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Efficacy of Expressive Therapy in Treating Combat-Related PTSD – A Critical Review of
Literature
Capstone Thesis
Lesley University

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Expressive Art Therapy

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Abstract

Recent advances in battlefield triage have curtailed combat-related deaths, simultaneously increasing the rate of combat-related trauma, and thereby emphasizing the need for access to efficacious treatment of PTSD in returning veterans. Veterans who may have sustained life-ending injuries from concussive elements such as explosions are instead surviving with PTSD and its debilitating effects. Recent studies suggest that traditional methods of treatment such as medication and talk therapy, while useful, are incomplete tactics when it comes to treating non-verbal trauma. The burgeoning field of expressive therapies (expressive art therapy, dance, drama, art, music, writing, etc.) offers a new approach that is supported neurobiologically to treat the whole of the mind by engaging with the trauma at its root in the nonverbal brain. This thesis defines PTSD, its historical presentation and treatment in the military, and identifies stigmas of mental illness and barriers to care for veterans. The history of therapeutic uses of art and the new field of expressive therapy is presented, alongside current programs using these methods to treat veterans and their families.

Keywords: military, PTSD, trauma, combat, expressive therapies, expressive art therapy, creative therapies, barriers to care, stigma, war on terror

Efficacy of Expressive Therapy in Treating Combat-Related PTSD – A Critical Review of
Literature

There must be those among whom we can sit down and weep and still be counted as warriors.

- Adrienne Rich, *Sources*

Throughout human history, it has had many names: soldiers' heart in post-Civil War era, shell shock in WWI, and battle fatigue in WWII (Friedman, 2004, 2019). Since the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 (Friedman, 2019), it has been known by its official name: post-traumatic stress disorder (PTSD) (para. 12). A further two editions of the *DSM* refined the original definition, reinforcing the movement toward trauma-informed care, alongside the past century's wars (paras. 13, 14). As shifts in warfare and types of deployment activity continually change, so does our understanding of the causes and presentations of this disorder. Modern warfare has illuminated a gap between our understanding of trauma and the available treatment options for those affected.

Following the 9/11 terrorist attack, the U.S. military launched into a series of drawn-out military campaigns and support efforts in Iraq and Afghanistan which have persisted for nearly two decades. Compared to the Gulf War of 1990, which lasted six months, the overlapping operations of Operation Iraqi Freedom (OIF; Iraq, 2003-2011), Operation Enduring Freedom (OEF; Afghanistan, 2001-2014), and Operation New Dawn (OND; Iraq, 2010-2011) provided ample time to collect significant data on combat trauma through independent and government-funded studies (U.S. Department of Veterans Affairs [VA], 2015). Between 2001 and 2015, a total of 2.77 million active-duty personnel deployed for a total of 5.45 million deployments overall; 610,000 of those deployed three or more times (Wenger et al., 2018, p. 8). Multiple

deployments mean multiple reencounters of the same types of traumatic and concussive events, which compound the initial trauma and prolong the subsequent post-traumatic stress (Lawhorne-Scott & Philpott, 2011, p. 2).

Military success is predicated upon healthy, functioning individuals in a hierarchical structure acting as a single unit on a common mission. “One of the best buffers against the psychological impact of any war zone operation is the unit, the cohesiveness of the unit” (Friedman, 2004, para. 8). Metaphorically, any weak link could damage the entire chain, rendering it flawed at best and, at worse, fatal. In an intensified social setting such as war, each soldier is expected to prioritize the life of another in their unit before their own; in such circumstances, strong attachments are formed. The U.S.’ individualistic culture of convenience is ill-equipped to provide a synonymous connection, even within a family unit. As of 2018, active-duty military personnel totaled 1.3 million – just under 0.5% of the U.S. population (Council on Foreign Relations, 2020, para. 5). Thus, veterans return home to the other 99.5% of America that lack the capacity to understand the nature of an attachment borne of reciprocal sacrifice. Junger (2014) depicts this war-born bond:

Think about all these soldiers...having a bond like that, in a small group...think about how good that would feel...and then they come home and they are just back in society like the rest of us...not knowing who they can count on...who loves them, who they can love...what anyone they knew would do for them when it came down to it. That is terrifying...compared to [alienation], war...is easy. (11:42-12:36)

The question that today’s mental health care providers are attempting to answer is that of care. How do we care for and interact with veterans with and without PTSD, in new and innovative ways that support social connection? How do we change our engagement in the

culture as a whole with returning veterans? How do we support their families while they are away and strengthen existing PTSD prevention measures? An overwhelmed Veterans Health Administration (VHA), created by the U.S. government as a separate entity from the Military Health System (MHS), has been inundated with those suffering from *invisible wounds*, not only from the most recent decades, but also those from the Korean, Vietnam, and Gulf wars of the 20th century (Wounded Warrior Project, 2021).

