

Running head: ART THERAPY WITH VETERANS

Art Therapy with Veterans: A Comprehensive Review of the Literature with Recommendations

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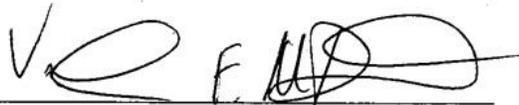
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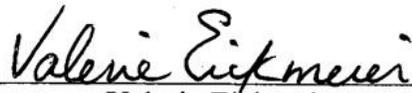


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ABSTRACT

Art therapy has been conducted with military servicemembers and veterans since the beginning of the profession itself. Veterans suffer from a myriad of diagnoses, some of the most prevalent being posttraumatic stress disorder (PTSD), combat trauma, military sexual trauma (MST), complicated grief, substance abuse, anxiety, and depression. Research exists that underscores the unique and vital role art therapy plays in the treatment of these diagnostic concerns; however, no known comprehensive literature review on the topic exists. An integrative, systematic literature review was conducted to gain an understanding of the format, setting, directives, materials, and approaches being used to treat veterans with art therapy. A total of 85 articles and books with a primary focus on art therapy with veterans were organized using the filing method recommended by Garrard (2011). A literature matrix was used to organize 26 of the publications for comparison and to identify themes among the content. Themes emerged in all categories of the matrix. Notably, it was shown that 68.6% of the 85 pieces of literature had been published in the last five years. Recommendations for future research were made in response to these themes, such as the need to identify the specific therapeutic factors of art therapy rather than simply its efficacy in comparison to more traditional talk therapy approaches. Finally, opportunities were identified to standardize and streamline the use of art therapy with this population, which would benefit both the clients and the replicability of studies to bolster the generalizability and validity of findings.

Keywords: alternative treatment, art therapy, complementary treatment, integrative medicine, military servicemembers, MST, PTSD, veterans

DEDICATION

This thesis is dedicated to my tribe of supporters and believers, without whom I surely would have done less than my best. To my parents, thank you for giving me such a solid foundation, fostering in me a sense of drive and dedication, and instilling in me the critical ability to believe I can do anything I set my mind to, while still keeping my feet on the ground. Mom, I am forever grateful for the many hours you spent letting me unload, being infinitely curious, and for the gestures of support that helped me get to the finish line. Dad, I appreciate your relentless efforts to help me whack all of the moles in my life that refused to stop rearing their heads despite my need to focus on school. Your persistent flexibility and understanding made me feel loved and gave me the motivation to keep going when it got tough. Sara, I am thankful for every unprompted dose of encouragement and reminder of your belief in me. Your wisdom and support gave me much needed perspective when I was deep in the trenches and reminded me just what I am capable of achieving.

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CHAPTER I

INTRODUCTION

Art therapy has been used in the treatment of veteran mental health conditions as long as the field has been in existence. In fact, Mary Huntoon – a pioneer in the field and an advocate for an organized association for art therapists 20 years before its inception – used art to treat veterans at the Winter Veterans Administration Hospital in Topeka, Kansas as early as the 1940s (Wix, 2010). Further connecting art therapy and veteran history, the term art therapy is believed to have first been coined by British military servicemember and artist Adrian Hill in 1942 during World War II (WWII) (Hogan, 2001).

Veterans suffer from numerous mental health conditions including but not limited to: PTSD, combat trauma, MST, complicated grief, substance abuse, anxiety, depression, and difficulties generated by the transition to civilian life (De Lucia, 2016; Smith, 2016). Research documents the array of therapeutic approaches historically and currently used to treat veteran mental health needs. The purpose of this research was to review the extant literature on art therapy being used to treat this population. Upon completion of the literature review, research findings were compiled into a literature matrix. Themes were identified from the literature matrix content and findings were discussed.

Research indicates that certain aspects of art therapy offer benefits well-suited for the veteran population (Avrahami, 2005; Campbell, Decker, Kruk, & Deaver, 2016; Collie, Backos, Malchiodi, & Spiegel, 2006; Palmer, Hill, Lobban, & Murphy, 2017). Avrahami (2005) lists art therapy's unique contributions to working with veterans with PTSD as falling into "three principal areas: processing of traumatic memories, the process of symbolization-integration, and containment, transference and countertransference" (pp. 6-7). An additional benefit to art therapy

is its action-oriented approach. Lobban (2014) stated, “Art therapy is an action therapy that combines movement, tactility, vision, memory, and imagery in the creative process and which addresses the non-verbal core of traumatic memories” (p. 11). Furthermore, art therapy offers a means of activating neural and sensory processing pathways to achieve a cohesive, holistic level of healing (Belkofer & Konopka, 2008; Lobban, 2014). The evidence provided indicates that art therapy is well-equipped to support veterans experiencing any mental health condition; however, the interventions and models currently used that arose in the literature vary in format, length and setting.

No known comprehensive review of art therapy literature with this population has been conducted. Collie et al. (2006) completed a content analysis of literature on the topic of conducting art therapy with veterans and included a survey of art therapists seasoned in working with this population. The results informed the proposal of best practices for using art therapy with veterans. This resource, however, is now dated and no specific literature or methods referenced in the content analysis conducted were included in the publication for the study to be replicated or expounded upon.

The current study aimed to provide a comprehensive review of published and unpublished literature pertaining to art therapy and veterans. It was hypothesized that by completing this review, themes would emerge among aspects such as the length, format, and setting of art therapy being conducted. Themes that result from an integrative literature review often generate a new perspective or framework (Tavares de Souza, Dias da Silva, & de Carvalho, 2010). Thus, the results of this study will aid the field in making more informed choices regarding format, interventions, and setting when conducting art therapy with this population.

Additionally, the results from this study could aid in providing the direction and guidelines for future research conducted on this topic.

Operational Definition of Terms

Alternative treatment – The National Center for Complementary and Integrative Health (NCCIH) (2017) defined alternative treatment approaches as those that are used in place of conventional medicine.

Art therapy – The American Art Therapy Association (AATA) (2017) defines art therapy as:

An integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship...Art therapists are masters-level clinicians trained to work with diverse populations of individuals of all ages, races, and socioeconomic status in a variety of settings...The alternative modes of receptive expressive communication used in art therapy circumvents language barriers to support personal and relational treatment goals.
(Broader Definition of Art Therapy, para. 1-4)

Complementary treatment – The NCCIH (2017) defined complementary treatment approaches as any unconventional approaches that are used in tandem with conventional medicine.

Complicated grief – Thimm and Holland (2016) described complicated grief as a level of bereavement in which:

The bereaved suffer from a persistent, intense, pervasive, and debilitating grief... characterized by a broad range of psychological symptoms, including intense yearning

for the deceased, avoidance of reminders of the reality of the loss, preoccupation with the deceased, rumination, anger or bitterness, numbness, and difficulties accepting the loss and moving on in life. (p. 348)

Electro-encephalograph – Siegel (1999) explained that the electro-encephalograph is a medical measurement device that uses electrodes placed on the scalp to measure "the way in which the brain functions through the energy-consuming activation of neurons" (p. 3).

Evidence-Based Practice/Therapy – The Institute of Medicine defined Evidence-Based Practice as, "the integration of best research evidence with clinical expertise and patient values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 147).

Integrative Medicine – The NCCIH (2017) defined integrative medicine as an independent category of medical treatment, referring to the bringing together of conventional and complementary approaches in a coordinated way.

Military Sexual Trauma – Military sexual trauma (MST) is defined by the Veterans Health Administration (VHA) as:

psychological trauma, which in the judgment of a Veterans Health Administration [VHA] mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty, active duty for training, or inactive duty training. (US Code, Title 38 §1720D)

Operation Enduring Freedom – Operation Enduring Freedom (OEF) was a military conflict initiated by United States (US) forces on September 26, 2001 in response to the September 11 attacks (Witte, 2018). Conducted in tandem with National Atlantic Treaty Organization (NATO) forces, this conflict officially ended in December of 2014 (Witte, 2018).

Operation Iraqi Freedom – Operation Iraqi Freedom (OIF) was a US-led alliance invasion of Iraq that began on March 20, 2003 and officially ended in 2010 (Bassil, 2012; Salazar Torreon, 2017). This US-led operation was intended to “conduct stability operations, focusing on advising, assisting, and training Iraqi Security Forces (ISF)” (USF-I, 2010).

Operation New Dawn – Operation New Dawn (OND) was a military operation that officially began following the end of OIF (Salazar Torreon, 2017).

Posttraumatic stress disorder – The American Psychological Association (APA) (2017) defined posttraumatic stress disorder as “an anxiety problem that develops in some people after extremely traumatic events, such as combat, crime, an accident or natural disaster” (Posttraumatic Stress Disorder, para. 1) and results in symptoms such as “intrusive memories, flashbacks and nightmares; ... [people with PTSD] avoid anything that reminds them of the trauma; and have anxious feelings they didn’t have before that are so intense their lives are disrupted” (Posttraumatic Stress Disorder, para. 2).

Servicemember – The US Department of Veterans Affairs (VA) (2016) defined servicemembers as “member[s] of the ‘uniformed services’, consisting of the armed forces (Army, Navy, Air Force, Marine Corps, and Coast Guard), the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA) and the Commissioned Corps of the Public Health Services” (para. 1).

Traumatic Brain Injury – The National Institute of Neurological Disorders and Stroke (NINDS) (2017) defined traumatic brain injury (TBI) as a form of acquired brain injury, that occurs when a sudden trauma causes damage to the brain. Causes of TBI include when “the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue” (NINDS, 2017, para. 1). Symptomology of a TBI varies depending on the extent of damage to

the brain and are labeled as mild, moderate, or severe. According to the NINDS (2017) symptomology includes:

headache, confusion, lightheadedness, dizziness, blurred vision or tired eyes, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, behavioral or mood changes, and trouble with memory, concentration, attention, or thinking for individuals with mild TBI. A person with a moderate or severe TBI may show these same symptoms but may also have a headache that gets worse or does not go away, repeated vomiting or nausea, convulsions or seizures, an inability to awaken from sleep, dilation of one or both pupils of the eyes, slurred speech, weakness or numbness in the extremities, loss of coordination, and increased confusion, restlessness, or agitation. (para 1.)

Veteran – Title 38 of the U.S. Code defined a veteran as, “A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable” (Definitions, para. 2).

CHAPTER II

METHODS

An integrative literature review was conducted to acquire data relevant to the art therapy approaches and interventions being used to treat veterans. An integrative review – considered the most comprehensive methodological approach of reviews – entails reviewing, critiquing, and synthesizing data from diverse methods on a topic, such as experimental studies, non-experimental studies, and theoretical literature (Tavares de Souza et al., 2010; Torraco, 2005). This comprehensive approach typically generates new frameworks or perspectives on the topic studied by “providing synthesis of knowledge and applicability of results of significant studies into practice” (Tavares de Souza et al., 2010, p. 102). An integrative review involves six phases including: preparing the guiding question, searching or sampling the literature, data collection, critical analysis of the studies included, discussion of results, and presentation of the integrative review (Tavares de Souza et al., 2010, p. 102).

This review was completed in an effort to synthesize the literature on this topic and serve as a reference for art therapists’ efforts with this population moving forward. Relevant studies were compared to identify themes among approaches and interventions being used with this population.

Investigational Methods and Procedures

A variety of published literature was reviewed including peer-reviewed articles, theses, dissertations, and books. This published literature was found by searching electronic databases made available by the Indiana University-Purdue University Indianapolis library catalog (IUCAT), the full list of which can be found in Table A1. Additional searches for relevant dissertations and theses were conducted in the library catalogs of universities with art therapy

programs listed on the American Art Therapy Association (AATA) website (see Table A2). References were also identified using reference lists from relevant journal articles. Books on the use of art therapy to treat veterans and trauma populations utilized in this review include: *Art Therapy with Military Populations* (Howie, 2017), *Art Therapy, Trauma, and Neuroscience* (King, 2016), *Complicated Grief, Attachment, & Art Therapy* (MacWilliam, 2017), and *Handbook of Art Therapy* (Malchiodi, 2012). A full list of search term combinations utilized to locate literature on art therapy with veterans (see Table B1), as well as all search term combinations used to identify supporting literature can be found in Appendix B (see Table B2).

Unpublished data considered included the contents of notes taken during conference lectures and information included in handouts from conference proceedings at the AATA 2017 48th Annual Conference in Albuquerque, NM. Paper presentations attended include: *Creative Forces: Outcomes of Creative Self Expression for Military Service Members with PTS and Traumatic Brain Injury (TBI)*, *Veterans' Experiences of Adjunctive Art Therapy during Cognitive Processing Therapy for PTSD*, *Adapting Art Therapy Sessions for Facilitation Via Telehealth*, and *Art Therapy for Veterans at the University of Texas at Arlington*. Panel discussions attended include: *Radical Acceptance: Art Therapy Clinical Approaches for Active Duty Military Sexual Trauma*, *Art Therapy with the Military: Working Across the Continuum*, and *Art Therapy with Military Populations: History, Innovations, and Applications*. Additionally, the following master class was attended which included paper presentations and a panel discussion: *Transforming the Pain: Art Therapy with Military and Trauma Populations - An In-Depth Discussion of Advanced Interventions*.

Collected literature was organized and electronically filed utilizing formatting suggested in the Garrard Matrix Method (2011). This method is intended to “create order out of chaos”

(Garrard, 2011, p. 107) and facilitated quicker retrieval of data while conducting the literature review and formulating the results and discussion.

Data Analysis

Data analysis followed guidelines of phase four of the integrative review process, which entails conducting a critical analysis of the studies included. Initial steps included reading the relevant published and unpublished literature collected for this study. Literature was deemed relevant based on its incorporation of art therapy with military and veteran personnel. Data extracted from the relevant data was recorded and organized using a literature matrix. The elements of literature captured in the matrix included the citation, topic, type of study, clinical concerns addressed, setting, framework of approach, directives used, materials used, format of treatment, outcomes of treatment, and limitations. A link to view the full matrix can be found in Appendix C1. The content of the matrix was reviewed to identify emerging content themes which were then listed and discussed in relation to the findings of the literature review.

Limitations and Delimitations

This study is limited by its inability to capture program models and protocols being used in the treatment of this population for which conference presentations occurred prior to the AATA 2017 conference or other related conferences, or for which literature has not yet been published. An additional limitation is the use of a single researcher in analyzing the literature which creates the potential for researcher bias to impact the results. Furthermore, the researcher's status as a female veteran who has utilized therapies, both art therapy and traditional talk therapies, in her own healing process could be both seen as a strength and a limitation to the interpretation of results, depending on the paradigm from which one approaches research.

Finally, the nature of creating and populating a literature matrix introduces researcher bias as the content is based on the researcher's interpretation of literature content.

Delimitations of this study included the choice to search for themes only in those publications that discussed art therapy with veterans and military personnel. Additionally, therapeutic art initiatives for veterans such as *Fatigues Clothesline* and the *Warrior Arts Studio* (Romero, 2012) were not included as they were not run by art therapists and thus fell beyond the intended scope of the study.

CHAPTER III

LITERATURE REVIEW

Mental Health Treatment of Military Personnel

Efforts to ensure military servicemembers and veterans have access to mental health treatment options has steadily increased since the Vietnam War (Jones, 2006). The literature shows ongoing gaps between the needs of this population and the barriers to getting the necessary treatment, and research continues to search for which treatments are most effective in reducing these gaps.

Needs and barriers. Stigma surrounding seeking treatment for mental health needs is a concern for many Americans. This stigma dates as far back as WWII, during which phrases such as ‘lack of moral fibre’ were used to describe individuals who refused to participate in military operations for mental health reasons (Jones, 2006). For military and veteran personnel, the barrier of stigma is exaggerated by the value placed on mental and physical toughness encouraged by the military culture and ethos (Dondanville, Borah, Bottera, & Molino, 2018). Along these lines, military culture places significant emphasis on psychological resilience, a fact supported by French’s (2005) finding that servicemembers are more likely to attend appointments to address physical health problems than for mental health difficulties. Media portrayal of military service personnel as ‘heroes’ adds to this already present stigma, fueling the idea that asking for help with mental health and well-being issues is unacceptable (Pratt, 2017). It has even been shown that pushing back against the stereotypes of heroes, victims, and perpetrators can be a necessary step toward healing for veterans of war (Bassin, 2017). Finally, the simple fact of veterans’ perception that there are barriers, even if they are not specifically identified or stated, as well as the belief by some veterans that individuals do not respond to

treatment – the belief, for example, that there is ‘no point’ in seeking treatment, serve as additional barriers to getting necessary mental health treatment (Palmer et al., 2017).

Studies have been conducted to identify the specific assumptions servicemembers hold that prevent them from seeking mental health treatment. Primary barriers identified include the belief that their career would be affected negatively by seeking treatment, the perception that they would be seen as weak, that their leaders would treat them differently, general embarrassment, that their peers would lose confidence in them, a negative attitude toward mental health treatment, and difficulty understanding the nature of the issue and how to ask for help (Adler, Britt, Riviere, Kim, & Thomas, 2015; Brown, Creel, Engel, Herrell, & Hoge, 2011; Greden et al., 2010; Hoge et al., 2004; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Pietzrak, Johnson, Goldstein, Malley, & Southwick, 2009; Stecker, Fortney, Hamilton, & Ajzen, 2007). Additionally, Walker, Kaimal, Gonzaga, Myers-Coffman, and DeGraba (2017) found that servicemembers involved in an inpatient program to treat PTSD and TBI voiced previous or current distrust in healthcare providers as an additional perceived barrier to seeking mental health treatment. Zinzow et al. (2013) explained in their study of perceived barriers to treatment that these particular barriers can serve as additional burdens on top of an already complicated diagnosis due to the uncertainty generated from ever-changing information regarding length or outcome of treatment and medication and symptom confusion.

Outside of stigma and misperceptions about mental health treatment, other barriers to veteran engagement exist. One such barrier is the denial of service-connected disability compensation by the VA. Fried, Helmer, Halperin, Passannante, and Holland (2015) found that individuals denied disability compensation were burdened by poor health and disability that impacted vocational functioning, physical functioning, deteriorating subjective health and

impaired activities of daily living (ADLs) to the same degree or worse than individuals who had been awarded disability compensation. Despite having equitable barriers to living, these individuals denied disability compensation were often not seeking or able to afford medical and mental health services. This aligns with Spooon's (2007) findings that veterans with PTSD used more medical and mental health services after filing a disability claim as compared to the preapplication period. He also found that the use of medical services dropped off considerably for those who were not approved to receive disability. Another barrier identified in the research is access to adequate mental health care facilities. Access to VA community-based outpatient clinics (CBOCs) in particular is limited in spite of recent efforts by the Veteran Health Administration (VHA) to develop these facilities and extend their reach by implementing telemental health coverage (Kirchner, Farmer, Shue, Blevins, & Sullivan, 2011).

