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THESIS APPROVAL FORM

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Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Art Therapy, MA**

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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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**Art Therapy and Parts Work with Survivors
of Sexual Violence: Development of a Method**

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Abstract

Trauma-focused approaches to psychotherapy continue to gather attention as a growing body of research demonstrates the pervasiveness of traumatic experiences and trauma-related disorders across the lifespan. Art therapy, a relatively young field within the mental health landscape, utilizes the creation of images in therapy through a variety of art media as a tool for intra and interpersonal communication in the therapeutic space. Parts work, a collection of trauma-informed theoretical methods that includes Internal Family Systems therapy, Structural Dissociation and Ego-State therapy, is a systemic framework that proposes that each person is comprised of various parts (or distinct inner voices), under the leadership of the authentic Self. There is limited research regarding the efficacy of combining parts work and art therapy with survivors of sexual violence. To expand upon current intersecting research in this field, the author explored methods of integrating art therapy and parts work at an outpatient clinic with eight sexual violence survivors (five adults and three children) over the course of eight months. As a result, all clients demonstrated an increase in self-awareness regarding symptoms and trauma-response triggers, and some demonstrated a decrease in intensity of trauma-related symptoms. Data was collected through therapist observation, client self-report surveys including the Post-Traumatic Stress Disorder Checklist for the Diagnostic and Statistical Manual of Mental Disorders, fifth addition (PCL-5) and the Center for Epidemiological Studies Depression Scale for Children (CES-DC), and client surveys tracking severity and intensity of symptoms. The positive responses to trauma-focused art therapy and parts work interventions indicated that this can be an effective trauma treatment modality that warrants further exploration.

Keywords: Sexual trauma, sexual violence, post-traumatic stress disorder, art therapy, parts work, internal family systems theory, structural dissociation, ego-state therapy, ACEs

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Art Therapy and Internal Family System Theory with Survivors of Sexual Violence: Development of a Method

Most of the syndromes that make up the Diagnostic and Statistical Manual are simply descriptions of the different clusters of protectors that dominate people after they've been traumatized. (Schwartz, 2021, p. 39)

Rates of sexual violence across the lifespan and its detrimental effects on communities, families, and individuals represents a pressing and ongoing crisis of generational trauma and disease (Herman, 2015; Menakem, 2017). Therapists, researchers, and others in the helping profession have historically overlooked the effects of trauma (Fisher, 2017; Van der Kolk, 2014). In recent decades, trauma research and evidence-based practices treating trauma and sexual violence have increased in popularity. This thesis will explore the pervasive psychological effects of sexual trauma and develop a method combining art therapy techniques and parts work to address the pressing concerns of trauma survivors and help clients on their journey towards healing.

According to research conducted by the U.S Department of Health and Human Services, Centers for Disease Control and Prevention, and Kaiser Permanente in their seminal 1995-1997 study surveying over 17,000 adults in the United States, violence and co-occurring adverse childhood experiences are correlated with high rates of revictimization later in life as well as other long-term negative health outcomes (Grady & Levenson, 2021; Petruccelli et al., 2019; Voith et al., 2020). Additionally, the study, supported subsequently by many other research

efforts, indicates the vast pervasiveness of adverse childhood experiences and potentially traumatic experiences amongst the adult population of the United States (Grady & Levenson, 2021; Herman, 2015). The prevalence of revictimization amongst survivors of sexual violence, the intergenerational revictimization amongst children of survivors, as well as the long-term negative health outcomes and impact to quality of life, are all areas of significant concern to providers treating this population (Voith et al., 2020; Wearick-Silva et al., 2014). Research indicates that higher exposure to physical, sexual, and emotional abuse in childhood correlates with higher rates of violent experiences as an adult, both in victimization and perpetration (Voith et al., 2020). Reducing cyclical violence and traumatization depends on the effective treatment of traumatic stress disorders. The research indicates that effective trauma treatment is an urgent need in communities across the globe.

Post-traumatic stress is the traumatic stress response that persists following traumatic incidents, which may elevate to a level of clinically significant daily dysfunction in some but not all incidences (Rothschild, 2000). Post-traumatic symptomatology varies in intensity, complication, duration, and onset depending on variables specific to the survivor, characteristics of the traumatic event, and how the survivor's surrounding supports respond to their post-traumatic presentation (Briere & Scott, 2012).

A traumatic event is defined as "exposure to actual or threatened death, serious injury, or sexual violence" by directly experiencing the traumatic events, witnessing the events happen to another, learning that the events have happened to a loved one, or by experiencing repeated or extreme exposure to details of traumatic events (Briere & Scott, 2012, p. 9). Growing interest in the field of trauma research has revealed rich information regarding how the body and brain both experience and store trauma (Howard 1990; Rothschild, 2000; Van der Kolk, 2014). As

evidenced by the Adverse Childhood Experiences study (ACE) study, approximately 61% of adults surveyed across 25 states reported that they had experienced at least one potentially traumatic event in their childhood, and one in six reported they had experienced four or more (Centers for Disease Control and Prevention, 2021). Women and individuals from racial and ethnic minority groups are more likely to have experienced four or more potentially traumatic events (Centers for Disease Control and Prevention, 2021). The costs to individuals, families and communities are significant.

Post-traumatic imagery, or “mental contents that had sensory qualities, which distinguished them from mental activity that was purely verbal or abstract” (Howard, 1990, para. 15) is central to post-traumatic stress disorder (PTSD), as is affective repetition and a myriad of defensive efforts. Howard (1990) argues that there appears to be a polarity of traumatic imagery in survivors; that the imagery is either very intense or absent altogether. According to Howard, “the self dissociates during trauma,” (para. 17) helping the brain to bear the intolerable. These “dissociated parts of the self” (para. 17) then may at times, appear to “break through” (para. 17) into full consciousness unexpectedly, though likely triggered by internal or external stimuli. The client may attempt to keep these dissociated parts out of consciousness, reducing their ability to symbolize, verbally express emotion, or dream, because “linking affect to cognition may lead to re-experiencing the trauma through dreams, nightmares, or flashbacks” (para. 17).

Parts work refers to a group of therapeutic theories that utilize the language and techniques of parts to describe different feelings, urges, and thoughts that arise within a person’s psyche. These theoretical frameworks serve as a metaphor for ways of understanding and identifying emotions as part of a multi-consciousness (as opposed to a uni-conscious) internal psychic structure. These theories, including Internal Family Systems (IFS), Ego-States, and

Structural Dissociation, can help clients to reintegrate dissociated and often conflicting parts. Parts work theories are systemic models that “attend to both the interpersonal and the internal experiences of every person in a system” (Wilkins, 2007, p. 41). Parts work understands that within the system, each person is comprised of various parts (or distinct inner voices), under the leadership of the adult self, also referred to as the authentic Self in Internal Family Systems Therapy (IFS). The parts within a person may conflict with one another, as polarization might occur between members of any system who are in conflict (Wilkins, 2007). Extreme parts emerge during highly stressful or traumatic experiences, often very vulnerable, child-like parts (called “exiles” in IFS) that try to stay hidden, parts that seek to comfort and protect vulnerable parts using control (“managers”) as well as fight-or-flight parts (“firefighters”) that seek protection for the vulnerable though often in self-sabotaging ways (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2019). This model seeks to “help a person successfully manage these parts through Self-leadership” (Wilkins, 2007, p. 41). The Self is distinguished from extreme parts and can relate to and distinguish itself from the parts, enabling them to respond appropriately and safely to external stimuli. Using parts work with survivors of sexual trauma, particularly those who are members of a minority group, can “provide openings for clients to explore the ways that they have been socialized to suppress parts of themselves that are not useful to them as a result of their membership in a marginalized community” (Wilkins, 2007, p. 44). Parts work can also provide a sense of safety to explore vulnerable parts of the self in a non-threatening manner.

Art therapy can provide an avenue to re-access and reintegrate overwhelming traumatic images (Howard, 1990). Clients are invited to transform the traumatic mental images in their own artwork. For example, veterans may be guided to transform images of life-threatening

memories by depicting themselves seeking help, finding escape, or dismantling bombs. Using this transformative arts-based process, clients may be able to increase their range of tolerance for feelings and memories associated with the traumatic event. Art therapy can assist in “restoring continuity between image and feeling” (para 24) and integrate one’s traumatic experience into their lives.

