

Craig Balfany MPS, Reader
Abstract

This study is an evaluation of the need for Art Therapy as a treatment modality for Veterans diagnosed with combat-related Post Traumatic Stress Disorder. The treatment approaches that art therapy utilizes are discussed as well as the benefits of a non-verbal therapy for this population. The primary focus among the various symptomatology of PTSD is that of self-identity, particularly the concepts of self-esteem, self-concept and self-ideal. These aspects of identity are explored due to their relationship with a successful reintegration of the Veteran into society post-deployment. Current art therapy tools are explored as well as the need for more research regarding the effectiveness of these tools and the possible innovation of new tools for successfully treating symptoms of PTSD. The benefits of group art therapy in the assistance of creating a new identity formation is discussed as well as the success of group therapy in treating PTSD symptoms of avoidance and isolation.
## Table of Contents

### CHAPTER ONE: INTRODUCTION

Introduction .................................................................................................................. 5  
Defining Veterans with Combat-Related PTSD ......................................................... 8  
How Many Veterans are diagnosed with PTSD? ....................................................... 9  
Current Treatment Modalities for PTSD ................................................................. 10  
Exploration of Art Therapy as a Successful Treatment Modality for PTSD .......... 11  
  The Three Sides of Self ......................................................................................... 11  
  Group Processes for PTSD ................................................................................. 12  
  Reintegration: Blending Past Experiences into a New Identity ......................... 13  
Research Questions ................................................................................................. 14  
Definition of Terms ................................................................................................. 14  
Assumptions ............................................................................................................. 15  
Limitations of Study ................................................................................................. 16  

### CHAPTER TWO: LITERATURE REVIEW

Aspects of Veterans Diagnosed with PTSD ............................................................... 16  
Prevalence of PTSD ................................................................................................. 18  
Adlerian Theory: Cognitive Schema in the Past, Present and Future .................. 19  
Self-Ideal and Worldview Revision ......................................................................... 22  
Summary .................................................................................................................. 23  

Group Processes for Veterans Diagnosed with PTSD ........................................... 24  
  Mutual Understanding ......................................................................................... 25  
  Safety within Group Environment .................................................................. 27
ART THERAPY AND COMBAT-RELATED PTSD

Summary.........................................................................................................................28

Art Therapy Tools for Veterans Diagnosed with PTSD..............................................29

Art Therapy and Trauma.............................................................................................29

Addressing PTSD Symptoms of Emotional Numbing and Avoidance....................31

Self Esteem, Self-Concept and Self Ideal....................................................................33


Current Practices.........................................................................................................36

The Formation of an Effective Art Therapy Process......................................................40

Summary.........................................................................................................................47

CHAPTER THREE: METHODOLOGY

Online Data and Research..........................................................................................48

CHAPTER FOUR: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Final Summary..............................................................................................................49

Conclusion.....................................................................................................................54

Recommendations.........................................................................................................56

REFERENCES...............................................................................................................58
Art Therapy for Combat Related PTSD

There is no doubt that once a military member experiences combat their lives are altered forever. This alteration is personally unique to the individual, depending on the experience and amount of exposure to combat, nonetheless the life story changes, and a new chapter inevitably takes shape. How does a veteran author this chapter of their life? It seems that the force of combat trauma, the sharp contrasts of life and death, often-unimaginable scenes to the naked and searching human eyes could lead a person to be caught in a fault line of an immeasurable quake. Caught in the impact of events, both body and spirit are shaken. Plateaus and ridges of the shaken earth and psyche can be difficult to navigate.

How then can one regain themselves from an experience that shakes the very ground beneath their feet? How can one find sure footing to travel successfully through a torn and unstable landscape to the next path that emerges as uncertain as it and life may be? All humans carry landmarks of memories from various life terrains, however for a veteran with combat-related Post Traumatic Stress Disorder their land of memories does not easily make way for new paths.

Deborah Golub, ATR, (1985) describes the artwork of a Vietnam veteran while he was in art therapy:

An elaborately reinforce but broken train-trestle spans a deep gorge labeled, “Heaven.” A train representing the veteran approaches the exposed chasm from the left. However, a barricade, insufficient fuel and unconsciously omitted wheels prevent the train from plunging toward destruction. Furthermore, a smiling stick figure stands on the far side of the ravine. The image suggests that he no longer perceived suicide as inevitable. The task now, as the man saw it, was to
“reconstruct the broken track and get over the bridge.” He was determined to find a way in therapy to confront his pain without being destroyed by it (p.285.)

The combat experience cannot be removed from a veteran’s story. However the human being is ever capable of transformation, of rerouting paths, clearing a new road, or building new train tracks. Human experience and memory has the capacity to be a foundation for the growth of a new identity formation to help further the individual down his or her life path.

The growth of a new identity formation is crucial during the veteran’s reintegration into civilian life. Currently there is a new generation coming back from areas such as Iraq and Afghanistan that may or may not have experienced traumatic events but nonetheless will need services to successfully transition back to both civilian and military life. For both active duty and National Guard/Reserve members this includes reintegration into the roles required of life tasks such as; work, family, school and other areas of social engagement.

Reintegration can be especially difficult for veterans with mental health conditions. PTSD, depression and substance abuse disorders are common mental health impairments of returning veterans. PTSD and depression often have a high co-morbid rate, but for the purposes of this paper I will focus specifically on the need to treat the prevalence of PTSD with this population.
Currently there are no treatment modalities that have proven to be effective for PTSD. Large numbers of vets are returning home with PTSD after experiencing 1 or more tours of duty. Vets are facing challenges of reintegrating into the civilian sector. These challenges include finding employment, maintaining healthy family relations, being an active participant of community involvement and various struggles with self-concept.

Vasterling et al. (2008) emphasize that in addition to a spectrum of psychological symptoms, PTSD is also associated with significant functional impairment, including increased risk of somatic symptoms and health disorders, health-related changes in day-to-day functioning, diminished overall well-being and quality of life, psychosocial and interpersonal dysfunction, and occupational impairment.

“15% to 17% of returning veterans are experiencing PTSD. This means that literally thousands of military returnees are returning home with a serious mental disorder that not only affects the soldier, but his or her family system as well” (Garske, 2011, p. 32). These numbers do not represent a possibly very large number of veterans who do not seek treatment due to factors such as shame, assumption that symptoms will dissipate with time, inadequate access or inadequate location to reach treatment facilities and being swayed by a stigma of mental health treatment in the military, (such as seeking treatment as a sign of weakness or lack of masculinity).

This paper will discuss the research pertaining to: the effects of multiple deployments and their linkage with higher rates of PTSD, healing combat-trauma from an Adlerian perspective with emphasis on the Adlerian concept of cognitive schemas (self-ideal, self-concept, environmental scan and worldview revision), the three sides of self, (self-esteem, self-concept and self-ideal) in connection with the individual’s experience of past, present and future,
the effectiveness of a group therapy approach versus individual therapy and an exploration of the aspects of identity in relationship to a successful reintegration into the post deployment society.

These topics will then be further explored through the art therapy lens. Current art therapy tools will be discussed including those developed for: accessing and releasing traumatic events, addressing the symptomatology of PTSD and focusing on patients’ self-esteem, self-concept and self-ideal. Examples and opinions of directive versus non-directive art therapy approaches will also be reviewed.

This paper will discuss the current need for art therapy as a treatment for combat-related PTSD and formulate a successful group art therapy process specifically with tools developed for exploration of personal identity and reintegration into society through the means of blending past experiences into new identity formations post deployment(s). This paper will then discuss how this formulated group art therapy process can be beneficial for art therapists to use with veterans in the future.

**Defining Veterans with Combat-Related PTSD**

The diagnosis of PTSD was added to the DSM in 1980. Prior to this diagnosis PTSD was called a number of different conditions including, “shell shock,” “Traumatic Neurosis,” “Gross Stress Reaction,” “War Neurosis” and “Combat Fatigue.” Although the diagnosis of PTSD is relatively new, the symptoms of vets and behavior changes that have occurred after witnessing war-zone events has been documented for thousands of years.

The diagnostic features and criterion of the PTSD diagnosis in the DSM-IV is as follows:

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor
involve direct personal experience of an event that involves actual or threatened
death or serious injury, or other threat to one’s physical integrity; or witnessing an
event that involves death, injury, or a threat to the physical integrity of another
person; or learning about unexpected or violent death, serious harm, or threat of
death or injury experienced by a family member or other close associate
(Criterion A1). The person’s response to the event must involve intense fear,
helplessness, or horror (or in children, the response must involve disorganized or
agitated behavior) (Criterion A2). The characteristic symptoms resulting from the
exposure to the extreme trauma include persistent re-experiencing of the traumatic
event (Criterion B), persistent avoidance of stimuli associated with the trauma and
numbing of general responsiveness (Criterion C), and persistent symptoms of
increased arousal (Criterion D). The full symptom picture must be present for
more than 1 month (Criterion E), and the disturbance must cause clinically
significant distress or impairment in social, occupational, or other important areas
of functioning (Criteria F) (American Psychiatric Association, 2000, p. 463.)

For the purposes of this paper literature reviewed will have case examples of veterans
that meet some, if not all of the above criteria for the PTSD diagnosis.

**How Many Veterans are Diagnosed with PTSD?**

“Studies are demonstrating that troops who serve in current conflicts are experiencing
PTSD and other mental health problems on a scale not seen since the war in Vietnam (Robinson,
2004). Roughly 29% of the veterans returning from Operation Iraqi Freedom (OIF) and
Operation Enduring Freedom (OEF) have already enrolled in Veterans Administration (VA)
healthcare, a historically high rate compared with 10% of Viet Nam veterans” (Garske, 2011, p.
It is difficult to know the exact numbers of post-combat veterans who have symptoms of the diagnosis of PTSD. Factors that contribute to an imprecise measurement include: inaccurate reporting by Veterans, low help-seeking behaviors, avoidance of stigmatization, avoidance associated with PTSD as a factor for not seeking treatment, unstable living arrangements and fears that seeking help will jeopardize a military career. “It was noted that in calendar years 2003 through 2007, the Military Health System (MHS) had recorded 39,365 patients who were diagnosed with PTSD. Unfortunately, it is estimated that only 10% of male and 26% of female active duty personnel reporting mental health symptoms will pursue treatment” (Garske, 2011, p. 32).