Although these perceived barriers impede access to mental health services, research evidence shows veteran use of VHA services has increased in recent years with approximately 61% of all separated or retired Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans having used VHA services since 2001 (Ramsey et al, 2017). These findings of VHA utilization are consistent with recent findings of increased mental health care utilization by veterans in the United Kingdom (UK). Murphy, Weijers, Palmer, and Busuttil (2015) found that the number of new referrals made to Combat Stress (CS) – the UK's equivalent of the US VA – “increased nearly fourfold between 1994 to 2014” (p. 654). Additionally, they found that the amount of time it takes veterans to seek help for mental health needs has dropped from 24.0 years in 1994 to 11.8 years in 2014. Murphy et al. (2015) attributed this drop in time taken to seek help as a period effect, stating that it was related to the combat arena and timeframe in which the veterans served. Murphy et al. (2015) noted that

an increase in both media coverage on the topic of PTSD and an increase in mental health awareness campaigns were conducted by CS around the same time as the increase in treatment seeking veterans shown in the data.

Veterans struggle with PTSD, depression, substance use disorders, TBI, anxiety, and suicide at an increased rate as compared to the general public (Ganzer, 2016). Acquiring an accurate rate at which this population suffers from these conditions is difficult, as the majority of data collected by the VA is done so only during the veteran's initial appointment (Ramsey et al., 2017). Ramsey et al. (2017) pointed out that this data misses any diagnoses acquired in later visits.

Factors exist that improve the chances of veterans seeking needed mental health treatment. Graziano and Elbogen (2017) found that social support had both an indirect and direct impact on supporting veteran mental health. Indirectly, it was shown that social support impacted veterans' perceived mental health in a positive way and reduced the need for treatment. Directly, it was found that social support impeded those in need of mental health services from seeking help due to receiving the message that they were responsible for solving their own problems (Johnson, Rosenheck, & Fontana, 1997). Similarly, Carlson, Stromwall, and Lietz (2013) cited social support as a positive factor in mental health treatment in women veterans, specifically citing topic groups and peer-to-peer support networks as particularly beneficial sources. Lobban and Murphy (2017) reiterated this finding, highlighting veterans' perceived benefit of participating in group art therapy with other veterans. Participants stated that:

Other veterans understand the written and unstated rules of serving in the armed forces and may have been exposed to similar traumatic experiences. The expectation that others

will maintain the military code of covering each other's back creates a supportive environment. (Lobban & Murphy, 2017, p. 12)

Furthermore, being approached with a strengths-based methodology to aid in identifying internal and external strengths, such as flexibility and family/unit support, can also serve as a supportive factor in seeking out and remaining in treatment (Saleeby, 2009).

Traditional therapeutic approaches. Therapeutic approaches recommended or required for use with veterans have historically been comprised of Evidenced-Based Treatments (EBTs) rooted in traditional psychotherapies such as Cognitive Behavioral Therapy (CBT) (Allen et al., 2017). Specific treatments recommended by the VHA are delineated in VHA Handbook 1160.01 (2015), and recommendations differ depending on the diagnosis being treated. The recommended traditional frameworks for each diagnosis explored in this study will be discussed in greater detail in their respective sections.

Complementary therapeutic approaches. Complementary treatments have emerged in recent years as a beneficial alternative to traditional therapeutic approaches and their inclusion in veteran treatment continues to grow. The range of treatments included in the scope of complementary and alternative medicine (CAM) is broad (Hull et al., 2015; Madsen, Vaughan, & Pérez Koehlmoos, 2017; Schuman, 2016). Complementary and alternative approaches to treatment designed for the veteran population have emerged in the last decade to address the often complex and chronic illnesses they face (Hull et al., 2015). Yoga and mindfulness-based interventions, as well as acupuncture, for example, have been successful in treating veterans with PTSD, substance abuse, anxiety, and depression (Groessler, Weingart, Johnson, & Baxi, 2012; Hollifield, Sinclair-Lian, Warner, & Hammerschlag, 2007; Rosenthal, Grosswald, Ross, & Rosenthal, 2011; Schuman, 2016). In fact, in 2011, a survey of 125 VHA facilities reported

offering CAM services, 80% of whom did so because of patient preference (Hammond & Vandenberg, 2011).

Taking this preference into account when deciding the service elements included in a treatment plan is a key component of providing care that is patient-centered (Barry & Edgman-Levitan, 2012). This statement underscores the VHA Office of Patient Centered Care and Cultural Transformation's initiative of promoting an "integrative, personalized, and patient-driven approach to veteran health care" (Hull et al., 2015, p. 13). As evidence of this intended approach, preliminary program evaluation data of the War Related Illness and Injury Study Center in Washington D. C. (WRIISC-DC) – which has integrated CAM services since 2007 – has shown that a majority of veterans receiving CAM services have noticed symptom improvement that they attribute to them and would recommend acupuncture and yoga nidra to other veterans (Hull et al., 2012).

The success of CAM services incorporation into WRIISC-DC programming spurred the creation of the center's Integrative Health and Wellness program (IHW) in 2012 (Hull et al., 2015). This program offered iRest yoga nidra, individual acupuncture, group auricular acupuncture, chair yoga, qigong, and an integrative health education group to veterans in a comprehensive clinical setting. Adding to the literature validating the efficacy of these treatments in supporting veterans' needs, Hull et al. (2015) reported a statistically significant reduction in severity of symptoms attributed to a range of diagnoses among the veterans who used the CAM services offered at IHW, advocating for their continued integration into veteran treatment.

In 2016, Schuman conducted a qualitative interpretive meta-synthesis of studies that looked into the effects of CAM and integrative health techniques when used with veterans. Five

major themes emerged: (1) symptom reduction/management, (2) improve well-being, (3) spirituality/existentialism, (4) personal responsibility, and (5) desire for natural, holistic health care (Schuman, 2016, p. 93). She found that veterans used CAM approaches to seek relief from the full range of PTSD symptoms affecting the mind, body, and spirit.

Acupuncture. Acupuncture is one of the most consistently offered CAM modalities across the military health system (Madsen et al., 2017). Previously, the benefits of acupuncture were believed to be brought on by the placebo effect, but recent research indicates nerve and neurotransmitter involvement in the positive benefits it has to offer (Madsen et al., 2017). Cantor and Gumbor (2013) were unable to find conclusive evidence of the efficacy of acupuncture in treating TBI, but Wahbeh, Senders, Neuendorf, and Cayton (2014) found evidence in their systematic review on the use of CAM modalities of its effectiveness in treating PTSD symptoms.

Mindfulness-based practices. Mindfulness-based practices have been shown to have healing properties in and of themselves, though their efficacy is often difficult to tease out due to their frequent incorporation into other approaches and therapies such as yoga and psychotherapy (Schuman, 2016). Mindfulness-based stress reduction (MBSR) is one such integrated approach that has been widely studied and implemented in the treatment of VA clients (Stephenson, Simpson, Martinez, & Kearney, 2017). Kabat-Zinn (1990) defined MBSR as “a group-based intervention emphasizing experiential practice of mindfulness meditation—cultivation of intentional, present-focused, nonjudgmental awareness of one’s experience” (as cited in Stephenson et al., 2017, p. 202). It is believed that the healing factors of this approach include a greater embodiment and application of mindfulness in one’s life (Stephenson et al., 2017), broken down into five structures: Non-Reactivity to inner experience, Observing, Describing, Acting with Awareness, and Non-Judging of inner experience (Baer, 2006). Among the

experiences of 92 veterans engaging in MBSR at a large VA-hospital, those who reported increased mindfulness also reported decreases in PTSD symptomology (Stephenson et al., 2017). More precisely, changes in patient integration of the specific mindfulness factors of Non-Reactivity and Acting with Awareness were the most significantly linked with a lowering of PTSD symptoms.

Rooted in mindfulness, one less common approach used with veterans to aid in combat veteran reintegration is incorporating the practice of “dignity for the enemy” (DFTE) into treatment (Eigen, 2017). Eigen (2017) explained that this practice, sometimes classified as falling under cognitive emotional therapy, is rooted in ancient Buddhist practices aimed at reducing violence and increasing calmness. Meditation – considered a sister practice – is incorporated, enhancing the elements of introspection, focus, and concentration. Additionally, this approach differs from other mindfulness-based approaches in its aim to transform the combat veterans’ enemies into friends, ultimately aiming to achieve dignity for the enemy (Eigen, 2017).

As a complementary therapy used to treat veterans, mindfulness-based interventions have proven successful. When studied in comparison with a control group of supportive group therapy or a psychoeducation group, many researchers have found a significant reduction in the symptoms of PTSD in the group receiving MBSR or MBSR-derived treatment (Kearney, McDermott, Malte, Martinez, & Simpson, 2012; King et al., 2013; Niles et al., 2011). Potentially of more importance, the mindfulness-based treatments’ effects proved to be longer lasting in comparison to control groups during follow up testing (Kearney, McDermott, Malte, Martinez, & Simpson, 2013; Polusny et al., 2015).

Yoga. Among the literature reviewed, many published articles discussed the use of yoga therapy as a complementary treatment successful in supporting veteran mental health needs. This multidimensional treatment combines physical, mental and spiritual healing aspects and has been shown to aid in building psychological resilience, promoting relaxation, and reducing symptomology associated with anxiety, depression, combat stress, PTSD, TBI and schizophrenia (Groessler et al., 2012; Madsen et al., 2017; Reinhardt et al., 2018; Stoller, Greuel, Cimin, Fowler, & Koomar, 2012). McCarthy et al. (2017) advocated for the use of yoga in treating PTSD symptomology in combat veterans, noting that unlike traditional psychological and pharmacological interventions, research on the effects of yoga therapy has not yet yielded any adverse side effects.

A specific trauma-sensitive yoga technique called integrative restoration (iRest) has been used extensively across the VA network. It works by drawing attention inward and increasing focus on the parasympathetic nervous system and has shown promise in addressing symptoms of PTSD (Madsen et al., 2017; Stankovic, 2011). Hurst et al. (2017) conducted qualitative interviews with 24 veterans and servicemembers who had participated in yoga, as well as 12 yoga instructors who had worked specifically with veterans. They reported five main themes among the results:

mental health benefits experienced from yoga practice; physical health benefits experienced from yoga practice; important yoga elements and conditions that promote effective practice and/or health benefit; facilitators for engaging military in yoga practice; and challenges and barriers to yoga practice for military. (p. 3)

Evidence like this has been growing in recent years, but has remained relatively small-scale (Hurst et al., 2017, Madsen et al., 2017; Reinhardt et al., 2018). Results from a large-scale,

VA-funded randomized controlled trial (RCT) on the effects of yoga as a treatment option for servicemembers and veterans is expected in 2018 (Hurst et al., 2017).

Neurobiological evidence has been found that supports the reported positive effects of engagement in yoga therapy such as a reduction in perceived levels of stress, increased sense of calm, and reduction of depression and anxiety symptomology. Streeter et al. (2007) found neurobiological evidence of these positive effects on individuals partaking in a yoga session, shown by a 27% increase in GABA levels after a 60-minute session. These findings pair with those of Vedamurthachar et al. (2006) in which they found a decrease in stress-hormone (cortisol and ACTH) levels and Beck Depression Inventory (BDI) scoring in all 60 participants of a two-week study that incorporated daily yoga practice into treatment.

Integrating complementary therapies into VA programming. Significant literature exists warranting the incorporation of complementary and integrative therapies in veteran treatment. Smeeding, Bradshaw, Kumpfer, Trevithick, and Stoddard (2010) classified integrative health models of care that include CAM services as being low risk, low cost, and acceptable to both patients and providers. Relatedly, Etingen (2016) reviewed survey responses from 234 veterans from a sample of 16,425 veteran responses collected during a large-scale, national evaluation aimed at examining the reach of patient-centered care innovations in the VA system of care. The selected veteran responses generated a control and test group, the latter of which represented individuals who had been diagnosed with PTSD, had engaged in integrated mental health (IMH) programming, used mental health care of any kind and had been seen some time in the last two years, and had similar comorbid mental health conditions. Test group findings showed that IMH treatment usage was associated with:

increased outpatient and primary care visits; decreased psychotropic medication use; increased recommendations for CAM treatment modalities and decreased recommendations for pharmacological treatment; discussion of patient preferences for mental health treatment during a greater number of VA primary care and mental health encounters; better patient perceptions of physical health status; greater patient-reported patient activation (e.g. engagement in health care), and; better patient perceptions of shared medical decision-making. (p. 105)

Related to Etingen's (2016) finding, Schuman (2016) found that veterans using CAM techniques were able to manage the overwhelming physiological and psychological effects without having to invoke them, which allowed this approach to overcome "one of the main challenges of exposure-based therapies" (p. 94).

Gaddy (2017) reported improved mental and physical health in 42 veterans surveyed after completion of a 4-week interdisciplinary integrative medicine program Dwight D. Eisenhower VA Medical Center in Leavenworth, Kansas. Participants suffered from a variety of mental health concerns such as mood disorders, PTSD, and substance use disorders, many of which were comorbid in nature. Notably, art therapy was included in the treatments offered, though specific data on its contribution was not captured (Gaddy, 2017). The art therapy portion utilized artistic techniques "to improve coping with emotional conflict, enhance self-esteem and self-awareness, and empower veterans to further explore the use of creative tools in their recovery" (Gaddy, 2017, p. 3).

In an interview with Dr. Benjamin Kligler (Liebert, 2016), the individual charged with expanding and improving the integrative approaches of the VHA, Dr. Kligler echoed the efficacy of these integrative approaches in meeting the mental health needs of veterans, but noted the lack

of policies, infrastructures, or strategies in place to standardize and expand their implementation network-wide. Dr. Kligler's team, the recently created Integrative Health Coordinating Center (IHCC), has been tasked with developing these policies and guidelines, spurred on by both the opioid crisis and the recent Congressional mandate requiring the VHA to expand its education and incorporation of these integrative and complementary therapies into its planned programming (Comprehensive Addiction Recovery Act, 2016). Dr. Kligler concluded by sharing that he hoped that in the next five to ten years integrative approaches to care will not only be normalized within the VHA system but can be expected by veterans to be included in their care options and will be something with which clinicians feel comfortable incorporating into their day-to-day routines of veteran care.

In contrast to these sentiments, Fletcher, Mitchinson, Trumble, Hinshaw, and Dusek (2017) found mixed reception to CAM treatments on the part of providers and administrators at VA medical facilities. Primary barriers identified in the results centered around lack of available space, skepticism on the part of medical leadership, and lack of funds and manpower needed to support the sustainment of alternative therapy programs. However, respondents also noted a number of factors that facilitated or encouraged offering these therapies in VA centers, such as a decreased need to take medication, reduction in pain symptoms, a decrease in PTSD symptoms, and improvement of staff morale. Interestingly, one factor that facilitated the inclusion of alternative therapies into practice was the recent VA directive to reduce the prescription of opioids. Fletcher et al. (2017) concluded by highlighting the need for system-wide acceptance and integration of complementary therapies into programming and funding at VA facilities, as they found most facilities who were able to offer these services were often only able to do so

thanks to dually trained service providers who were able to devise and implement workarounds within the VA system.

Of note in Fletcher et al.'s (2017) study findings, among reported complementary treatments being integrated or desired to be integrated at respondents' VA facilities, such as massage, yoga, and acupuncture; art therapy was not listed as one such complementary treatment approach by any of the respondents. Discussing the subject of CAM development in the VA system of care, Howie (2017) reiterated this observation, stating that "Although most VA research has been directed toward the use of yoga and meditative practices, art therapy is considered a CAM" (p. 18). It is unclear from the literature if this is a result of art therapy's acceptance as a more mainstream approach.

These observations are further underscored by Madsen et al.'s (2017) discovery that therapy classification varied widely between sources and depended heavily on rate of usage. The National Center for Complementary and Integrative Health (NCCIH) definition of nonconventional modalities could help in standardizing the descriptions and classifications used. The NCCIH (2017) defined complementary approaches as any unconventional approaches that are used in tandem with conventional medicine, differing from alternative approaches that are used in place of conventional medicine. Integrative medicine (IM) is a category all its own, referring to the bringing together of conventional and complementary approaches in a coordinated way (NCCIH, 2017). Standardization of treatment classification in the areas of CAM and IM would be needed to generalize findings on these topics to specific therapies, such as art therapy.

Art Therapy Treatment for Veterans

Art therapy is one alternative treatment approach being used to meet the mental health needs of veterans. This approach, supported by neurobiological evidence of its efficacy in reducing feelings of stress and increasing feelings of calm, has been used to treat military personnel since the beginning of the 20th century. Examples of how art therapy is being used to support this population are included as they pertain to each diagnosis explored in this literature review.

History of treatment. In her book *Art Therapy with Military Populations: History, Innovation, and Applications*, Howie (2017) described in great detail the interwoven beginnings of art therapy with military history, even titling one element of her introduction ‘Beginnings: A Profession Facilitated by War’ (p. 2). Pre-dating art therapy even, therapeutic art interventions were used by occupational therapists (OT), artists, and volunteers to treat the physical and psychological trauma faced by military servicemembers during and after World War I (WWI). In 1917, the first OT was hired at Walter Reed Medical Center and evidence of the art used in those early sessions – which included ceramics, arts and crafts project kits, and art activities – is still on display in the National Museum of Health and Medicine (Howie, 2017).

After emerging as its own discipline from OT and art education roots, art therapy was used with veterans as far back as WWII (Howie, 2017). Predicated on the work of Mary Huntoon at the Winter Veteran Veterans Administration Hospital in the early 1940s, art therapists were hired officially as early as 1945 by the VA to treat returning veterans for psychiatric services (AATA, 2009). Huntoon described her approach as providing the avenue for veterans to do their own ‘self-therapy’ by engaging in art making, describing her role as simply ‘pointing out’ that which emerges from deeper levels of consciousness in the art (Huntoon, 1953). Around the same

time, from 1944 to 1948, “therapists were trained in the visual arts as a means of rehabilitation of service members” (Howie, 2017, p. 6), working to support WWII veterans at the War Veteran’s Art Center housed in the Museum of Modern Art (MOMA) in New York City. Using classes in media such as drawing, painting, jewelry, sculpture, and ceramics, D’Amico (1944) outlined the program’s goals as “to discover the best and most effective ways to bring about, through the arts, the readjustment of returning to the civilian life” (as cited in Howie, 2017, p. 6).

Art therapy’s connection with military and veteran treatment has grown steadily since it’s WWII beginnings. Haesler and Howie (2017) described the gradual blossoming of the art therapist’s role in VA healthcare, from one therapist here and there in the mid 1990s to over 40 art therapists across the country in 2015. Boston (2017) described her involvement with Paula Howie in transforming the role of art therapy in the inpatient psychiatric ward at Walter Reed Army Medical Center, in which they and four other art therapists used art to help provide structure, reality orientation, build self-esteem and develop insight (Howie et al., 2017). The presence and impact of art therapy in veteran treatment continues to grow, and art therapists are persistently advocating for the creation of a government service (GS) designation specifically for art therapy rather than being grouped with recreation therapy (Haesler & Howie, 2017).

Art therapy. Art therapy is a modality of treatment that has been quantitatively and qualitatively proven to be helpful for veterans (Maujean, Pepping, & Kendall, 2014; Palmer et al., 2017). Elements of art therapy that have been shown to be helpful with this population include its ability to provide the opportunity for nonverbal communication, serving as an avenue to unlock memories and feelings stored in the unconscious brain, and the soothing characteristics of the art materials in and of themselves that induce a sense of calm in the art maker (Avrahami, 2005; Lobban, 2014; Chong, 2015; Lobban & Murphy, 2017; Palmer et al., 2017). No matter the

affliction faced by the veteran client, art therapy's ability to provide a means for channeling the imagination allows for new possibilities to be conceived and in most cases, ultimately realized (Lobban & Murphy, 2017). Art therapy research proving the efficacy of this treatment approach, both with the traditional case study approach and in RCTs, is growing and this includes evidence of its value in supporting veterans (Kopytin & Lebedev, 2013; Maujean et al., 2017).