In this thesis, I will discuss the symptoms and common clinical themes afflicting victims of sexual violence. Recent advances in the mental health field have shown clinicians the pervasiveness of the issue and given the field the opportunity to utilize and expand the use of effective trauma-informed practices. In my development of a method, I will explore utilizing the theoretical framework of parts work in combination with art therapy interventions.

Literature Review

The following literature review discusses current related research on sexual trauma’s psychological, sociological, and physiological effects, as well as trauma-focused art therapy methods, along with a review of several parts work theories and their efficacy in trauma work.

Effects of Sexual Trauma

Post-traumatic stress is the traumatic stress response that persists following a traumatic incident, which may elevate to a level of clinically significant daily dysfunction in some but not all incidences (Rothschild, 2000). Post-traumatic symptomatology varies in intensity, complication, duration, and onset depending on variables specific to the survivor, characteristics of the traumatic event, and how the survivor’s surrounding supports respond to their post-traumatic presentation (Briere & Scott, 2012). Trauma responses fall into three major categories: depressive disturbance, anxiety, and stress disorders. Depressive disturbances may include major depression, psychotic depression, and traumatic grief. Anxiety disorders may be marked by panic

attacks or the development of specific phobias. Stress disorders, namely post-traumatic stress disorder (PTSD), Acute Stress Disorder (ASD), and more rarely Brief Psychotic Disorder with Marked Stressor, differ from anxiety and depressive disturbances in that they are comprised of features including avoidance of trauma-related stimuli, intrusively reexperiencing a traumatic event, efforts to numb emotions, hyperarousal, or hypo-arousal, hyperreactivity and hypervigilance (Blevins et al., 2015; Briere & Scott, 2012).

Sexual violence can be a complex traumatic experience due to the relational nature of the traumatic event itself. Sexual violence, intimate partner violence, rape, incest, or molestation is much more likely to occur between a perpetrator and victim who know one another, including within families. Of juvenile victims in 2000, 93% knew the perpetrator and 34% of perpetrators were within their family (Bureau of Justice Statistics, 2000, 2017). Sexual violence “call[s] into question basic human relationships. [It] breach[es] the attachments of family, friendship, love, and community. [It] shatter[s] the construction of the self that is formed and sustained in relation to others” (Herman, 2015). The damage to relationships is a primary, not a secondary, effect of trauma. It not only impacts the psychological structures of the self, but also the systems of attachment and meaning linking the individual and community (Herman, 2015).

When experiencing perceived danger, the body releases a flood of hormones including adrenaline, critical to helping the body in a self-preserving fight or flight response (Van der Kolk, 2014). Under normal conditions, individuals respond to danger with this heightened stress response and the body returns to normal; however, in the case of those with repeated exposure to potentially traumatizing events, the body does not return to baseline and responds “quickly and disproportionately in response to mildly stressful stimuli” (p. 46). The long-term effects of this heightened state of arousal are significant: poor long-term health outcomes, memory and

attention deficits, irritability, and sleep disturbance to name only a few (Van der Kolk, 2014; Voith et al., 2020).

According to research conducted by the U.S Department of Health and Human Services, Centers for Disease Control and Prevention, and Kaiser Permanente in their seminal 1995-1997 study surveying over 17,000 adults in the United States, violence and co-occurring adverse childhood experiences are correlated with negative health outcomes and high rates of revictimization later in life (Grady & Levenson, 2021; Petruccelli et al., 2019; Voith et al., 2020). Additionally, the study, supported subsequently by many other research efforts, indicates the vast pervasiveness of adverse childhood experiences and potentially traumatic experiences amongst the adult population of the United States (Grady & Levenson, 2021; Herman, 2015).

While there are currently no clear answers regarding the question of revictimization and perpetration, there are several theories. Van der Kolk (2014) postulates that with the gradual adjustment to discomfort and even terror with repeated exposure, individuals begin to normalize, and then crave, the familiar pattern of engagement with their environment. In a study with Vietnam veterans, Van der Kolk observed the release of “morphinelike substances manufactured in the brain,” (p.33) when veterans were exposed to graphic scenes of war and concluded that strong emotions can block pain. He suggests that for trauma survivors, the “reexposure to stress may provide relief from anxiety” (p.33).

Voith et al. (2020) facilitated a study that sought to evaluate the interconnection between victimization and later perpetration in college aged men. In their report, “Extending the ACEs Framework: Examining the Relations Between Childhood Abuse and Later Victimization and Perpetration with College Men,” the authors administered a battery of standardized questionnaires to 423 college men (2020). Using an anonymous web survey, the authors

collected self-report data to evaluate the potential relationship between the following three experiences amongst the male participants: childhood victimization, adult victimization, and adult perpetration (Voith et al., 2020). Victimization and perpetration are defined as consisting of physical, sexual, and psychological violence. According to the data collected and measured using the Revised Conflict Tactics Scale and the Sexual Experiences Survey (Short Form Victimization and Short Form Perpetration), 27% of the male participants self-reported polyperpetration (two or more types of perpetrations of violence), 43.5% reported polyvictimization (two or more types of victimization), and 60% reported experiencing victimization as well as engaging in perpetration in the past year (2020). Research prior to this study identified links between childhood abuse and adult male intimate partner violence perpetration and adult perpetration of sexual violence. One such study using discourse analysis with adult sexual offenders indicated that 63% of adult male offenders interviewed had experienced psychological abuse, 61% had experienced child physical abuse, and 33% had experience child sexual abuse. These results indicate that the higher exposure to physical, sexual, and emotional abuse in childhood correlates with higher rates of violent experiences as an adult, both in victimization and perpetration (2020).

A second study aimed to investigate the intergenerational prevalence of sexual violence in childhood. The study considered the how likely women who were sexually abused as children were to have their own children be sexually abused. In a sample of 123 mothers, 41 had children with documented reports of childhood sexual abuse and 82 had children who were not sexually abused (Wearick-Silva et al., 2014). The mothers of sexually abused children “had significantly higher scores” (p. 119) on the Childhood Trauma Questionnaire – Short Form (CTQ), as well as on subscales of sexual abuse, physical abuse, emotional abuse, physical neglect, and emotional

neglect as compared to mothers of non-sexually abused children. According to the data collected, the authors report that higher scores on the CTQ “significantly predicted the status of being a mother of children exposed to sexual violence” (p. 119) in this sample. Wearick et al.’s research indicates the importance of early intervention and consideration of intergenerational trauma in the treatment of both child and adult survivors of sexual violence.

Art Therapy and Trauma

Art therapy is a modality within the creative arts therapies that engages clients in nonverbal visual expression through a variety of media including but not limited to photography, painting, drawing, and three-dimensional materials such as clay. Different qualities in these materials can engage various parts of the brain, facilitating targeted therapeutic experiences and outcomes depending on client needs (Hinz, 2009). Therapeutic art products can be understood as external representations of internal reality, making explicit what has been implicit (Braus & Morton, 2020). Art therapy can help facilitate the expression of subconscious, suppressed or preverbal memories, and therefore can act as the bridge between the client’s subconscious and conscious, and between client and therapist (Rubin, 2010).

Researchers and practitioners in recent years have developed a growing body of evidence for the efficacy and applications of arts-based interventions with clients with traumatic experiences (Murray et al., 2017). Themes of arts-based interventions applied to various groups of trauma survivors include giving voice to the experience, sharing one’s narrative, engaging in self-expression without necessarily verbalizing, offering containment for difficult content and emotions, fostering a practice of self-care, and lastly, facilitating social connection and support (2017). Studies indicated that the use of art therapy with trauma survivors can lessen intensity of symptoms of anxiety and improve overall self-concept (Rowe et al., 2017).

Post-traumatic imagery, or “mental contents that had sensory qualities, which distinguished them from mental activity that was purely verbal or abstract” (Howard, 1990, para. 15) is central to PTSD, as is affective repetition and a myriad of defensive efforts. Howard (2017) argued that there appears to be a polarity of traumatic imagery in survivors; that the imagery is either very intense or absent altogether. According to Howard, “the self dissociates during trauma,” (para. 17) helping the brain to bear the intolerable. These “dissociated parts of the self” (para. 17) may at times, appear to “break through” (para. 17) into full consciousness unexpectedly, though likely triggered by internal or external stimuli (1990). The client may attempt to keep these dissociated parts out of consciousness, reducing their ability to symbolize, verbally express emotion, or dream, because, the author states, “linking affect to cognition may lead to re-experiencing the trauma through dreams, nightmares, or flashbacks” (Howard, 1990, para. 17).