**Current treatment modalities for PTSD**

The prevalence of PTSD among our returning veterans is reason enough for mental health practitioners to seek out successful psychotherapy treatment options. Although certain medications including SSRI’s and antidepressants have worked well to relieve PTSD symptoms and improve life quality in many patients they are not much help for many others. Therefore current PTSD treatment guidelines call for psychotherapy as well as medication. Another reason that demonstrates the need for further research and identification of other possible treatment methods, including art therapy, is that a definitive treatment is still inconclusive. Despite multiple treatment options currently available, none have been found to be completely effective in treating the symptoms of PTSD. “In spite of the multiple ways described for treating PTSD in the vast empirically based trauma literature, consensus on a definitive treatment remains elusive” (Carr, 2011, p. 472).
Some of the more common psychotherapy treatment modalities currently available are: Prolonged Exposure Therapy, Virtual Reality Exposure (VRE), Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing and Stress Inoculation therapy (SIT).

Exploration of Art Therapy as a Successful Treatment Modality for PTSD

Art therapy as a treatment method for combat-related PTSD has been around for many years, but has been more in the spotlight recently due to case studies and research projects that support its effectiveness. “Theorists have identified psychological and neurological mechanisms that most likely are operating in art therapy indicating it has unique capacities to promote recovery from PTSD” (Kaiser, 2005, p. 4).

Through the art-making process veterans can communicate in a visual language, which is useful for those who do not have words for the trauma they have experienced. Art therapy can also help reduce symptoms of PTSD such as intrusive thoughts, hyper arousal, avoidance and emotional numbing. Because traumatic expressions are difficult to externalize and are imprinted in visual areas of the brain, art therapy can be effective in the phase of treatment which requires access and release of the traumatic experiences. “The purpose of the working-through phase is to change the coding of the traumatic event from a global, all or nothing representation to one that is integrated into the rest of the personality, is connected via associative links to other thoughts and feelings, and is therefore brought under the client’s control. Intrusive re-living of the event is transformed into mere remembering” (Johnson, 1987, p. 10).

The three sides of self. For veterans with PTSD, the past, present and future are not always clearly defined. Symptoms such as flashbacks, intrusive thoughts and nightmares allow the past to suddenly and powerfully invade the present. The veterans present moment is replaced with his or her traumatized past.
“The symptoms that characterize PTSD are relieving the traumatic event or frightening elements of it. With this in mind, Wilson, Friedman and Lindy (2001) explained that the key element of the psychotherapy of people with PTSD is the integration of the alien, imposed from the outside upon passive victims, must come to be personalized and integrated as aspects of one’s history and life experiences” (Garske, 2011, p. 33).

Art Therapy assists in creating a new trauma narrative in which the past, present and future can be clearly defined once again. By externalizing and sharing traumatic memories that invade the present, they can become a part of one’s story and not who one is. When the traumatized self is reintegrated from the present into the past, or one’s history, through creation of a trauma narrative, self-esteem can then be gained in the veteran’s present.

**Group processes for PTSD.** The art therapy processes and tools will be discussed within the context of group therapy rather than individual therapy. The various benefits of veterans being in a therapeutic art space with other veterans will be examined. The ways in which group art therapy can contribute to the veterans’ accessing and releasing of traumatic events and the role it plays in an individual’s reintegration into society will be key issues for the need of a group therapy format. The group process is an important component to the overall goal of helping veterans to reintegrate into society and blend their past experiences into their new identity formations through the use of specific art therapy tools.

Group art therapy for veterans with PTSD enhances the treatment for issues that are identity related, by combating the PTSD symptoms of isolation and avoidance through social interest. “Carefully planned and facilitated groups can provide a structured and safe environment for promoting self-awareness, emotional expression and cognitive reframing to aid coping and symptom reduction” (Westwood, 2010, p. 46).
Group art therapy and other group therapy approaches have been shown to be beneficial for most populations with PTSD. This especially proves to be true with veterans. Research shows that the group modality format relieves feelings of isolation, mistrust, and a negative uniqueness. The group process also confronts socially avoidant and self-isolating individuals by creating a space of mutual support and understanding. Veterans generally have an appreciation of others who have “been there” and share the military life experience. The mutual support and understanding of other veterans also can aid in the creation of a safe place for the individual to explore self-awareness, express emotions such as anger, fear, sadness etc. Veterans learn from each other and give feedback. Overall the group process can create a sense of belonging and encouragement.

**Reintegration: blending past experiences into a new identity.** Post-Traumatic Stress Disorder is directly related to combat exposure, however in the majority of cases, the symptoms of PTSD do no begin to manifest until the veteran returns home from service and begins to reintegrate into all of his or her past civilian areas of life. Helping veterans to understand and integrate their emotions and feelings into their new sense of self is one of two critical goals. The other goal is to seek out support within the society, within the veteran’s environment. The veteran had to adapt to a combat environment, so too does the veteran have to adapt to an environment post-combat. Unfortunately, particularly in the United States, society does not offer consistent, clear ceremonies or rituals of transition for our returning veterans. Without clear transition assistance, the veterans need to reintegrate can become more complicated at a time when they need support the most.

Group therapy can aid the veteran immensely through the reintegration phase of post deployment. By maintaining the bonds with military friends a veteran may not feel as alone and
alienated in their quest to obtain a normal and healthy life post deployment. Because of the strong bonds that military members form during often lengthy deployments, (members often assuming the roles of surrogate family members) transitioning back to civilian life can be filled with a great sense of grief and loss because of the great distances and varied directions veterans are separated by when returning home. Once contained closely in a military salt-shaker of sorts, upon the return home they are released and sprinkled into deep corners and pockets of the U.S. Far away from the close quarters they once shared with one another.

Art Therapy within a group modality can become a new container for veterans. The safety, trust and mutual understanding between military members can provide the groundwork for effective and cathartic therapy sessions with the ultimate goal of blending the veterans past experiences into a new identity formation. By being able to safely explore personal experiences within the group setting, the seeds of reintegration with a renewed and integrated sense of self can be safely planted in a new stage of the veteran’s life.

Research Questions

The primary research interest for this paper is the exploration of self-identity and tools that can be useful in reconnecting the pieces of a shattered self. Ways that art therapy is effective in examining the past, present and future selves, (self-esteem, self-concept and self-ideal) will be explored in order to help veterans reintegrate into society by successfully blending their past experiences into their new identity formation.

Definition of Terms

Absolutisms - Advocacy of a rule by absolute standards or principles. An absolute standard or principle.
Cognitive schemas (Apperceptive schemas) - The opinions that individuals have of themselves within the world. Actions are determined by the opinion of oneself and the world.

Combat-related PTSD - common in soldiers that have experienced time in combat on the battlefield where they were exposed to many different traumatic scenes and situations.

Combat veterans with PTSD after experiencing 1+ tours of duty - Veterans that have been deployed to a combat environment more than one time and have an increased percentage of Post Traumatic Stress Disorder due to multiple and prolonged exposure to traumatic scenes and situations.

Environmental Scan - Ways in which people automatically perceive and think about their environment.

Self-concept- The idea that you have about the kind of person you are. The mental image one has of oneself.

Self-esteem - A feeling of having respect for yourself and your abilities. A confidence and satisfaction in oneself.

Self-ideal - A perception of how one should behave based on certain personal standards. The standard may be either a carefully constructed image of the kind of person one would like to be or merely a number of aspirations, goals or values one would like to achieve.

**Assumptions**

This writer believes that the more combat deployments that a veteran has, the more his or her chances will increase for developing combat-related PTSD. Also this writer assumes that more combat deployments will increase the chances of developing symptoms related to chronic PTSD, specifically avoidance and emotional numbing. To address these hard to treat symptoms of PTSD a treatment method must be developed that using methods aimed at resolution of these
symptoms and increases social interest, engagement and reactivation of both feeling positive and negative emotions. This writer believes that art therapy can provide tools to aid in the reintegration process of traumatic experiences and post-combat identity so that veterans can successfully reintegrate into post-combat society.

Limitations of Study

Although there are art therapy assessments to measure disorders such as depression and anxiety, none exist for PTSD, or more specifically combat-related PTSD. I believe that an inclusion of an art therapy assessment, along with both directive and non-directive approaches may be beneficial to the continued growth of therapy with this population, as well as providing evidence to suggest that art therapy should be integrated into mental health and trauma systems.

Another limitation of this research is that there are no quantitative studies provided. Quantitative research that could track a veteran’s treatment progress over time would be beneficial in supporting art therapy for this population in the future. There are numerous case studies and qualitative research projects regarding the benefits of art therapy treatment; however there was no research found that scientifically examines the effects and outcomes of art therapy as a treatment for combat-related PTSD.

Veterans also do not have as much access to art therapy as they do with other therapies. Although art therapy programs for this population are growing, art therapy is still not common in the U.S’s mental health care systems, the V.A and trauma response systems. Large-scale studies, performed over longer durations of time, would benefit the growth of art therapy for veterans.

Veterans Diagnosed with PTSD

Aspects of Veterans Diagnosed with PTSD

When a veteran comes home they are faced with the various life tasks that they left
behind before deployment. A veteran with combat-related PTSD however is altered by their experiences and returns home a different person than when they left. Veterans must re-enter into their previous roles within family, friendships, their career and their community. The difficulties for veterans when reestablishing these roles however; is that they cannot assume these roles as they had previously done before combat/war exposure. The veteran’s sense of self has changed, and he or she may no longer know how to fit into these roles that everyone seems to require them to do.