The setting, format, and directives of art therapy with veterans discussed in the literature is varied. For example, Avrahami (2005) utilized a stage-oriented art therapy approach on an individual basis rooted in the basic tenets of art therapy and trauma treatment, primarily letting the client lead the focus of each session over the course of six months of meeting. Alternatively, Walker, Kaimal, Koffman and DeGraba (2016) described the use of a group-oriented, 4-week intensive program in which veterans are a part of a cohort, promoting cohesion and a sense of community, with the inclusion of individual art therapy sessions upon request. Taking still another approach, DeLucia (2016) detailed an art therapy program housed in a veteran's outreach center that utilizes a gallery and drop-in art therapy studio approach. In her protocol, no specific interventions are provided, which she found to be especially supportive for veterans reluctant to participate in treatment. No matter the format or setting, this action-oriented approach to therapy – underpinned with neurobiological evidence of its usefulness – allows veterans a supportive space to tackle the myriad of mental health concerns generated by their military service (Pratt, 2017).

Neurobiological evidence. Mental health issues modify our neurobiological networks, meaning any mental health treatment that can rewire these modifications is of particular benefit (Hass-Cohen & Carr, 2008). Art therapy is one such approach that can make these modifications to neural processes. Chong (2015) highlighted this fact by explaining the various ways in which

utilizing art therapy aided in the alteration of neurobiological pathways negatively affected by early childhood trauma. As an example, he cited trauma's simultaneous impact on the suffocation of language systems and arousal of the limbic system as driving forces behind the utility of art therapy in treatment of individuals with early relational trauma, describing the ways that art serves in counteracting these neurobiological impacts. Specifically, Chong (2015) discussed how art allows for containment of "high impulse affects such as anger and frustration [caused by] the combination of prolonged hyper-arousal and instinctual reflex of disconnection from part of the cortex" (Chong, 2015, p. 121).

Chong (2015) explained further how the art aspect of art psychotherapy serves a unique role in being both neutral and instantly responsive in the therapeutic relationship by reflecting, mirroring and at times amplifying expression of the client's internal world without the need for words. This process, facilitated by the art materials' ability to absorb and slow down these high impulse emotions, opens opportunities for the cortex to be reconnected and reintegrated into the process of stress response. Chong (2015) also explained the role of touch in art making when using materials such as clay, connecting the manipulation of art materials to the ability of touch to cause mild sedation, a decrease in blood pressure, and improved autonomic nervous system (ANS) functioning and cardiovascular health. Additionally, Chong (2015) noted the utility of art in providing a concrete form in which unconscious emotions can emerge and be expressed in a tangible manner that can later be reflected upon. These unconscious emotions are often denied or dissociated due to the prolonged state of hypo-arousal typical in PTSD symptomology (Chong, 2015).

In addition to the aforementioned benefits of art psychotherapy in addressing the neurobiological effects of early relational trauma, Chong (2015) listed the following examples of

neurobiological impact as “qualities distinct to art psychotherapy interventions” (p. 124) that ameliorate adverse symptomology:

- Provide access the shared region of the brain responsible for emotion regulation and implicit memory: right brain, ANS, visual-spatial, tactile-sensorimotor;
- Activate these regions of the brain and ANS to create new emotional memories and neural pathways;
- The art serves as a channel for non-verbal communication;
- The art serves as a platform that allows for the expression, amplification and ‘tracing down’ of the bodily felt vitality affects;
- Allows for containment through the additional dimension of art, on top of the therapeutic relationship;
- Materials such as clay and thick paper allow high impulse to be contained, articulated externally and acknowledged as tangible visual and sensory experiences in a less confrontational way;
- The art dimension allows dissociated, unconscious emotions to emerge as vitality affects expressed and articulated in concrete external forms;
- The concrete form encourages acknowledgement and later reflection on these emotions that might be otherwise denied or dissociated;
- The development of the capacity to reflect fosters auto-biological memory. (p. 124)

The impact of art making on the brain has been measured using technical instruments as well. Belkofer and Konopka (2008) were able to capture the impact of one hour of drawing and painting on the brain activity of an individual using quantitative electroencephalograph (qEEG),

which measures “the way in which the brain functions through the energy-consuming activation of neurons. The degree and localization of this arousal and activation within the brain—this flow of energy—directly create[s] our mental processes” (Siegel, 1999, p. 3). They found an increase in brain wave activity in the qEEG measurement of temporal lobes after art making. Newberg, D’Aquili, and Rause (2001) suggest this change in temporal lobe activity is linked to an increased ability to reach a deeper level of self-awareness because of the connection of the temporal lobes to “experiencing a profound sense of meaning, connections to a higher power, deep feelings of peace, and a loss of time” (p. 61). Additionally, the increased activation of temporal lobes has been linked to the solicitation of dormant memories, emotions, and sensations that often lead to moments of insight in therapy (Rubin, 2001). Belkofer and Konopka (2008) advocated for conducting additional research into the difference in neurobiological impact between drawing from observation as opposed to drawing from memory, stating that the results of this distinction could be integral in understanding the value of art therapy treatment.

In 2014, Belkofer, Vaughan Van Hecke, and Konopka conducted a similar study to that of Belkofer and Konopka (2008) but increased the number of participants, standardized the procedure, and looked solely at the change in alpha brain waves, which “are generally found in relaxed yet alert mental states or shifts of consciousness” (Belkofer & Konopka, 2008). Their findings replicated those from the previously conducted study, in addition to previous research that suggested decreases in alpha brain wave activity promotes relaxation and self-regulation. Belkofer et al. (2014) expounded on the impact of this concept in the facilitation of art therapy, stating that the induction of alpha rhythms in art therapy mirrors the effects of exercise and meditation. In so doing, it serves as a means to access the inner reality of the client, as White and Richards (2009) described the alpha frequency as “a bridge from the external world to the

internal world, and vice versa” (p. 149). The difference in results between which areas of the brain are activated by art making in the artists and non-artists studied speaks to the important role of the therapist in scaffolding for the client when new to art making (Belkofer et al., 2014).

This finding of decreased alpha brain wave activity during art making was replicated in a study completed by Kruk, Aravich, Deaver, and deBeus (2014) in which they used qEEG to measure the brain activity of individuals after drawing versus making art with clay. Irrespective of the material used, a decrease in alpha and gamma activity was observed, in addition to a decrease in theta and delta activity, and a decreased report of anxiety levels made by participants between pre- and post-questionnaires (Kruk et al., 2014). These changes in brain activity align with previous research that posited this particular type of change is correlated with the production of “meditative states that benefit attentional and cognitive processing” (p. 58).

Spearheading a new framework through which one can begin to link neuroscientific evidence to the benefits of art therapy, Lusebrink (2014) wrote about her attempts to align the theory of Damasio’s (2012) convergence-divergence zones (CDZs) in the brain’s architecture with “the process of art therapy, art therapy approaches that emphasize the sensorimotor aspects of visual expression, and the perception of images as living entities” (p. 87). She delineated in detail how each aspect of the CDZ model aligns with our basic understandings of the elements of art therapy as explained by the Expressive Therapies Continuum (ETC). The ETC – developed by Lusebrink and Kagin in 1978 and further elaborated by Lusebrink in 1990 – provides a framework to understand the healing dimensions of expressive experiences and the restorative power of creativity (Hinz, 2009). Furthermore, it “represents a means to classify interactions with art media or other experiential activities in order to process information and form images” (Hinz, 2009, p. 4). One such example of how the ETC framework is linked to the CDZ model is

in the act of tracing symbols created by a client back to their root belief, which aligns to the neural patterns connected to certain memories or objects created across association cortices described in the CDZ model. Further connecting the two models, Lusebrink (2014) stressed how the different combinations of neural patterns in the sensorimotor areas and association cortex areas of the brain explained by the CDZ model involved in the creation of an image align with the metaphor described by Hinz (2013) in which she described the ‘life cycle’ of an image due to the way an image's meaning changes and evolves over time. For these reasons, Lusebrink (2014) postulated the utility of the early steps of the CDZ framework in offering a greater understanding of the “unique aspects of processing information via expression in art media” (p. 90) inherent in art therapy.

Konopka (2014) and Lusebrink (2014) have identified art therapy as an alternate means of accessing primitive brain networks – processing visual information, motor information, and memories – and aiding in the establishment of new neural pathways. Lobban (2014) echoed this, stating, “Art expression activates the tactile-haptic, visual-sensory and perceptual channels with subsequent processing of the material through the verbal and cognitive channels to find associations and meaning” (p. 11). Similarly, Gantt and Tinnin (2009) pointed out the utility of art therapy in creating a bridge between the verbal and nonverbal minds that typically does not exist in the wake of trauma due to the traumatic event often being coded in nonverbal regions of the brain. This theory of nonverbal coding of the trauma is further evidenced by a measured reduction of activity in the Broca’s area of the brain in individuals with PTSD which impacts verbal self-expression (van der Kolk, 2014). The production of art in art therapy provides an opportunity to integrate these memories and develop a coherent narrative of the trauma (Lobban, 2014).

Homer (2015) combined the aforementioned evidence of art therapy's ability to access neurobiological networks with Walker's (2009) suggestions for a neurodevelopmentally sensitive approach to therapy. To support the incorporation of the five R's of Perry's (2009) Neurosequential Model of Therapeutics, Homer (2015) introduced sensory-stimulating fabrics into therapy with clients. Clients created a fabric collage in a structure that was relational, repetitive, rhythmic, relevant, and rewarding to "facilitate [a] relationship and holding environment [that] fulfill these individuals' need for a supportive regulating relationship to freely and safely explore, as well as master their environment" (Homer, 2015, p. 25). In so doing, she presented two clients who were able to utilize this neurodevelopmentally appropriate intervention to repair neurobiological damage from early childhood trauma. Homer (2015) found that this intervention was easily adapted to work with both children and adults due to the well-rounded considerations it incorporated that were independent of the brain's developmental level.

In his 2010 article discussing the intersection of neuroscience and art therapy, Franklin focused on the healing capacities of mirror neurons when their functions are leveraged intentionally in session. Franklin (2010) described how making empathic art with a client helps clarify the affective experience of the client and fosters opportunities for reparation of attachment issues. Franklin (2010) described in detail the intent of empathic art, a process in which an art therapist – acting as the auxiliary ego or what Kramer (1986) described as the 'third hand' – scrutinously sifts through his or her own experience to incorporate intuitive knowledge, cues from the client, and affective resonance of the client's experience to create a visual narrative in response to the client. He incorporated this concept of using empathic art – based in the understanding of mirror neuron functioning – to support the client in regulating affective states

that arise throughout the process of forming a secure attachment in the safety of a therapeutic relationship (Franklin, 2010).

Carr (2014) also leveraged Kramer's third hand principle and took a unique approach to incorporating neuroscience into her art therapy work with individuals in palliative care. Carr (2014) discussed that when physical and mental health deterioration impact an individual's ability to create art in art therapy, talk therapy is often the default and that this approach falls short of meeting the client's needs. She argued that making art on the client's behalf could fill the voids created by talk therapy and allow a visual representation to be created and benefited from by the client.

Carr (2014) provided examples in which portraits she created of clients aligned with their needs from a neuroscience perspective. Among those benefits, she stated that it provided them an opportunity to leverage bottom-up neurological processes impacted by sensory stimuli in the environment. In so doing, clients were able to alter deep-rooted incongruences between their perception of self and the reality of physical changes as a result of illnesses that required palliative care. An additional benefit of this approach was the engagement of the client's mirror neurons, allowing the client to take the perspective of another individual who might view their portrait and in turn gain a deeper understanding of their experience as it might be perceived by others. Finally, Carr (2014) cited the neuroscience research behind imagination and explained that by incorporating it provides efficacy to the 'third hand' intervention by allowing the client a platform for imagining himself as he was unable to do otherwise.

Finally, McNamee (2005) incorporated the neuroscience research highlighting the advantages of engaging both the left and right hemispheres of the brain in developing a bilateral art therapy protocol. She presented a case example in which incorporating bilateral art into

individual and joint sessions with a family allowed for a change in both belief and behavior on the part of the mother by allowing her to integrate her cognitive awareness with her felt awareness. McNamee (2005) highlighted how this presumed neural integration facilitated by the bilateral art intervention led to a change in behavior on the part of the client in the area of her life explored in the artwork, as well as a verbal declaration by the client that the art intervention is what led to her ability to make different choices.

Current diagnostic issues. The literature highlights a number of mental health concerns commonly faced by the veteran population. These include but are not limited to PTSD, combat trauma, MST, complicated grief, and substance abuse (De Lucia, 2016; Smith, 2016). Although veterans also suffer from symptomology caused by depression, anxiety, insomnia, and suicidal ideation in large numbers, significant literature on the use of art therapy to address these concerns was not found.

PTSD. According to the National Center for PTSD (2016), an estimated 15 out of every 100 American veterans are currently living with PTSD, depending on the era in which they served. The source of trauma leading to PTSD in veterans varies greatly and includes but is not limited to: a pre-military personal history of trauma, childhood abuse, adult sexual and physical assault, combat experiences, and MST (Lehavot et al., 2017). The high prevalence rate of this diagnosis in veterans makes finding effective strategies for addressing the symptomology imperative, a matter magnified by the costs for PTSD treatment which have been estimated at \$6 billion dollars in the US alone (Bahraini et al. 2014; Wall, 2012).

Effects of PTSD. PTSD affects an individual's physical, physiological, neurobiological, and psychological well-being. Symptoms include but are not limited to: hypervigilance, hyperarousal, avoidance of stimuli, difficulty concentrating, trouble sleeping, flashbacks,

nightmares, anger, depression, fear of triggers, and fatigue (Haun, Duffy, Lind, Kisala, & Luther, 2016).

In addition to these symptoms, PTSD has been shown to have neurobiological effects on the brain. Jokić-Begić and Begić (2003) conducted a quantitative study using the electroencephalogram (EEG) results of combat veterans with PTSD in an attempt to demonstrate the extent and targeted area of these effects. They expressed a desire to achieve more conclusive EEG results than had been achieved previously, noting various other studies that identified a decrease in hippocampal volume and a change in amygdala function as neurobiological impacts of PTSD. In studying the resting EEG of individuals with PTSD compared to those individuals without, the researchers noted suppressed lower alpha band results and increased beta band results in those participants with PTSD. Suppression of the lower alpha band has been connected with a deficit of attention and increased beta band activity has been associated with cortical hyperexcitability and anxiety, both of which are consistent with symptoms of PTSD (Jokić-Begić & Begić, 2003).

Similarly, McNally, Kaspi, Riemann, and Zeitlin (1990) studied the extent to which PTSD affected the processing of threat cues. Their results showed that individuals with PTSD experienced delayed processing of PTSD-related words – such as body bags, firefight, medevac, and Charlie – at a rate of higher statistical significance than those veterans without PTSD (McNally et al., 1990). Although they were unable to conclusively determine if this was a trait or state phenomenon, this interference surrounding PTSD-related words suggests an emotional disturbance.

An often-overlooked effect of PTSD is that of posttraumatic growth. Posttraumatic growth is defined as “the positive changes that emerge from coping with a personal challenge or

trauma” (Kern & Perryman, 2016, p. 449). It contains five domains: Personal Strength, Enhanced Relationships with Others, Spiritual Change, Appreciation of Life, and New Opportunities (Tedeschi & McNally, 2011). Discussion of posttraumatic growth is not intended to dismiss or undermine the negative impacts of trauma, but rather to recognize this potentially positive outcome of a traumatic experience and the probability that these effects will ebb and flow in the years following an event (Tedeschi & McNally, 2011). Pierce and Decker (2017) reiterated the importance of not focusing solely on symptom reduction in treatment, but also on areas of posttraumatic growth and improvement of resilience, focusing on not just what got better because of treatment but what got healthier.

Access and engagement. Naff (2014) pointed out that it is an individual’s subjective emotional reaction and not the nature of the traumatic event that determines how PTSD will manifest for different people. Furthermore, the complicated presentation of PTSD influences the efficacy of various treatments depending on the degree to which veterans feel capable or comfortable discussing their trauma, putting words to their trauma narrative, and sharing the details of their trauma with others. Collie et al. (2006) highlighted a point to consider: The very real possibility that the number of veterans with PTSD is even greater than we know and is underreported for reasons such as not seeking treatment, the barrier of stigma associated with seeking mental health treatment, or resistance to seek treatment at VA facilities due to the factor of its military affiliation being a trigger for their PTSD. This claim is echoed by Ramsey et al. (2017) who found that out of 888,142 OEF, OIF, and OND era veterans studied, PTSD was the most frequently diagnosed disorder, with some subpopulations, such as men aged 18-29, reaching as much as 41% for this diagnosis.

An additional barrier to treating all veterans with PTSD in need of services is difficulty with engagement. The VA has expended extensive effort to screen for PTSD and connect veterans with mental health services. Potentially related, since 2000, there has been an increase by one-third the number of women accessing VA outpatient mental health services (Lehavot et al., 2017). Despite this increase, “40% [of women veterans surveyed] reported that they needed counseling in the past year but did not seek those services” (Lehavot et al., 2017, p. 69). Similarly, Haun et al. (2016) found that women veterans perceived a number of issues with their PTSD treatment at the VA, including a lack of female-centric programming, no continuity of care, and an absence of programming specific to their type of trauma. The number of veterans with PTSD as well as the number of those not currently seeking VA support services highlight the urgent need to ensure that PTSD treatment for veterans is accessible, effective, and sufficient.

Traditional theoretical frameworks and PTSD. To properly lay the foundation for effective treatment in support of veterans with PTSD, it is critical to start by understanding how many veterans are affected with this mental health concern. McCarron, Reinhard, Bloeser, Mahan, and Kang (2014) stated, in their study on the accuracy of the VA’s data on the number of OEF and OIF veterans with PTSD, “Estimating rates of posttraumatic stress disorder (PTSD) among Iraq and Afghanistan veterans is an important but difficult task” (p. 626). The researchers noted that finding efficient means to identify veterans with PTSD would not only increase the possibility of helping provide them with proper treatment but would also help to adequately inform VA health care policies. McCarron et al. (2014) identified that as of 2013, the VA system of care had seen “934,264 (56.7%) of all eligible OEF/OIF/OND veterans, and of these, 274,319 (29.3%) had at least one ICD-9-CM code for PTSD assigned by a VA health care provider” (p. 626). An estimated 23% of OEF and OIF veterans suffer from PTSD, as well as an estimated

17% of Vietnam veterans and 10% of Gulf War veterans (Fulton et al., 2015; Goldberg et al., 2016; Kang, Natelson, Mahan, Lee, & Murphy, 2003; Price, 2016). Focusing on women in particular, Lehavot et al. (2017) estimated that among women veterans attending VA primary care clinics, the lifetime PTSD prevalence rate is 27%, which they noted is significantly higher than the estimated 10-12% of women in the general population (p. 68).