Art therapy can provide an avenue to re-access and reintegrate these overwhelming traumatic images (Howard, 1990). Clients are invited to transform the traumatic mental images in their own artwork. For example, veterans may be guided to transform images of life-threatening memories by depicting themselves seeking help, finding escape, or dismantling bombs. Using this transformative arts-based process, clients may be able to increase their range of tolerance for feelings and memories associated with the traumatic event. Art therapy can assist in “restoring continuity between image and feeling” (para. 24) and integrate one’s traumatic experience into their lives.

According to Pliske et al. (2021), play and expressive therapies can serve as protective factors for children who live through ACEs. It is well documented that children who are exposed to a high number of ACEs are likely to suffer from negative health outcomes as adults.

As part of Pliske et al.'s (2021) study, participants were asked to create a family play genogram, a visual representation of complexities and "a gateway for emotions to emerge about family members' personalities and experiences" (p. 244) including abuse, neglect, and uncertainty. The play genogram involved selecting toys or characters to represent family members and placing them in relation to one another on the written genogram map.

Participants in this study indicated that the play and arts treatment provided "a context for identity formation and integration of emotion and cognitive process in relation to early trauma" (Pliske et al., 2021, p. 244). Clients also described the "activating therapeutic powers of play" (p. 244) that facilitated emotion catharsis, self-expression, stress management and creative problem-solving. Play and art both offer somatic experiences as well as cognitive engagement, offering a holistic treatment modality.

Malka (2019) sought to explore methods of art making as a means of communicating during therapy with young children exposed to intimate partner violence (IPV). IPV is an umbrella term for several types of spousal violence, including but not limited to physical, verbal, and psychological abuse, coercive control, and sexual abuse. Children may be exposed to IPV by overhearing, seeing the abuse occur or seeing its effects later, or by being a direct target of violence (2019). Art interventions can facilitate direct and indirect communication between children and therapists (Malka, 2019).

A child survivor's cognitive and behavioral coping patterns are a result of how they remember traumatizing events and how that child integrates those memories (Malka, 2019). Future ability to adjust is impacted by early exposure and memory processing. Children with early violence exposure experience a negative effect on their sense of self and self-worth,

interpersonal relationships and attachment, and increased sense of alienation, helplessness, and guilt (2019).

Using visual art modalities with children can enhance various levels of communication: conscious, unconscious, symbolic, cognitive, and emotional. It can be both a diagnostic tool as well as a therapeutic one. According to Malka (2019)

Art serves as means to for children exposed to traumatizing events... to express a range of emotions and memories associated with their traumatizing experiences, as well as process and cope with such incidents, and the effects on their psyche. Art has been found effective as a vehicle for children to express their traumatizing experience when struggling to speak of them directly. (p.186)

The author goes on to describe six case vignettes that span the course of treatment at a domestic violence clinic (Malka, 2019). At the time of therapy, the child's mother was also in treatment at the center, and the parents were undergoing a divorce. The six vignettes demonstrate the evolution of the child's processing and meaning making within the therapeutic relationship. At the start of therapy, Malka (2019) discusses the youth's resistance to engage with the therapist and eventual explosive disclosure that adults "don't understand children" (p. 188). The youth went on to develop a comic depicting characters engaged in name-calling and knife fights to teach the therapist "how dangerous life is" for children (Malka, 2019, p.188). The child expressed several other dysregulated and destructive episodes in therapy, which the therapist contained appropriately. Through these early interventions, the child was able to establish trust in the relationship and learn that while her anger is an important feeling, it could also be appropriately contained to keep herself and others safe. After early symbolic play and drawings in therapy, the child was able to move towards direct verbalization of traumatic memories and

content. In the final phase of treatment, the youth began to develop her identity outside of the victimization (Malka, 2019).

Parts Work

Parts work refers to a group of therapeutic theories that utilize the language and techniques of parts to describe different feelings, urges, and thoughts that arise within a person's psyche. These theoretical frameworks serve as a metaphor for ways of understanding and identifying emotions as part of a multi-consciousness (as opposed to a uni-conscious) internal psychic structure. Different theories stipulate that parts may serve certain roles or functions, that parts may have arisen at specific times in life, and that those parts can communicate with one another. Shapiro (2016) describes parts as having an age:

For every age and learning situation, we develop neural pathways. We've got them for right now, and all our current experiences, and we have them for every age and everything we've learned. Sometimes old pathways arise, and we feel and do things that belong to the past, when the more current ones might work better. [Parts] work gives us a way to connect the 'right now' parts of our brains with the 'back then' parts so that you are feeling and doing what's right for 'now.' (p. 19-20)

Several theoretical frameworks that utilize the concept of parts work include Internal Family Systems Theory (IFS), Ego-State therapy, and Structural Dissociation. Because these theories have significant overlap and support one another foundationally, I will primarily focus my literature review on the framework of Internal Family Systems while also drawing on research by Shapiro (2016) and Fisher (2017) to support these findings. Table 1 delineates the differences between these three parts work theories that this thesis draws upon.

Ego states, or parts, are “bundles of neural connections that hold consistent patterns of information, affect, attention, behavior and sometimes identity, which belong to specific developmental ages or situations” (Shapiro, 2016, p-). Trauma survivors often present as fragmented in their sense of self (Brown, 2020). This phenomenon is referred to as dissociative splitting, different from dissociative identity disorder, and is considered a normal component of the trauma response, allowing the individual to “survive in a precarious environment through the use of cognitive dissonance” (Brown, 2020, p. 114; Fisher, 2017). For example, when children are the victims of abuse and neglect, especially if the primary caregivers are the perpetrators, they need enough psychological distance from traumatic events in order to avoid becoming overwhelmed (Fisher, 2017). Preserving any sense of self, self-esteem, attachment to caregivers or family, or hope in the future, requires the child to disconnect from what occurred, and doubt or disremember the events (Fisher, 2017). In this process, the child may disown the “bad [victim] child” who endured the abuse and understand them as “not me,” thereby fragmenting the self in order to survive (Fisher, 2017, p. 19). Once this fragmentation occurs, the individual might develop a “going on with life” (2017, p.19) self who is able to engage in basic day-to-day survival and functioning; however, the dissociated child parts may arise in situations of stress, activating the needed protective parts.

Theory	Key Figures	Main ideas
Structural Dissociation	Janina Fisher	A traumatized person contains fragmented, dissociated parts of the self. Fragmentation occurs in an attempt to protect the self and go on with life (Fisher, 2017).
Ego-State Therapy	John and Helen Watkins	Parts are bundles of neurological pathways influencing cognitive, emotional, and behavioral patterns that belong to developmental stages and life events (Shapiro, 2016).

Internal Family Systems Therapy	Richard Schwartz	Parts fall into three categories: exiles, managers, and firefighters. Exiles are the vulnerable parts while managers and firefighters are protective parts. The goal of IFS is Self-Leadership (Anderson et al., 2017).
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*Table 1****Internal Family Systems Therapy***

Internal Family Systems (IFS) theory, an evidence-based treatment, focuses on the network of internal relationships in which each ego state or part is embedded (Brown, 2020). The framework builds upon Bowen's Family Systems model that asserts that family members engage in roles that impact and maintain one another's behaviors. Bowen asserts that a normal, or healthy family system is comprised of appropriately differentiated members. Similarly, in IFS, the multi-conscious individual's family of parts must move from enmeshment (or blended parts) to differentiation; holding in balance the need for togetherness and separateness (Fisher, 2017; Nichols & Davis, 2019; Schwartz, 2021). Similarly, as with family therapy, "for any one family member to change, the entire family system must change" (Brown, 2020, p. 113).

