

CALL FOR ART THERAPY RESEARCH ON TREATMENT OF PTSD

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According to the National Center for Post Traumatic Stress Disorder (NCPTSD), an agency of the U.S. Department of Veterans Affairs, most Americans will experience a traumatic event in the course of their lifetime. Close to 8% will develop the debilitating symptoms associated with Post Traumatic Stress Disorder (PTSD). Recent research estimates that veterans from the wars in Iraq and Afghanistan are at risk for PTSD at the rates of as high as 18% and 11% respectively (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004).

While many PTSD patients get the help they need, many others either do not respond to the recommended treatments or respond only after long, expensive, and often painful therapies. With a new generation of American combat veterans returning from Iraq, and with the possibility that future terrorist attacks may traumatize civilians, the nation has an obligation to do everything possible to improve care for PTSD.

Despite this national obligation to improve care, a promising treatment option— art therapy —is not being appropriately evaluated. Art therapists have reported remarkable results from work with combat veterans, traumatized children, sexual abuse survivors and survivors of major disasters including the 9/11 terrorist attacks. Theorists have identified psychological and neurological mechanisms that most likely are operating in art therapy indicating it has unique capacities to promote recovery from PTSD. Published case studies and research projects also support the efficacy of the approach. Yet no major clinical studies have been launched to scientifically examine the outcomes of art therapy as a treatment for PTSD.

This document briefly summarizes the literature on current treatments for PTSD and highlights the relationship between art therapy and trauma to suggest that a significant research effort is warranted. Currently, individuals suffering from PTSD have extremely uneven and limited access to art therapy. The evidence thus far suggests that art therapy should be thoroughly integrated within the nation's mental health and trauma response systems. Such institutional change, however, will not happen in the absence of compelling evidence from large-scale, peer reviewed, multi-year studies that use control groups to compare the effect of art therapy to other treatments.

Current Treatment Options

Of the treatment options recommended by The NCPTSD, the following have been subjected to careful clinical trials: pharmacological approaches, cognitive-behavioral treatment, and eye movement desensitization and reprocessing (EMDR). While studies validate the efficacy of each approach to an extent, the literature also finds they have shortcomings and clinicians are urged to continue to experiment with a variety of new or combined therapeutic interventions.

Psychopharmacological treatment has been found effective in the reduction of frequency or severity of some intrusive symptoms associated with PTSD (Davidson & van der Kolk, 1996).

Many psychotropic agents have been used and reported effective although few have been systematically studied since double blind studies are extremely costly and time consuming. Van der Kolk (1996) notes that effectiveness of treatments varies among populations (i.e. veterans with

PTSD vs. a sample of non-veterans with PTSD, female rape survivors vs. childhood incest survivors) and implores clinicians to trust their own clinical experience when trying to prescribe a particular drug for a particular patient. Even when effective, the goal of pharmacological treatment is to ameliorate or reduce symptoms, not to heal the disorder. And for children, this treatment modality is highly controversial. Most behavior and mood oriented pharmacology has been studied only with adults and although children are receiving prescriptions, the effects on brain development during childhood are unknown.

Cognitive-behavioral therapies include exposure techniques such as flooding, stress inoculation training, systemic desensitization, anxiety management training, and marginal exposure or prolonged exposure. The goal of these therapies is to desensitize the client to the intense emotional reactions to the relived event by bringing that event repeatedly into consciousness (Cicione, Fontaine, & Williams 2002). Once the memories are brought to consciousness, cognitive re-framing techniques are used to change the trauma narrative from victim to survivor and from present to past event. Most studies of these therapies have included either Vietnam veterans or rape victims. Although some researchers have found adverse effects of exposure (Rothbaum & Foa 1996), some benefit has been demonstrated for the use of a combination of exposure therapy and anxiety management training (AMT). (Pantalon & Motta, 1998).

While effective in some cases, the literature shows that cognitive-behavioral therapies have a highly inconsistent success rate, succeed only with select symptoms, and involve a relatively intensive and lengthy treatment, sometimes including hospitalization. (van der Kolk, 1996). Some of the cognitive-behavioral therapies are not appropriate for children and many therapists do not feel they are appropriate at all.

Eye movement desensitization and reprocessing (Shapiro, 1989) is a form of exposure that incorporates eye movements into a comprehensive cognitive approach (Parnell, 1997). The efficacy of EMDR is equivocal (Rothbaum & Foa, 1996), although some patients seem to find relief from some symptoms in as few as one treatment (Parnell 1997; Boudewyns, (1983). Positive results have been found in at least four controlled studies, mixed results in two studies, and negative outcomes in two studies (Turner, McFarland & van der Kolk, 1996).