Currently, the VA primarily advocates for the use of – and VA hospitals are required to provide – EBTs that involve a manualized cognitive-behavioral psychotherapeutic approach to include Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy for the treatment of PTSD (Allen et al., 2017; Eigen, 2017; Veterans Health Administration, 2008). Advocating for use of these two treatments stemmed from the significant amounts of empirical research validating their effectiveness in the treatment of civilians with PTSD (Allen et al., 2017). These findings have continued to hold true and evidence of their usefulness with veterans specifically has begun to accumulate (Goodson et al., 2013; Walter, Buckley, Simpson, and Chard, 2014). Importantly, their effectiveness has been shown to continue following treatment (Resick et al., 2012).

The approach of Prolonged Exposure contains four main elements: psychoeducation, in vivo exposure, imaginal exposure, and in-session discussion which facilitates emotional processing and corrective learning (Foa, McLean, & Yusko, 2013). This process typically involves a client attending 90-minute sessions once weekly over the course of eight to 15 weeks, and clients are required to review recordings of their sessions in between (Foa et al., 2013).

Contrastingly, Resick (2001) delineated CPT as a 12-session structured approach that entails cognitive-focused interventions, psychoeducation, and written assignments designed to clarify ‘stuck points’ caused by trauma-related beliefs. Resick (2001) explained that worksheets

are used by clients between sessions and ultimately therapists conducting CPT work to modify held beliefs in the areas of safety, trust, control, esteem, and intimacy. Although the treatments approaches and rationales of CPT and Prolonged Exposure are very different, they share the following common goals: “to reduce avoidant coping; purposefully confront traumatic memories; and modify maladaptive, trauma-related thoughts” (Allen et al., 2017, p. 137).

Treatment models based in CBT are primarily informed by research centered on the experience of civilians rather than that of military personnel (Steenkamp et al., 2011), however, and further evidence of their efficacy in treating military-specific trauma is needed.

Despite the VA’s requirement of incorporating either of these EBTs into PTSD treatment, Cook et al. (2015) found that not all VA programs are meeting even this minimum requirement. In their study looking at the implementation rates of EBTs for PTSD by VAs nationwide, the researchers noted that among six outpatient VA programs for PTSD in the New England area, only 6.3% of veterans surveyed were receiving Prolonged Exposure therapy or CPT as part of their treatment (p. 464). They found that many VA mental health providers felt that they needed additional support measures to follow the requirement of using individual and group CPT as well as Prolonged Exposure therapy in their programming, such as dedicated time and resources, incentives and mandates. Becker, Zayfert, and Anderson (2004) found that a reason for this lack of implementation could be treatment provider discomfort at implementing these protocols. Of a total 207 psychologists surveyed, a large majority – 72% – reported discomfort in utilizing exposure therapy to treat PTSD, despite over half reporting having previous training in at least one type of exposure therapy.

Several studies have been conducted focusing on the therapies traditionally provided by the VA for treatment of PTSD. Although these treatments have proven effective in some studies,

researchers have attempted to address the barriers involved in their implementation to increase utilization. To aid in combatting the issue of lack of participation in treatment by women veterans, Lehavot et al. (2017) studied ways in which a web-based CBT treatment for PTSD already established and in use could be improved to boost participation by and the benefits for women veterans. They found that small modifications such as the addition of an individual assigned to guide the participants throughout the process greatly increased perceived benefit by the women veterans who completed the 16-week program (Lehavot et al., 2017). Additionally, participants in the study found that the web-based nature of the treatment addressed their propensity for isolation that had prevented them from utilizing other clinic-based treatment options. Similar findings were made by Krupnick et al. (2017) after studying the efficacy of their web-based intervention in reducing PTSD symptomology in OEF, OIF, and OND veterans. The intervention was used in conjunction with typical trauma unit programming, and while all aspects of PTSD symptomology improved to some degree, the online and in-person combination proved most useful in decreasing the hyperarousal effects of PTSD.

A qualitative study conducted by Mott et al. (2013) focused entirely on the perspective of veterans regarding the efficacy and tolerability of exposure therapy in a group setting. Mott et al. (2013) found an overall high rate of satisfaction among group members, as well as an improvement of symptoms and high levels of tolerance regarding sharing in vivo experiences in front of other group members. In fact, many participants stated that the group format was a vital component to their sustained commitment to the treatment.

In addition to the required Prolonged Exposure and CPT, other EBTs are widely used in the VA system despite not being referenced explicitly in the VHA Handbook (2015) (Bernhardt, 2009). Acceptance and commitment therapy (ACT), for example, has its roots in treating anxiety

and depression and is now commonly used to address the wide array of symptomology associated with PTSD, aiming to reduce experiential avoidance and clients' fusion of painful memories to thoughts that are believed to be true (Bernhard, 2009). This 'defusion' allows clients to move forward with their lives and see thoughts for what they are (Jones et al., 2017). ACT is considered a third-wave cognitive therapy, as symptom reduction is not the goal, rather it aims to change the relationship we have with our thoughts and feelings (Backos & Mazzeo, 2017).

Another such efficacious approach being used to treat PTSD is eye movement desensitization and reprocessing (EMDR) therapy. Oren and Solomon (2012) described EMDR as an integrative therapy in which the practitioner instructs the client to employ bilateral stimulation – often through eye movements, hand claps, tones or buzzers – to reduce sensitization to a distressing traumatic memory, followed by a reprocessing of the memory to facilitate more adaptive cognitions. This particular approach has been the subject of extensive research and has been approved and recommended by a number of regulating bodies in the field of mental health worldwide (Blankenship, 2017). Compared to other approaches, EMDR has been shown advantageous in the area of time commitment required for treatment due to the lack of required homework and its ability to effectively treat trauma in as little as three 90-minute sessions with maintained effect 90 days posttreatment (Shapiro, 2012). The mechanism of bilateral stimulation and its importance in treatment, however, has yet to generate cohesive empirical evidence (Blankenship, 2017; Logie, 2014).

Trauma-focused group therapy (TFGT) – which combines Prolonged Exposure and cognitive restructuring – is another approach being used to treat this demographic discussed in the literature. This approach values the group's ability to help one another, expose clients to other individual's trauma, share the details of their trauma in a safe space, normalize symptoms,

and increase the generalizability of acquiring coping skills (Foy, Rezek, Glynn, Riney, & Gusman, 2002). Proponents of this approach highlight these elements of TFGT as beneficial to clients with PTSD, however little conclusive evidence exists regarding the helpfulness of the group component in this exposure-based approach (Levi et al., 2017).

Literature argues for alternative therapies, but evidence-based practices focus on those therapies rooted in CBT practices. Bernhardt (2009) explained, “CPT seeks to reduce the need to avoid strong negative feelings by altering the PTSD sufferer’s irrational thinking” (p. 349). The verbal emphasis in Prolonged Exposure therapy is also described – “The client repeatedly describes his imaginal experience of the traumatic event following which the therapist assists him in processing the resulting thoughts and feelings” (p. 349). Significant evidence of the efficacy of these cognitive-behavioral interventions exist (Allen et al., 2017); however, their success is often limited by high rates of patients declining or withdrawing from treatment (Stephenson et al., 2017).

The lack of engagement and underutilization of EBTs at VAs could underscore the claim made by some researchers of the need for more inclusive and approachable programming for veterans with PTSD, both within and outside of the VA healthcare system (Hurst et al., 2017; Madsen et al., 2017). Furthermore, the talk therapy component of these EBTs is problematic and likely a deterrent for individuals who do not have verbal encodings of their traumatic memories (Kaur, Murphy, & Smith, 2016; Lobban, 2016b; Mandić-Gajić & Špirić, 2016).

Art therapy and PTSD. Researchers are highlighting the importance of offering complementary therapies to provide comprehensive healing for individuals suffering from PTSD and the amount of research substantiating art therapy’s utility in this endeavor is growing (Nanda, Gaydos, Hathron, & Watkins, 2010; Walker et al., 2017). In a systematic review of six

controlled studies looking at using art therapy in trauma treatment, a significant decrease in trauma symptoms was found in half of the studies and a significant decrease of depression in one study (Schouten, de Niet, Knipscheer, Kleber, & Hutschemaekers, 2015). Further justifying the need for varied approaches, Kaur et al. (2016) found that a subset of individuals with PTSD with high levels of avoidance and dissociation find it difficult to engage in verbal-heavy therapies.

On a broad scale, image-making helps address PTSD symptoms such as alleviate recurring nightmares, reduce arousal, reactivate positive emotion, enhance emotional self-efficacy, improve self-esteem, and improve concentration, memory, attention, and organization (Collie et al. 2006; David, 1999; Hines-Martin & Ising, 1993). Johnson (2009) argued for the ease of increasing evidence of art therapy's role in the treatment of PTSD considering how many elements of currently promoted approaches such as CBT are rooted in expressive therapies. Johnson (2009) listed these contributions as (a) imaginal exposure and guided imagery; (b) cognitive restructuring derived from role playing; (c) restorying of traumatic events; (d) relaxation techniques for stress and anxiety management; and (e) the use of creativity, humor, spontaneity, flexibility, and activity to enhance resilience.

Campbell et al. (2016) identified key effective methods and factors of art therapy in the treatment of PTSD outlined in the literature. The most widely identified approach of incorporating art therapy in treating PTSD was the practice of creating a visual trauma narrative (Campbell et al., 2016; Collie et al., 2006; Gantt & Tinnin, 2007, 2009; Harber, 2011; Pifalo, 2007; Rankin & Taucher, 2003; Sarid & Huss, 2010; Talwar, 2007). Additional research noted the importance of creating this trauma narrative after developing a safe therapeutic environment and connecting the participant to body sensations (van der Kolk, 2014).

Johnson (1987), as cited in Avrahami (2005), explained that “when the sympathetic nervous system is extremely aroused, as in a traumatic situation, verbal encoding of memory shuts down and the central nervous system returns to the sensory-iconic memory form reminiscent of early childhood” (p. 7). As such, the memories made in these moments are non-declarative and only able to be accessed situationally when triggered automatically by trauma-related cues (Lobban, 2014; Lobban, 2016b). Avrahami (2005) similarly noted in her study on the contributions of visual art therapy to PTSD treatment, that traumatic memories, unlike normal adult memories:

are not coded in a verbal and linear framework that can be assimilated in an ongoing life story... Thus, non-integrated memory is considered the basis for behavioral reenactment, somatic sensation, or intrusive images as flashbacks that are disconnected from conscious, verbal memory. (p. 7)

Art therapy can serve as the missing link in treating these aspects of PTSD symptomology due to its ability to provide a means of access to nonverbal memories, a way to approach and consolidate these memories using symbols, and the inclusion of materials and processes that allow for externalization and emotional distancing (Avrahami, 2005). Tripp (2016) explained further, “Expression through art can facilitate a shift of traumatic material from implicit to explicit memory. Ultimately, the creation of a coherent pictorial narrative of the trauma may be required for symbolic processing and trauma resolution to occur” (p. 174).

Out of 15 treatment components, art therapy was found to provide the most benefit to combat veterans in an inpatient PTSD unit (Johnson, Lubin, James, & Hale, 1997). In self-report responses of 25 veterans across two cohorts, veterans reported changes in feeling states, documenting a greater improvement in symptoms after art therapy treatment for individuals with

higher levels of PTSD. Additionally, veteran participants reported an ability to tolerate war-zone related content during art therapy that they were unable to tolerate in other treatment modalities (Johnson et al., 1997). Johnson et al. (1997) hypothesized that the improvement in symptomology following art therapy, such as a decrease in levels of distress, could be attributed to the shift in focus from internal states to external foci, as well as the action-oriented nature of art therapy.

Similarly, 89% of participants in Gantt and Tinnin's (2007) program using art therapy for trauma treatment experienced a full recovery or met the criteria for improvement. Gantt and Tinnin (2009) attributed the success of their model to the nonverbal elements of the solution and their abilities to address the nonverbal problem. "Once the deleterious effects of the traumatic event have been reversed then one can proceed to working on the meaning of the event, but not before. This is a reversal of the usual sequence of therapy" (Gantt & Tinnin, 2009, p. 151).

Mandić-Gajić and Špirić (2016) observed in their study of the artwork of 89 veterans who participated in art therapy group treatment for PTSD that individuals who struggled or preferred not to verbalize their suffering found exploring these topics through imagery more accessible than talk therapy approaches. Additionally, the veterans with PTSD that participated in the art therapy group demonstrated a marked increase in openness to discuss non-war related themes throughout the time spent in group which increased their social integration both in and out of the group setting.

This level of comfort in sharing in a group art therapy setting was also seen by Kopytin and Lebedev in their RCT on the use of art therapy with 112 war veterans in a specialized psychotherapy unit. Specifically, they looked at the role of humor as a therapeutic factor and its link to the creative and cognitive resources of veterans. When compared to Silver's (2002) study,

the veteran participants used humor in their artwork at 3 times the rate seen by Silver, typically more positive rather than negative. Similarly, Kopytin and Lebedev (2013) found increases in the emotional content, self-image, and cognition significantly higher in the art therapy group as compared to the control group, supporting the hypothesis that artistic activity plays an important role in creative problem solving and improved self-esteem.

PTSD is categorized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as having four clusters of symptoms – Re-experiencing, Avoidance, Negative Alterations in Cognitions and Mood, and Marked Alterations in Arousal and Reactivity (American Psychiatric Association, 2013) – which can serve as significant barriers to treatment and can hamper the natural process of recovery after trauma (Pineles et al., 2011). Re-experiencing typically entails the persistence of flashbacks and nightmares pertaining to the traumatic event (Wade, 2016). The Negative Alterations in Cognitions and Mood cluster can involve thoughts of self-blame – often inaccurate – as well as beliefs of inadequacy and weakness, and expectations about the future can be permanently altered (Resick et al., 2012). Alterations in Arousal and Reactivity are often hallmarked by hypervigilance that can be perceived as paranoia (Friedman, 2016). The Avoidance cluster is defined as, “Persistent avoidance of stimuli associated with the traumatic event(s), either through thoughts and feelings or external reminders such as people or places” (American Psychiatric Association, 2013, p. 271).

Art therapy is well-suited to address this specific symptomology, evidenced by Lobban and Murphy’s (2017) study of veterans in an inpatient PTSD unit. In their study, veterans’ involvement in treatment programming was restricted to only closed art therapy groups and individual sessions, rather than the full psychoeducation and CBT-focused group programming.

Lobban and Murphy (2017) studied the impact of the center's art therapy program, modeled after Lobban, Mackay, Redgrave, and Rajagopal's (2017) model which utilizes a "phasic, theme-based approach...to facilitate gradual, paced exposure to difficult material" (as cited in Lobban & Murphy, 2017, p. 2). This approach modifies group themes to support each unique group at a given time, which in turn provides a framework and focus while still encouraging an individual approach to the task. Lobban and Murphy (2017) found a reduction of scores in the avoidance cluster of PTSD symptoms on the PCL-5 (the PTSD checklist for DSM-5) from 2.9 at the beginning of treatment to 2 at discharge. Additionally, of interest coming from a group labeled as being highly avoidant, the researchers noted that veterans "regularly report the benefits of being with other veterans, where no pretence is necessary and they can be their 'true selves'" (Lobban & Murphy, 2017, p. 12). These findings replicated Lobban's (2017) findings that veterans were able to use art therapy to aid them in overcoming the barrier of avoidance after participating in a 12-week outpatient art therapy treatment. Furthermore, Stadler (2017) spoke to the ability in art therapy to discuss the visual representation of the veteran's feelings rather than the feelings themselves, acting as a way to meet the veteran where they are at as it pertains to the propensity to enact avoidance.

Art also provides an avenue for integrating dissociated memories that can manifest in impaired self-regulation processes (Bat Or & Megides, 2016). By physically connecting objects loaded with emotional content through the process of art making in therapy, the art medium has the potential to mend the broken connections of the inner world disconnected by the trauma faced by veterans (Haesler, 2002; Herman, 1992). Megides et al. found that naming and verbalizing the process of making readymade art could offer an opportunity for a gradual

encounter with the dissociative emotional and memory-based aspects to begin the process of reconstructing their experience (as cited in Bat Or & Megides, 2016).

Recently, Palmer et al. (2017) surveyed 547 veterans and found that, on average, they not only found art therapy useful and applicable outside of treatment, but that art allowed for the facilitation of communication among group members and allowed them to access previously inaccessible feelings. This finding echoed that of Lobban (2016b) which indicated that the art made in group therapy facilitated a different understanding of their peers for veteran art therapy participants. The art created also generated an interpretation of themes they found useful and that stimulated new ways of thinking. Relatedly, the first RCT on the effects of art therapy in the treatment of combat-related PTSD was conducted by Campbell et al. (2016). Campbell et al. (2016) found that the inclusion of art therapy in trauma treatment could reduce dropout rates and increase participant satisfaction.

Although these studies are paving the way, more research needs to be done to advocate for the inclusion of art therapy as a standard PTSD treatment modality both in and out of the VA. Slayton, D'Archer, and Kaplan (2010) cited art therapist researchers' calls for the prioritization of structured inquiry as early as 1977. Slayton et al. (2010) noted a significant improvement in their ability to find statistically significant evidence of the efficacy of art therapy as compared to that of Reynolds, Nabors, and Quinlan (2000). Johnson (2009) discussed the lack of research on the impact of art therapy in the treatment of trauma, citing the over-use of case studies as a difficulty in demonstrating the efficacy of the art therapy approach. Four years later, art therapy for treatment of trauma was identified as one of the top priorities of the art therapy field (Kaiser & Deaver, 2013). As recently as 2016, Ramirez noted three major themes among the 12 articles identified focusing on art therapy in the treatment of PTSD, to include: (a) the ability to express

thoughts which could not previously be verbalized; (b) improved social relationships which led to reduced social detachment; and (c) a general reduction in re-experiencing, hyper-vigilance and avoidance/ emotional numbing symptom clusters with notable improvements in experiencing less anxiety, being able to control intrusive thoughts, and feeling less emotionally numb (p. 45). Similar to Ramirez's (2016) ability to identify only 12 articles on this topic, Lesser (2017) underscored the need for continued research in her interview with past President of the AATA (2017) Donna Betts, who stated, "There is some evidence-based (art therapy) research, but we need more of it to demonstrate with certainty that art therapy works and how it works and why it works."

Traumatic Brain Injury. In 2016, the Defense and Veterans Brain Injury Center reported 352,619 US military servicemembers had been diagnosed with TBI worldwide. Although primarily acquired during combat, TBI can be obtained from non-deployed settings including military training events, vehicle crashes, recreational activities, or from falls (Blakeley & Jansen, 2013). In addition to the impact on well-being of individuals affected, Bahraini et al. (2014) reported treatment costs of TBI at an estimated \$910 billion in the US. Although the acquisition of a TBI does not necessarily always predict the onset of PTSD symptoms, research evidence on the high rate of comorbidity of these two diagnoses has been significant (Blakeley & Jansen, 2013; Yurgil et al., 2014). Dolan et al. (2012) argued that the overlap in symptoms of PTSD and TBI can cause individuals to experience – among other symptoms – anxiety, depression, cognitive deficits such as memory loss and attention difficulties, irritability, and sleep disruptions. This comorbidity was reiterated in Miles et al.'s (2017) study in which they found that 20% of OEF and OIF veteran's medical records studied indicated a diagnosis of TBI and at least one other mental health condition.