IFS is a systemic model that "attends to both the interpersonal and the internal experiences of every person in a system" (Wilkins, 2007, p. 41). The theory's framework stipulates that within the system each person is comprised of countless parts (or distinct inner voices), who "interact internally with each other and externally with other people" (Anderson et al., 2017, p. 3) under the leadership of the authentic Self. The Self is the core resource, not a part, characterized by balance, curiosity, and compassion (Anderson et al., 2017). The parts within a person may be in conflict with one another, as polarization might occur between members of any system who are in conflict (Wilkins, 2007). Extreme parts emerge during highly stressful or traumatic experiences, often very vulnerable, child-like parts (exiles) that try to stay hidden for

safety, parts that seek to protect vulnerable parts (managers), and some parts that seek protection for the vulnerable though often in self-sabotaging ways (firefighters). These parts are often frozen in frightening moments in the past and carry the burdens of the time of the memory (Schwartz, 2021). IFS seeks to “help a person successfully manage these parts through Self-leadership” (Wilkins, 2007, p. 41). The Self is distinguished from extreme parts, can relate to, and distinguish itself from the parts, enabling the Self to respond appropriately and safely to external stimuli.

In Wilkin’s 2007 qualitative article, “Using an IFS Informed Intervention to Treat African American Families Surviving Sexual Abuse: One Family’s Story,” the author outlines a case study using an IFS model with a single parent and her daughter who has experienced sexual abuse. The author posits that using the IFS model can challenge issues of power, privilege, and oppression in the therapeutic space.

An individual’s internal system is impacted by macro-systems including social, political, and cultural systems. Parts work provides a culturally informed and sensitive therapeutic intervention if therapists tap into the macrosystems affecting client’s individual and generational histories.

Regardless of race and culture, sexual violence has been repeatedly shown to have grave effects physically, mentally, and emotionally on survivors and their families in the short and long term (Wilkins, 2007). However, racial and ethnic minorities in the United States are at greater risk for victimization and the negative repercussions due to systems of inequality and barriers to access to support services, legal aid, and more. Additionally, according to Wilkins (2007), African Americans survivors’ clinical presentations are often further complicated by symptoms of depression, dissociation, and anxiety, which may be more prevalent due to preexisting racial

trauma. Wilkins (2007) discussed the historical context of sexual abuse during American slavery, as it was a diffuse method of intimidation and control perpetrated by White participants in the slave trade. Remnants of this historical context continue to impact Black women's experiences through "multigenerational transmission of the effects of sexual trauma" as well as by American cultural norms that stereotype Black women as promiscuous, angry, strong, invincible, and matriarchal (Wilkins, 2007, p. 40). To provide treatment for African American women recovering from sexual trauma, "therapists must understand damaging fictional ideas that have been perpetuated since the time of slavery" (Wilkins, 2007, p. 44).

Using IFS with adult survivors of sexual violence and racial minorities can "provide openings for clients to explore the ways that they have been socialized to suppress parts of themselves that are not useful to them as a result of their membership in a marginalized community" (Wilkins, 2007, p. 44). IFS can also provide a sense of safety to explore vulnerable parts of the self in a non-threatening manner. Schwartz (2021) describes the liberating effects of compassion towards parts as learning to establish "a new, loving relationship with them and help them transform" allowing the parts to "become wonderful companions, advisors, and playmates" (p. 39). Once clients can unblend with parts, they become much less threatening and the individual can become "a good inner parent" (Schwartz, 2021, p.39), giving activated parts love and appropriate boundaries when needed. This element of self-compassion is empirically correlated with reduced symptoms of anxiety and depression, as well as improved reports of life satisfaction, psychological wellbeing, and social connection (Braus & Morton, 2020).

Wilkins (2007) presented a case study that discusses a single mother and her seven-year-old daughter who had recently been molested by a close family friend. Both caregiver and child entered each therapy session "perfectly coiffed," discussing how everything was "fine," and

emphasizing significant improvement since the previous session (Wilkins, 2007, p. 47).

However, this was incongruent with the mother's frequent expressions of tears and grief, difficulty discussing the traumatic incident and, according to Wilkins, indicated a façade of strength due to cultural norms and societal pressures that depict Black women as "strong" and able to endure great hardship in silence. The child engaged in avoidant behaviors and sought to comfort and protect her mother from her own abuse, acting as the caregiver for her mother's emotional pain.

The therapist invited the mother to externalize her inner pain by coming to therapy dressed as she internally felt. The therapist facilitated a conversation with the mother's exiled parts that held deep and vulnerable pain while she looked at herself in a mirror. The client was able to express vulnerable feelings of guilt and shame, which contrasted the historical legacy of suppression of inner turmoil, inability to safely express psychological distress following sexual violence, and a cultural legacy of avoiding expressions of vulnerability (Wilkins, 2007).

In sum, the literature supports the efficacy of internal family systems therapy and parts work for the use of alleviating symptoms related to traumatic stressor related disorders due to sexual violence. Additionally, art therapy, a nonverbal modality that engages multiple developmental levels and physiological elements within a person, has been shown to improve treatment outcomes, reduce symptoms, and improve overall self-concept and psychological well-being in trauma survivors across the lifespan. Given the many theoretical applications of art therapy, utilizing this modality with parts work offers immense potential in the field. I will next discuss how I combined art therapy and parts work methodology in the treatment of trauma survivors at an outpatient level of care.

Methods

Therapeutic interventions integrating parts work and art therapy were implemented with adult and child survivors of sexual violence through the following methods.

Setting and site processes

Clients in this study received therapy services at a grant-funded out-patient level of care clinic in a large Midwestern city in the United States. The clinic was part of a national non-profit organization that provided many services to families including vocational training, economic empowerment, and children's programs, as well as education in schools and businesses in the community. The counseling branch of the organization was under the umbrella of Sexual Violence Support Services. These services were comprised of medical and legal advocacy, a 24/7 Rape Crisis Hotline, case management, and trauma therapy services for survivors and their non-offending significant others. The counseling services had three locations across the city to increase accessibility for vulnerable populations. Services included individual therapy, family therapy, and group therapy. Sexual Violence Support Services were free of charge to clients.

The first two weeks of the study were primarily spent in training. After becoming familiarized with the policies, procedures, and expectations of the clinic, I was assigned to the eight clients included in this study. Prior to the therapist assignment, clients engaged in an intake process which was comprised of a phone screen to assess appropriateness for services and obtaining consent for services. Phone screens also gathered demographic information and general facts regarding the identified sexual trauma.

Surveys and data collected

Upon first meeting clients, I administered several surveys to collect baseline data for client emotional, interpersonal, physical, and behavioral functioning. Adult clients were also

administered the Post-Traumatic Stress Disorder Checklist for the Diagnostic and Statistical Manual of Mental Disorders, fifth addition (PCL-5), a 20 item self-report assessment in which clients rank the severity/frequency of PTSD symptoms. Additionally, I administered the Dissociative Experiences Scale (DES), a 28 item self-report questionnaire that asks clients to rate how often a given dissociative experience occurs on a scale of 0 to 100 percent of the time, to two adult clients who demonstrated dissociative symptoms. Child clients were given the Center for Epidemiological Studies Depression Scale for Children (CES-DC), a 20 item self-report assessment that asks children to rate symptoms associated with depression within a one-week period from the time of assessment. As services were grant-funded at the site, no formal diagnosis was given to clients. Client symptoms and presentation at this organization were conceptualized as a normative response to traumatic events, rather than an abnormal, disordered response. However, the PCL-5, DES, and CES-DC offered a reliable and valid scale, giving clinicians valuable information regarding clients' baseline functioning and change over the course of treatment.

After surveys were completed, clients developed a service plan in conjunction with their therapist. Service plans reviewed the self-reported emotional, interpersonal, physical, and behavioral concerns clients noted in their surveys, and invited clients to set goals.

Participants

Eight participants were included in this study. Five individuals were adult survivors of adult and/or child sexual abuse. In addition, these individuals had had multiple traumatic exposures across the lifespan which cumulatively included sexual assault, sexual abuse, intimate partner violence, homelessness, financial abuse, early separation from primary attachment figures, and child abuse and neglect. Two of the five adult clients voluntarily participated in

group art therapy in addition to individual work. Three of the participants in the study were children and suffered traumatic experiences of a) directly experiencing child sexual abuse b) learning of the sexual abuse of a sibling by a known perpetrator or c) learning of the sexual abuse of a sibling perpetrated by a primary caregiver. Each participant voluntarily sought services at the organization and agreed to weekly therapy. Child clients also received parent/guardian consultations and occasionally family therapy as requested.