Bodily injuries preclude veterans from military duty, so their treatment has been given priority in healthcare and research funding. These invisible wounds, while less nefarious at the outset, might provoke an indifferent response from superior officers and persist for decades, potentially threatening a veteran's marriage, parenthood, livelihood, and life itself. The military's response to the mental health needs of its 21st century veterans and an unbalanced budget allotment for PTSD research and treatment has placed a tremendous burden of care upon an overwhelmed VHA system in recent years (Bowman, 2011). In the presence of such a disparity of care, contemporary clinicians have acknowledged a needed shift in treatment focus (Harris, 2009), the accessibility to resources for veterans with PTSD (Balfour, 2019; Jones et al., 2019; Walker et al., 2017), and the language used around returning veterans within the general population (Boston & Creekmore, 2017).

The founder of the VA's National Center for PTSD, Dr. Friedman (2004), referenced the politically charged and divisive response to the Vietnam War as having a "devastatingly adverse impact on the recovery of the Vietnam veterans" (para. 2), perhaps partially accounting for the hesitation to include therapeutics that evolved from the 1960s and 70s. For the purposes of this literature review, *veteran* refers to any military personnel not currently on active duty, *soldier*

refers to those in conflicts (e.g., Civil War soldier), and *operation* refers to the name of a military conflict, either specifically or generally.

Expressive art therapy, “art, music, dance/movement, drama, poetry/creative writing, play, and sandtray” (Malchiodi, 2005, p. 2), also known as the expressive therapies (ET), are among the newest forms of treatment to be included in the wider mental health field. They have yet to be adopted as a whole by the MHS or the VHA, although intensive outpatient programs such as the one at Walter Reed’s NICOE facility are regularly employing these techniques (Little, 2020, para. 4).

This literature review will draw attention to the ways in which the arts are being used to complement traditional talk therapy and medication. The review is organized into multiple parts which define and differentiate post-traumatic stress (PTS) from PTSD as well as discuss combat-related stressors, and therapeutic arts from the art (in its many forms) as psychotherapy. It will present the historical representations of PTSD in the arts and the military, and discuss the military culture surrounding mental illness stigmas and barriers. This review will show the efficacy of ET in engaging with nonverbal trauma and will highlight the programs currently using these techniques to engage with veteran populations.

Literature Review

PTS and PTSD

It is important to note the difference between PTS and PTSD: one is a natural response, while the other is abnormal and prolonged. PTS, as described by Dr. Bender (2013) of the Deployment Health Clinical Center, is “a common, normal, and often adaptive response to experiencing a traumatic or stressful event... [It triggers a] fight-or-flight response... [which pumps] more blood and oxygen to your muscles” (para. 2). Gantt and Tinnin (2009) refer to the

brain's reaction as "involuntary, instinctual survival," and not one of "internal conflict, impulse control, or insufficient maturation of the ego" (p. 150); the reaction enables the person to escape from the traumatic event while the verbal, rational mind recovers. Sometimes the recovery of normal cognition takes longer to recover, and results in PTS, which causes the person to appear constricted emotionally, leading to "trauma phobia" (p. 150), or alexithymia (fear of the trigger event).

Since the brain is responding normally to a perceived threat, the presenting PTS is not considered a mental illness (Bender, 2013, para. 2). If the symptoms persist for more than a month, the PTS is considered severe, though a clinical diagnosis is required to label it PTSD (para. 7). The American Psychiatric Association (APA, 2020) adds the additional requisite of "[causing] significant distress or problems in the individual's daily functioning" (para. 6) to a diagnosis of PTSD, while the VA's National Center for PTSD (2019) suggests contacting a health care provider after a few months of prolonged symptoms (p. 3).