In an official RAND Corporation report, Tanielian and Jaycox (2008) delineated EBT options for PTSD and TBI for servicemembers and veterans as CBT, pharmacotherapy, and psychological debriefing.

The literature on art therapy and TBI is limited (Walker et al., 2016). However significant research on the use of art therapy with individuals with PTSD and TBI has been published in recent years by researchers from the National Intrepid Center of Excellence (NICoE), part of Walter Reed National Military Medical Center. For example, Walker et al. (2016) published a case study capturing one veteran's experience in NICoE's Intensive Outpatient program (IOP). Through a combination of complementary and integrative therapies, medical and psychiatric care, the veteran made significant improvements in reducing his TBI and PTSD symptoms, primarily attributed to his experiences with acupuncture and art therapy.

In his description of art therapy's incorporation into treatment programming at the Jesse Brown VA Medical Center, Morrissey (2013) shared a case example of a veteran with a TBI, showcasing his transformation from attending services barely functioning simply to achieve placement in a homeless shelter to functioning, obtaining a sense of self, identity, and limitations. Morrissey (2013) described the utility of art therapy in creating lasting evidence of the therapy session, a fact that is pertinent when groups often have 30 minutes to process the needs of 15 patients. The artwork becomes a way not only for individuals to work simultaneously, but for topics to be addressed in individual sessions or for clinicians to observe potential issues if unable to do so during group therapy due to time constraints. In the case of the veteran highlighted by Morrissey (2013), bilateral symmetry allowed him to begin to regain control over thought processes and make progress in his functioning as well as communicate his needs regarding trauma treatment.

Combat trauma. When veterans experience PTSD primarily as a result of combat trauma, it often generates specific mental health difficulties. In studying the medical records of 55,458 OEF and OIF veterans who received a new-onset mental health diagnosis in 2010, Miles et al. (2017) found that 57% had been diagnosed with PTSD. Combat-related PTSD clients often experience guilt, grief, shame, and difficulties in relating intimately with partners due to emotional numbing, in addition to the traditional PTSD symptomology (Levi et al., 2017). Longitudinal research indicates that combat-related PTSD can be chronic and involve several remissions and relapses (Friedman, 2016). Moreover, Price, Gros, Strachan, Ruggiero, and Acierno (2012) studied 111 OEF and OIF veterans' responses to 8 weeks of exposure therapy and found that increased combat exposure is connected to poor treatment response in veterans with PTSD.

Specific steps exist to aid individuals with combat-related PTSD in achieving posttraumatic growth. These steps, identified by Tedeschi and McNally (2011) are "(a) understanding the trauma response, (b) development of emotional regulation, (c) engaging in constructive self-disclosure around the aftermath of the trauma, (d) developing a trauma narrative with posttraumatic growth domains, and (e) developing life principles that can withstand challenges" (pp. 21-22). Tedeschi and McNally (2011) discussed the myriad of examples in the literature of veterans' ability to find positive impacts of war on their lived experience. Psychotherapy can nurture these positive takeaways through cognitive processing, support of attempts at mastery of new experiences, and assistance in the enhancement of relationships.

Traditional frameworks and combat trauma. Traditionally, exposure-based therapies have been recommended and utilized in the treatment of combat-related PTSD, primarily

Prolonged Exposure and CPT, as the VA does not discriminate between PTSD and combat-related PTSD when delineating preferred treatments (Beidel et al., 2017b).

Another psychotherapeutic approach to combat-related PTSD is Trauma Management Therapy (TMT). This multi-component behavioral approach consists of imaginal exposure therapy followed by a group therapy format aimed at addressing depression, anger, and social isolation (Turner, Beidel, & Frueh, 2005). This protocol consists of 29 treatment sessions over the course of 17 weeks. Beidel et al. (2017a) modified this approach by incorporating 14-sessions of virtual reality exposure therapy (VRET) after completing TMT. VRET combats the limitations of traditional imaginal exposure therapy by using virtual reality technology to allow for the development of a near-real-life recreation of the traumatic memory, with newer versions incorporating visual, auditory, olfactory, and tactile cues (Beidel et al., 2017a). In comparing the impact of this modified TMT approach to a test group of individuals who only used VRET coupled with a psychoeducation group with OEF, OIF, and OND veterans, they found significant decreases in PTSD symptoms in both groups, and a significant decrease in social isolation of those individuals who completed TMT. Treatment gains were maintained at 3- and 6-month follow-up (Beidel et al., 2017a).

Traditional and modified versions of exposure therapies have generated evidence of their efficacy. However, individuals frequently still meet criteria for PTSD upon completion of these treatments (Steenkamp, 2016) and they often are accompanied by high dropout rates (Beidel et al., 2017a). For these reasons, Beidel et al. (2017b) modified TMT to fit an Intensive Outpatient (IOP) model in an attempt to increase retention. The group consisted of 112 participants at the beginning of their 3-week IOP, and only two individuals dropped out for other than administrative reasons.

Wade (2016) recommended the inclusion of spirituality into traditional CPT treatment for combat-related PTSD, citing its utility in addressing distorted thinking while strengthening the veteran's sense of support and guidance in the treatment process. In addition to spiritual support, Beidel et al. (2011) found that TMT improved veteran frequency and time spent in social activities as compared to a group receiving exposure therapy. This interpersonal element proved to be an element of this multi-component CBT approach that not only advocated for alternatives to exposure therapy approaches, but also lasted after completion of treatment (Beidel et al., 2011).

Art therapy and combat trauma. Art therapy approaches for combat-related PTSD differ slightly from treatment designs for traditional PTSD. Little research exists on art therapy with this population despite widespread application (Malchiodi, 2011). Pierce and Decker (2017) discussed the utility of art in art therapy in reactivating positive emotions through the process of creating pleasurable and satisfying art, noting that what is destroyed through trauma, can be healed through creation. In their presentation discussing the impact of adjunctive art therapy use during CPT, Pierce and Decker (2017) underscored veterans' comments on art therapy's ability to provide veterans a way not to engage in avoidance and cope at the same time. Veterans that participated in the combined art therapy and CPT attested to the value of having a visual safe space – created during an art therapy session – in which they could immerse their attention to aid in grounding during verbal processing from which they generated a sense of safety, noting that the experience of CPT alone was useful but painful.

Kern and Perryman (2016) highlighted the ability of creative therapeutic approaches to aid in the development of protective factors and facilitate steps toward posttraumatic growth in ways that talk therapy alone cannot. They focused on the aggressive behaviors often seen in

individuals with combat-related PTSD and linked creative therapy's abilities to induce calm with the reduction of this symptom of PTSD. Backos reiterated the supportive factors inherent in art therapy and art's ability to reinforce messages of defusion in ACT-based PTSD treatment (Jones et al., 2017). She described leveraging the 'monsters on the bus' metaphor as an art directive adapted from Hayes, Stroshal, and Wilson (1999). The directive is described by Backos & Mazzeo (2017) as:

Each veteran imagines himself or herself as a bus driver and thoughts were described as passengers on a bus with unhelpful passengers/thoughts attempting to derail the bus driver's route. Veterans created three drawings of 'monsters' that represent their commonly fused thoughts, as well as externalizing the details of these distorted thoughts via written descriptions, including the age of the monster, what the monster says, other related monsters, and what situations bring out each monster. (p. 170)

Clients are encouraged to explore this metaphor through the art and develop a greater understanding as to how the passengers divert them from living the life they desire, allowing them to make life decisions based on goals and not distorted thoughts (Backos & Mazzeo, 2017; Jones et al., 2017).

Levi et al. (2017) studied the implementation of a modified version of TFGT with 80 male veterans seeking treatment at the Unit for the Treatment of Combat-related PTSD (UTC-PTSD) in which art therapy techniques were incorporated. The incorporation of art therapy was believed to benefit the group's ability to immerse themselves in the process more quickly. Additionally, the researchers believed that the participants would have more time to share and describe their artwork because the talk therapy element is short in this approach (Levi et al., 2017); however, the art therapy element of this model was not administered by trained art

therapists, a fact not listed as a limitation to the study. It was hypothesized that the incorporation of all three therapeutic approaches would reduce both PTSD symptomology and depression. Levi et al. (2017) found that dropout rates for the group were lower than in other studies, which they attributed to the short duration of therapy in this format. They also found that the “art therapy” component allowed clients to distance themselves from emotion and to begin to integrate cognitive functioning and meaning-making processes.

Military sexual trauma. The nature of MST comprises factors that make it uniquely traumatizing, including most often a sense of betrayal when it involves fellow servicemembers, the lack of perceived opportunity to escape, and even the belief that there may be military-imposed repercussions for disclosing the sexual trauma (Ferdinand et al., 2011). The risk of acquiring PTSD is high in individuals who have experienced MST, and these odds increase when the incident is ‘blue on blue’ – a term used to describe a sexual assault occurring between servicemembers. (Kimmerling et al., 2010; Van Fossen, Earley, & Ghurani, 2017). In fact, MST is more likely to result in a diagnosis of PTSD than any other type of trauma, including combat-related trauma (Department of Veteran Affairs, 2010). Exact rates of MST among male and female veterans is difficult to acquire due to the propensity to withhold report or file a restricted report in this population (Johnson, Robinett, Smith, & Cardin, 2015); however, a recent update by the National Center for PTSD (2018) reported that 1 in 4 female veterans and 1 in 100 male veterans screened during VA treatment identified as victims of MST.

Importantly, Gilmore et al. (2016) proposed the use of home-based telemedicine with this population to increase engagement, noting the significant number of inherent triggers – such as military clothing, protocol, and terminology – for this population when receiving treatment in a VA medical center. They compared asking veteran survivors of MST to come to the VA for

PTSD treatment to asking a patient with agoraphobia to come in for regular treatment and highlighted the significant systemic barriers that currently inhibit widespread treatment of this population.

Traditional theoretical frameworks and MST. Research evidence of effective treatment programs for specifically addressing MST is minimal (Michael Husby, 2014). The VHA has yet to endorse a specific approach for treatment of MST, although references have been made in the literature to the recommendation of using CPT and Prolonged Exposure therapies as is recommended for PTSD (Ferdinand et al., 2011). Contrastingly to these recommendations, some survivors do not respond well to these therapies or have treatment-resistant symptoms that persist following treatment (Stadler, 2017).

Additionally, the VHA has provided training for ACT to treat MST, and many VAs offer the cognitive behavioral *Seeking Safety* model as a treatment option this population (Michael Husby, 2014). In one case study, ACT substantially improved a female veteran with MST's depression symptoms, her ability to attend to the present moment, tolerate uncertainty, and make decisions consistent with her values (Hiraoka, Cook, Bivona, Meyer, & Morrissette, 2016).

Two studies were found looking at the effects of a particular therapeutic approach with this population, both of which used CPT. Surís, Link-Malcolm, Chard, Ahn, and North (2013) studied the effects of CPT on veterans with MST-specific PTSD and found it to have lasting effects in reducing PTSD symptomology in an RCT. Holliday, Holder, Williamson, and Surís (2017) reviewed data from this RCT and found no statistical difference in effect or dropout rates due to racial self-identification. Mullen, Holliday, Morris, Raja, and Surís (2014) found similar positive results in the reduction of both depressive and PTSD symptoms in 11 male veteran survivors of MST.

Finally, Hurley (2016) advocated for the use of EMDR in the treatment of MST. Citing the key element of using a client-centered approach in EMDR, Hurley (2016) explained that this approach increases the air of collaboration and trust necessary to develop a treatment plan best-suited to address the many facets of MST's physical and psychological impact. Importantly, Hurley (2016) pointed out the fact that veterans need not share the details of their trauma in this nonverbal approach to therapy, and that the therapist can simply direct questioning to the client's current lived experience.

Art therapy and MST. Very little has been published pertaining specifically to the treatment of MST with art therapy. Walter Reed National Military Medical Center offers a partial hospitalization (PHP) program to support servicemembers in conjunction with the psychiatry continuity service (PCS) (Van Fossen et al., 2017).

This program has three tracks: one for combat trauma recovery, one for general affective/anxiety disorders, and the last for sexual trauma recovery – nicknamed the Interpersonal Recovery Program (IRP) by patients, as they stated that the interpersonal aspect was what was missing from other programs with similar foci. This program – the first of its kind developed and run by the Department of Defense (DOD) and currently under review to serve as a unified approach – is a 4-week inter-disciplinary format program aimed at allowing patients to process and desensitize trauma-related experiences and assist them in the comprehension of abstract or difficult to understand therapeutic concepts (Van Fossen et al., 2017). The art therapy component of treatment incorporates trauma-informed art therapy practices that facilitate acceptance, meaning making, acknowledgment of trauma, reduction of avoidance, and dialectical thinking, as well as theoretical foundations pulled from dialectical behavior therapy (DBT), CBT, and motivational interviewing (MI) (Collie et al., 2006; Lobban, 2014; Pifalo, 2007;

Rankin & Taucher, 2003). One such model included in the IRP program is the *Seeking Safety* model, a resiliency-oriented model that boasts 25 topics, each with an associated coping skill (Najavits, Lande, Gagnani, Isenstein, & Schmitz, 2016).

Stadler (2017) described the importance of the art therapist's role in the treatment of MST in carefully selecting materials and directives depending on the client's sense of safety. Although unstructured materials can be beneficial when a client is avoidant or feels stuck (Hinz, 2009), these less structured materials could be overwhelming for an individual who is highly activated or angry (Stadler, 2017). He provided an example of how art therapy can be beneficial in the processing of intrusive nightmares or flashbacks by offering the survivor highly-structured materials such as cut shapes or collage that are then laid onto a piece of paper. In so doing, the client is able to verbally share the nightmare, and then is asked to rearrange the shapes or images into a new image that is antithetical to the first and discuss the new image (Stadler, 2017). Further, Stadler (2017) described the art making process as a way to combat common consequential thoughts of sexual trauma such as 'I've lost my soul' and 'I can never truly be safe', by providing an inherently calming medium to counteract these negative alterations in mood and cognition.

Complicated grief. Although PTSD is often discussed as the product of psychological injury caused by war and other military-induced traumas, the veteran experience of facing complicated grief is an emerging topic of research (Charney et al., 2018). Thimm and Holland (2016) defined complicated grief as a level of bereavement in which "the bereaved suffer from a persistent, intense, pervasive, and debilitating grief" (p. 348). Veterans are prone to this type of bereavement due to the many layers of and opportunities for loss in the military, of which Bassin (2017) listed a few:

Losses include the death of comrades, unattended civilian fatalities, bodily injuries, the loss of the innocence of youth, trust in the mother country, radical shifts in identity and purpose, and, last and perhaps most significantly, the loss of moral integrity. (p. 238)

Complicated grief is linked to moral injury, which is defined as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Mobbs & Bonanno, 2018, p. 144). This has become an aspect of the stresses of war that the VA acknowledges is an experience of veterans that often but not always accompanies a PTSD diagnosis (Bassin, 2017). Bassin (2017) explained that complicated grief is rooted in the perception by the individual of himself or herself as both perpetrator and victim, which drives intense feelings of shame, guilt, and grief, and an overwhelmingly complicated existence in which all aspects of life and values are questioned. The demand placed on veterans to stay focused externally inhibits an internal focus on emotions (Jones, Backos, McKee, Gantt, & Arrington, 2017).

Charney et al. (2018) found expansive impacts of complicated grief on veterans, such as poorer quality of life and worsened PTSD, depression, anxiety, and stress symptomology among 468 treatment-seeking veterans who served after 2001. Among the 468 veterans studied, 30% met the threshold for complicated grief. Toblin et al. (2012) found that complicated grief negatively impacted both health and occupational competence in 21.3% of servicemembers returning from combat.

Traditional theoretical frameworks and complicated grief. Although there are common symptoms for complicated grief, grief is often individualized and requires a personalized approach to therapy (Beaumont, 2013). Additionally, complicated grief is often accompanied by other mental health diagnoses that also need to be addressed. Coll, Weiss and Yarvis (2011)

advocated for the importance of addressing and accommodating for complicated grief alongside the treatment of PTSD and TBI when working with servicemembers who served in combat, highlighting the need to remain sensitive to the bereavement process and acknowledge and validate the experience of loss.

One approach for addressing complicated grief symptoms is using CBT (CG-CBT) to address the core cognitive distortions involved (Boelen, van den Hout, & van den Bout, 2006). This approach aims to help clients by integrating the loss into his or her current autobiographical knowledge, change any negative beliefs associated with the loss, and reduce his or her use of avoidant coping strategies (Boelen et al., 2006). By integrating relaxation techniques, Solution Focused Brief Therapy, Multigenerational Family Therapy, Gestalt therapy, and imagery work, clients experience a multi-faceted approach that aids in stabilization, exposure and restructuring, and finishes with integration and transformation (Beaumont, 2013).

Based on their findings mentioned above, Charney et al. (2018) recommended further research on the efficacy of Complicated Grief Treatment (CGT) – a manualized 16-session psychotherapy treatment for complicated grief based in attachment theory and CBT principles – for treating veterans with complicated grief. This approach, intended to aid clients in enjoying fond memories of the deceased and reengaging in daily activities and relationships, has been shown to reduce anxiety, depression, and complicated grief in non-veterans (Shear et al., 2001; Shear, Frank, Houck, & Reynolds, 2005).

Art therapy and complicated grief. Art therapy, when used to support individuals suffering from complicated grief, is rarely intended to address only this one clinical concern. Due to the many layers of this mental health concern, the art therapy directives used to address it are inherently multifaceted. Bassin (2017) described how *Combat Paper* – a traveling workshop

experience in which uniforms are transformed into paper using a portable pulping machine (Cameron, 2018) – has been used to focus on transforming veterans’ self-concept “from ‘bystanders’ to self-witnessing veteran artists” (p. 240). The creation of paper from the fibers of uniforms that have also born witness to and contain the remnants of war and other military-induced tragedies allows them to become symbolic art objects. These objects begin to extricate the individual from the guilt and shame interwoven with the experience of both perpetrating and witnessing acts of war by allowing the veteran to start the process of storytelling and to reconstruct past unspeakable losses (Bassin, 2017; Cameron, 2018). This is a reintegrative function of art and makes these processes possible even for veterans whose traumatic memories have not been captured in words (Bassin, 2017).

While this art-based workshop aligns more as a therapeutic art process rather than art therapy, the healing elements it has to offer are undeniable and its transformation into art as therapy can be made possible by the involvement of an art therapist. McMackin (2016) highlighted this distinction in her study into the usefulness of a papermaking workshop for six student veterans, which she deemed art as therapy due to the lack of therapeutic processing incorporated into the workshop. Although her workshop was not directly connected to the *Combat Paper* efforts, it mimicked the structure and intent, leveraging the inherent properties of turning a personal object from the past – a uniform – into a new form – paper – to serve as a symbol of the participant’s personal transformation (Richard, 2013). Participants in her study commented on the ability of the papermaking workshop to provide an avenue to stir up memories from their time spent in the military, both good and bad, in the safety of peers familiar with their core struggles. Additionally, participants spoke to the act of papermaking as a means to process unresolved grief and the completed paper product’s role as a symbol in memorializing

the experience, the grief, and the memory of what was lost, whether within themselves or in the form of a friend (McMackin, 2016).

