

Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP)

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Abstract

“We use our minds not to discover facts but to hide them.” Antonio Damasio

“Art makes the invisible visible.” Paul Klee

In this article I propose an art therapy trauma protocol (ATTP) designed to address the non-verbal core of traumatic memory. Trauma theorists [van der Kolk, B.A. (2003). *Frontiers in trauma treatment. Presented at the R. Cassidy Seminars*, St. Louis, MO 2004; Steele, W. & Raider, M. (2001). *Structured Sensory Intervention for Traumatized Children, Adolescents and Parents-Strategies to Alleviate Trauma*. New York: The Edwin Mellen Press] have endorsed alternative treatment methods such as eye movement desensitization reprocessing (EMDR), body-based psychotherapy, and expressive arts therapy as an alternative to verbal psychotherapy. Following an overview of the role of memory and emotions in trauma and theories of art making and brain function, I describe a protocol that has had success in integrating the cognitive, emotional and physiological levels of trauma drawing on EMDR, McNamee’s bilateral art and Michelle Cassou’s method of painting. A one-session example serves to illustrate its use.

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In this article I propose an art therapy trauma protocol designed to address the non-verbal core of traumatic memory. Recent developments in neurobiology have shown that memory is an active and constructive process, and that “the mind constantly re-assembles old impressions and attaches them to new information” (van der Kolk, 2002, p. 2). Most memory researchers “deny that the mind is capable of precisely reproducing the imprints of prior experience,” (p. 2) including precisely recalling memories of smells, images or sensations. Individuals diagnosed with post-traumatic stress disorder (PTSD), however, report exact sensations, memories and emotions related to the trauma, and sometimes do so months or even years later. Individuals with PTSD symptoms experience a lack of control, as if they were involuntarily reliving the trauma, even when they may be aware of the disproportionate nature of their reactions. One of the primary challenges for the psychotherapeutic process is regulating the sensory imprints associated with trauma.

In recent years, advances in neurobiology and psychotherapy have informed the practice of art therapy, which has increasingly been utilized when verbal psychotherapy has failed to help clients. Numerous therapists have reported the benefits of creative arts therapies in their settings (Chapman, Morabito, & Ladakakos, 2001; Brett & Ostroff, 1985; Howard, 1990; Klorer, 2000; Rankin & Taucher, 2003; Yates & Pawley, 1987, among others), although few controlled studies have been published. Researchers in the field of art therapy have begun to pay attention to neurobiology and

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its relationship to art making and its implications for art therapists (Chapman et al., 2001; Klorer, 2005; Lusebrink, 2004; McNamee, 2004). Chapman et al. (2001) published a study with pediatric trauma patients. They reported that although the clinical trial did not indicate significant differences in the reduction of PTSD, there was evidence that children receiving art therapy did show reduction in acute stress symptoms. A recent study, however, conducted at Thomas Jefferson University, Philadelphia, provides data on improvement of the quality of life (Monti et al., 2005), and emphasizes the connection between the body–mind and creativity, illustrating the efficacy of art therapy.

In trauma treatment it is not the verbal account of the event that is important, but the non-verbal memory of the fragmented sensory and emotional elements of the traumatic experience (van der Kolk, 2003). Art therapy has long been recognized as a method that constitutes a primary process (Kramer, 1958; Levick, 1975; Naumburg, 1966; Rubin, 1984; Ulman and Dachinger, 1975) that taps into the non-verbal realm of imagery (Cohen & Riley, 2000). Successful art therapy can serve to integrate right and left brain functions that, in turn, help integrate experiences (McNamee, 2003, 2004, 2005), especially on a non-verbal level. In the first part of this article I define “trauma,” and review current research into how it acts to subvert, or is a subversion of, normal brain functions that integrate experience and memory. In the second, I survey current thinking on the subject of art making and creativity and how they may involve specific areas and functions of the brain; this is a topic for which considerably more research is needed, so mine is necessarily only an overview of an emerging field. In the third part I describe the art therapy trauma protocol (ATTP), give a one-session example, and relate the technique to the issues raised in parts one and two.

Current views of trauma and brain function

Affect regulation, according to Omaha (2004), is the foundation for an adaptable healthy human, whereas affect dysregulation is the basis for clinical intervention. “Affects are genetically hard-wired, physiological building blocks from which feelings, emotions, and moods are constructed” (Omaha, 2004, p. 4). The individual’s self-organization depends on his or her affect and emotion regulation. In the course of our lives, most of us will be exposed to one or more adverse life events, which may include directly experiencing trauma or indirectly witnessing a traumatic event. According to the nature of the event, its impact will ultimately be determined by each individual’s ability to cope and regulate affect in the distressing situation. Greenwald (2005) argues that individuals who experience a traumatic event deal with their trauma in two ways. One is the adaptive method, in which the individual processes the stressful event in a supportive environment by moving through the normal stages of grief and loss. The other is the non-adaptive method; here the event is pushed behind a wall in order to seek emotional and affective relief from the distress it causes.

Walled off memories due to trauma retain their power and freshness on an affective level, even years after the event. Trauma creates a state of heightened physiological arousal initiated by a sensory experience, whether sounds, images, sensation of touch, smell or, in rare cases, taste (Rothschild, 2000; van der Kolk, 1994). Memories of the trauma can also trigger or sustain the arousal response (Steel & Raider, 2001). The effects of trauma on the body and the mind are well documented, and are defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV, 2000). One of the major symptoms characterizing trauma is PTSD, which is “persistent increased arousal” in the autonomic nervous system. This is called “somatic memory” (Rothschild, 2000; van der Kolk, 1994).

The primary issue in treating trauma clients is that certain sensory experiences related to the traumatic memory do not fade over time. Theorists (van der Kolk & van der Hart, 1991; van der Kolk & Fislser, 1995; van der Kolk, Hopper & Osterman, 2001; van der Kolk, 2003) argue that the effects of trauma persist for months, years or even decades after the event has occurred. “Particularly emotions, images, sensations, and muscular reactions related to trauma may become deeply imprinted on people’s minds and the traumatic imprints seem to be re-experienced without applicable transformation” (van der Kolk, 2003, p. 2). It is the failure to transform and integrate these sensory imprints related to the trauma that keeps traumatized individuals at an increased level of hyper-vigilance, a cognitive state that prevents the individual from feeling a sense of psychological well-being and physical safety. We thus confront a particular form of memory dysfunction.

Memory consists of the storage, categorization and recall of information under appropriate circumstances (Rothschild, 2000). In the last decade, a growing body of research has established the importance of the limbic system for understanding emotions and memory and their relationship to trauma (for example: Nadel & Jacobs, 1996; Rothschild, 2000). Known as the “the seat of emotions,” the limbic system guides the reactions and behaviors necessary for self-preservation and, ultimately, survival of the species. According to Rothschild (2000), the two areas of the limbic system central to the storage and retrieval of memory are the amygdala and the hippocampus. The amygdala is

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