The *DSM-I* categorized the yet-unnamed PTS as a "gross stress reaction" (Friedman, 2019, para. 10), which assumed a relatively quick recovery time and only recommended another diagnosis if symptoms persisted past six months; the *DSM-II* omitted the diagnosis all together (para. 11). When *DSM-III* was published in 1980, the diagnosis "stemmed from research involving returning Vietnam War veterans, Holocaust survivors, sexual trauma victims and more...the links between the trauma of war and post-military civilian life were established" (para. 12). The *DSM-5* is the first edition to move PTSD from the category of Anxiety Disorder to Trauma- and Stressor-Related Disorders (para. 14).

According to Hoge et al. (2008), the majority of people who develop PTSD "meet the criteria for the diagnosis within the first 3 months after the traumatic event," and thereby need an

immediate response to address the “problem of stigma and other barriers to seeking mental health care in the military” (p. 15). Balfour (2018) lists particular barriers to care for the military: “stigma...loss of self-esteem, lack of confidence in mental health professionals, negative impact on career...and fear of being released from the military on mental health grounds” (p. 61).

The APA (2020) lists the following symptom categories for PTSD:

- Intrusion – intrusive thoughts, nightmares, flashbacks (sometimes intense enough that it seems as if the event is occurring again)
- Avoidance – avoiding anything that triggers memories of the event; people, places, things, activities, situations, etc.); substance misuse is often used as a coping mechanism to avoid triggers
- Alterations in cognition and mood – distortions occurring in beliefs about one’s self, others; events leading up to the traumatic event causing the person to think they are to blame (whether factual or not); and an inability to experience positive emotions
- Alterations in arousal and reactivity – heightened irritability and angry outbursts; recklessness and self-destructive behaviors; problems concentrating and sleeping, and hyperarousal surroundings (*Symptoms and diagnosis*, para. 1)

Though the APA (2020) highlights a number of familiar, proven psychotherapy treatments, they do not specifically mention ET but do include a description under “other psychotherapies” (*Treatment*, para. 2) in which it may be found: “interpersonal, supportive and psychodynamic therapies [that] focus on emotional and interpersonal aspects of PTSD” (para. 2). It is telling that the foremost authority on definition and treatment of mental illness clearly

prefers cognitive-based and exposure therapies, with little consideration for or extrapolation of ET. Similarly, the 2019 VA digital resource on PTSD suggests prolonged exposure therapy (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR), all of which are based in the verbal cortex of the brain; the one exception is EMDR, which engages both verbally and nonverbally (National Center for PTSD, 2019, p. 12). No mention of a psychodynamic expressive therapy is made, which is significant for the purposes of this literature review.

PTSD in early 20th century military. Possibly the earliest known recording of PTSD occurs in the *Epic of Gilgamesh* (2100 B.C.E., as cited in History.com Editors, 2018), an ancient Mesopotamian narrative, wherein the hero, who witnessed his closest friend's death experiences "intrusive recollections and nightmares related to the event" (History.com Editors, 2018, para. 10). Other ancient texts (Greco-Latin, Icelandic, Indian, etc.) describe blindness, nightmares, and reclusive behavior following near-death experiences during battle (paras. 11-13). Doctors in the 17th and 18th centuries attempted to categorize the unnamed malady that presented in soldiers as anxiety, sleeplessness, and *nostalgia*, used to describe despair (Friedman, 2019, para. 3). While the Civil War term *soldier's heart* (History.com Editors, 2018, para. 16) was used to describe the psychological effects of war on soldiers, it was often considered a weakness of constitution. Not until the expert diagnostician Dr. J. M. DaCosta published his 1871 findings on a "form of cardiac malady common among soldiers" (Wooley, 1982, p. 1145) was a scientific connection officially made between the psychological effects of war on the physiological body.