Art Therapy and PTSD

Art therapy approaches reflect the current thinking on treatment of PTSD. Researchers suggest that the debilitating symptoms associated with PTSD follow from the psychologically toxic effects of the memory of the traumatic event. These memories manifest themselves largely outside of the control of the individual, either arising involuntarily and obsessively or, in the process of suppression, motivating avoidant and maladaptive behaviors. Trauma specialists believe that the key to treating PTSD is to engage traumatic memory in a way that releases the individual from, as van der Kolk puts it, “the black hole of trauma.”

For example Morgan and Johnson (1995) piloted the use of a drawing task for treating nightmares in combat-related PTSD. They report fewer and less intense nightmares when participants used art versus writing to express their nightmares. In addition they note improvement in the

ability to return to sleep and a reduction in startle response upon awakening. They hypothesize that the use of language for representing the emotional states of trauma may be less useful while use of symbolization in art provides a mechanism for expression of nightmares because they are a visual phenomenon. In a more recent pilot study on group art therapy with veterans, Dobbs (2002) found that feelings of anxiety and depression decreased over 8 weeks of treatment (although not at statistically significant levels). The artwork and individual comments also indicate that the group intervention is a positive experience for most of the veterans.

Art therapy is used with a broad range of clients with varied trauma histories. Numerous authors describe the benefits of art therapy for these clients (Appleton, 2001; Brett & Ostroff, 1985; Howard, 1990; Meekums, 1994; Rankin, & Taucher, 2003; Yates & Pawley, 1987, among others). In a recent article Rankin and Taucher (2003) described their approach to using art therapy with patients experiencing either acute or chronic trauma that reflects many of the current art therapy treatments for trauma. They emphasize the usefulness of trauma-focused art therapy for promoting expression of emotional, physical, and mental states, for constructing a narrative of trauma that ties together feelings, thoughts, and behaviors, and for exploring meaning regarding these aspects of the trauma experience. They also emphasize that art therapy helps in the management of stress, physical symptoms, intrusive or avoidant symptoms, behaviors and affect, as well as ultimately promoting an integration of the trauma event into the patient's life history.

There are a few studies that point to the need for continued research. In one study at an urban hospital trauma center Chapman, Morabito, Ladakakos, Schreier, & Knudson (2001) found that art therapy helped to reduce PTSD symptoms in pediatric trauma patients. Although statistical significance was not demonstrated in their trauma measure between experimental and control groups, the art therapy treatment group showed a reduction in all DSM-IV PTSD Criteria C (avoidance) symptoms at 1 week and a sustained decrease at 1-month follow-up. In another study on group art therapy for child and adolescent survivors of sexual abuse Pifalo (2002) found statistically significant reduction in scales for anxiety, posttraumatic stress, and overt dissociation on the Trauma Symptom Checklist (Briere, 1995). Other scales revealed symptom decrease though not at a statistically significant level.

Pizarro (2004) investigated the use of art and writing therapy for increasing positive outcomes after traumatic experience. Results indicated that participant satisfaction was greater for those who used art while those who used writing experienced overall negative affect after the first session (though they had significant increase in social dysfunction). The researcher concluded that art might encourage treatment retention while writing seemed to promote reduction in social dysfunction.

In a study of mindfulness-based art therapy for cancer patients experiencing distress, Monti and Peterson (2004) found that art therapy treatment reduced stress-related symptoms and improved health-related quality of life for patients in the experimental group. Although not directly related to trauma, the study points to the value of art therapy for patients experiencing significant stress.

In addition to the research, descriptions are of the benefits of art therapy with several populations who have experienced trauma exist. Many authors assert that art therapy is a valuable treatment

in the area of sexual abuse trauma (Anderson, 1995; Backos, 1999; Pifalo (2002); Powel, & Faherty, 1990; Taylor, 1990; Yates & Pawley, 1987) and trauma resulting from war and natural disasters (Byers, 1996; Howie, Burch, Conrad, & Shambaugh, 2002; Kalmanowitx, & Lloyd, 1999; Klingman, Koenigsteld, & Markman, 1987; Roje, 1995, to name a few).

Conclusion

While the studies described above used small samples and were necessarily time-limited they constitute an emerging body of research indicating the need for larger and more sustained inquiry. Moreover there is a larger body of literature supporting the use of art therapy for treating a variety of traumas and their associated symptoms.

Because traumatic experiences are imprinted in the brain in such a way that they are not easily accessed through language, art therapy may be the treatment of choice for PTSD. Many believe that art therapy uses imagery in a way that effectively accesses traumatic memories safely, promotes verbal processing, and encourages active construction of a trauma narrative, all of which is understood to support healing and recovery. A significant research effort is warranted to test the efficacy of art therapy for PTSD treatment and to improve services for veterans as well as the many other individuals who suffer from this debilitating disorder.

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