The element of witnessing in the approach used in *Combat Paper* speaks to what Bassin (2017) described as the importance of the veterans' grief being witnessed – both internally and by others. McMackin (2016) echoed this importance and the role of the paper made during her workshop for veterans played in acting as a piece with which civilians could interact to deepen their understanding of the veterans' lived experience. She noted how the labeling of veterans by non-veterans as either heroes/victims or perpetrators denies them an adequate space where their losses can be named or mourned. This denial stands in the way of the opportunity for a public validation of their experience. McMackin (2016) explained, “While loss is unique and individual, understanding of the loss often requires social validation of the moral transgressions and injuries to the sense of self-worth, as well as an empathic nonjudgmental community to help the veteran manage affects” (p. 240). Watkins and Shulman (2008) aptly described why this communal understanding of trauma and loss is so difficult and is often denied, forgotten, or overlooked, stating, “Confronting the crypt in the other is to confront the crypt in the self” (p. 68). They reiterated the importance of creating a space in the community to allow individuals to become engaged witnesses rather than by-standers as this allows for intergenerational and intercommunal recovery from the trauma.

Walker et al. (2017) recorded the emergence of complicated grief in the masks made by servicemembers in their inpatient interdisciplinary program. Servicemembers used mask making to address and express their grief over the loss of comrades, feelings of survivor's guilt, and grief surrounding the many relational losses between them and their peers and family members, often depicted through memorialized imagery (Jones et al., 2017; Walker et al., 2017). Jones et al.

(2017) highlighted the importance of the creative process in healing complicated grief and the inherent externalization of feelings of self-blame, guilt, anger, sadness, and avoidance that complicates grief. The creative process in art therapy facilitates meaning making, which allows positives that have been suppressed with negatives to surface and shifts power back to the creator (Jones et al., 2017).

As an alternative approach, Beaumont (2013) recommended incorporating art therapy and narrative approaches to address complicated grief symptomology. The integration of creative approaches with narrative techniques allows clients to bridge internal and external experiences, which aids in the reconstruction of meaning.

Substance abuse. Ramsey et al. (2017) found that among OEF, OIF, and OND veterans, prevalence of substance use disorder (SUD) diagnoses was highest among the youngest veteran VHA users and declined with age. Their findings also aligned with previous research on this topic, showing a greater risk of incidence in men than women, at almost double the rate in all subcategories. Within the umbrella of alcohol use disorder (AUD), servicemembers struggled in particular with binge drinking – the consumption of 5 or more drinks for males and 4 or more drinks for females in a single instance. Bray et al. (2013) analyzed the most recent DOD survey on excessive alcohol use and found that 33 percent of surveyed military personnel had engaged in binge drinking in the previous 30 days.

Treatment of SUD can be complicated due to the often comorbid nature of this disorder with other diagnoses, specifically PTSD in veteran clients (Allen, Crawford, & Kudler, 2017). Historically, the consensus of clinicians advocated for the treatment of any SUD prior to addressing PTSD symptomology, but emerging research indicates that these can be addressed concurrently (Allen et al., 2017). This development could be valuable since individuals with

AUD and PTSD are often at greater risk for developing other psychiatric disorders, respond less favorably to interventions designed to address the AUD, and are at increased risk of relapse to partake in problematic drinking (Torchalla, Nosen, Rostam, & Allen, 2012).

Traditional theoretical frameworks and substance abuse. Models have been developed over the years to guide the treatment of individuals with mental health treatment needs, and even more specifically designed to meet the needs of individuals struggling with substance use disorders (Allen et al., 2017; Mims, 2014). The Substance Abuse and Mental Health Services Administration (SAMHSA) (2012) developed a working definition of recovery designed to guide treatment of these disorders that included four primary dimensions that support recovery. These include Health – managing symptoms and making choices to support emotional and physical well-being, Home – defined as a safe and stable place to live, Purpose – including meaningful daily activities, and Participation in society, and community – including relationship and social networks. These four dimensions, in combination with guiding principles outlined by SAMSHA (2012), underlie most recovery-focused programming. The principle of recovery being person-centered, however, can be one that is difficult to achieve in a treatment program that only offers verbal or pharmacotherapies (Mims, 2014).

The VHA requires that patients with alcohol problems have access to at least two of the following psychotherapeutic treatments:

- *Cognitive–Behavioral Therapy for Relapse Prevention*, which assist patients in identifying internal and external stimuli that prompt drinking, and in learning skills and alternative ways of thinking to cope with these cues and avoid alcohol use.

- *12-Step Facilitation*, which promotes participation in Alcoholics Anonymous and working the steps of the program. It employs a treatment manual with activities and homework assignments and is conducted in a one-on-one counseling relationship.
- *Community Reinforcement Approach*, which helps patients establish a strong environmental support system to help sustain sobriety.
- *Substance Use Disorder–Focused Behavioral Couples Counseling/Family Therapy*, which emphasizes the participation of significant others in treatment. Sessions focus on improvements in communication and interactional patterns of the couple or family, especially as they relate to drinking.
- *Motivational Enhancement Therapy*, which builds on principles of motivational interviewing. It employs treatment processes that reflect the patient’s level of readiness for change. (Allen et al., 2017, p. 136)

The *VA/DOD Clinical Practice Guideline for Management of Substance Abuse Disorders* (2010) advocates for the use of certain pharmaceutical treatments as well, including naltrexone, acamprosate, and disulfiram. Although these have shown success in reducing the rate of return to drinking, Jonas et al. (2014) noted the missed opportunities for treatment when this is the only approach used, as less than one-third of individuals with AUD receive treatment.

Few studies have been conducted in which treatments were studied for individuals with co-occurring PTSD and AUD or SUD. Researchers have speculated the cause of this to be the frequent belief that therapies intended to address PTSD symptoms would trigger increased or relapsed alcohol or substance use (Allen et al., 2017; Bernhardt, 2009). A meta-analytic review of over 1,400 participants conducted by Roberts, Roberts and Bisson (2012) found that treatment

interventions designed to address both PTSD and AUD or SUD, by offering skills in grounding and other elements of DBT, performed as well or better than had been typical when addressing only one or the other. Furthermore, Bernhardt (2009) highlighted the importance of considering the generation-specific needs of dually diagnosed veterans. He pointed out that today's veterans are often facing so many struggles outside of these diagnoses that flexible hours, individualized treatment, and additional offering of choices are vital to program engagement and retention.

One such approach used in the VA system to meet the needs of individuals dually diagnosed with PTSD and AUD or SUD is ACT, which views the veteran's substance use as an example of 'experiential avoidance' – an attempt to avoid unwanted and painful thoughts associated with memories of the trauma (Bernhardt, 2009). Another approach used is the *Seeking Safety* model, which does not incorporate any exposure-based exercises, as each session seeks to increase a client's sense of safety in response to trauma triggers as well as diminish alcohol or substance use in the same fashion – responding to maladaptive behaviors discussed in session with adaptive coping skills. *Seeking Safety* has shown success in over 20 studies (Najavits & Hien, 2013) and can be a useful approach in contrast to no trauma-focused therapy at all; however, a number of small-scale studies using this model solely with veterans indicated the need for further research on its use with this population before making it the treatment of choice (Allen et al., 2017). These conflicting results reiterate the need for approaches to treatment other than pharmacotherapies or traditional VA-supported approaches.

Art therapy and substance abuse. The art making aspect of art therapy can provide a means to address some of the traditional road blocks in substance abuse recovery treatment. Van Lith, Fenner, and Schofield (2011) found that individuals in SUD treatment interviewed felt that art allowed them the means to effect real change and move toward rather than simply talk about

a life of balance. Additionally, they found that it allowed individuals in recovery to channel their energy into the art process and focus on something other than their ongoing issues. The study participants noted that the art made in session became an external object that not only physically represented their progress, but also provided insight and facilitated emotional expression.

McKee (2017) viewed recovery as a creative act, paralleling the ways in which art therapy is used to augment SUD treatment in her work at the VA, utilizing directives that explore a myriad of dyads faced by military personnel, such as: resistance and ambivalence, the tension between self and organization, compliance versus authenticity, and order versus mess (Jones et al., 2017). McKee stressed the importance of including art making in treatment as it allows for individuals to connect to their own creative potential and in turn creates opportunities for success in treatment (Jones et al., 2017). She also offered directives such as, “Depict anger. Use line, shape, space, color to create an abstract, representational work” (Jones et al., 2017) to demonstrate how each person will experience it differently.

MacWilliam and Schapiro (2017) discussed art therapy’s utility in training individuals to make choices for themselves – such as color choice, placement, and materials – and increase their self-awareness. They describe an addict’s use of his or her drug of choice as a way to essentially feel nothing in the face of their powerlessness. By increasing consciousness and in turn improving reality testing, clients begin to feel they have choices available to them other than substances (MacWilliam & Schapiro, 2017).

Likewise, the art made in art therapy with individuals with SUD can serve as a way to engage defended individuals by proxy. Springham (1998) found that in using art therapy in a group setting of individuals with AUD and SUD, the art making process was able to circumvent narcissistic defenses and engage clients who kept therapy and the therapist at bay by only

participating with a 'false self' (as cited in Lobban, 2016b, p. 15). Pertaining to this therapeutic approach's effect on veterans, Mims (2014) found that visual journaling by homeless veterans during recovery facilitated a greater sense of self-knowledge and deepened insight into the participants' lived experience.

Backos and Mazzeo (2017) alluded to the difficulty in treating the veteran population effectively due to the often-comorbid nature of their treatment needs. Although the groups they conducted were aimed at addressing PTSD, 81% of participants were diagnosed with comorbid substance use disorders. This combined ACT and art therapy approach proved successful in addressing both diagnoses and experienced zero attrition on the part of the veteran participants (Backos & Mazzeo, 2017).

Readjustment issues. In addition to psychiatric concerns generated by military service, veterans also struggle with issues brought about by transitioning from military service back to civilian life. As Bernhardt (2009) pointed out, OEF and OIF veterans' needs are significantly different than those from the Vietnam era who have been separated for 30 years or more. Today's veterans have often been in combat relatively recently and are in the midst of an identity crisis, still determining their educational, occupational and relationship goals (Bernhardt, 2009).

Significant amounts of research pertaining to the readjustment experience of veterans has been published in recent years and focuses primarily on the role of social supports, the unique needs of military families, the impact of PTSD and TBI on a veteran's ability to readjust to civilian life, and the experience of veterans going back to college. Furthermore, evidence exists that demonstrates potential implicit bias by civilians in seeing veterans as unstable due in part to messages received in the media (Schreger & Kimble, 2017). This bias has the possibility of making an already difficult transition even worse for separating veterans.

Traditional frameworks and readjustment issues. Difficulties readjusting to civilian life are a possibility for every veteran that are often exacerbated by existing mental health disorders. In their study of 1,292 OEF, OIF, and OND veterans, Sayer et al. (2015) found that 54% reported having at least some difficulty reintegrating with additional measures indicating that this did not improve over time since separation even with VA healthcare use. This reported difficulty aligns with findings from Kukla, Rattray, and Salyers' (2015) study of the work experiences of 40 veterans receiving mental health treatment in a Midwestern urban city in which they compared the number of perceived barriers between combat veterans and non-combat veterans. Kukla et al. (2015) found perceived barriers to reintegration to be significantly higher both quantitatively and qualitatively for veterans who served in combat than those who did not.

In an RCT of 100 veterans from a larger sample of 1,292 veterans who were asked to describe their reintegration experiences, Orazem et al. (2017) found that identity adjustment played a key factor in level of difficulty readjusting. More specifically, veterans stated that they felt they did not belong in civilian society, missed the military culture and structured lifestyle, felt left behind by their civilian counterparts, and had difficulty finding meaning in the civilian world. The latter difficulty underscores Elnitsky, Blevins, Warren Findlow, Alverio, and Wiese's (2018) findings that student veterans struggled to find a sense of connection with non-veteran peers. On a broader scale, they found that despite considerably difficulties brought on by chronic pain and mental health disorders, veterans often did not utilize campus services for support, or that adequate services did not exist, further exacerbating veteran's difficulties in reintegrating in civilian life.

Social support has been found to be a supportive factor for easing readjustment difficulties (Elnitsky et al., 2018). For example, Cederbaum, Wilcox, and Lucas (2017) found

that social support of any kind improved the dyadic functioning and decreased PTSD, depression, and anxiety symptomology of veterans in the midst of reintegrating. Achieving this support can be especially difficult for veterans with PTSD, TBI, and depression, where socialization is particularly challenging or seen as undesirable (Moriarty, Winter, True, Robinson, & Short, 2016). Moriarty et al. (2016) stressed the importance in addressing depression in treatment to alleviate difficulties readjusting in the community, noting its impact on every aspect of reintegration and its often secondary or nonexistent role in PTSD and TBI treatment programs. Additionally, Thomas and Bowie (2016) found that it is critical that support networks be culturally relevant to the returning veteran for them to be of benefit, often needing to go beyond the traditional sense of community to find the necessary support.

Significant published research exists detailing veteran difficulties in readjusting to civilian life, however the research is primarily on the lived experience of these veterans and entails attempts to understand the difficulties of these causes (Mobbs & Bonanno, 2018; Thomas & Bowie, 2016). Elnitsky, Blevins, Fisher, and Magruder (2017) conducted a critical analysis of 186 articles on the topic of veteran reintegration and found little published evidence on the evaluation of “interventions for health conditions, rehabilitation, and employment, or effective models of integrated delivery systems” (p. 114). Continued research is needed to understand what therapeutic approaches would be best suited to meet the needs of these veterans (Mobbs & Bonanno, 2018; Orazem et al., 2017).

Art therapy and readjustment issues. Little research has been conducted on the use of art therapy with veterans in transition. McMackin (2016) utilized art as therapy with a small sample of student veterans by combining individual art therapy sessions and papermaking using old uniforms. Participants reported desirable outcomes in the areas of making connections with

veteran peers, as well as an increased sense of belonging to the university and a strengthened sense of self-efficacy. With a similar objective, Canto, McMackin, Hayden, Jeffery, and Osborn (2015) discussed the benefits of using both papermaking and glass pouring workshops to support student veterans in transition. Canto et al. (2015) found that despite certain limitations such as limited involvement during initial workshops and limited creative engagement on the part of veterans in the glass pouring workshop due to its specialized nature, participants benefitted from the inclusion, relationship building, and community building aspects of the workshops. Veteran participants noted finding the workshops both fun and deeply meaningful, with one veteran stating that the paper he created in the workshop allowed him to speak about his experience rather than carrying his feelings and memories inside him as he had done previously.

Mandić Gajić (2016) presented a case study in which a veteran participant struggling to readjust to his role as a parent found support in an art therapy group to aid in his transition. The veteran reported replicating art directives provided in group with his three-year-old son and stated that it gave them a common foundation on which to rebuild their relationship. The veteran also reported a reduction in BDI rating from 18 to 6 throughout the course of art therapy treatment, potentially contributing to his increased satisfaction with his attempts at readjustment after deployment.

At the Veterans Outreach Center in Rochester, NY, art therapy is conducted three times weekly in an open studio setting to support veterans working to reintegrate into civilian life (DeLucia, 2016). DeLucia (2016) advocated for the use of a drop-in model to mitigate veteran resistance to commit to long-term treatment but recommended communicating new arrivals when possible to create an atmosphere of safety in the studio setting. Despite this open structure, a core group of veterans has consistently participated, creating group cohesion that participants

deem as beneficial, with art making serving as a means of communication and sharing among group members (DeLucia, 2016). Veterans rarely talk about their struggles directly but serve as witnesses for one another through art. DeLucia (2016) has integrated a gallery component to the art therapy programming, facilitating conversation and interaction with the community at large, which aids in the veterans' sense of community and belonging during reintegration.

Programs, Models, and Interventions

Art therapy literature reviewed included specific programs, models and interventions being used to treat veterans.

Programs. As mentioned earlier, the UK's equivalent of the VA, Combat Stress, offers art therapy programming for its veterans system-wide. As part of these efforts, Combat Stress offers an adaptive art therapy model that integrates neuroscience to meet the needs of veterans with PTSD in a 6-week setting (Lobban, 2016b; Lobban et al., 2017). This program incorporates the neuroscientific understanding of how traumatic memories are encoded to determine the format for programming, choosing to couple nonverbal creative expression with verbal discussion. In doing so, adaptive understandings can be incorporated into the veterans' understandings of the trauma experience and insight can be gained (Lobban, 2016b).

This gradual exposure approach helps address the avoidant cluster of PTSD symptoms and increase tolerance of emotional content. In her quantitative study into the factors that led to veteran engagement in this art therapy program, Lobban (2016b) found that the obligatory nature of the group helped clients overcome tendencies to engage in experiential avoidance.

Additionally, she discovered that participants found group bonding and unexpected discoveries that arose in the art therapy sessions to be key factors in veteran engagement (Lobban, 2016b).

This group bonding element helped them realize they were not alone and reduced feelings of

isolation. These findings on the experience of unexpected discoveries replicated that of Campbell et al. (2016) in which all participants stated they either recovered previously blocked memories or gained realizations crucial to their healing process by participating in art therapy.

Literature on the incorporation of art therapy in multi-modal treatment programs for PTSD has shown it to be an integral element in the success of these integrated approaches (Rademaker, Vermetten, & Kleber, 2009; Walker et al., 2016; Walker et al., 2017). Walker et al. (2017) reported that art therapy was rated in the top five treatment modalities by servicemember participants among 41 potential techniques and tools provided to the veterans during their participation. They also found that the art therapy component of treatment increases servicemember's ability to talk about their traumatic experiences, which improves the treatment team's ability to meet their therapeutic needs (Jones et al., 2017; Walker et al., 2017). Due to the success of the 4-week NICoE program in supporting servicemembers with PTSD and TBI, NICoE integrated with the TBI Outpatient Clinic at Walter Reed to create long-term treatment component within the art therapy program (Jones et al., 2017).

Similarly, Rademaker et al. (2009) studied the success of an outpatient phase-based treatment program, rooted in Ford, Courtois, Steele, Van der Hart, and Nijenhuis' (2005) trauma approach and offering CBT, creative arts therapy, psychodrama, psychomotor therapy, socio-therapy, psychoeducation, and case management over the course of 21 months. They found that this multi-modal approach improved social and professional functioning and decreased reported levels of anxiety, depression, and PTSD symptoms in all 22 veterans' files and treatment tests that were reviewed. In this approach, art therapy was used as a means to address and resolve emotional difficulties common in PTSD (Rademaker et al., 2009).

Models. Collie et al. (2006) recommended the incorporation of art therapy into the three-stage approach of treating complex PTSD developed by Ford and colleagues (2005). Ford et al.'s (2005) recommend the following format:

1. Reduce arousal symptoms, develop emotional self-efficacy, reactivate positive emotions, and create emotional safety and social bonding among veterans to serve as the foundation for further therapeutic work.
2. Process traumatic memories and emotions by using nonverbal expression and progressive symbolic exposure to recall, express, and consolidate a verbal or visual trauma narrative that is owned and acknowledged by the person and accepted as part of the person's past.
3. Facilitate group member incorporation of new insights and understanding into their lives.