Only for the past 40 years have we had the language to properly describe PTSD and its physiology. A combination of factors led to this recent discovery, including the technology and internet boom of the late 1990s and early 2000s, advances in psychological research and

treatment, and two decades of war. For those who survived the trauma of the Great War of 1914 (now known as World War I), bizarre symptomology presented itself: nightmares, facial tics, incoherent verbal utterances, and bent bodies (van der Kolk, 2015, p. 186). Soldiers were initially diagnosed with *shell shock* (a name the soldiers coined), initially used to describe the hidden injuries (Friedman, 2019) of close proximity to explosions and artillery rounds. Soldiers who were not near the same concussive events but suffered identical symptomology caused the term to evolve into “war neuroses” (para. 6). Treatment ranged from a “few days’ rest” (para. 7) between engagements to daily treatments of hydrotherapy, electrotherapy, and hypnosis, all relatively new technologies. The British banned the diagnosis of shell shock in favor of “NYDN (not yet diagnosed (nervous))” (van der Kolk, 2015, p. 187), and the Germans, who considered it a character flaw, treated it with painful treatments such as early electroshock therapy.

Psychologists William McDougall and Charles S. Myers (1940, as cited in Jones, 2012) studied the effects of shell shock on the front lines of WWI and suggested repressed trauma was the root of the symptoms soldiers were experiencing: “tremor, loss of balance, headache and fatigue” (p. 18). They proposed “integration of [the] consciousness” and noted the necessity of “promptness of action, suitable environment and psychotherapeutic measures” (p. 18).

PTSD in mid- to late-20th century military. Amidst the rising tensions of Soviet-era control, the U.S. backed the Republic of South Korea in the Korean War (1950-1953) (Palmer et al., 2019). “One of the most decisive points for a returning veteran combatant with PTSD is the kind of reception that they’re going to receive when they come home” (Friedman, 2004, para. 2). Only 33% of Korean veterans felt appreciated upon returning home, compared to 70% of WWII veterans (Palmer et al., 2019, p. 556). The “underrecognized and undertreated” Korean veterans

experiencing PTSD, paired with a stoicism (p. 556) typical of those in military service created a large barrier to veterans' ability to seek care.

Vietnam War veterans returned to a politically charged atmosphere where they were called baby killers (Friedman, 2004, para. 2), and protesters burned the American flag which 60,000 of their fallen brethren represented. Although the stressors are similar to those of other military conflicts, the symptomology of Vietnam and Korean veterans experiencing PTSD included more stomach-related illnesses than their 20th century counterparts (Palmer et al., 2019, p. 554; van der Kolk, 2015, p. 186). Renowned war journalist Sebastian Junger (2014) spoke of the bonds formed in combat:

[A veteran was asked] "is there anything you miss about the war, about Afghanistan?" and he... finally said, "Ma'am, I miss almost all of it."...What is he talking about?... He doesn't miss killing people. He doesn't miss seeing his friends get killed. I think what he missed is brotherhood...what he missed was the opposite of war... [it was] connection. Brotherhood is different from friendship...it's a mutual agreement within a group that you will put the welfare of the group...the safety of everyone in the group above your own. In effect, you're saying, "I love these other people more than I love myself."
(08:42-10:12)

Military culture in the 20th century deigned any sign of physical or emotional weakness as feminine and thus not fit for war (Jones, 2012, p. 18; van der Kolk, 2015, p. 187). Therefore, repression of the individual in service of the unit does not allow psychologically for vulnerability. This mentality is useful in wartime deployment but does not foster an ability for successful post-deployment processing and examination of wartime experiences. Howie (2017a) describes the military ethos of a warrior culture:

The military ethos relies on strength, cunning, and the ability to successfully confront a challenge. Service members do not want to appear weak by asking for help. This prohibition applies to those in charge as well as lower ranking veterans. No one wants to be considered the “weakest link” ... this puts one in an untenable position, especially if mental healthcare is sought. (p. 53)

The enactment of this ethos can be seen in the stoic military mentality of WWII and Korea. While previous wars had a perceived noble sense of patriotism and duty, the Vietnam War was disputed from the start (Friedman, 2004, para. 3). Thus, the U.S., adrift in the myriad revolutions of the 1960s, was unable to help itself or assist its returning veterans.

PTSD in post-9/11 military. Prior to 9/11, “we were not yet talking about the effect of trauma and war on the human psyche” (Junger, 2016, 00:14). No significant studies reporting incidence of PTSD pre- and post-combat occurred prior to OIF (Cameron et al., 2019, p. 4), so estimates of combat-related trauma are limited to the most recent conflicts. This may be due to the somewhat recent addition of PTSD in 1980 to the mental illness vocabulary, and to the brief nature of the Gulf War which did not necessitate an operation-specific study of large-scale PTSD and its long-term effects.