Symptoms of PTSD are often debilitating and the reintegration period post-deployment is often when symptoms of mental distress and PTSD begin to manifest. So veterans are often faced not only with the requests of others to fill their expected roles, but also with various degrees of symptomology that can range from mild to severe. These symptoms also may be accompanied by feelings of shame and guilt, feelings that veterans may have never had to deal with.

Traumatic experiences of combat continually cycle back into the veterans present in the forms of mental flashbacks, intrusive thoughts and dreams and memories. The continuous nature of these disturbing thoughts and images eventually lead to symptoms of avoidance, emotional numbing, a sense of alienation and isolation (Garske, 2011).

Unfortunately these avoidant coping strategies associated with PTSD lead to low help-seeking behaviors among veterans. Other reasons for not seeking treatment include a military stigma of mental health; frequent deployments which cause unstable living arrangements and an inability to relate to those who have not experienced combat (Garske, 2011). “Among current combat-related PTSD treatments the dropout rate continues to be high because of these low-help seeking behaviors” (Carr, 2011, p. 472).
With the high dropout rates of current treatment options, it is imperative that a treatment option is available that addresses the symptoms that cause non-responsiveness from veterans; primary emotional numbing and avoidance. These two symptoms can lead to PTSD becoming chronic which adds to the resistance of treatment due to leaving an “indelible physiological imprint on the brain” (Collie, 2005, p. 158).

Research indicates that severe trauma becomes fragmented with the brain and disconnected from areas that control meaning, making it impossible to process information symbolically (verbally or otherwise) (Collie, 2005, p. 158). A treatment method that can help the veteran to once again have positive experiences of the world and a positive view of themselves in the world is ideal. In order to do this the veteran must create of a narrative of meaning from their combat experiences. “Adaptation to trauma involves construction of new self- and world-perspectives that are different from those prior to the trauma” (Rankin, 2003, p. 138).

Prevalence of PTSD. The rate of PTSD continues to rise as more troops are deployed to areas such as Afghanistan and the Middle East. Factors that contribute to this rise are the numbers of tours of duty and the number of firefights veterans are involved in either directly or indirectly. “PTSD increases according to the number of firefights or other combat experiences a veteran experiences. The percentage of PTSD also increases with each tour of duty” (Richardson et al., 2010).

Veterans can also develop PTSD by witnessing traumatic events on or near the battlefield but not being in the direct line of combat. “92% of soldiers and Marines serving in Iraq reported being attacked or ambushed, 86% reported seeing dead or seriously injured Americans, and 53% reported handling or uncovering human remains” (Garske 2010, p. 32). There is significant research to verify that multiple deployments increase a veterans risk for PTSD and developing
chronic PTSD (Garske, 2011). The more traumatic combat experiences a service member experiences the higher the chances for PTSD.

Traumatic combat experiences that veterans may encounter include: fellow military members, civilians and enemy combatants being injured or killed in combat situations, the devastation of towns and communities being destroyed by the effects of war, intense sensory experiences (seeing, hearing and smelling the dying or injured), unpredictable attacks and observing or handling the dead. These combat stressors can vary in intensity and duration. Multiple deployments can increase the chances for more exposure to these stressors. Veterans may be exposed to one firefight or any combination of these war-zone stressors. The more exposure a veteran has to any combination of these stressors, the more likely for the prevalence of PTSD.

**Adlerian theory: cognitive schema in the past, present and future.** If an individual always relates himself or herself to the outside world according to his or her own interpretation of the self and the present problem, (Ansbacher & Ansbacher, 1956) then it could be said that a veteran with combat-related PTSD has a shattered, disjointed relationship to the outside world. The traumatized self becomes the veterans self in the present. “The person may still feel trapped in the moment of emotional trauma, unable to escape that past as it constantly invades and dominates the present. In those moments of frank dissociation, there is no present. Time feeds circularly back to the traumatic event” (Carr, 2011, p. 476). Some debilitating characteristics of the traumatized self in the present include; isolation, avoidance, a sense of alienation and emotional numbness.

In “Combat and Human Existence” Carr (2011) references to the work of Robert Stolorow and Intersubjective Systems Theory. Stolorow’s ideas about the experience of the
effects of trauma on an individual are focused on affect: “His ideas about it include understanding trauma as unbearable affect and its effects as “an excruciating sense of singularity and solitude,” the loss of “absolutisms” of everyday life, the loss of a sense of time (temporality), loss of a sense of being (ontological unconscious), being overcome with facing and witnessing death (authentic being-toward-death) leading into the eventual resoluteness to live again, and loss itself as a relational phenomenon” (Carr, 2011, p. 475).

An effective therapeutic process for combat-related PTSD will aid the veteran in recreating a coherent personal narrative that reunites the veteran’s past, present and future. In the Adlerian concept of cognitive schema (apperceptive schema) an individual’s past, present and future also refer to the individual’s self-concept, self-esteem and self-ideal. When the traumatized self can be integrated into the veterans’ past or a part of their self-concept rather then being in the present, then Veterans are able to reconstruct their sense of self in the present, or self-esteem. Veterans can then be able to draw meaning from the trauma and reconstruct a self-ideal for the future based off of their experiences. “We are self-determined by the meaning we give to our experiences, and there is probably always something of a mistake involved when we take particular experiences as the basis for our future life” (Ansbacher & Ansbacher, 1956, p. 208).

Developing self-esteem is of particular importance in an effective treatment method for combat-related PTSD. Self-esteem is a main component of identity and veterans often have very low self-esteem due to the traumatized self constantly relinquishing a sense of control and numbing of emotions in the present. A sense of control and the ability to feel and process both positive and negative emotions are core attributes of high self-esteem and effect the way individuals react to their environment in the present. “Personal resources, such as self-esteem,
optimism and perceived control are expected to support the processing of threatening experiences. The present study examined these expectations among a sample of veterans that faced adversity by being in a war zone. Self-esteem, optimism and perceived control may be thought of as core resources that contribute to a resilient personality” (Schok, Kleber & Lensvelt-Mulders, 2010, p. 328).

An Adlerian approach to treating combat-related PTSD emphasizes increasing involvement with the external world by working with the veteran’s altered concept of self and outer world. “Our clinical experience suggests that individual responses to combat experiences can be understood in terms of Adlerian variables of self esteem (SE) and social interest (SI). The affected veterans are severely discouraged persons” (Blackburn, O’Connell and Richman, 1987, p. 319).

Therapeutic tools that encourage exploration of identity in the past, present and future, the relationship between self identity and the environment and active participation in the environment itself are important considerations in treatment from an Adlerian perspective. The tools to initiate these explorations of self and environment should help veterans regain a sense of control and mastery to rebuild self-esteem. Self-esteem can also help veterans to reengage in social spheres with empathetic listeners and other veterans that can provide mutual understanding of experiences. Telling and sharing of experiences can then enhance social interest and further help the veteran to find a place in the larger society. “…Adlerian psychotherapists work to help clients develop an awareness of core dysfunctional schemata and resultant maladaptive actions; they encourage the growth of self-esteem and provide corrective social experiences; and they facilitate the development of more pro-social methods for achieving a positive self-ideal and a place in society” (Azoulay & Maniaci, 1996, p. 421).
Self-ideal and worldview revision. In order for a veteran to create a new self-ideal and revision of the world post-trauma a sense of meaning of the trauma must be obtained. Carr (2011), says that Stolorow uses the Intersubjective Systems Theory approach to argue that traumatic material must be processed with others: “Instead of the event itself, Stolorow focuses on the inability to bear the emotions related to the trauma as the source of pathology. This traumatic emotional experience must be processed with others in order to be integrated into one’s experiential world. Affects, or emotions, occur between people, and disturbing emotional experiences require what Stolorow calls “attunement” from another person or group in order to bear and integrate them” (Carr, 2011, p. 475).

A successful treatment for combat-related PTSD will allow veterans access to the tools for self-esteem and social interest building in order to help veterans reach the ultimate goal of successful reintegration into society post-deployment(s). With these tools veterans can gain a sense of meaning of their experiences. “A person’s opinion of himself and the environment can best be deduced from the meaning he finds in life and from the meaning he gives to his own life, [his philosophy of life]. Here the possible dissonance to an ideal social interest, to living together, working together, and being a fellow man, will clearly show itself” (Ansbacher & Ansbacher, 1956, p. 197). Veterans must find meaning within themselves, through attunement with trusted others and also within their community and the larger society. Society too, must be willing to accept that veterans are changed from their experiences and be willing to listen and welcome veterans home.

“Today in the United States, combat veterans and their experiences are treated sympathetically, but nonetheless as “other” by the society at large. There is no universal transition home, unlike the tradition of communal reintegration rituals that were practiced in non-
Western societies cited by Freud in Totem and Taboo (Freud, 1913) and provided by international humanitarian agencies in the 21st century global south (Moran, 2004). By the absence of these collective rituals of transition, the society beyond the consulting room forces veterans to maintain a rigid separation between the world that they experienced in combat, the world from which they came and that to which they return” (Bragin, 2010, p. 318). Bragin (2010) quotes Shay (2002) as going as far as saying that society has a large, pivotal role in the mental health of our servicemen post-combat. Evidence in society’s impact upon the return of veterans can be seen in the case of Vietnam and other wars that had less approval from society.

Schok, Kleber & Lensvelt-Mulders (2010), discuss how resilience among veterans can be affected by varying responses by society: “The concept of resilience may also include social resources that support bouncing back from adversity strengthened and more resourceful. For example, lack of social support has been one of the strongest predictors of PTSD, especially in military samples (Brewin, Andrews, & Valentine, 2000). Moreover, a negative homecoming reception was associated with posttraumatic stress symptoms” (Schok, Kleber & Lensvelt-Mulders, 2010, p. 335). In order for Veterans to form a positive self-ideal and worldview revision, the world also needs to do its part in supporting veterans and allowing them to feel supported and welcomed home.