Participants indicated on self-report client surveys several primary themes. Four out of five adult participants reported difficulty with eating and feeding, two of whom struggled with restricting, and two of whom struggled with bingeing. No clients reported purging behaviors or met criteria for admittance to an eating disorder program. One adult client reported episodic feelings of unreality and all adult clients reported some dissociative symptoms. The DES was administered to two clients. Both clients reported dissociating on average 40% of the time. Four of five adult clients reported symptoms of fragmented thoughts, difficulty focusing, distractibility, and periods of low motivation. All five adult clients reported intrusive thoughts, flashbacks, episodes of dissociation, confusion, distractibility, and hypervigilance.

All child clients reported feelings of responsibility and guilt regarding the abuse and demonstrated difficulties in attachment with primary caregivers. Two children reported wanting to run away. One child client disclosed problem sexual behavior. One child client reported hearing voices, suicidal ideation, and delusional thinking.

Other clinical themes amongst child and adult clients included feelings of isolation, guilt, and shame. Most adult and child clients reported sleep disturbance. Most clients identified goals of learning to trust themselves to decipher safe versus unsafe people and situations, to reduce feelings of overwhelming anxiety and sadness, and increase ability to regulate emotions. Three

of eight clients reported intense feelings of anger and irritability. All adult and child participants reported difficulty trusting others, feelings of sadness, anxiety, and low self-worth. All clients reported difficulty communicating with family and friends. All clients presented with a labile mood and reported incidences of anhedonia and either hypersomnia or hypsomnia.

Theoretical Approach

The theoretical framework utilized in the therapy sessions draws from multiple sources. First, a Rogerian client-centered disposition that allows the client to steer the session, secure in the understanding that they will receive unconditional positive regard from the therapist was embraced. Second, a relational, trauma-informed approach that stipulates that the quality and connection of the therapeutic relationship is both the primary method of understanding the client and their interpersonal relationships outside of therapy, as well as the primary method of healing was also a foundational method used (Yalom, 2002). As sexual violence occurs in the context of relationships, healing must therefore take place within relationships (Herman, 2015). Third, a parts approach informed by IFS, Ego-States and Structural Dissociation facilitated an understanding of clients' internal structure, inner-conflicts, and reactivity to specific stimuli. Art therapy was the underlying method through which therapeutic interventions flow.

Figure 1 demonstrates how I conceptualized parts work with a traumatized client. The client experiences an activating or triggering event. To another person, the event may seem innocuous; however, the client experiences a significant reaction. In the example in Figure 1, the client's protective parts react in one of three ways, fight, flight, or freeze. Due to the traumatic event, the client's nervous system is in a state of hyper or hypo-arousal. This state of hypervigilance means that the client's cortisol levels are high, and they are less likely to function using their frontal lobe, through their authentic Self-leadership (Schwartz & Sweezy, 2019; Van

der Kolk, 2014). Reactive parts, such as those that seek to protect the individual from danger by extinguishing emotional pain (in IFS these are referred to as “firefighters”), are on high alert. Sensing that danger may be present, such as abandonment in this example, the firefighters engage using the base, evolutionary processes available to that part (Schwartz, 2021; Van der

Figure 1



Kolk, 2014). This diagram does not address the other type of protective parts called the “Managers” in IFS. Managers are proactive helpers who focus on functioning, preparation, and vigilance to prevent the system from being flooded with emotion or triggered by exiled parts (Anderson et al., 2017). Fisher (2017) also refers to these parts as the “going-on-with-life” parts.

Fight, flight, and freeze can take on many more forms than the example below depending on what parts are activated

and when those parts first learned they could be effective at coping (Schwartz, 2021; Van der Kolk, 2014). Underneath the Firefighter's protective behavior is a vulnerable, young, and exiled part that feels afraid, sad, and in need of protection and comfort (Anderson et al., 2017; Schwartz, 2021).

Figure 2

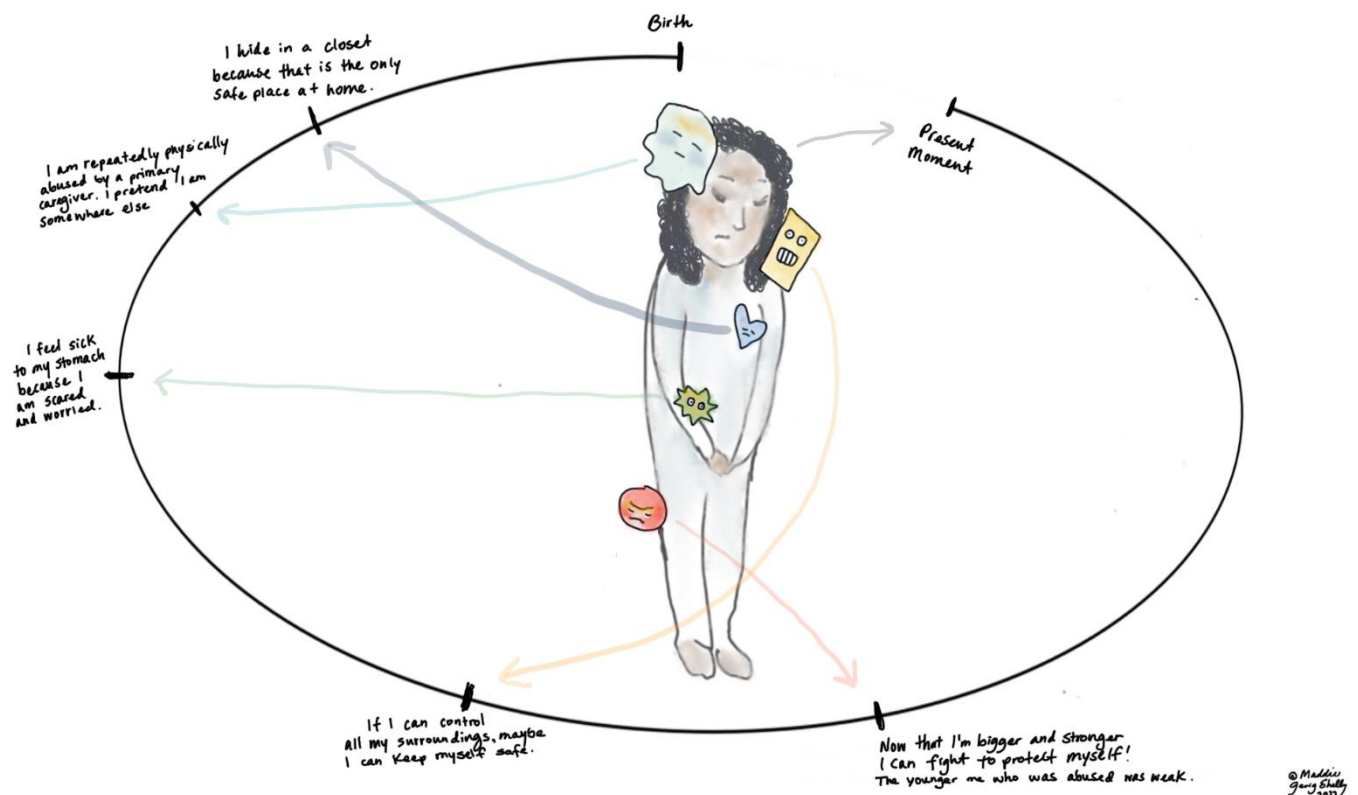
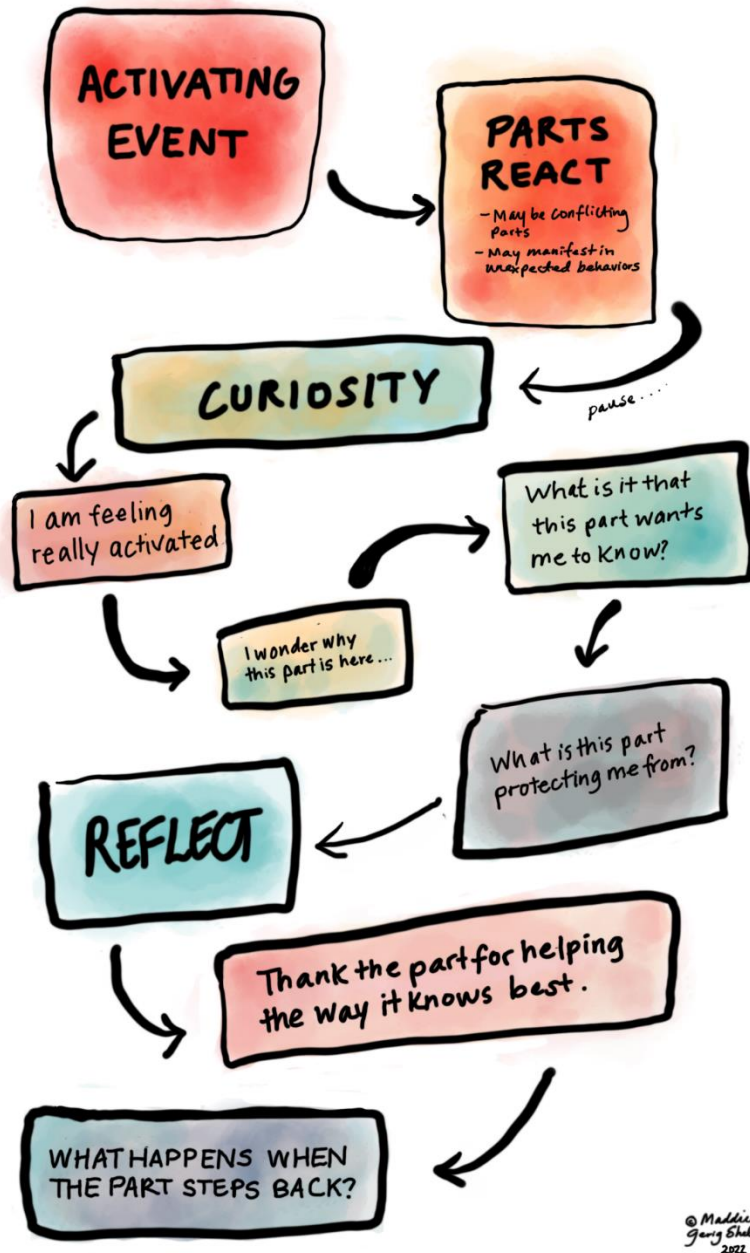