It should be noted that while the VA and the military serve the same population, they belong to distinct organizations. The MHS is a part of the Department of Defense (DoD), while the VHA is the healthcare branch of the U.S. Department of Veterans Affairs (VA, n.d., p. 28). Despite the systematic organizational overhaul of the VA in recent years, a generation of veterans dealing with combat-related PTSD are flooding an already lagging system of care, as they did in WWI and WWII (p. 23). Haesler and Howie (2017) cite a 2003 commission which estimated 236,000 veterans waited six months or more to receive care or follow-up treatment at

VHA facilities, revealing a staggering inadequacy of available resources and space (Pearson, 2017, as cited in Haesler & Howie, 2017, p. 27).

In a 2007 series by *The Washington Post* (Priest & Hull, 2007) investigative journalists revealed truly decrepit conditions in the Army's preeminent medical facility, Walter Reed. The hospital had black mold and cockroaches, cheap mattresses, and a backlog of care brought on by years of sustained conflict that transformed the once venerable facility into a "holding ground for physically and psychologically damaged outpatients" (para. 3). While the Vietnam veterans' psychosocial wounding upon returning home resulted from hostility, OEF/OIF/OND veterans' wounds were created through neglect; both serve to reenforce the need to isolate and break dependency on others. Walter Reed became shorthand for *scandal* after the exposé alerted the Nation to the neglect of its patriots (Bowman, 2011). In 2005, the Army began integrating with the National Naval Medical Center to become an integrated military system. Both the Walter Reed scandal and the VA facility wait times signaled a systemic gap in care and available resources.

Rare instances of untreated PTSD, undiagnosed preexisting mental illness, and other stressors (financial, marital, career) have led veterans, active-duty personnel, and military healthcare workers to attack the people at their workplaces, health facilities, and homes (Hutchison, 2019). Fifty-seven percent of Iraq and Afghanistan veterans report owning a firearm (Maffucci & Frazier, 2015, p. 13). Of the 22 daily veteran suicides, 69% are by firearm (Maffucci & Frazier, 2015, p. 18; VA, 2019, p. 18). The daily rates of veteran suicide (not including active-duty service members), while usually slightly less than or commensurate with the civilian population, increased between 2005 and 2018, according to the Veteran Suicide Prevention Annual Report (VA, 2020, p. 9).

Walker et al. (2017) cite a 2016 report which estimates U.S. funding for traumatic brain injury (TBI) research and treatment cost at \$910 billion, whereas PTSD cost just over \$6 billion (p. 1). According to a 2020 analysis of Pentagon spending, the U.S. spent \$46 billion between 2000 and 2010 on weapons programs that either never made it past the prototype stage or were so poorly designed as to be rendered ineffectual (Negin, 2020, para. 7). These failed programs total \$37 billion more than was spent on life-saving corrective treatment and research into PTSD within approximately the same time period. Such budgetary discrepancies reveal the historical bias toward mental illness.

Therapeutic Uses of the Arts in Military Populations

Two and a half millennia ago, the Greek poet Sophocles and his contemporaries were writing about the shattered spirit of men embroiled in an 80-year war with Persia (Doerries, 2015, p. xiii). As a high-ranking Athenian general, Sophocles, who knew the deleterious effects of war chose to engage the warrior culture with plays of tragedy (p. xiii). Tragedy, as a form of storytelling, “evokes powerful emotions in order to erode stigmas, elicit sympathy, generate dialogue, and stir citizens to action” (p. xiii). Sophocles’ audience of 17,000 citizen-veterans could relate to the breakdown of the mighty Ajax: the depth of his depression after losing his best friend, the feeling of betrayal by his commanders, the slaughter of a field of animals in his blind rage, the rejection of his wife out of fear of hurting her, the unending nightmares, and, finally, his lonely suicide (pp. xii, 3-4).

Following that ancient example, contemporary author and classicist Bryan Doerries (2015) translated the several tragedies by Sophocles and Aeschylus and founded a production company, *Theater of War*, to “[present] readings of ancient Greek plays to service members, veterans, caregivers, and families to help them initiate conversations about the visible and

invisible wounds of war” (Theater of War, n.d., para. 2). Doerries kept the production accessible for the audience by limiting the design of his presentation to a dramatic reading by seasoned actors.