Summary

Lifetime prevalence of PTSD is approximately 6-31% (Richardson, Frueh, & Acierno, 2010). With the number of troops that have been deployed in recent years and the numbers that are still presently being deployed there needs to be more research into practices that may be more effective than current practices are. The number of deployments for military members is also high (especially for Guard members) which also affect the rates of PTSD. “It is understood that
combat-related trauma creates isolation, solitude and a loss of “absolutisms” in everyday life. It affects a loss of temporality that creates an incoherent sense of past, present and future. It affects the loss of one’s sense of being. A veteran with combat-related PTSD becomes more isolated and the traumatized self becomes split off from the rest of the self (Carr, 2011, p. 476).

Traumatic material must be integrated into a new identity formation in order for the traumatized self to become a part of one’s history and not the main focus of identity and worldview. The Adlerian concept of cognitive schema (apperceptive schema) can be utilized by therapists to observe how the veteran relates himself according to his own interpretation of himself and of his present problem (Ansbacher & Ansbacher, 1956). “Adaptation to trauma involves construction of new self and world perspectives that are different from those prior to the trauma. Through new self and world perspectives and redevelopment of the self in the present (integrating the self so that the traumatized self becomes a part of one’s past rather than intruding on one’s present) two goals of trauma treatment can be attained. 1) A decrease in the intensity and frequency of PTSD symptomology and 2) increasing positive life experiences to enhance well-being and reintegration into a post-deployment society” (Rankin, 2003, p. 138).

**Group Processes for Veterans Diagnosed with PTSD**

Yiddish saying: “Pain shared is pain halved” (Wilson, 2009, p. 411)

Group therapy versus individual therapy is an important consideration for art therapists working with veterans. Group art therapy directives such as murals and integrated images of individual work can unite a group in mutual understanding through the visual image(s). Processing the art can relieve feelings of isolation and promote member support outside of the therapy group. The military system is group orientated and structured, with the traumatic
experiences often occurring close to other military members, so modeling the therapy session after this group format can be very effective.

Sharing experiences with others in the context of an art therapy group also helps to address the shame that many veterans with PTSD have. PTSD symptoms of isolation and avoidance often come from feeling rejected and misunderstood by others. These symptoms are particularly prevalent in chronic combat-related PTSD.

“Within the group framework patients have the opportunity to work on intrapsychic and social problems. Brende (11) has noticed that work within a group with other PTSD victims permits patients to break with the pattern of rage, guilt, grief, shame, hiding and a sense of dehumanization, abandonment and betrayal” (Makler, Sigal, Gelkopf, Kochba, & Horeb, 1990).

In order to share experiences within the group therapy context, a patient must establish a sense of safety and build a sense of trust for his or her peers and therapist. Being able to identify with people through shared military experiences can create a solidly rooted foundation upon which self-disclosure is possible. A safe environment in which to disclose information is created when a veteran feels connected to the group and feels that he or she belongs there.

Mutual understanding. “No matter how bad a situation was in the (Marine) company, it was still home…. I belonged in it and nowhere else. Most Marines I knew felt the same way about “their” companies in whatever battalion, regiment, or Marine division they happened to be….A man felt that he belonged to his unit and had a niche among buddies whom he knew and with whom he shared a mutual respect welded in combat. This sense of family was particularly important in the infantry, where survival and combat efficiency often hinged on how well men could depend on one another” (Hinojosa, 2011, p. 1146). Veterans form a sense of belonging with the men and women that they are deployed with. The “sense of family” often felt by
veterans amongst their military peers often provides a surrogate support system when other
support systems are unavailable during deployment, (family, friends, co-workers etc. that are
back home). Providing a therapeutic environment with this peer support system can be an
important factor for successful treatment, by allowing material to be expressed between this
support system, a support system built strongly on literal survival.

When group cohesion is formed through common life experience (war trauma) as well as
similar problems in the present time, the group members can then identify with one another and
the therapy can then move into deeper realms of processing and healing. A social identity
through the group dynamics has then been formed by the veteran, an identity often so desperately
sought and felt to be out of reach or impossible. This lack of social identity often provides a
ground for the symptoms of avoidance, isolation and feelings of self-alienation to occur for the
veteran, who does not feel connected to a social web outside of him or her. “Few men or women
who have not been deployed in combat can understand what the warrior has endured. This lack
of understanding creates an environment where the veteran may feel isolated and is reluctant to
share his or her thoughts and feelings with anyone except those who will understand: former and
current military members” (Hinojosa & Hinojosa, 2011, p. 1154).

Group therapy provides a foundation for veterans to begin the reintegration process into
society post-deployment. Mutual understanding through the sharing process of experiences with
other veterans eases the disclosure of extremely personal trauma, and helps the veteran begin to
feel comfortable with telling their story. Sharing with veterans who “have been there” can ease
the fears of feeling judged by others and slowly open doors to expressing these personal accounts
to the civilian community. “In group art therapy, troubling or shameful material is expressed
ART THERAPY AND COMBAT-RELATED PTSD

openly, witnessed non-judgmentally, and recognized and even appreciated by others” (Collie, 2006, p. 160).

Sharing traumatic material with others who understand and have also experienced military combat can make the integration process of the past, present and future (self-concept, self-esteem and self-ideal) easier to navigate. Self-esteem can grow through the reassurance of others and feelings of personal control when able to share experiences with others. “A sense of sharing the burden of overwhelming affect with someone else in a “holding context” gives these feelings a place to “live and become integrated” (Carr, 2011, p. 475).

Safety within group environment. By creating art, such as trauma narrative timelines with other veterans, a veteran can begin to tell their story with others who have “been there.” They can build trust in others, however strong the feeling of dissociation, or broken sense of self. Through the accounts of art therapists working with this population, the group art therapy process is successful in the telling of trauma stories, processing of stories, and aids the individual through their reintegration into civilian or post-combat military life.

According to Wilson (2009), “Healing from trauma depends upon communalization of the trauma- being able safely to tell the story to someone who is listening and can be trusted to retell it truthfully to others in the community. So before analyzing, before classifying, before thinking, before trying to do anything, we should listen…”Just listen!” say the Veterans when telling mental health professionals what they need to know, and I believe that is their wish for the general public as well” (Wilson et al., 2009, p. 398).

Creating a safe therapeutic space with listeners who can be trusted is a very important part of the initial therapy sessions with veterans. Veterans with combat-related PTSD no longer feel that the world is a safe place. Through communalization of traumatic experiences with those
who mutually understand, veterans can regain a sense of belonging and safety. A sense of belonging and attunement from others can help alleviate the chronic PTSD symptom of avoidance that can cause isolation for many veterans. “People don’t feel stronger with such traumatic experiences. Instead, a perceived loss of safety creates a sense of singularity and isolation, of “alienation and aloneness” (Carr, 2011, p. 476).

Military members form strong bonds with their fellow soldiers during deployments in combat missions. Other soldiers serve as surrogate family members, providing support and a sense of belonging during times that can be filled with intense combat experiences. Group therapy is an effective treatment option for veterans because group cohesiveness is built around common experiences and also similar experiences in the time post-deployment. Although veterans’ personal combat experiences will all vary in intensity and duration, veterans will all have to similarly integrate their experiences into a new personal narrative for successful reintegration into society post-deployment.

**Summary.** Combat-related PTSD symptoms of isolation and avoidance within the group therapy format can be minimized by acceptance and understanding from other Veterans. Sharing experiences with other Veterans also helps to address shame and break the pattern of rage, guilt, grief, abandonment and betrayal. A safe environment, a sense of belonging and the ability to express openly and to be witnessed non-judgmentally aids the Veteran in building self-esteem. Mutual understanding builds cohesiveness in the group therapy format and allows veterans to feel less threatened when sharing traumatic experiences with other veterans that have “been there.” “The self can become integrated through attunement of others in a therapeutic ‘holding context’ without the attunement of others Veterans cannot endure emotional trauma states and continue in a state of dissociation” (Carr, 2011, p. 475).
The group therapy format also mimics the group dynamics of the military. The personal relationships that military members form during deployments and during times of combat provide a large amount of emotional support (Hinojosa & Hinojosa, 2011). A group therapy format with other Veterans can help maintain the strong bonds between “military families” so that additional grief and loss does not occur. Mutual understanding through the group process can not only help one to feel understood and supported in order to form an individual post-combat identity, but also to form an identity that is socially connected and actively engaged in post-deployment society.

**Art Therapy Tools for Veterans Diagnosed with PTSD**

*Art therapy and trauma.* Verbal therapy alone is often times not effective enough for Veterans to create a coherent and cohesive trauma narrative. Words alone cannot hold the depth and feeling of a visual traumatic memory. Most of the trauma occurs as a persistent re-experiencing of the traumatic event in such forms as; nightmares, flashbacks and intrusive thoughts. Such symptomology is primarily visual in nature and is stored in the visual warehouse centers of the brain, which verbal therapy alone cannot access. “Traumatic memories are encoded differently than non-traumatic memories, “locked” in the right brain, and therefore less accessible through verbal language” (Stadler, 2010, p.1).

By externalizing traumatic memories visually in creative expression directly from their visual home centers in the brain, a veteran can continue to own these experiences, yet have control over them and their visual recreation through the art media. The veteran maintains a strong control over what is depicted and how it is depicted, therefore maintaining a sense of control of their own integration process of their newly constructed personal narrative. They are in control of their story and can use forms of visual metaphor and symbols which can be less
threatening then modes of verbal expression which are more concrete in nature. Veterans become the “observer” through externalizing the art material. They are then able to maintain a distance from the traumatic material displayed and able to examine it with more emotional distance, which allows more ease in eventually weaving this piece of their personal history into a revised self-concept for their future. “It was acknowledged that individuals with PTSD may have difficulties constructing a coherent trauma narrative with words alone and that art making provides a non-verbal form of communication that may be more suitable to consolidating and integrating traumatic memories” (Collie, 2006, p.160).