Figure 2 demonstrates the concept that parts develop during critical life experiences.

Parts are bundles of neurological pathways that develop in response to stimuli and represent the brain's best attempt at coping with stressors at the time (Shapiro, 2016). For example, a scared child might hide in the closet in order to achieve a feeling of safety in an unsafe home. However, when an adult hides in a closet, it is not the most effective strategy of coping with stimuli that the individual perceives as dangerous. It indicates that the individual is back in fearful child mode,

enmeshed with the child part. New developmentally appropriate strategies for coping with perceived danger are indicated.

Figure 3



In Figure 2, the symbols placed on the clients' body represent the activated parts stored as physical triggers connected to the traumatic events in which these parts originated. In using IFS language, I would refer to the sad and dissociative parts as the exiles, and the anxious and angry parts as protectors. The anxious part may present as a manager, and the angry part may present as a firefighter, depending on how the emotion manifests in client behaviors.

The therapeutic purpose of these interventions is to help

clients move from enmeshment with the activated part towards reflective distance. A flow chart of this movement is demonstrated in Figure 3. Once reflective distance is achieved, the client can act as the autonomous differentiated self, able to examine activated parts and care for them, just

as a loving parent might. Moving from enmeshment, or, as Schwartz calls it “blended parts,” towards differentiation is crucial for trauma survivors, as many report feeling stuck in cycles of reactivity and patterns of destructive behavior, unable to gain relief (Fisher, 2017; Herman, 2015; Schwartz, 2021).

Procedure

The clients in this study engaged in weekly individual therapy and some also participated in trauma-focused group treatment during the study. Individual sessions were conducted through a mix of in-person and virtual services.

Before entering each session, I reviewed previous therapeutic work and client goals and considered how I could shape the session to enhance the client’s strengths, moving towards the outcomes they wished to see.

Interventions

Before artmaking took place, I first helped the client identify parts. During a session, as a client would begin to describe an event or issue from the previous week, I wondered with them, “which parts do you think were activated in that situation?” or “which parts are present right now as you are telling me this story?” I then invited the client to increase the level of reflective distance between themselves and the part by asking questions such as, “How do you feel towards that part?” and “Do you think you understand why that part feels that way or behaves that way? Could we find out?” These questions were intended to help the client unblend with activated parts and adopt a stance of curiosity. I might also invite other parts into the room by asking “Are there parts that disagree with this part?” or “Do you notice any other parts?” (Anderson et al., 2017). On one occasion, a client became increasingly angry in session. I noted, “it sounds like an

angry part has joined us!” This prompted the client to laugh at herself, a brief interruption that broke the familiar pattern of protection and escalation.

The next step was to transition between internal imagery of parts to externalization. One way to accomplish this was to engage in a guided visualization. I assessed whether this was clinically indicated based on the client’s level of regulation in the session. If the client was feeling anxious or unfocused, a visualization prior to engaging in art making to assist in concretization of mental images was appropriate. However, if a client appeared dysregulated or flooded, a visualization may have pushed the client outside their window of tolerance, and a grounding exercise that incorporated here-and-now experiences, including the five senses and breathwork was a better fit.

One of the primary visualization exercises I utilized was based on the concepts of direct access, resource installation, and life-span integration (Shapiro, 2016). I began by inviting the client to consider a time when they felt strong, engaging with in the senses to concretize this mental image into a here-and-now physical sensation (2016). I then invited the client to visualize the young, vulnerable part related to the traumatic event, their age, and their feelings at the time. I invited the client to imagine their strong part taking the vulnerable part out of the dangerous situation and into the therapy room or other identified safe space.

After exploring the parts verbally and through visualization if indicated, I invited clients to depict the parts using materials I gathered for the session (discussed further below). The following are six art directives developed to facilitate image making of parts:

1. *Depict strong part and vulnerable part.* This directive is used in conjunction with the visualization described earlier in which the client’s identified strength pulls the vulnerable part out of the traumatic experience. Create two side by side 5x7 canvases

- for the client using masking tape on the same piece of paper. Depict the strong part on one side and the vulnerable part on the other.
2. *Depict polarized parts.* Polarized parts are in an adversarial relationship. They are in conflict regarding how to manage an exiled part (Anderson et al., 2017). Create two side by side 5x7 canvases for the client using masking tape on the same piece of paper. Invite the client to depict the conflicting parts, one on each canvas. Invite the client to title each image.
 3. *Self and Activated Part.* Create an image showing the relationship between the Self and the activated part. The client may depict themselves as enmeshed, close to, intertwined, or far away from the part. This image gives the client and therapist the opportunity to explore the feelings towards the part and identify what the part and the Self may need.
 4. *Protector and Exile.* Invite the client to create two boxes – a small box within a larger box on a piece of paper. This can be done through drawing boxes or by using a resist such as masking tape. Invite the client to depict the protective part(s) in the outside square and the vulnerable part or exile inside the smaller box in the middle. Invite the client to explore if the protective part is helping the vulnerable part, what each part may need, and how the client might care for each part.
 5. *Conference Table.* Invite the client to depict a large table. Ask the client to depict identified parts and the client's Self at the table. Consider where parts are in relationship to one another.
 6. *Safe Place.* Create an image or three-dimensional object of a real or imagined place that offers safety to the vulnerable parts. Invite the client to consider what the parts

might need or want in order to feel comfortable or joyful. This image or object can be a place to return to, or return parts to, when the client needs to set aside the pain or activation of certain parts.

Table 2 describes when these different interventions may be clinically indicated, and the purpose of each intervention.