As with Sophocles’ audience, Doerries’ (2015) first rows are reserved for generals and their wives, while officers, enlisted personnel and their families comprise the rest of the audience. Following the reading, an open-ended comment portion occurs. The responses of Doerries’ audience signals a need for honest conversation and stigma-breaking about PTSD. The first tragedy presented by Doerries’ Theater of War was *Ajax* for a 2008 Marine Corps conference in San Diego. In response to that first reading, Doerries (2015) wrote:

One after the other, the Marines and their loved ones stood up – a chaplain, a sergeant major, a general’s wife, a wounded veteran, a psychiatrist, a colonel, a lance corporal – and testified to the truth of Sophocles’ tragedies, quoting lines from memory and weaving them into their personal stories, as if they had known the ancient plays their entire lives.
(p. xii)

The poetic work of young men in the trenches of World War I ranged widely from nostalgic patriotism (Rupert Brooke), and stark tension and political indifference (Edward Thomas), to sharp satire of the war (Siegfried Sassoon) (Ward, 1997). Many of them died in battle and their work was published posthumously, seemingly emphasizing their need to create in the midst of life and death turmoil. Robert Graves, a young soldier poet, wrote pithy verse about the futility of diplomacy for foot soldiers in his poem *To Lucasta On Going To The War – For The Fourth Time*:

It doesn’t matter what’s the cause,
What wrong they say we’re writing,

A curse for treaties, bonds and laws,
When we're to do the fighting! (Ward, 1997, p. 39)

Poet Randall Jarrell served in WWII as a control tower operator (Poets.org, n.d.) which served to inform his writings on war. Jarrell (1969) is best known for his striking poem *The Death of the Ball Turret Gunner* which closes with the stark statement: “When I died they washed me out of the turret with a hose” (p. 144, line 5).

According to trauma expert Bessel van der Kolk (2015), “denial of the consequences of trauma can wreak havoc with the social fabric of society... culture shapes the expression of traumatic stress” (pp. 188-189). As a result, the Vietnam War “produced some of the most significant ruptures in social and political life across the country and stoked a divisiveness” (Catlin, 2019, para. 4) that continues to shape art and how we respond to tragedy.

Arts in therapy and PTSD. Just as global traumatic events in the 20th century led to the creation of PTSD as a diagnosis, so artists’ and art educators’ contributions lead to the modern usage of art in therapy (Hinz, 2009, pp. 21-22). The majority of research in the field of using the arts in therapy relies on the independent modality of art therapy itself. Margaret Naumberg, the mother of art therapy, argued that the “symbolic aspects of imagery as well as the verbal and cognitive aspects of experience” (p. 24) when part of an art therapy session, created an “integrative and healing” (p. 24) opportunity. Despite its exponential growth in the latter half of the 20th century, the idea of art therapy as medicine has “taken fifty years...to catch the attention” (Betuel, 2019, para. 2) of the World Health Organization. “Art therapy, while increasingly accepted as a form of complementary care for military veterans with PTSD symptoms” (Walker et al., 2017, p. 2), has been limited by a substantial lack of empirical evidence due to the narrative nature of early studies (Reynolds et al., 2000; Slayton et al., 2010).

Neurobiology shows us how the brain is separated into hemispheres – the left analytical (verbal) side, and the right (visual, nonverbal) expressive side. In a healthy, functioning brain, both sides are able to process information and communicate without issue. Gantt and Tinnin (2009) argue that “verbal and nonverbal narrative processing of the traumatic experiences” (p. 150) allows the patient to overcome “trauma phobia” (p. 150). “In order for therapeutic change to occur,” argues Levine (2005), “there must be a process of deconstructing in which one’s old identity comes into question and is taken apart” (p. 45).

Exploring one’s emotional reaction to the traumatic memory within a therapeutic framework can help manage affect by allowing the individual distance and, to some degree, objectivity... [Art therapy] can assist the exploration of basic emotion and affect without causing further stress to the individual. (Tinnin & Gantt, 2013)

Art therapy assessments serve to determine the client’s level of functioning and strengths, formulate treatment objectives, gain a more comprehensive view of the presenting problems, and evaluate any progress made by the client (Betts, 2006, p. 423). Boston and Creekmore (2017) found that art therapy created in a communal expressive art therapy group space “reduced anxiety and behaviors that interfered with emotional and cognitive functioning” (p. 49).