Art Therapy allows the veteran to control many aspects of the delivery of therapeutic tools. Clients can control the content of the visual material, the pace of the creation process and the selection of art media. This control throughout the therapeutic process can improve self-esteem, reduce hyper arousal symptoms through relaxation and self-regulation, reactivate positive emotions through reward-driven motivation and participation in a pleasurable activity, and boost confidence by being able to express one’s emotions effectively. “Trauma takes choice away from clients; treatment should facilitate its return by empowering the client to choose the direction, pace and intensity of treatment” (Johnson, 2012, p.56).

What often underscores the drive to make changes, to redevelop a fulfilling life, is the need to feel a sense of belonging and acceptance. This is a fundamental need for all humans, but especially for veterans who often feel that they are outsiders after returning from war. They believe that others cannot understand or “just won’t get it”. Before the processing of the traumatic material can begin, a sense of belonging must be established. This is the core element of the art therapy space, but also of all the other social realms: peers, family, the local community and hopefully our nation.
Addressing PTSD symptoms of emotional numbing and avoidance.

**Emotional numbing.** Research has shown that emotional numbing is not simply avoidance that provides protection against painful emotions (as previously thought), but an inability to feel both negative and positive emotions-as a result of emotional exhaustion due to prolonged hyper arousal.

According to Kashdan et al. (1992), “The inability to feel positive emotions is at least as important as the inability to feel negative emotions, because positive emotions are related to social activity, the broadening of psychological resources, and the pursuit of reward-driven goals and therefore have considerable impact on the ability to thrive in society. Recent research suggests that treatment for emotional numbing in PTSD needs to include pleasant activities in order to rekindle responsiveness to rewards and to re-establish adaptive social functioning” (Kashdan, Elhai, & Frueh, 2006, p. 218).

Art Therapy can provide an alternative route for Veterans who so often have difficulty putting emotions into words. Art Therapy allows Veterans to express emotions through symbolic and iconic mode. Veterans can reveal as little or as much emotion as they choose through an activity that is pleasant and rewarding. Art Therapy provides the key elements needed to target and treat the symptom of emotional numbing: distance from the experience, (control) a sense of mastery, (through creation of the artwork) sharing the experience with peers and therapist (relief of symptom of alienation) and acceptance (through the peer group and therapist). Through these elements it is possible to create positive reward-driven emotions to help re-establish safety and interest in social activities.

**Avoidance.** Art Therapy helps Veterans transform internal trauma into external trauma. When a mental image of trauma is taken out of the body and distanced from the combat survivor,
the material can be tolerated easier and is less threatening to the Veteran. This method of externalization helps with the PTSD symptom of avoidance that occurs because the traumatic experiences are too emotionally-distressing for the individual. Veterans do not feel comfortable talking about these experiences or hearing about them from peers. The symptom of avoidance often intercepts the success of trauma treatment with many Veterans leaving treatment early or getting “stuck” in treatment and unable to progress. “Researchers suggest that the debilitating symptoms associated with PTSD follow from the psychologically toxic effects of the memory of the traumatic event. These memories manifest themselves largely outside of the control of the individual, either arising involuntarily and obsessively or, in the process of suppression, motivating avoidant and maladaptive behaviors” (Kaiser et al., 2005, p. 3).

In order for traumatic experiences to be integrated cohesively into one’s life story, the symptom of avoidance must be addressed in the beginning stages of treatment. Art Therapy successfully does this by allowing the patient to take control of their memories through a slow externalization of the experiences. Then, from a distance outside of the body, the patient is able to reintegrate the emotionally difficult content through an enhancement of emotional self-efficacy. The artwork is contained within the art media in a safe therapeutic space. Through progressive exposure memories can slowly be constructed into a personal narrative rather than being avoided and uncontained within the patient. “Art therapy was presented as a way to address the avoidance symptom cluster through progressive exposure, in symbolic form, to stimuli that are being avoided and to emotions associated with these stimuli. It was pointed out that it is generally less threatening to express and reveal traumatic material non-verbally than verbally because the level of symbolism (more or less overt) can be more easily modulated” (Collie, 2005, p. 160).
Self-esteem, self-concept and self-ideal. Boudreau, (2008) includes a veteran’s personal account of integrating combat experience post deployment:

They say that war is hell, but I say it is the foyer to hell…I say coming home is hell, and hell ain’t got no coordinates. Hell is no place at all, so when you’re there, you’re lost. The narrative, that’s your chart, your own story. There are guys who come home and live fifty years without a narrative, fifty years lost…They live inside the narrative like a cell, and their only chance is to understand its dimensions…There is no single code to break. It’s ever changing. I don’t have a recipe, but there’s one thing I do know and that’s the power of the narrative. Put the story together. Understand the story. Ask questions of the story; make it answer you…You will find the answer. You keep building the narrative until the answer comes around.

There are art therapy tools that can be beneficial in the revision process of veterans’ conception of self in relationship to the world. These art therapy tools can address the healing of the “shattered self.” In chronic PTSD trauma can become the center of the identity, an identity that is shameful, out of attunement with others and alienated from society. Self-revision goals in art therapy can reconnect with the past, present and future selves, or self-esteem, self-concept and self-ideal. “Since the most basic psychological defenses are used to preserve the survival of the self, the organization of the self is in many cases permanently altered. First, a basic splitting or dissociation of self occurs in which those parts of the self associated with the trauma are set off from the other parts of the self. The attempt to preserve a sense of the good self, characterized by safety, control, and gratification, leads to an encapsulation and elimination of all aspects of the traumatic situation from consciousness” (Johnson, 1987, p. 7).
Art Therapy is effective in the process of reconstructing the trauma narrative. It helps the client to piece together their story so it becomes their story and not who or what they believe that they are. Art Therapy actively helps transform a traumatic experience that is still active in the present for the patient. Through an integration process the material becomes external to the patient, and a past experience rather then being still lived actively in the present.

While externalization and other methods of processing trauma help to rewrite a past narrative or self-ideal, there also must be methods to transform the patient’s present state. For those with PTSD, the present state is often unsafe and uncontrollable. It is the present that is in constant threat of being taken over by the past trauma. Emotional numbing and avoidance are linked to this present state for combat-trauma, which interfere with the ability to experience positive emotions in the present. Often times the traumatic memories revisit the Veteran exactly how they occurred in the past, creating an ever-present fear of arousal symptoms.

After the traumatic material is externalized, contained and processed, Art Therapy can then begin to reconstruct the personal narrative and build self-esteem in the space left behind by the processing or processed traumatic material. Improved self-esteem can be attained through the following art therapy mechanisms: a gained sense of mastery by controlling the output and frequency of traumatic material (self-management), the reciprocation, recognition and appreciation of others in a group art therapy session, being supportive and empathetic of others in a group art therapy session, the pleasurable, relaxing benefits of creative expression, building confidence through the control of self-expression to self and others, the participation in a goal/reward driven activity (the process and final piece of art) and regaining responsiveness to rewards.
Along with all of these self-esteem focused aspects, art making in and of itself is an activity that helps one to be in the present, enhancing focus and concentration. When self-esteem is lifted it is much more possible to construct a future self-ideal. The patient has restored confidence and control in their abilities in the present and by doing so, can restore hope in carrying these abilities into their future. “For the “normals,” or non-traumatized, a moment in time always contains the person’s past, the present, and perceptions of the future. All three of these dimensions are present and united in any given moment. For those who have experienced emotional trauma, unification of these three dimensions of time is shattered, just like the rest of their experiential worlds. The person may still feel trapped in the moment of emotional trauma, unable to escape that past as it constantly invades and dominates the present” (Carr, 2011, p. 476).

**Directive vs. non-directive approaches.** Among the literature of art therapy tools used for veterans there is not much reference to directives using metaphor to help with issues of self (mask-making being one of the few that is written about often). I believe that directives such as using mirrors, various containers (for the concept of a holding place), windows, self-symbols, and nature based metaphors, (such as creating a bird’s nest as a metaphor of safety), could be beneficial. Through metaphor, traumatic material could be released in a form that may be tolerated easier by the veterans and held at a comfortable distance. It could also give them a sense of control when first beginning to tell their trauma story by allowing them to expose as little or as much of the trauma that they feel comfortable with.

Using more of this metaphorical approach could be extremely beneficial and aid in the processing portion of treatment. However, art therapists give mixed reviews regarding directive versus non-directive approaches. “In general, therapists working with younger populations (e.g.,
medically injured children) favored more structure than therapists working with older populations (e.g., war veterans and war refugees). An art therapist with extensive experience working with war-zone veterans claimed it is crucial for veterans with PTSD to have the freedom to self-direct because permission for free expression gives the message that they can handle whatever emotions may arise” (Collie, 2006, p.161).

Non-directive approaches give veterans a sense of control and self-mastery, which are important factors in enhancing self-esteem and self-efficacy. However, a more directed approach, or an approach with both directive and non-directive art, may help the progress of treatment to be more measurable in regards to the overall outcome of art therapy treatment.

**Current practices.** Although Art Therapy has been offered through VA mental health services since 1945 and established as a job series since 1980, (GS638 series for Creative Arts Therapists and Recreation Therapists) individuals still have limited access to art therapy services partially because art therapy as a treatment for PTSD has not had the appropriate evaluations. According to Kaiser (2005), “Such institutional change, however, will not happen in the absence of compelling evidence from large-scale, peer reviewed, multi-year studies that use control groups to compare the effect of art therapy to other treatments.”

Current practices are promising and do address and minimize “negative” symptoms such as emotional numbing and avoidance. They also address the rebuilding of a trauma narrative through exploring the aspects of the self: self-esteem, self-concept and self-ideal, however further examination into these specific areas is needed. Particularly the examination of the tools used to address the relationship with identity and reintegration into post-employment society and the cognitive schemas that play a role in successful reintegration.
Before a trauma narrative can be created a level of safety must be present. Current practices emphasize the importance of management in regards to destructive and self-injurious behaviors. Part of the art therapists’ role is to make sure a certain level of safety is obtained for the client. Art therapists also help Veterans self-manage distressing symptoms by providing self-soothing tools and creating an environment that acts as a safe container for distressing feelings, thoughts and behaviors that may emerge. Art therapy utilized during the initial stage of treatment includes techniques adapted to: learn how to use art-making to relax (reduce hyper arousal), regain control, and build trust. “Expression and management-type art interventions are most often used during this phase. Cognitive restructuring, problem solving, relaxation, and self-care strategies are methods used in management-type interventions” (Rankin, 2003, p. 140).