Furthermore, Collie et al. (2006) recommended art therapists seeking additional training in trauma-specific techniques to develop a greater understanding of trauma's impact on emotions and physiology.

Similarly, Malchiodi (2011) did not clearly define her model of conducting art therapy with veterans who suffer from combat PTSD; however, she provided three areas of focus for treatment drawn from various trauma treatment approaches such as those outlined by Ford et al. (2005), Foa, Keane, Friedman, and Cohen (2009), and the Army Resiliency Directorate (2018). These areas – (a) stress management; (b) cognitive restructuring and exposure therapy; and (c) resilience enhancement – are underscored by art directives that allow veterans to incorporate the sensory experience as they focus on these areas of improvement, which leads to the amelioration of PTSD symptoms (Malchiodi, 2011).

Lobban and colleagues have created an adaptive model for the treatment of PTSD using art therapy as part of CS (Lobban, 2014; Lobban, 2016b; Lobban & Murphy, 2017; Palmer et al.,

2017). This 6-week program model, informed by neuroscience and an understanding of military culture, has two primary sections – a theme-based approach and a therapist-facilitated discussion of the veterans’ creative expressions (Palmer et al., 2017). The theme-based approach begins with:

an introduction of a theme or question relevant to the veterans’ mental health or experience. The veterans then use art materials to express their thoughts and feelings associated with the theme. Veterans have access to a wide range of materials, including pencils, paints, pastels, clay and collage materials. As well as visual art, veterans are able to produce written materials such as poetry or prose. (Palmer et al., 2017, p. 2)

In the therapist-facilitated discussion portion, non-verbal expressions of art can be explored verbally which assists in meaning making and increases self-awareness. Relaxing music is played during image making and the therapeutic environment is one of openness and acceptance (Palmer et al., 2017).

In NICoE’s long-term TBI and PTSD art therapy program, a stage-based protocol has been developed based on Herman’s (1992) model of trauma treatment and offers three levels of treatment. The introductory level primarily mimics the directives and approach used during the short-term 4-week NICoE model and involves mask-making and montage painting. Level two directives are aimed at fostering “increased insight, identity development, emotional regulation, and empathy and support for self and others” (Jones et al., 2017, p. 5). Level three interventions primarily take place in individual or open art studio settings and explore goal areas clearly defined during levels one and two. The overwhelming majority of participant responses to evaluations of the program note positive changes in symptomology, primarily in the areas of ability to experience positive emotions, decreased guilt, decreased anger, and decreased feelings

of depression and sadness (Jones et al., 2017). Participants described art therapy as allowing them to develop strategies to combat ‘personal enemies’ and ultimately gain a sense of control over their symptoms and experiences. “The art therapy journey serves as an agent of change, during which [servicemembers] establish a new sense of self as creator rather than destroyer, as productive and efficacious instead of broken, as connected to others as opposed to isolated, and in control of their future, not controlled by their past” (Jones et al., 2017, p. 14).

Based on her literature review of art therapy treatments to support veterans with combat-related PTSD, Donnelly (2013) determined that the elements of a successful art therapy program for combat veterans with PTSD would “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” (p. 56).

Although not explicitly a model for treatment, Lande, Tarpley, Francis, and Boucher (2010) developed the Combat Trauma Art Therapy Scale (CTATS) to detect common themes associated with war time experiences among artwork made by veterans. This 62-item scale is divided into four sections that align with the original paradigm designed by Appleton (2001) in which trauma resolution was broken down into four stages (1) impact; (2) retreat; (3) acknowledgment; and (4) reconstruction. After establishing inter-rater reliability, Lande et al. (2010) found a general gestalt of thematic images in the coding of 158 pieces of artwork created by 37 combat veterans. While the authors recommend further clinical testing, they note that this instrument could be beneficial in detecting the stage of emotional recovery of combat veterans in treatment for PTSD.

Interventions. Identifying one specific approach that would be guaranteed to help every veteran in need of mental health treatment is unlikely. Lobban (2016b) stated, “Different contexts call for adaptive approaches with specific frameworks to meet particular needs. It is not a case of one size fits all” (p. 15). However, a multitude of specific directives have been identified in the literature on art therapy with veterans as being especially beneficial. These include: graphic narrative, mask making, safe place, and viewfinders.

Graphic narrative. Gantt and Tinnin (2009) incorporated the use of art making in their Instinctual Trauma Response (ITR) model in the form of creating a graphic narrative of the traumatic event. In this process, individuals create a series of drawings that compound into specific aspects of the ITR – made up of the startle, thwarted intention (fight or flight), freeze, altered state of consciousness, body sensations, automatic obedience, and self-repair – from the perspective of a ‘hidden-observer’ who is detached emotionally from the situation (Gantt & Tinnin, 2009; Jones et al., 2017). Participants make before and after bookmarks of the event, as well as transition drawings that help advance the story on 12” x 18” paper. In so doing, the brain is presented with a beginning, middle, and end for the event, facilitating closure otherwise impossible due to the nonverbal, often fragmented neural coding of trauma (Gantt & Tinnin, 2009). After completing the graphic narrative of the traumatic event, the images are hung on the wall in order and the art therapist then presents the account of the event depicted by the pictures. Any gaps identified by the client are then filled. The client then enacts a give and take discussion with the dissociated past self, using the graphic narrative as a point of reference - a process that promotes integration with the present self (Gantt & Tinnin, 2009). This verbal coding and narrative closure of the trauma is achieved, the images are no longer dissociated, and they are permitted to become something of the past rather than present (Tinnin & Gantt, 2013).

Mask making. Art therapists incorporated mask making into practice to address communication, personal orientation in psychotherapy, and to help process identity (Walker et al., 2017). It is a commonly used method in art therapy in working with individuals affected by trauma since “it is a medium that allows for some psychological distance for expression and externalization” (Walker et al., 2017, p. 2). Additionally, this directive can be beneficial in revealing veterans’ self-concept as well as identifying their self-ideal in the future (Donnelly, 2013).

For these reasons, this art directive is particularly favorable to aid veterans suffering from combat-related trauma in visualizing and communicating its effects, build a sense of self-efficacy, and promote normalization (Sargent et al., 2013). Among other symbolic opportunities, masks can symbolize duality and the sense of taking on different personas due to the two sides of the masks, the portions seen and not seen by the viewer (Walker et al., 2017). Masks offer a medium for exploring the split sense of self often faced by veterans (Walker et al., 2017). Frenz (2007) remarked on the opportunity presented in mask making for veterans to explore the concept of living in the space between military and civilian life, as well as the impact of symptoms of military trauma on both past and present identity. Veterans who have created masks in art therapy aimed at addressing their PTSD and TBI have attested to the masks ability to express what it feels like to live with these diagnoses in a way they described as impossible prior to art therapy treatment (Chen, 2016).

Walker et al. (2017) studied the visual and narrative data connected with the masks made by 370 veterans in an intensive 4-week interdisciplinary outpatient program comprised of 17 conventional and integrative disciplines designed for servicemembers with chronic PTSD symptoms and mild-to-moderate TBI using a grounded theory approach. In this program,

veterans make masks during their first week of care and are given the directive to “create masks representing any aspect of their experiences and/or identities” (Walker et al., 2017, p. 3). Walker et al. (2017) found that servicemember mask content fell into the categories of self as individual, self in relationships, self in community, self in society, self over time, and conflicted or split sense of self, with the most common subthemes containing references to physical and psychological injury. Lobban (2014) found similar struggles in her directive of depicting the veteran’s ‘invisible wound’. Specifically, veterans portrayed a split between past and present self, inner and outer presentation, society and veteran, and whether or not opening up to others would be helpful or harmful. In 2016, Lobban (2016a) published her findings from visits to art therapy programs for veterans around the world. She and other art therapists she interviewed identified many similarities between the art made in response to similar directives, such as making a mask or a clay self-portrait, between veterans with PTSD in the UK and the US, which speaks to the common struggle in the realm of identity inherent to PTSD.

By externalizing these struggles in the form of the mask, the contents could then be talked about and serve as an aid in communication with caregivers and family members. Importantly, they found that “discoveries made by the patient and art therapist can...be shared and incorporated into a comprehensive treatment plan” (Walker et al., 2017, p 9). Finally, many servicemembers visually depicted the feeling of being ‘broken’, likely linked to the fragmentation aspect of trauma (Herman, 1992; Rubin, Feldman, & Beckham, 2004). The mask offered a way for the servicemembers to then literally and metaphorically merge the fragments of their trauma memory into a cohesive representation of the self (Walker et al., 2017). Some participants found it beneficial to work on their mask throughout the entirety of the 4-week treatment (Jones, Walker, Masino Drass, & Kaimal, 2017).

The findings of Walker et al. (2017) were echoed by Mims (2014) in her small-scale study involving two veterans in which both members expressed the placing of significant value in the mask making process. The veteran participants stated that making masks in individual art therapy sessions “increased recognition of feelings and self-understanding” (Mims, 2014, p. 84), as well as a decrease in cognitions and an increase in feelings of calm. Importantly, both individuals also declared the ability of the masks to aid in their communication to the world their “real” selves, stating that they often keep hidden certain aspects of themselves in order to feel protected. Additionally, Pierce and Decker (2017) found the mask making intervention to be one of the preferred interventions by veterans participating in CPT with adjunctive art therapy.

Safe place. Pierce and Decker (2017) stated that veterans participating in adjunctive art therapy during CPT viewed creating a safe place during trauma treatment as the most important intervention. The directive given was to “create a safe place where they felt free from the traumatic incident” (Pierce and Decker, 2017), and they recommended allowing material choice for this directive rather than solely using collage so that it is fully accessible and can be invested in and individualized by the veteran. When art therapy is incorporated in Trauma-focused CBT (TF-CBT), a safe space drawing is incorporated for these reasons, as it allows the brain an additional sense with which to experience safety and calm during potentially re-traumatizing acts such as developing the graphic narrative of a traumatic event (Wolf, 2017). Donnelly (2013) noted how the creation of a safe space allowed for a redeveloping of the self-ideal for veterans. She added to this directive and included the creation of the traumatic place after creating a safe place, and then a third image that combines the two. Donnelly (2013) discussed how this directive both aids in reintegrating the past and future, but also allows for a visual contrast between the two places.

Viewfinder. Finding a way to take a new perspective on one's experience, particularly by way of dialectical thinking, has been shown to be beneficial in the treatment of individuals who have experienced trauma (Van Fossen et al., 2017; Wolf, 2017). Creating and incorporating the use of a viewfinder in art therapy is a way this perspective taking can be facilitated using art. Van Fossen et al. (2017) incorporated this task in their IRP program for servicemembers with MST. The directive has multiple parts beginning with, "In the time allotted, create a drawing of an unpleasant, difficult, or challenging emotion that you have been feeling lately. Use colors, lines, shapes, or scribbles to create the drawing" (Van Fossen et al., 2017). The directive continues, "Use a viewfinder to hover over the image and observe. Try to find an area that you find pleasant or tolerable. Hover over what's there. Just sit with it. Next, trace it with another material and cut out the square." (Van Fossen et al., 2017). The directive finishes by creating an entirely new piece of art. The directive concludes, "Glue the square to a new piece of paper. Create a new drawing stemming from the square that you have just glued onto the blank sheet. Try to focus on a different emotion or idea. Or you may choose to begin drawing from the square and see how it transforms into something different" (Van Fossen et al., 2017). Van Fossen et al. (2017) found that the majority of patients created artwork stemming from the original square and attempted to make something more orderly, stating that it was metaphorical of their process of seeking treatment to address the impact of their MST. Patients also commented that they appreciated that no words were needed and also that there was no requirement to name the artwork.

Although rooted in a different procedure, Hass-Cohen, Findlay, Carr, and Vanderlan (2014) used a similar process in the 'Check, Change What You Need to Change and/or Keep What You Want' art therapy trauma protocol. In the third step of the protocol, clients are invited

to “Check in; if you could change or keep one aspect of the drawing or painting, which aspect would you choose and what does it look like?” (p. 73) and alter the trauma image they have created. In so doing, this process increases the client’s internal sense of control and emotional awareness while decreasing arousal and/or dissociative responses. Hass-Cohen et al. (2014) present a case example in which the client expresses a sense of relief after this step of the protocol.

CHAPTER IV

RESULTS

Overview of Results

This study aimed to provide a comprehensive review of published and unpublished literature pertaining to art therapy and veterans. It was hypothesized that by completing this review, themes would emerge among various aspects of art therapy being conducted. Due to the use of an integrative literature review, it was hypothesized that a new perspective or framework on the topic could emerge and that the results of the study would aid the field in making more informed choices when conducting art therapy with this population (Tavares de Souza, Dias da Silva, & de Carvalho, 2010). Furthermore, it was hypothesized that the use of this research framework could provide guidelines and suggestions for future research conducted in the field of art therapy on this topic.

Publications on art therapy with veterans were found by searching in the sources listed in Tables A1 and A2. The search terms used to find these publications on these search platforms can be found in Table B1. From the initial search, 362 published resources were gathered pertaining to the topics outlined in the integrative literature review. A breakdown of the categories within which the resources fell can be found in Figure D1. Information documented from four unpublished conference proceedings was also integrated into the literature review.

Among the published resources, a total of 89 resources were identified that primarily focused on the use of art therapy with veteran and military populations, including four individual chapters from books on the topic. Notably, of the 89 publications found in the integrative literature review in which the focus was conducting art therapy with veterans, 59 were published since 2013. The breakdown is as follows: (a) 17 articles and a book published in 2017; (b) 16

articles published in 2016; (c) nine articles in 2015; (d) eight articles in 2014; and (e) 10 articles in 2013.

Of these 89 resources, 26 articles were selected for inclusion in the literature matrix. Articles and chapters selected met the following criteria: (a) the primary focus was limited to conducting art therapy with veterans and military servicemembers; (b) the content correlated with diagnoses covered in the scope of this study; (c) the content was original or provided information about published data that could not be otherwise accessed by the researcher; and (d) the art therapy being conducted was led by a trained or in-training art therapist.

The information from these 26 articles and chapters was input into a literature matrix to organize information from each in the areas of: (a) Citation; (b) Topic; (c) Type of Study; (d) Clinical Concerns; (e) Setting; (f) Framework of Approach; (g) Directives; (i) Materials; (j) Format of treatment; (k) Results and Findings; and (l) Limitations. A link to view the full matrix can be found in Appendix C1. The literature matrix was then reviewed for themes among the content areas provided.

Citation themes. A theme emerged from the citations of the included literature in the use of the words art, therapy, and veterans. Pertaining to diagnostic content discussed in the citations, the included article and journal titles included themes of trauma, PTSD, and stress. This aligns with the findings of the integrative literature review, in that a majority of the collected literature fell into the categories of PTSD – including combat-related PTSD – and other trauma-related disorders (see Figure D1). Notably, 18 of the 26 pieces of literature were published in the last five years (since 2013). Three of the included publications were graduate theses. Furthermore, of the 20 non- thesis, dissertation, or book chapter publications, seven were published in journals not specific to art therapy.

Topic themes. Among the topic descriptions generated by the researcher for the published literature, themes that emerged included a focus on the efficacy of art therapy, using art therapy in the treatment of PTSD, and different venues where art therapy is conducted with veterans such as the VA. Words such as treatment, therapy, support, and efficacy repeated frequently. This finding is congruent with the overarching topic of authors attempting to demonstrate and validate the ways in which art therapy is a viable treatment method when compared to more traditional therapeutic approaches. Other themes included the presentation of current or proposed program models, graphic indicator rating scales, and treatment models.

Type of study themes. Using the Evidence Based Medicine (EBM) Pyramid (Glover, Izzo, Odat, & Wang, 2006) as a guide for categorizing the level of evidence of research, the publications were labeled according to details provided in the text. This process ranks studies “based on the methodological quality of their design, validity, and applicability to patient care” (Ackley, Swan, Ladwig, & Tucker, 2008, p. 7). The published literature was divided into: (a) two RCTs (Level II); (b) five retrospective cohort studies (Level IV); (c) four literature reviews, two of which included information from case studies (Level V); (d) 12 case studies and surveys (Level VI); and (e) three expert opinions (Level VII).

Clinical concerns themes. The literature indexed focused primarily on two clinical diagnoses: trauma-related disorders and stress generated from military transition. Among the 23 publications in the category of trauma-related disorders, 21 focused specifically on PTSD, one on unspecified trauma and one on MST. All three of the remaining publications discussed the impact of art therapy on reducing transitional stress and readjustment issues.

Setting themes. The art therapy highlighted in the literature was conducted in a variety of medical and non-medical settings. For those 19 studies conducted in medical settings, all were

conducted in inpatient, residential, and IOP units of programs for military veterans and servicemembers with PTSD. Notably, all of these programs were VA or government run, or run by an equivalent organization in the respective country. Among the remaining seven publications, one took place in a Veterans Outreach Center in the community, two on a university campus, one in a therapeutic housing community for veterans, and three did not specify.

Framework of approach themes. Published literature was categorized by therapeutic framework used in the execution of art therapy with veterans if specified. A framework was not included unless it was explicitly stated in the text, even if a framework was implied based on literature content. For this reason, ten of the 26 publications were labeled as unspecified. Three publications listed a single framework that was incorporated into art therapy practice, including ACT, CPT, and humanistic. The remaining 13 incorporated multiple frameworks including but not limited to: CBT, Adlerian, psychodynamic, humanistic, and exposure therapy. Additionally, nine publications presented programs with an interdisciplinary therapeutic approach, incorporating alternative therapies such as yoga therapy, acupuncture, and mindfulness-based techniques. No themes among topic, type of study, clinical concerns, or setting were identified among the publications that did not identify the framework used in session.

Directive themes. Specific directives utilized in practice with veterans were outlined in 17 of the 26 pieces of literature. Only explicitly stated directives were included in the literature matrix, even if directives could be implied from included artwork or case study description to prevent misinterpretation of intent. Topics that repeated among directives given included depicting a safe place, depicting or creating a container, mask making, montages, identity-focused tasks, visual trauma narrative, past, present and future self, life lines or time lines,

leveraging metaphors, and exploring dichotomous relationships. Furthermore, multiple directives aimed to merge or rearrange conflicting points of view held by the veteran client pertaining to a specified topic. By and large, the authors reiterated the importance of creating a sense of safety in therapeutic space and providing the veteran client with a sense of control over the pace and direction of session content. Of those publications without specified directives, one explicitly stated that clients were encouraged to direct the content of artwork each session. The remaining nine were surveys, retrospective cohort studies, and literature reviews and therefore this lack of inclusion of details is consistent with these research designs.

Materials. Materials offered in session were specified in 21 of the 26 articles and chapters. The most frequently occurring materials offered were paper, pastels, colored pencils, clay, paint, gouache and markers. Of those that did not specify art materials available to clients, nine specified that individuals were free to use the art material of their choice; however, the selection from which they had to choose was not defined. Notably, of the six publications that did specify materials offered, one of them was an RCT. Of the materials clearly identified in the text, choices represented materials on both ends of the spectrum from rigid to fluid as identified by the ETC (Hinz, 2009); however, when only minimal choices were offered, they were more rigid in nature, which aligns with the theme of containment and prioritization of a sense of safety identified among the directives.