These are all forms of art as therapy, which should not be confused with art therapy, although the two are often used interchangeably. Art as therapy uses art making “as a therapeutic tool [in] healing, clearing the mind, and self-expression” (Malchiodi, 2015, para. 2), while art psychotherapy “is a form of expressive therapy based on the idea that art is a vehicle for symbolic communication” (para. 2). The distinction is important to clarify for purposes of current and future program design and funding.

Using expressive therapies to treat PTSD. Traditional methods of treatment for mental health (primarily individual talk and/or group therapy) are not enough to treat mental illness (Gantt & Tinnin, 2009, p. 149). Art therapy appropriately interacts with the injured brain because it allows the nonverbal mind to express itself from the areas that store non-verbal trauma (p. 150). Paula Howie (2017b) cites a 1995 report which says those who “used art versus just writing to express their nightmares reported fewer and less intense nightmares...the non-verbal brain codes traumatic material in pictures... an arts-based approach offers a unique means by which these may come to consciousness” (p. 30).

“Art therapy can overcome the obstacles imposed through dissociation by tapping into the person’s nonverbal world...viewed from a safe psychological distance offering opportunities to rework images” (Lande et al., 2010, p. 42). Jones et al. (2019) argue that art therapy alleviates TBI and PTS symptoms through:

- (a) improved self-awareness...(b) improved ability to safely express a range of emotions...and integrate traumatic experiences through art making; (c) improved interpersonal communication with others...(d) improved self-regulation and cognition...and (e) improved ability to manage stressors. (p. 28)

Expressive art therapy as distinct from art therapy. While art therapy includes any visual medium in its processing, expressive art therapy (EXAT) differs in that it relies on the fluidity of the psyche during the psychological processing (Knill et al., 2005, p. 62). Rather than focusing artistic efforts on creating “immortal fame for the poet”, the symbolic expression (whether through dance, writing, art, music, or drama) retains its transitory space (p. 62). Simply put, when an expressive art therapist is facilitating the session, symbolism is plucked from the nonverbal mind and communicated through a medium that may include overlapping elements

from the other art modalities (e.g., dance, music, etc.) (p. 62). The resulting information can be discussed with the client but not translated or interpreted. The role of the therapist is never to interpret but to further uncover, to be a “witness” (p. 62).

Within this fluidity, trauma, which exists as a “repetition of the same” (Knill et al., 2005, p. 63), can be interacted with in a contained space. The function of the therapist in the session is to create a stable environment for the client to interact with the feelings and conflicting mental states brought about by the trauma. In this regard, *poiesis*, the fluid space where change occurs, “happens not in accordance with intellect...but through the experience of surrender to a process” (p. 41) which cannot be controlled.

Creative arts therapists may choose to [forego verbalization of the trauma] on the pathway to healing...in favor of nonlinguistic modalities of communication and expression...[traumatic memories exist] as inexplicably amorphous sensations and images rather than linear narratives with explicit beginnings, middles, and ends. (Harris, 2009, p. 94)

Rankin and Taucher (2003) list two goals for treating trauma: “(1) decreasing the intensity and frequency of negative aftereffects to improve daily functioning, and (2) increasing positive life experiences to enhance well-being” (p. 138). There is a significant gap in empirical studies done with EXAT and PTSD in the military population, although the expressive therapies modalities which EXAT uses (e.g., art, music, drama, dance) are independently displaying their ability to “overcome obstacles imposed through...the person’s nonverbal world” (Walker et al., 2017, p. 1).

Programs Currently Using Expressive Therapies in a Military Population

ET currently falls under the VA umbrella of complementary alternative medicine (CAM) which “refers to a group of health care systems, practices, and treatments that are not considered to be a part of conventional medicine,” and is not art-specific (Libby et al., 2012, p. 1134). “Accessing creativity can be a turning point for some veterans” (Lobban & Murphy, 2019, p. 43). A 2012 report, in which 125 out of 170 VA programs employing complementary and alternative medicine (CAM) with a PTSD population responded, 58 used art, music, dance, or drama therapies (Libby et al., 2012, p. 1135). EXAT was not included in the parameters of the survey.