In this initial phase the sense of distance between the veteran and the artwork is also important. With the act of art-making itself, (rather then the material produced) Veterans can gain a sense of control by the physical distance between themselves and the artwork, but still being in control of this physical extension of themselves. Separating the trauma from the person is one of the main goals of the initial phase of treatment. This distance provides a sense of safety. “During this stage, art directives that help clients access safety and self-soothe are useful, such as: draw a safe place (one that is known or imagined); draw a protector; and decorate a container to hold difficult feelings” (Rappaport, 2010, p. 2).

During the initial phase it is imperative that the art therapist is able to build a therapeutic relationship with the patient so that the therapy can advance to the next stage of treatment. The therapist must assume also, the role of container. “After containing the veterans’ reality, both the shared and the unique, within herself, and linking to the veteran, the clinician can move toward
enabling a co-constructed narrative of past, present and future to begin to form in the consulting room, and allowing the veteran to begin to heal” (Bragin, 2010, p. 317).

Current practices almost all agree that a new personal narrative must be enabled in order to reconstruct the sense of self. Similar clinical approaches are being utilized by present art therapists in the field, but there is limited research on these approaches from an Adlerian perspective.

Masking making is one directive used by art therapists working with veterans that addresses identity and the Adlerian concept of cognitive schemas. Melissa Walker, an art therapist at Walter Reed National Military Medical Center (Cronk, 2012) said the following about mask-making with veterans: “Service members’ mask designs vary, she said, recalling a service member who divided his mask into the halves of two faces, depicting how he saw himself as both a civilian and a member of the military. The split-self has to do with identity, she said. Some who still have war images in their minds might design a scene of the injuries they and their fellow troops suffered. The groups discuss their mask creations and what they mean” (Cronk, 2012, p. 1).

Other art therapists have written about the aspects of self that reveal themselves through the art. These aspects of self are often described as dissociated or split. One of the goals of the “working through phase” or processing phase is to integrate these split aspects of self into a cohesive narrative. By doing so, one can then successfully reflect upon his or her perceptions to better understand and know the transformations that have occurred to the inner self from combat experiences. Deborah Golub, EdD, ATR, has presented case studies of Veterans art that reveal split or opposite aspects of self reflected within the art. “The process was not easy and often was characterized by ambivalence. A sense of duality wherein vets simultaneously experienced
opposite aspects of self permeated both art products and process. Specifically, men oscillated between emotional flooding and the need to fend off feeling” (Golub, 1985, p. 288).

Golub used primarily non-directive art therapy approaches through her case studies. Veterans had the choice of various media, everything from pencil to clay. Through this non-directive approach themes of timelines, “before and afters,” (before and after combat) self in various roles (as soldier and civilian), self as victim/agent and self as living/dead emerged. These emergent themes mirror many directives art therapists use to help veterans explore the concept of self in the past, present and future. From Golub’s non-directive approach, however, Veterans slowly worked through the conflicting aspects of self, self-initiating the portrayals of self. They are often gradually able to separate the dissociated parts of self through a series of drawings and artworks to create a sense of past, present and future, or unite the selves in an attempt to put “the pieces back together.”

Other current art therapy practices also include directives that focus on integrating the often dissociated parts of self that are common among veterans with PTSD. There is often, even without a directive, as in the case of Golub’s non-directive approach, a theme of self that arises out of the veteran’s artwork. It is a visual dialogue that the Veterans self-initiate to better understand who they were, are, and will become. “Walker said the service members with psychological health issues and traumatic brain injury have “layers and layers of complications. In a similar manner, the montages they design often reflect the past, present and future of who they are, which helps them clarify their sense of self” (Cronk, 2012, p.1).

Various adaptations of a series of three drawings are utilized by art therapists currently practicing, but the overall therapeutic goal of these three drawings is similar. Although the three drawings are often separate (although sometimes combined into one as in Golub’s case study)
each drawing carries a piece of the story of the drawing before it. The trauma, for example, will always be there for the Veteran, but it can be integrated visually into a new outlook for the present and future. The trauma can be transformed into a chapter of the life story, and not the life story itself. In other words, current art therapy practices aim to diminish black and white, or all or nothing thinking. “Overall revision goals include creating a “life review” to acknowledge pleasant, unpleasant, and neutral memories of the time before, during, and after the trauma; identifying resources, strengths, beliefs, and skills not inherently impaired by the trauma; and affirming dignity and self-worth along with imperfections” (Rankin, 2003, p. 141).

Asking clients to create three separate images to represent the time before trauma, during trauma and after trauma would be an example. Rankin (2003) also suggests asking the clients to create three drawings: the traumatized self, the un-traumatized self and a third that combines elements of the first two. Then the author suggests having the client create a “worldview revision series” with each drawing having separate backgrounds. One would represent an environment filled with trauma, another a trauma-free environment, and a third that combines elements of the two. Then the author suggests having the clients do the following: “…move each of the three self-images onto each of the three backgrounds and talk or write about the nine resulting compositions, using “I” statements, relating the compositions to past and present and to distorted, idealized, and more realistic outlooks” (Rankin, 2003, p. 140).

The formation of an effective art therapy process. An effective art therapy process for Veterans with combat-related PTSD would include the following elements: a therapeutic space and art therapist presence build upon a foundation of safety, active listening to the Veterans’ stories and the allowance of time for the Veteran to tell his or her story within the safe space, group therapy format grounded in the empathetic presence of other veterans, an emphasis on
exploration of self in the past, present and future, construction of a post-combat personal narrative and active involvement within the society at large.

Laying groundwork of safety and building a therapeutic relationship through empathy and trust must be accomplished before the externalization of trauma can take place. Veterans often come to therapy with massive defenses and self-protective measures. These defenses serve them so they will not become overwhelmed with the traumatic events and often debilitating emotions such as guilt and shame that occur from witnessing scenes outside of the scope of normal human experience.

Ways to create a safe therapeutic space for the veteran include the following: treating the Veteran as an equal, focusing on the Veteran’s strengths, allowing the Veteran to control the pace and course of treatment, group rather than individual therapy to provide empathy and support from peers who “have been there”, and providing a peaceful, calm physical space that is soothing to the senses, (considering lighting, sound and individual working space within the shared space.) Creating a space with these elements can support the Veteran and help ease avoidance through empathy and allowing them to be in control of the artwork by how little or how much they are willing to share in the session. “The most profoundly healing aspect of art therapy came neither from men’s interaction with materials nor from my presentation of techniques. Rather, it arose from the human relationship” (Golub, 1985, p. 287).

Longer-term therapy is preferred over short term therapy. There is often layers and layers of complex emotions and defenses that Veterans have built for themselves as a way to cope with the intrusive symptoms, persistent re-experiencing of traumatic events and intense feelings. Accessing and processing the traumatic events should occur over the course of many sessions, so not to re-traumatize the Veteran and a non-directive approach is favored to allow Veterans to
reclaim control of their personal narrative. “An art therapist with extensive experience working with war-zone veterans claimed it is crucial for veterans with PTSD to have the freedom to self-direct because permission for free expression gives the message that they can handle whatever emotions may arise” (Collie, 2005, p. 161).

The freedom for veterans to self-direct and slowly gain control of the traumatic material are two very important factors to consider as an art therapist working with veterans. Not only do veterans need a safe environment for the therapy to take place but they also need to be able to trust the listeners of these experiences. Group therapy with a small group of veterans is ideal so that the veterans can give each other feedback and have time to share experiences as well as discuss the material presented in the individual art if they choose.

Art therapists should be aware of the importance of their role as a listener and witness to the veterans’ stories. Listening is an important part of building a therapeutic relationship with this population. The role of listener should be emphasized because veterans can be avoidant and hesitant of revealing experiences often times because of societies lack of acknowledgement of their experiences, (or negative acknowledgement) and because of fear of re-experiencing the trauma that they have tried to hide even from themselves, because of the intensity of such experiences.

Within a small, group therapy environment veterans can form social bonds with other veterans and build trust based on common experiences. They can also build trust with the art therapist who listens, practices empathy and is able to provide the tools for the Veteran to build upon strengths and a positive outlook for the future. “I approached veterans with an attitude of genuine care and respect. I did not consider their PTSD a “disorder” but rather a normal, self-protective response to extremely abnormal situations of war. In other words, I focused on their
strength and resilience. I did not treat veterans as patients but as equals and as individuals, honoring their intelligence, their struggle, their right to determine their course of treatment” (Golub, 1985, p. 287).

Once a foundation of safety and trust is established, the processing phase can begin. Although a non-directive approach is favorable (to allow self-direction and self-control) there are a few directives that can be helpful in the processing and reconstruction of a new self-narrative. “Through non-verbal expression and progressive symbolic exposure, traumatic memories are recalled, expressed, and consolidated into a coherent trauma narrative (verbal or visual) that is owned and acknowledged by the person and seen as part of the person’s past” (Collie, 2005 p. 161).

Art directives that integrate visual images of the past, present and future can help the veteran’s create a chronological trauma narrative. Perhaps most important for treatment goals regarding reintegration into society and a positive outlook for the future self-ideal, would be the third image in these series. In these images the trauma is combined with a non-trauma ideal or environment. This visually represents a future state that is not trauma free, but rather one that is built upon events of the past. In this way the directive is not about forgetting the trauma, leaving it in the past, or ignoring it (which trauma survivors attempt to do, and as a result often experience PTSD symptoms of flashbacks or nightmares) but blending that experience with a new ideal. The goal is to create a linear sense of continuity into the future, a continuity of movement, rather then cycling backward to the traumatic experience and getting stuck in that place.