Intervention	Clinically indicated when...	Purpose
Depicting the strong part and vulnerable part	-Client needs to concretize mental images from guided visualization involving resource installation and lifespan integration	-Identify strengths -Let vulnerable part know that the trauma is over -Orients client to present safety and Self-Leadership
Depicting Polarized parts in a diptych	-Two conflicting parts are struggling to take charge	-Explore conflicting feelings -Both parts are heard -Examine usefulness of part behavior
Relationship between Self and Part	-Client appears blended or enmeshed with a part	-Examine relationship between part and Self -Empowers client to shape/change relationship between part and Self
Protector and Exile	-Client is lacking in compassion towards vulnerable and/or protective parts	-Fosters self-compassion towards parts -Demonstrates adaptive qualities of protective parts -Offers containment for vulnerable parts
Conference Table	-Many parts or voices are struggling to be heard. -The client feels overwhelmed or confused by the many parts struggling to gain attention or control	-Organizing complex and conflicting emotions -All parts feel seen
Safe Place	-The client appears activated -The client is struggling to set aside painful memories outside the therapy room	-Offers containment -Gives clients a sense of safety and control in accessing or setting aside painful content -Allows distance from painful memories -reduces guilt of “leaving” parts at the end of session

Table 2

Materials

Materials choice was based on availability when utilizing video for a session. If a choice was available, or if conducting the session in person, I chose materials based on the client's emotional regulation status and known history. For clients who became flooded with memories and emotion easily, I chose materials that offered containment such as colored pencils or markers (Hinz, 2009). For clients for whom accessing emotional expression was difficult, I utilized acrylic paints or watercolors (2009). The texture and qualities of acrylic paint offered a more kinesthetic and sensory experience. Watercolors offered an affectively activating and fluid experience (2009).

Quality paper or canvas was utilized for in-person sessions when available. To provide containment for clients, I taped the edges of the paper, limiting the size of the artwork and to provide clean edges for whatever content clients produced (Hinz, 2009).

Record keeping and reflection

After sessions, my method was to complete required clinical documentation before engaging in my own written and expressive reflection of the session. Reflection artwork was developed in response to clients and their therapeutic work intermittently throughout the eight months I was engaged in treatment with them. Additionally, I met weekly with an art therapy supervisor as well as an on-site supervisor specializing in parts work, to review and discuss cases, clinical content, issues of transference/countertransference, and feedback for future sessions.

Results

The client surveys conducted with all eight clients at the start of treatment, as well as the PCL-5 and CES-DC assessments, indicated that a majority showed a reduction of intensity of

symptoms. Several clients who reported symptom maintenance simultaneously demonstrated an increased awareness regarding the symptom trigger and physiological reasoning behind the symptom. One adult client terminated services within two months of beginning treatment and was unable to engage in a termination session to determine progress and reasons for departure. Four of five adult clients reported feelings of safety and being seen within the therapeutic relationship. All three child clients reported feeling “better” after engaging in art therapy and parts work directives during sessions.

Client observations

One client, who at times spoke in a rushed, urgent tone, typically described her life events in a fragmented manner and described traumatic events with a flat affect, conveying facts and dates. Early in therapy, although committed to treatment and consistent in attendance, she resisted therapeutic interventions and often reported feeling frustrated and irritated with others. At times she was able to engage authentically: this often occurred in abrupt shifts within a session. Most of the time she presented as anxious and guarded, which I conceptualized as a potential fear of releasing the deep sadness and pain within. Later during treatment, she was able to identify that she was having periods of dissociation and dissociative amnesia, which explained some of the abrupt shifts in mood and feelings of unreality.

During a difficult but productive session in which we had discussed traumatic content, I asked this client to thank her child parts for coming to the therapy that day. The client’s demeanor shifted suddenly. She abruptly responded with a no, indicating that she was not able to thank the parts. The following session, I broached the topic. The client noted that it was difficult to extend gratitude to this part, and she was not sure why. “I wonder why there is resistance there,” I said. “Could we ask this part what she is trying to protect you from?” The client replied that the

part was not sure, indicating to me that the part was not yet accessible. She added that she thought that it was not okay to thank herself, and that particularly the young part did not deserve her gratitude. I expressed my sorrow that she had such painful thoughts towards her young self, simultaneously thinking that there was a strong protective part preventing the client from engaging with the young part. I reflected this to her. She appeared neutral and unmoved in her response, indicating that the protective part was not ready to allow for this direct access.

I invited the client to engage in a polarized image, a diptych that depicted the child part and protective part using watercolors on two side by side 5x7 inch panels on watercolor paper. In the first image, the client started by depicting a stick figure in a triangle dress with a big grin in light pink in the right half of the canvas using her right hand. She painted a sun in the upper left-hand corner, green grass beneath the figure and blue sky, all in watery, pastel colors, almost disappearing into the page. She then added in faint red, the outlines of many people in the background behind the figure. The resulting image was eerie and ominous. The shadowy figures in the backdrop of the child gave a feeling of foreboding and danger, the child's stereotyped smile a facade. The sunshine, green grass, and child's smile gave me a sense of unease and dissonance.

In the second image, the client began by depicting a small cross-legged figure in the center of the canvas using purple paint and a small brush. Then, using blue, she painted tears bursting from the figure's face, pooling below the seated figure. She then selected a larger brush and saturated it in dark, black paint. She painted a box around the figure with bold, quick strokes. She then added lines coming out of the four corners, making an image of a long tunnel. She then painted the walls of the tunnel black. This bleak image of loneliness and isolation invited me into her deep feeling of isolation and grief. The long dark tunnel aptly depicted the client's frequent

expressions of feeling stuck. When asked to title each panel, she titled them in bold, capital letters THEN and NOW.

Upon original discussion of the images, the client discussed the happiness of her early childhood and how she was surrounded by her community that she now longed for. In contrast, her protective part was the sadness and grief of her present-day life.

She revealed through her artwork that she was enmeshed with the depressed part. There was no depth, or even source of reality for the THEN image as I would come to find later. In the following session, we engaged in psychoeducation, reviewing common symptoms and patterns of behavior in trauma survivors. The client's mood shifted. She brightened, noticing her patterns, and connected these directly with her trauma experiences. I saw an opening. I invited her to notice what was happening in her body, and to place her hand on her chest above her vagus nerve (Menakem, 2017). After a pause, she stated that she was ready to talk about her childhood. She had previously referred to some of her childhood sexual experiences as being ambiguous. It soon became clear that these experiences were entirely unambiguous.

She opened with herself in college. I interrupted: "You were not a child in college. I am wondering if you are 'adultifying' your child self." She responded that yes, she was. After some fragmented stories, she would go on to disclose that her childhood was rife with sexual abuse from family, peers, and strangers beginning as an incredibly young child, and disclosed perpetration towards another child when she was little. She was then able to connect the ominous features of her "THEN" image with her trauma and note that her deep guilt and shame prevented her from having empathy for the young part.

The parts images show this subconscious, suppressed material that would otherwise not have been communicated to me or to the client. The stereotyped depiction of the child

demonstrated constriction and anxiety. The ominous figures indicated a lack of safety. The inability to have compassion for her young self is logical, considering that the client saw herself as a responsible adult as a young child, who both deserved the abuse she received and was responsible for the abuse perpetrated towards another child. Once this was established, I was able to engage further in psychoeducation with the client to foster empathy for this child part and to make sense of child-to-child perpetration. This vignette demonstrates how parts language can be translated into art therapy directives to help clients concretize internal self-beliefs and understand part to part relationships.

Another client who experienced abuse and neglect at an early age utilized parts work to revisit early periods of her life to “mother” the young parts who lacked an understanding and loving caregiver to help make sense of her experiences and emotions.

During one session, the client was describing her anxiety surrounding a new job. She was working late into the night, filled with fear that she was falling short of expectations, despite consistent, positive reviews from her supervisor. “I am wondering if the anxiety is protecting you from something. Is she here for a reason?” I asked. The client looked surprised and paused for a moment. She affirmed that yes, the anxiety was there for a reason and posited that it was there to prevent her from failing. “When did that part, the anxiety to keep working and working to avoid failure, first show up?” The client thought for a beat. She identified a young, pre-adolescent part, within the context of stressful home events. She described herself as striving hard to please her mother at this time, thinking that if only she were perfect, her mother would finally turn to her with affection. She never received this affection. She absorbed the criticism from her primary caregiver, living in a state of perpetual fear of inevitable failure.

I summarized, “It sounds like this part was trying to protect you from failure at the time, that she was working so hard for her mom to notice her. And now, the young part is helping you to work so hard, maybe too hard, so that you do not fail in this job that is especially important to you.” I invited the client to use art materials to depict her current relationship to this part. Using a purple marker, she created a quick sketch with scribbly lines of a small orb encircled by an oblong shape.

She identified the small orb as the eight-year-old and the encircling shape as her current self. This image indicated that the client was still enmeshed with the anxious, hardworking eight-year-old part that could not let herself relax for fear of messing up and falling apart. I reflected this observation back to the client. She agreed that the young part was close to her and could not be separated yet.