During their time at Walter Reed, Boston and Creekmore (2017) observed “beliefs, customs, and language” (p. 41) unique to the military culture also applied to inpatient veterans’ medical treatment. Acronyms and shorthand language vital to military communication only served to distance non-military personnel and visitors from the patients. At the National Intrepid Center of Excellence (NICoE) on the Walter Reed campus, veterans forego rank and uniform for names and civilian clothes (M. Walker, personal communication, March 12, 2018). This exemplifies the concept of person-centered treatment, which prioritizes the identity of the individual over their organizational role.

The NICoE program, which started in 2010, was a carry-over of Walter Reed’s creative therapies department, and has since become the flagship of outpatient early intervention PTSD programs using traditional and alternative treatments (Little, 2020, para. 1). According to Thomas DeGraba, Chief Innovations Officer of the NICoE program, “NICoE [helps] break down the stigma of those treated for TBI and PTS” (para. 8).

Not only is the facility technologically innovative (brain scanning and virtual reality simulators), it also combines various creative therapy programs (music and art), in conjunction

with mindfulness and yoga, and psychiatric sessions (Little, 2020, para. 3). Walker et al. (2017) suggests multiple benefits to mask making for service members in a therapeutic context: “to address communication and social skills in education, improve psychopathology and personal orientation in psychotherapy, and help process identity” (p. 2). The mask-making occurs in a small group setting that “literally and metaphorically externaliz[es] [participants’] inner experiences” (p. 10) and helps them communicate their struggles by allowing “some psychological distance for expression and externalization” (p. 10).

The NICoE facility treated more than 2,000 patients in the last year alone and provided more than “34,000 clinical encounters during their Intensive Outpatient Program, in TBI outpatient services, and in collaboration with inpatient teams from other [Walter Reed] directorates” (Little, 2020, para. 4). Of those who received art therapy at the NICoE facility, 85% reported that it aided their healing process, and 79% of the music therapy program participants requested follow-up sessions (National Endowment for the Arts [NEA], n.d., sec. 4).

The intensive clinical program at Home Base (Boston, MA) features a “holistic and innovative approach to clinical care” that includes “integrative therapies such as yoga, art & Thai chi” (Home Base, 2020, sec. 1) but only has one expressive art therapist on staff and does not have a distinct expressive therapies program. Eight *Intrepid Spirit Centers*, built by the Intrepid Fallen Heroes Fund, follow the NICoE’s “brief outpatient trauma therapy” (Gantt & Tinnin, 2007, p. 69) model and act as satellites of care for “troops suffering the effects of TBI and PTS” (p. 69). **Discussion**

Trauma-informed treatment has quickly become the norm in mental health care, but ET has yet to catch up. Evidence suggests that including more expressive therapies alongside

traditional psychoanalytic models has the potential to yield faster holistic results (Gantt & Tinnin, 2009; Harris, 2009; Jones et al., 2019).

While the military has begun to include expressive therapies programs in their treatment programs, bureaucratic progress is slow, and funding has shifted to a shared approach by government and non-profit and/or private entities. Programs like the NICoE at Walter Reed use government funding from the DoD and the NEA, while non-military organizations like Home Base use private funding.

Aside from the requisite mental health screening exams upon entering the military, there does not seem to be any focused PTSD prevention measures aside from occasional psychoeducational programs. Creation of such prevention measures are pivotal for soldiers and their families, in addition to expanded early intervention programs. The more time that is spent in preventative and early intervention measures with those experiencing PTS (or who have PTSD) could prove life changing to individuals, family units, and the military as a whole. While efficacious art therapy programs are plentiful, expressive art therapy programs are few and far between. Home Base employs an expressive art therapist to create individual and group therapy sessions utilizing these methods, which is likely how the future of EXAT in the military will appear. Given the highly individualistic and fluid nature of EXAT itself, it stands to reason that the most effective use for this modality is through a registered expressive art therapist rather than a program with set methods.

I recommend that current expressive art therapists seek out work with military populations and that current social workers and mental health professionals engage with arts-based education through independent research or further formal education. The expressive therapies offer a new way for veterans to reestablish connections with themselves, each other,

and their families, diminishing the effects of war and helping those who have served our country in the military reenter society successfully.

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THESIS APPROVAL FORM

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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