Art directives such as the timeline trauma narrative can help a veteran create a cohesive timeline of their life and experiences. Recreating a sense of time can also help veterans
reintegrate with the rest of society. By getting “unstuck” in the traumatic experience (or living in a shattered self-concept, of where they belong and who they are) veterans can move past them and process what these experiences mean to them now, and how these experiences will shape themselves during the construct of a new future ideal.

Another effective directive, similar to the trauma timeline, would be to create a safe place, a second image of the traumatic place and a third image that combines the safe place with the traumatic place. This directive can help to reintegrate the past with the future, rather than avoiding the traumatic material, but also can be used to visually depict the contrast between the two places. Colors, shapes and lines can be observed which correlate with the sense of safety in the “safe place.” These calm representations of a safe place can be a foundation for redeveloping the self-ideal. “The ultimate goal of trauma therapy is to help Veterans make changes to redevelop a fulfilling life and reincorporate meaningful activities that are frequently abandoned as an expense of ensuring their perceived sense of safety” (Stadler, 2010, p.2).

Directives such as mask making and self-portraits can be useful in revealing a Veterans self-concept and self-ideal for themselves in the future. The process of sharing masks and personal portraits with other veterans can build upon a veterans self-esteem by giving them confidence through the validation of their personal stories and creation of the artwork along with reactivating positive emotions and enhancing goal-driven motivation through the process of the artwork itself. “The groups discuss their mask creations and what they mean. Walker said these discussions bring up personal and symbolic experiences. Sharing and discussing artwork establishes a sense of community and bonding with one another, which is particularly helpful to those with post-traumatic stress who tend to isolate themselves and don’t trust others, she said” (Cronk, 2010, p. 1).
The next crucial step to a successful art therapy practice with veterans is the construction of the post-combat personal narrative and active involvement within society. The goal of directives such as the trauma timeline in the art therapy group, is for the Veteran to no longer associate the trauma with who he or she is in the present, but rather to associate the trauma with his or her past. Once combat traumas become a part of one’s history, Veterans can share these experiences with others (family, friends, colleagues, the public). Once these experiences become integrated, they no longer pose a threat to the Veteran’s self in the present (by bringing debilitating symptoms with them) rather, Veterans can gain self-esteem and reintegrate socially with others through attunement and empathy of such experiences as a part of their past.

As important as it is to provide a group therapy format with fellow Veterans and to maintain military friendships, it is also as important to address the Veteran’s family situations. “15% to 17% of returning veterans are experiencing PTSD. This means that literally thousands of military returnees are returning home with a serious mental disorder that not only affects the soldier, but his or her family system as well. As noted by Moon (2006), “Now more than ever, counselors need to educate themselves about PTSD treatment and to be prepared to offer innovative individual and family therapy to military families” (Garske, 2011, p.63).

An effective art therapy process should include involvement of the individual’s family and close support systems. The veteran’s sense of self is changed from combat-experience despite the varying levels of intensity and number of deployments. Families need support because the individual coming home is altered from the individual that left and this in turn can alter the family dynamics from what they once were. Having an art show at the end of treatment specifically for family and loved ones is one option. Another is to actively involve the family in art-making. Melissa Walker includes family art-making as a part of her practice: “One night a
week, family members come to Walker’s family class to do the same projects as the service members, to give this group of caregivers a break and a chance to breathe” (Cronk, 2012, pg. 1).

Society too, has a role to play in Veterans’ successful reintegration into post-combat life. “As long as the veteran is seen as alien other, whose changed view of the world is to be treated not as a normal response to extreme violence, but as a sickness from which recovery is to be achieved; it may be difficult for veterans to heal and equally difficult for society to grow” (Bragin, 2010, p. 318).

Veterans’ artwork can successfully bridge the divide between themselves and the rest of society. Actively displaying art work at the end stages of treatment allows Veterans to share their past trauma in a safe and controlled way (contained within the canvas and the trauma content revealing as much or as little as the Veteran desired to expose) The effect can be immensely strengthened by the work of fellow peers and comrades placed next to their own, like a military formation of soldiers standing at attention, fully saying without words “this is who I am, this is what I stand for” a body of art work has the ability to command the viewers’ attention without words, yet speaking silent volumes of commanding presence.

There are currently various programs that exhibit veteran’s art in the community. This connection with community is a vital part of the formation of an effective art therapy process. Wilson’s article highlights the work of the Veterans Education Project (VEP) and the “100 Faces of War Experience” project (100 Faces). These organizations encourage Veterans to tell their stories of wartime experiences. Not only does the author claim that it can help the Veterans find a “pathway to healing” but also that it gives the audience a sense of understanding of soldiers’ experiences. The personal soldier accounts can ignite a need for the public to respond to our Veterans and walk alongside them down the hard and arduous roads of reintegration into society.
The veteran’s sense of self can transform from a shattered identity to one that is integrated by finding a place in the larger whole of society. Art, as a real extension of the veterans self, is a powerful vehicle of connection. By viewing a veteran’s artwork, the viewer shares the veteran’s experience and in a sense becomes a part of the experience. A veteran is then no longer on the fringes of society, but rather actively becomes a part of it, by sharing their artwork with others. This act of integration is also evident in other creative therapies, such as drama therapy: “For the group members, who perceive themselves as alien, the audience’s identification with their struggles brings about a sense of belonging to the larger community rather than exclusion from it. The self, already part of a small group, now becomes part of the world” (Emunah & Johnson, 1983, p. 238).

**Summary.** Art therapy is an effective treatment option for combat-related PTSD because it directly reduces symptomology of PTSD (including hard to treat symptoms of avoidance and emotional numbing) by developing emotional self-efficacy, reactivating positive emotions, creating emotional safety and social bonds among veterans. Externalization of the traumatic material through the art therapy process allows the veteran to examine the trauma with more emotional distance, allowing the veteran to gain self-control of their story and a foundation to construct a new self-narrative which weaves together dissociated parts of self into a coherent timeline of past, present and future (Collie, 2005).

Non-directive approaches are favorable to directive approaches because they allow the veteran to self-direct, building self-esteem (positive emotions in the present) and enhance motivation and reward-driven goals (Collie, 2005). A three-stage process is recommended: establish a safe place, so that Veterans can gain access to traumatic memories in a safe and controlled way. The second stage is to transform the trauma from a re-living of the event to a
memory that can be recalled when one wishes. In the third stage the Veteran needs to re-join the world of others through interaction with other trauma victims, to tell their stories to others and to go on with one’s life (Johnson, 1987, p. 9).

The art therapy directives most commonly used with Veterans have a goal of re-integrating the Veterans sense of self and include: timeline trauma personal narratives, mask-making, montages, creating a safe place and group collages. The formation of an effective art therapy process includes creating a safe therapeutic environment, building trust between the therapist and other group members, giving Veterans freedom to self-direct and engaging family members and society in the process of the Veterans healing. By allowing oneself to take in and share an experience with the Veteran through the vehicle of art, empathy and attunement can exist and veterans may not feel as alienated or on the fringes of society. They can reestablish a sense of belonging that is lacking for so many veterans post-deployment and become an active member of society

**Methodology**

**Online Data and Research**

This researcher compiled information from thirty-three peer-reviewed journal articles and sources to answer the following research questions: What tools can be useful for veterans with combat-related PTSD to reconnect the pieces of a shattered self and explore self-identity? In which ways is art therapy effective in examining the past, present and future selves, (self-esteem, self-concept and self-ideal)? How can art therapy help veterans re-integrate into society by blending past experiences into new identity formations?

There were approximately fifty-two journal articles that were read and reviewed over an eighteen-month period during the process of compiling information and narrowing down sources
to include in this study. Topics that the author focused on included: The prevalence of PTSD and effect of multiple deployments, the reintegration of identity post deployment(s) (self-concept, self-esteem and self-ideal), a group therapy format, current art therapy practices with veterans and a formulation of an effective art therapy practice as a template for art therapists working with veterans with combat-related PTSD in the future. The goal was to discuss the current need for art therapy as a treatment for combat-related PTSD and formulate a successful group art therapy process specifically with tools developed for exploration of personal identity and reintegration into society through the means of blending past experiences into new identity formations post deployment(s).

Summary, Conclusions and Recommendations

Final Summary

This literature review strived to answer the question: Does group art therapy successfully reintegrate Veterans’ experiences of past, present and future into coherent personal narratives in order to provide a successful treatment for combat-related PTSD? Furthermore, which specific art therapy tools are useful in the exploration of self-identity and formation of a new post-combat identity? These research questions were developed in order to address the need for effective treatment for Veterans with combat-related PTSD. Effective treatment is necessary because currently there are no treatment methods that have proven to be effective for combat-related PTSD and large numbers of Veterans are returning home with PTSD after experiencing 1 or more tours of duty.

The purpose of this literature review was to discover a treatment that successfully reduces symptomology of PTSD and helps reintegrate traumatic experiences through a new identity formation. The ultimate goal of this treatment is for Veterans to successfully reintegrate into
society post deployment. The evidence found in the literature reviewed in this paper suggests that art therapy approaches and current practices help to reduce symptoms of PTSD and help with the reintegration process. A formation of an effective group art therapy process is also examined that can be useful for art therapists working with Veterans in the future. The prevalence of combat-related PTSD in U.S soldiers serving in combat-related activities can be difficult for researchers to measure. According to Garske (2011), based on a Congressional Research Service Report for Congress by Fischer (2009) between the years of 2003 through 2007, the Military Health System (MHS) had recorded 39,365 patients who were diagnosed with PTSD. It is estimated however that only 10% of male and 26% of female active duty personnel reporting symptoms will pursue treatment.