To begin to transform this relationship, I wanted to help the client notice that in the present moment, as an adult, the client was safe to receive positive feedback without fear of manipulation. The client needed to be reminded that this young, anxious part was only a child and needed to be loved rather than expected to take on so many responsibilities. I decided to engage the client in a direct-access visualization, taking into consideration that the client appeared well-regulated and grounded.

I invited her to bring an image of the identified young part to mind. I guided the client in envisioning how young and small this part was, and what kinds of things the part liked to do. I invited her, with her permission first, to take the hand of the child part, and take them somewhere safe. “Where would you like to take this part? Maybe here to your home so she can see all the incredible work you are doing?” The client first took the young part to her favorite neighborhood park by her present-day apartment to play, then envisioned showing the part her home and

showed her how hard she was working. “Can you tell this young part in words she would understand that you are an adult now and can work hard, and take care of yourself, so she doesn’t have to worry?” The client agreed and communicated this to her young self. I then said, “Let’s tuck her in somewhere where she can be safe so you both can get some needed rest. Where would she like to be?” The client said she loved to read and left her in a reading nook with lots of books. We then came back to the present moment and processed the experience.

I invited the client to depict the relationship again using the same materials. On the same piece of paper, with the same pen and quality of line, the client depicted the smaller orb-like figure looking up. The larger oblong shape curved over the smaller figure like a hug, but separate, gazing down towards the smaller figure. The shapes were separated by about an inch, still close, but no longer entangled.

This vignette demonstrates how this client was able to move from a state of enmeshment with her anxious young part to allowing enough reflective distance for her authentic self to mother her child part. This enabled the reactive child part to step back so that the client could function as an adult.

During the study, several other clients were noted to enlist their parts to help in daily life. One client enlisted an intense hardworking part to oversee the wind-down routine each night rather than having the part keep her entire system awake and working. Another enlisted an 11-year-old part, a tween exploring her individuality and self-expression, to help her with her creative work. One client described utilizing the “Table” directive to have council meetings in her mind with her family of parts, designating them tasks fitting to their strengths to help her in her goal of healing and healthy day-to-day functioning.

Response art

With several adult clients, it appeared to me that they craved connection and intimacy yet kept me at arm's length to protect vulnerable feelings. Figure 4 depicts my response art to one client who presented this way in the first several months of treatment. I am the blues and greens below, while the client is the glowing orb above. At her core is a bright yellow of joy and innocence that she herself cannot seem to access. This vulnerable part is surrounded by the client's deep sadness. The anxious, angry, and irritable part is protecting the client's pain.

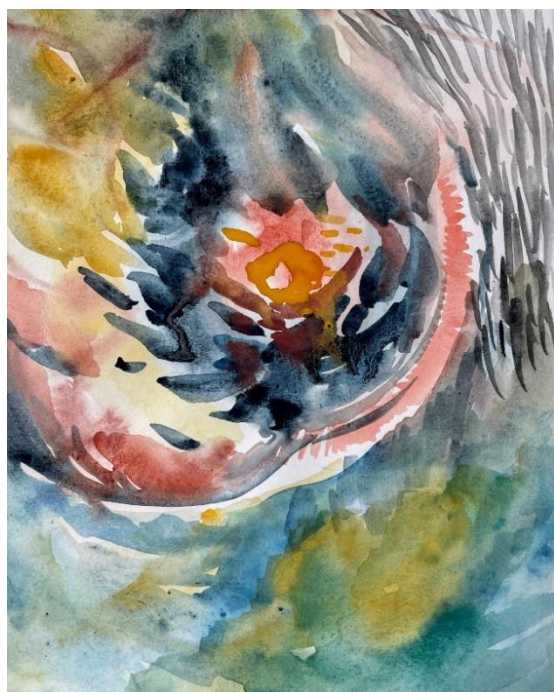


Figure 4

The response art surprised me at first. I had not realized to what extent I experienced this client's anxious presentation as an effort to keep me at bay. Her abrupt resistance to therapeutic suggestions and interventions embodied the irritability towards others in her life she frequently complained about, however simultaneously reported an unwillingness to change. These parts served an important purpose: they kept her vulnerable parts, both those of joy and pain, hidden within where she perceived their

increased safety. At one point in therapy, the client identified a memory of herself as a young child hiding in a closet. She was having intense feelings of wanting to die at the time, and although isolated and neglected in the closet, it still provided greater safety than her world outside. This hiding child part continues to be an important part of this client. The part conveys

to the rest of the system that she is safer locked in a closet of her own deep suffering than she is opening that door to let help in.



Figure 5

My response art to another client held similar themes of reaching in and supporting; however, it depicted a distinct experience of the client in the therapeutic relationship.

This client, whose traumas

were characterized by early neglect and experiences of manipulation, struggled to notice and maintain appropriate boundaries. This is demonstrative of many sexual violence survivors' difficulties with attachment and trust (Herman, 2015; Van der Kolk, 2014). Within the therapeutic relationship, this client was charismatic and sought closeness and intimacy with me, at one point referring to me as being like the mother she never had. While this statement demonstrated the level of trust that we established, in my response art I noticed themes of this desire to protect and care for her in a mothering way emerge. I felt deep grief for this person, whose colors shone so vibrantly but were dampened repeatedly by perpetrators' violations. I wished to show her the comfort and care that she was working so hard to give to herself and all her young child parts. My experience of this client informed the way I conducted therapy, helping her to provide containment, appropriate boundaries, and unconditional care for her child parts.

Potential issues

Several patterns to be mindful of while using this method emerged during the study. Particularly anxious clients at times used the curiosity and reflection technique in a way that spiraled into a pattern of insecurity and self-doubt. In these instances, in an effort to be mindful, the client was instead becoming enmeshed with an anxious, controlling part. Utilizing grounding techniques such as guided meditation and deep breathing was found to be helpful in developing and/or maintaining “bottom-up” regulation (Van der Kolk, 2014). Direct access of parts can be highly activating and coping mechanisms such as grounding are key in trauma therapy (Fisher, 2017; Herman, 2015; Van der Kolk, 2014).

Some clients used the curiosity and noticing technique as a way of avoiding experiencing difficult emotions entirely. While reflective distance and differentiation from parts is the first goal in this method, a normal range of human emotion includes anger, sadness, worry, grief, and more. It is important for these emotions to be fully expressed and cared for sensitively and appropriately (Schwartz & Sweezy, 2019). Avoidance, as discussed previously, is a frequently expressed symptom of post-traumatic stress disorder, and many clients may express this as a protective factor without realizing the part has entered the room.

Discussion

Art therapy and parts work interventions were applied over the course of eight months to eight clients, five adults and three children, at a non-profit outpatient clinic focusing on treating sexual violence survivors. Clients presented with symptoms characteristic of PTSD, including avoidance of trauma-related stimuli, intrusively reexperiencing the traumatic event, efforts to numb emotions, and hyperarousal, hyperreactivity, hypervigilance, and dissociative episodes (with or without amnesia) and/or derealization. Client self-reports indicated one of two outcomes

at the end of the study: either symptom reduction, or symptom maintenance with increased self-awareness of triggers. These results demonstrate the general efficacy of the interventions and therapeutic approaches utilized and discussed in this thesis.

Several clients responded to the parts work in different ways, adapting the language of parts to their own needs and way of visualizing themselves. One client frequently utilized the concept of the “conference table” to enlist parts in supporting her going-on-with-life functioning, while another client utilized parts as a way of diffusing intense emotions and extending herself self-compassion. Clients also utilized parts work to reintegrate parts of themselves that had been hidden or forgotten due to the effects of trauma.

Response art was utilized during this study to enhance my conceptualization of clients and relational dynamics (including transference and countertransference) in the therapeutic space. My art reflections assisted me in identifying client parts and internal structures. This data was applied to case conceptualizations and impacted therapeutic interventions used with clients.

This study can potentially contribute to clinical practice of expressive therapies by demonstrating methods of integrating two trauma-informed theoretical frameworks in order to enhance client outcomes. Further steps for exploration include expanding art materials used in interventions, expanding the use of guided imagery to enhance client access to parts, considering further methods to scaffold fragmented thoughts and memories using visuals, and continuing research in trauma-informed practices to enhance effectiveness of interventions.

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