Format of treatment themes. If specified in the literature, publications were categorized by being individual, group or a mixture of both in format. Of the 24 that specified, only three were entirely individual in nature whereas 16 were exclusively group format. One of the group-only formats described consisted of an open art studio and a gallery space and one was a group workshop. Of the six that utilized both individual and group formatting, one specified that the

format was primarily individual with a 2-hour group. In addition to format, four publications specified the duration of treatment, three of which were group format for treatment to include a 2-week, a 6-week, and an 8-week format. The individual treatment duration was described as one-hour weekly meetings over the course of six months.

Outcome themes. Of the results and findings noted in the literature, overarching themes of success, improvement, and benefits specific to art therapy emerged. Communication was a primary theme, with a number of publications discussing an increase in veterans' ability to communicate their needs with peers, caregivers, and the community after completing art therapy. Additionally, a common theme emerged in the articulation of the role of art in instilling a sense of safety, providing containment of emotions and memories, and an alternative avenue of verbalization to process feelings such as grief and loss.

As it pertained to symptomology, 12 publications explicitly stated that art therapy quantitatively and qualitatively relieved veterans of symptoms related to mental health issues, as measured by pre- and post- scales and qualitative interviews. Interestingly, one article discussed the primary difference between CPT combined with art therapy in comparison to standard CPT to be zero attrition in the art therapy group despite 81% of group members having a comorbid SUD. A final theme that emerged was the identification of themes among content of the artwork, to include: (a) use of red/black; (b) trauma/combat content; (c) various explorations of self and relationships with others; and (d) fragmented parts of the self.

Limitations themes. Among the limitations noted by both the researcher and the publications' authors, three primary themes emerged: (a) the material was dated and potentially not generalizable to veterans of recent conflicts; (b) the sample sizes were small, consequently reducing generalizability of results; and (c) no clear measurements of change were used and only

anecdotal evidence by the veteran participants existed. Moreover, for the nine publications for which art therapy was a component of an interdisciplinary approach, being able to attribute improvement exclusively to the impact of art therapy is difficult to validate.

CHAPTER V

DISCUSSION

Integration of Results

A number of themes emerged in the course of this integrative literature review pertaining to the published and unpublished literature on art therapy being conducted with veterans. A number of those themes will be discussed in further detail.

Recency and type of research. As mentioned previously, 71% of the found art therapy literature with veterans had been published since 2013. The recent sharp increase in published literature on this topic aligns with findings that verbal therapies are not universally sufficient in addressing the needs of veterans, as well as the VHA's recent push for the use of CAM when treating veterans for this reason (Etingen, 2016; Liebert, 2016). The acceptance of this knowledge in the healthcare field – further evidenced by the inclusion of 7 of 26 art therapy publications in non-art-therapy journals – has sparked increased interest into identifying the benefits of art therapy by conducting reviews of what is currently being practiced. Additionally, this increase in published research aligns with the official conclusion of US participation in OEF in 2014 (Witte, 2018), presumably due to the increased observation of and desire to ameliorate the impact these conflicts have had on our military servicemembers.

Furthermore, the integrative literature review revealed that veteran participants perceived traditional talk therapy to be useful but more painful in comparison to when art therapy had been integrated into the same style of treatment (Pierce & Decker, 2017). Kern and Perryman (2016) found that the incorporation of art facilitated the development of protective factors that could not be accomplished in talk therapy alone. These findings are valuable in advocating for further research, as another finding from the integrative literature review was the predominantly

retrospective nature of recent research on this topic comprised mostly of surveys, retrospective cohort studies, case studies, and literature reviews. The literature matrix revealed that with the exception of case studies, these research approaches often did not include details such as the framework of approach, directives, or materials used in the art therapy conducted. In fact, the only replicable RCT captured in the matrix to identify all content areas except the theoretical framework used is that of Kopytin and Lebedev (2013). Without this information, replication of studies is difficult and our understanding of the true impact of art therapy remains limited.

Finally, of interest, the use of the phrase ‘art therapy’ increased gradually in titles and descriptions of more recent research, as evidenced by the literature matrix themes evaluation. Earlier articles on the subject often referenced primarily the art element or aimed to create a more ‘catchy’ title, but the use of the phrase ‘art therapy’ was more frequent in recent publications on the subject. This increase could represent a rise in the acceptance of art therapy as a credible treatment approach for use with the veteran population.

A standardized model and therapeutic factors. Authors of art therapy discuss various treatment models for use with different populations and in various treatment settings. In the art therapy literature on working with veterans, the models proposed or currently being utilized centered on the treatment of PTSD. The models discussed or proposed were stage-oriented and integrated principles from existing trauma treatment models. Lobban (2016a) traveled to various sites around the world to find similarities and differences between art therapy models being used to treat this population and found that they were rooted in a ‘theory of change’ approach. Common themes from the models referenced include: creating a sense of safety, amelioration of symptoms, meaning-making, discovering a sense of self, integrating elements of identity, increasing communication, and developing resiliency and stress management skills (Collie et al.,

2006; Jones et al., 2017; Lobban, 2014; Lobban, 2016b; Lobban & Murphy, 2017; Malchiodi, 2011; Palmer et al., 2017). These findings among themes align with the model proposed by Donnelly (2013) after studying the published literature on art therapy for combat-related PTSD available at the time of her study.

The efforts of these individuals to create a model from which to conduct art therapy for veterans with PTSD is beneficial for increasing replicability and generalizability of findings; however, it could be argued that the focus of these models solely on PTSD fails to address the many other diagnostic needs of the veteran community. Moreover, the merging of the current models into a standardized model would be advantageous in the near future as it would allow for more rigorous research to be conducted, reducing variations and limitations to understanding the therapeutic factors behind art therapy's utility and efficacy in this context.

Creating a safe space and place. Safety was a predominant theme in the art therapy literature with veterans. As it pertained to the therapeutic space where art therapy was conducted, researchers noted that it was important that veterans felt safe in sharing their experience and in the reliability and consistency of the therapeutic relationship (Collie et al., 2006; Donnelly, 2013). Avrahami noted that the element of art making facilitated this sense of safety by allowing traumatic material to be explored in a nonverbal, symbolic way which allowed for emotional distancing and a sense of control in how the material was approached. In fact, van der Kolk (2014) insisted that the exploration of traumatic material should only occur after the development of a safe therapeutic environment and after connecting the individual to body sensations.

Many authors also spoke to the importance of creating a visual safe place in art therapy with veterans. Pierce and Decker (2017) discussed, for example, the utility of this safe place in

grounding veterans as they processed difficult material outlined in manualized CPT by giving them a reference point in which they could become immersed that was free from association with the traumatic event. Additionally, the visual safe place allows the brain an additional sense with which to experience safety and calm during potentially re-traumatizing acts, such as developing the graphic narrative of a traumatic event (Wolf, 2017).

Although the idea of safety was underscored primarily in the literature on PTSD, it is likely that this is an element of treatment that is vital to the treatment of all veterans' therapeutic needs. By signing on the dotted line and agreeing to follow the orders of those appointed over them, we are asking people to be in a constant state of vulnerability by choosing this line of work. Whether they end up serving in harm's way directly or indirectly, decisions are often out of their control and administered without any predictability or concern for the impact on the veteran's safety and well-being. Creating an environment in which a sense of trust and safety can be fostered should, therefore, be a focus in the treatment of all veterans, regardless of primary diagnosis.

Containment and communication. In addition to safety, art therapy conducted with veterans focused on facilitating containment and communication. In addition to the therapeutic relationship serving as a container for veterans' intense emotions, the art can serve as a physical container (Chong, 2015). Materials such as clay and thick paper allow high impulse to be contained, articulated externally and acknowledged as tangible visual and sensory experiences in a less confrontational way (Chong, 2015, p. 124). Jones et al. (2017) spoke to this ability of art when discussing the use of containers to serve as memorials or methods of processing previously unexplored grief and loss experienced by servicemembers. In fact, Avrahami (2005) listed containment as one of the three key principles of art therapy in serving the veteran population,

discussing its ability as an action therapy to address the core of traumatic memories and allow for integrated processing.

Art making was found to be a way for veterans to communicate their needs to caregivers and family members that had previously been hindered due to the nonverbal nature of the traumatic memory. Importantly, researchers found that these discoveries and difficulties that manifested in the artwork could be used to inform and individualize treatment planning (Lobban, 2016a; Lobban & Murphy, 2017; Walker et al., 2017). Research also showed that art allowed for the facilitation of communication among group members (Palmer et al., 2017) and allowed them to develop a different understanding of their peers which boosted group participation and morale (Lobban, 2016b).

Similar to safety, these themes of containment and communication are consistent with the needs of veterans regardless of primary diagnosis. Thanks to the military ethos that communicates it is better to be tough and not ask for help, powerful feelings such as anger and fear are often denied by the servicemember or veteran and go uncommunicated (Dondanville, 2018; Pratt, 2017). Therefore, art serves as a valuable means to offer a tangible outlet for both discovering and channeling intense emotions, followed by a physical rather than merely hypothetical containing of these emotions in a safe space.

Expanded interdisciplinary treatment and the VA. The integrative literature review revealed an expanded inclusion of complementary and alternative treatment techniques like art therapy into the treatment of veterans and servicemembers through holistic and interdisciplinary treatment models. This interdisciplinary approach has proven useful in improving symptomology and supporting the multi-dimensional needs of veterans (Gaddy, 2017; Hammond & Vandenberg, 2011; Hull et al., 2015; Jones et al., 2017; Walker et al., 2017). A surprising finding

of this study was the role of the VA as a home to many such programs. Additionally, efforts to include art therapy as its own classification of employment in its treatment centers, rather than falling under another discipline such as recreation therapy or occupational therapy, continue to be made. Although this acceptance and integration expands veteran access to art therapy, it also proved difficult to hone in on the specific contributions of art therapy to veteran symptom improvement while in treatment (Gaddy, 2017; Walker et al., 2017). Without a clear understanding of the true, individualized impact of art therapy in these programs, advocacy for art therapy's continued inclusion could be difficult as funding for these programs is still primarily driven by the production of 'hard evidence'.

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

Summary of Findings

Art therapy was found to be qualitatively and quantitatively beneficial in ameliorating symptoms related to common diagnostic difficulties faced by veterans. Current published and unpublished literature on the topic uncovered themes in the areas of creating a safe therapeutic environment, the ability of art therapy to ameliorate symptoms of PTSD and other mental health diagnoses, and the continued integration of art therapy and other alternative treatments into VAs and other mental health treatment programs serving veterans nationwide. Along these lines, Churchill fellows Janice Lobban (2016a; 2016b) and Dena Lawrence (2012) echoed in their findings the importance of providing this form of treatment to support servicemembers.

Although a significant number of publications were found on the topic, a need for more robust, quantitative data exists to meet the demands for ‘undeniable proof’ generated by systems like the VA to warrant continued funding. Although dated, the following sentiment from Kaiser et al. (2005) appears to reign true today:

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. (p. 5)

Much of the identified literature on the incorporation of alternative treatment approaches into VA and other programming made no reference to art therapy as one such alternative

treatment. Additionally, many of the literature reviews conducted in recent years on the treatment of art therapy with veterans noted the difficulty in generalizing findings on the efficacy of art therapy due to small sample sizes and the often anecdotal nature of the research findings (Donnelly, 2013; McMackin, 2016; Michael Husby, 2014; Schuman, 2016; Smith, 2016).

Furthermore, a number of the programs currently being implemented to treat veterans with art therapy are being conducted in an interdisciplinary setting. In so doing, identifying the therapeutic factors specific to art therapy are difficult to isolate. Moreover, art therapy models being proposed or utilized are informed by different pre-existing trauma treatment models. This variation prevents the replication of studies which would increase the generalizability of findings.

Future Directions and Recommendations

Based on the findings of this literature review, it is recommended that the current models for art therapy in treating PTSD be evaluated and consolidated to create a standardized model to allow for replication of use and refinement of findings. Similar to the sentiment of Skaife and Huet (1998) who question whether there ever could be a universally applied model for art therapy groups due to the range and diversity of client groups, it is unlikely that such a model exists for all veterans. Therefore, there appears to be an opportunity for the creation of art therapy treatment models for use with veterans for diagnoses other than PTSD to ensure varying treatment needs are met.

It is recommended that art therapists continue to publish their work with art therapy and veterans, with a focus on increasing the amount of detail included in the areas of directives, materials, environment, format, and duration. Doing so will increase the ability to replicate use of these factors in future studies and begin to allow for the identification of specific therapeutic contributions of each element of art therapy, as well as expand our understanding of its value.

Furthermore, it is believed that by increasing the inclusion of these details and in turn the replicability of studies there will be an increase in the reliability of findings and an improvement in justification for expanded use of art therapy in the treatment of veterans. As Slayton et al. (2010) concisely stated on this topic:

There is a lack of standardized reporting and utilization of control groups, and a tendency to use anecdotal case material to demonstrate treatment outcomes rather than measured results. Often, poor or only vague descriptions of the treatment interventions are provided, which makes it difficult or impossible to determine the study procedures. Finally, studies that mix interventions prevent an examination of which intervention led to the changes reported. (p. 116)

Additionally, although numerous studies have explored the use of art therapy, few controlled studies have been conducted. The design and methodological rigor of studies conducted have varied widely, leading to mixed and inconclusive findings (Maujean et al., 2014). In comparison to the research on the neurobiological impact of art therapy, for example, the literature on art therapy with veterans is considerably lacking in detail and structure. It is recommended that additional controlled studies be conducted on the use of art therapy with veterans for these reasons.

Finally, it is recommended that additional research be conducted specifically looking at the therapeutic elements of art therapy. For example, a number of studies were conducted comparing the impact of art therapy treatment for veterans to the use of a traditional therapy like CPT. In essence, these studies are comparing apples to oranges, and although improvements were seen in symptom reduction, the actual therapeutic factors of the art therapy approach could not be identified. In comparison, research studies such as those conducted by Lehavot et al.

(2017) and Krupnick et al. (2017) took a formatted treatment already in existence (CBT) and only added one element – a web-based component – which allowed them to understand the impact of this one factor. Mimicking such an approach would allow for greater understanding of the therapeutic factors of art therapy but will require a more standardized art therapy treatment approach as mentioned previously.

In conclusion, this systematic, integrative literature review revealed the current needs of the field in the area of conducting art therapy with veterans. These needs include the creation of standardized models of conducting art therapy in order to increase generalizability of findings. Furthermore, doing so would allow for the therapeutic factors of art therapy to emerge rather than simply comparing outcomes to those of talk therapy approaches. As the field of art therapy continues to grow, an opportunity exists for art therapists to simultaneously conduct research of this nature alongside art therapists who would rather simply accept our approach as ‘other’ and one which need not be defined. Regardless, there exists an opportunity to include increased detail about the materials, frameworks, directives, and other relevant information in art therapy publications on the treatment of veterans to allow for continued development, replication, and improvement of methods to better support this population.

CHAPTER VII

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APPENDIX A

Tables of Sources

Table A1

Databases, Journals, and Books

<u>Databases</u>	<u>Journals</u>	<u>Books</u>
Academic Search	<i>Administrative Policy Mental Health</i>	<i>Art Therapy, Trauma, and Neuroscience</i>
EBSCO	<i>American Psychologist</i>	<i>Art Therapy with Military Populations</i>
ERIC	<i>Art Therapy</i>	<i>Handbook of Art Therapy</i>
Google Scholar	<i>Contemporary Clinical Trials</i>	
OneSearch	<i>International Journal of Art Therapy</i>	
Premier	<i>International Journal of Stress Management</i>	
PsychArticles	<i>JAMA Psychiatry</i>	
PsychiatrOnline	<i>Journal of Abnormal Psychology</i>	
PsychINFO	<i>Journal of Counseling & Development</i>	
PubMed	<i>Journal of Poetry Therapy</i>	
Web of Science	<i>Journal of Trauma & Dissociation</i>	
WorldCat	<i>Journal of Traumatic Stress</i>	
	<i>Military Medicine</i>	
	<i>Nord J. Psychiatry</i>	
	<i>Psychological Trauma: Theory, Research, Practice, and Policy</i>	
	<i>The Arts in Psychotherapy</i>	

Table A2

AATA Approved Art Therapy Masters and Doctoral Program Databases Reviewed

<u>Theses</u>	<u>Theses and Dissertations</u>
Adler Graduate School	Drexel University
Adler University	Lesley University
Albertus Magnus College	Mount Mary University
Antioch University-Seattle	Notre Dame de Namur University
Caldwell University	
College of New Rochelle	
Concordia University	
Eastern Virginia Medical School	
Emporia State University	
Florida State University	
Hofstra University	
Long Island University-Post Campus	
Loyola Marymount University	
Marylhurst University	
Marywood University	
Nazareth College of Rochester	
New York University	
Phillips Graduate University	
Pratt Institute	
Saint-Mary-of-the-Woods College	

School of the Art Institute of Chicago

School of the Visual Arts

Seton Hill University

Springfield College

Southern Illinois University at Edwardsville

Southwestern College

The George Washington University

University of Louisville

Ursuline College

Wayne State University

APPENDIX B

Tables of Search Terms

Table B1

Search Terms for Art Therapy with Veterans

<u>Search Term 1</u>	<u>Search Term 2</u>	<u>Search Term 3</u>
Art therap*	Veteran	NOT Antiretroviral
Art therap*	Military	NOT Antiretroviral
Art therap*	Combat	NOT Antiretroviral
Art therap*	War	NOT Antiretroviral
Expressive therap*	Veteran	NOT Antiretroviral
Expressive therap*	Military	NOT Antiretroviral
Expressive therap*	Combat	NOT Antiretroviral
Expressive therap*	War	NOT Antiretroviral
Creative art* therap*	Veteran	NOT Antiretroviral
Creative art* therap*	Military	NOT Antiretroviral
Creative art* therap*	Combat	NOT Antiretroviral
Creative art* therap*	War	NOT Antiretroviral
Art*	Veteran	NOT Antiretroviral
Art*	Military	NOT Antiretroviral
Art*	Combat	NOT Antiretroviral
Art*	War	NOT Antiretroviral

Table B2

Search Terms for Supporting Literature

<u>Search Term 1</u>	<u>Search Term 2</u>	<u>Search Term 3</u>
Psych*	PTSD	Veteran
Mental health treat*	PTSD	Veteran
Veteran	PTSD	Therap*
Veteran	"*traumatic stress disorder"	Therap*
Veteran	"*traumatic stress disorder"	Psych*
Veteran	"*traumatic stress disorder"	Mental Health
Combat	Therap*	
Art Therap*	Neuro*	
MST	Therap*	
Military Sexual Trauma	Therap*	
Substance Abuse	Veteran	Mental Health
Substance Abuse	Veteran	Art Therap*
Substance Abuse	Veteran	Therap*
Substance Abuse	Military	Therap*
Transition*	Military	
Transition*	Veteran	
Military	Readjust*	
Veteran	Readjust*	
Veteran	Reintegrat*	
Military	Reintegrat*	

Veteran	Complicated Grief
Military	Complicated Grief
Combat	Complicated Grief
Art Therap*	Complicated Grief

APPENDIX C

Link to Literature Matrix

Table C1

Literature Matrix of Publications on Art Therapy with Veterans

Full literature matrix can be found at: <http://hdl.handle.net/1805/15859>

APPENDIX D

Figure of Publication Topics

Figure D1