Reasons that Veterans do not seek treatment for PTSD symptoms, according to Garske (2011) are factors such as avoidant coping strategies associated with PTSD, frequent deployments (that destabilizes home and living arrangements) and fears that seeking help will have a negative impact on their careers. According to Castro (2009), a report issued by the Mental Health Assessment Team #4 concludes that “longer and multiple deployments are likely to lead to more mental health issues” (Castro, 2009, p. 259). As the United States continues to utilize military presence in world conflicts and continues to send military veterans on multiple deployments to combat areas, more and more veterans will need effective PTSD treatment options upon return. According to Garske (2011), Research indicates that troops serving in current conflicts are experiencing PTSD and other mental health issues on a scale not seen since the Vietnam War.

Current treatment options for PTSD are not effective because they do not address all of the symptoms of combat-related PTSD. According to Collie (2005), standard treatments for
PTSD bring a reduction in symptoms such as hyper arousal, intrusive thoughts, nightmares and anger. They do not appear to be effective in reducing the symptoms that often lead to combat-related PTSD becoming chronic: avoidance and emotional numbing. Art therapy can address the characteristics of emotional numbing that are; a disinterest in activities, detachment from others, and a restricted range of emotional expressiveness. Emotional numbing along with avoidance can be worked through by using art therapy tools that process the traumatic material, reintegrate the parts of self (self-concept, self-esteem and self-ideal), build safety and trust through the attunement of others in a group process, provide a sense of control and a pleasant, relaxing activity.

Based on the research by Collie (2005) with combat veterans, she has outlined a conceptual foundation for using art therapy as a treatment for PTSD. Characteristics that distinguish art therapy from other forms of treatment for PTSD include the following: relaxation, non-verbal expression, containment (of traumatic material within an object or image), symbolic expression, externalization and pleasure (of creation) (Collie, 2005, p. 159). These characteristics address the symptoms of avoidance and emotional numbing by: reducing hyper arousal, facilitating the expression of memories and emotions that are hard to put into words, giving the veteran a sense of control, promoting self-efficacy, making the progressive exposure of traumatic material tolerable, helps Veterans claim ownership and control of trauma and builds self-esteem.

In the research gathered by Schok, Kleber and Lensvelt-Mulders (2010) it is pointed out that there is a growing body of empirical studies recognizing that processing threatening events results in personal growth or psychological benefit. It is also noted that; “Personal resources, such as self-esteem, optimism and perceived control are expected to support the processing of threatening experiences” (Schok, Kleber & Lensvelt-Mulders, 2010, p. 328).
Self-esteem is also built during art therapy treatment by sharing artwork and personal experiences within a group setting and being validated by other veterans. Melissa Walker, an art therapist currently working with veterans says that when groups discuss masks they’ve made (that represent the self) personal and symbolic experiences are brought up and shared within discussions. “Sharing and discussing artwork establishes a sense of community and bonding with one another, which is particularly helpful to those with post-traumatic stress who tend to isolate themselves and don’t trust others” (Cronk, 2010, p. 1).

The enhancement of self-esteem gained through the self-control of the art-making process and through the validation and attunement of others, assists the veteran in creating a new self-narrative. After the trauma narrative is integrated and the trauma becomes a part of the veteran’s history, the veteran can establish a new self awareness in the present.

Art therapy research has concluded that art making builds self-esteem, integrates all parts of self (past, present and future) helps veterans regain feelings of self-control, self-mastery and safety. Veterans built trust in their peers in the group art therapy format, which can extend to other interpersonal relationships outside of therapy. They build trust by not feeling isolated or detached from others and by learning that they can expose intimate parts of their experiences and not be judged, but rather respected. They regain a sense of safety by releasing the trauma in a visual format, process at a distance and release the images from the roles that they once played in the individual’s identity. Veteran’s can then be able to regain control in their lives through a newly constructed self-narrative and worldview revision. All of these factors warrant the need for more research and clinical studies on the effectiveness of art therapy for veterans with PTSD. “Art serves to help develop a different perspective and break black-or-white thinking, to illustrate and remind that happiness is indeed possible. Helping to change Veteran’s perspective
to see the world as something other than an unsafe place opens up possibility to develop self-sufficiency, reintegrate into society, and develop more meaningful lives” (Stadler, 2010, p. 2).

For Veterans to reintegrate and become an active participant in society post-deployment, society must be willing to support them in the reintegration process. “As long as the veteran is seen as alien other, whose changed view of the world is to be treated not as a normal response to extreme violence, but as a sickness from which recovery is to be achieved; it may be difficult for veterans to heal and equally difficult for society to grow” (Bragin, 2010, p. 318).

Adlerian literature reviewed for this paper suggests that: “...individual responses to combat experiences can be understood in terms of Adlerian variables of self esteem (SE) and social interest (SI). The affected veterans are severely discouraged persons” (Blackburn, O’Connell & Richman, 1983, p. 318). Positive emotional responses gained through an effective art therapy process can restore both self-esteem and social interest allowing the veteran to thrive in society (Blackburn, O’Connell & Richman, 1983, p. 331). From this Adlerian viewpoint, it is recommended that veterans with combat-related PTSD are encouraged. Encouragement can be found in an effective art therapy process through the attunement and trust of the therapist and group members and the creation of a new self-narrative in a safe therapeutic space. Encouragement should also come from the community that the veteran is re-entering.

Research points out that the rate of PTSD among veterans engaged in current conflicts is on a scale not seen since the Vietnam War (Garske, 2011, p. 31). The message today is not too far from the writings of Golub (1985) when discussing the need for society to accept and encourage Veterans to come back into the world, though altered and reconstructed. “We must recognize and remember the extraordinary strength and resilience of the human spirit that these
individuals represent. We must risk hearing their stories and witnessing their special knowledge. We must learn from them” (Golub, 1985, p. 295).

Conclusion

The measurement of veterans with combat-related PTSD is difficult to accurately formulate due to various factors effecting access to treatment including, but not limited to: stigma of mental health in the military, unstable living situations, avoidant coping strategies and fear that seeking help will negatively impact veterans’ careers (Garske, 2011). Although it is difficult to measure the number of cases of combat-related PTSD, it is imperative that a treatment exists that will prove to be effective in reducing symptomology, particularly the symptoms of avoidance and emotional numbing which are factors in combat-related PTSD becoming chronic (Collie, 2005). Such chronic symptoms can further deter veterans from seeking treatment in the future and cause PTSD to become more complex and therefore more difficult to treat. Current treatment modalities are often lengthy and intensive and no single treatment has proven to be effective in treating the chronic symptoms of avoidance and emotional numbing (Collie, 2005).

Based on the findings of the research, art therapy is suited to treating these symptoms. The unique factor of art therapy treatment is its visual therapy component. Research shows that trauma is processed differently then other experiences in the brain and verbal language is not sufficient enough to successfully process traumatic experiences. “Art has been described as “the key that unlocked those things I had locked away forever”. Traumatic memories are encoded differently than non-traumatic memories, “locked” in the right brain, and therefore less accessible through verbal language” (Stadler, 2010, p. 1).
The research found regarding Adlerian approaches to combat-related PTSD suggests that an Adlerian treatment model focuses on veterans’ self-esteem and social interest to successfully help the veteran reintegrate into society post-deployment. “Our clinical experience suggests that individual responses to combat experiences can be understood in terms of Adlerian variables of self esteem (SE) and social interest (SI). The affected veterans are severely discouraged persons. Courage (active social interest) with which to manage routine life tasks has been lost, while physically threatening, high-risk situations may be sought in useless strivings for power and control” (Blackburn, O’Connell & Richman, 1987, p. 319).

The art therapy research reviewed suggests that art therapy can successfully address both self-esteem and social interest. Self-esteem can be reestablished by the veteran’s visual externalization of the trauma and the control and mastery of the re-creation of the trauma. Through the process of creating a new trauma narrative, veterans can replace the traumatized self that has resided in the veteran’s present state, with self-esteem and the ability to express emotion through pleasurable creative expression. The pleasure of creating reduces emotional numbing and further boosts self esteem (Collie, 2005).

Social interest can be addressed through an art therapy group process and through the courage it takes to tell the trauma story, and the positive rewards gained through having the trauma story accepted by peers, family, the community and society. “It was Tichener’s view that the difficulty arises when both warrior and society see his or her task as preventing the entrance of violence, real or imagined into the city gates, and thus believes himself or herself required to split off genuine experience from expression in the peacetime community. The violence is then contained within the warrior, split off, not understood, but lying in wait to cause outbursts or debilitating depression at any moment. Thus Titchener opens the door to discuss the need to
accept the wartime narrative, with all of its violent parts, as essential to the wellbeing of returning combat veterans” (Bragin, 2010, p.319). The formation of a successful art therapy program will combine group therapy, sessions which work to address the symptomology of PTSD, including avoidance and emotional numbing, a safe therapeutic space to create a new personal trauma narrative, and a connection with family, community and society through the artwork itself.

**Recommendations**

There is a need for quantitative research in art therapy. Because art therapy is generally qualitative in nature and treatment with veterans is often short-term, it can be difficult to establish research that spans a longer time period and with easily measurable results. Development of this research, though perhaps difficult, would be highly beneficial for the future of art therapy treatment for combat-related PTSD. “Currently, individuals suffering from PTSD have extremely uneven and limited access to art therapy. The evidence thus far suggests that art therapy should be thoroughly integrated within the nation’s mental health and trauma response systems. Such institutional change, however, will not happen in the absence of compelling evidence from large-scale, peer reviewed, multi-year studies that use control groups to compare the effect of art therapy to other treatments” (Kaiser, 2005, p. 2).

Other recommendations for art therapists working with veterans with combat-related PTSD include: a group therapy approach, creation of a safe environment, extra emphasis on building trust with client, relatively brief treatments because of often unstable living arrangements, and involvement with family and community. “More attention needs to be given to treatments for combat-related PTSD that are appropriate for complex PTSD, can reduce immediate symptoms, and can facilitate the organization and integration of traumatic memories
in order to address the underlying situation that gives rise to the symptoms. These treatments should be relatively brief, but not burdensome to patients, and effective in the long-term. Art therapy may meet all these criteria” (Collie, 2006, p. 159).
References


