A multi-modal approach to overcoming childhood trauma, using cognitive behavioural therapy and art therapy

Vera Keatley

Abstract

In this paper I reflect on what made for a positive treatment outcome of childhood traumas for an adult patient. I underline the importance of promoting safety for the patient and in being particularly attentive to the therapeutic alliance. The therapeutic interventions reflect my dual training as a psychologist and an art therapist; Cognitive Behavioral Therapy techniques such as relaxation and safe place visualisation are combined with Imagery Rescripting and Reprocessing Therapy (IRRT, an imagery-based CBT treatment) and art therapy. The first allows the patient to visualise the traumatic scene as a helpful adult witness grounded in safety. This in turn allows for the opening up of unprocessed emotions and sensations of the traumatic memory. Art therapy has the ability to contain, express and transform the emotions and sensations, and facilitates the healing process by giving the patient a sense of mastery and closure.

Keywords

Trauma, therapeutic alliance, safety, art therapy, CBT, visualisation.

Introduction

This article focuses on process in the healing of childhood trauma with adults through a case example. I begin by presenting the patient story and the therapeutic goals. I emphasise the fundamental prerequisite of fostering safety for the client; a safety that must also be embedded in a sound therapeutic alliance. I focus mainly, however, on techniques and processes that combine different approaches to therapy. Being primarily trained as a psychologist in Switzerland, I later trained as an art therapist in Australia. Getting the two types of training to co-exist and enrich one another has at times been a challenge. But 15 years in private practice have seen me draw knowledge and inspiration from both disciplines and I now consider them a strength. This paper provides an example of an eclecticism that seems to fit the patient's personality and needs as well as the nature of their problem. To me what matters is what 'works' and helps the patient. The interventions here are divided into four steps:

1. Setting the scene, grounded in safety;
2. Visualisation of the traumatic scene as a witness;
3. Listening to the unprocessed emotions and responding to them appropriately;
4. Externalisation of the remaining trauma-related emotions and sensations through art therapy.

These steps are illustrated by describing three sessions towards the end of therapy.

Rose[1] and her story

Rose is a dynamic and confident 50 year old woman. She is married and has two teenage boys. She is a high-school teacher who feels passionate about her job. She has a rich social and cultural life. Even though she feels generally happy, she now seeks therapy for the first time to control binge-eating behaviours. She initially saw a dietician and it quickly became apparent that there were strong unresolved emotions underlying the disordered eating behaviours. This is how Rose came to see me.

Along the course of many sessions, Rose shares being presently unhappy in her marriage, and a history of abuse and neglect as a child.

Her mother was under the influence of alcohol and would often leave Rose alone for days without food – she remembers once eating a whole slab of butter because she was starving. She suffered neglect from birth until she was five years old. She was then forcibly taken into the care of her great-grandparents, whom she describes as loving and caring. When she was ten years old her father abruptly reappeared in her life and took her to live with him and his new partner, who was physically violent and neglectful towards her while her father turned a blind eye. As an adult she experienced traumatic incidents: being taken hostage at gunpoint in a bank, and miscarrying at a funeral when five months pregnant with twin boys.

Specific therapy goals

Determining goals and rating them seems to me an important aspect of the therapeutic alliance. It conveys the intention of working together to reach them. At times when the therapeutic relationship might feel a little weaker, I find it useful to go back with patients to the therapeutic goals and rate them, to see if we have made progress or not. In the latter case, it might mean we must try to work differently.

We collaboratively establish specific goals of therapy. To allow for an evaluation of progress and outcome I ask Rose to rate each goal from 1, meaning the goal is not achieved at all, to 10, meaning the goal is completely reached (Molnar & de Shaezer, 1987).

Rose's two goals, and the rating she gives them, are as follows:

- Feel more confident and able to assert herself with her husband (2/10).
- Respect her hunger and satiety and stop binge-eating (4/10).

Important aspects before working on trauma

Being anchored in the present while revisiting the past

It is widely accepted that for trauma work to be effective, the patient must feel safe and in control (Malchiodi, 2015; van der Kolk, 2014). Some aspects of that safety might be: feeling safe and stable in her everyday life, within a sound therapeutic alliance, and in control during the therapy session.

Before talking or working on trauma, a few sessions are spent on assessing the stability of Rose in her everyday life. As previously stated, she feels content and passionate in her job and has good relationships with her colleagues. She benefits from a close circle of trusted friends she can call upon in times of need. More importantly, she has the ability to self-soothe alone, by taking a walk along the lake, reading, drawing, going for a swim, among other strategies that we discussed.

Near the end of each session, I enquire about her emotional state. If she is feeling overwhelmed, we plan together what she might do to self-regulate after the session. Rose always walks to and from sessions and finds that it helps her process and calm down. She often chooses to draw and brings the drawings to me in the next session. It is important that a therapist is attentive to the ability of patients to self-soothe, as patients who cannot do this may feel overwhelmed and conclude that therapy is making them feel worse, possibly resulting in their early dropout.

Before we proceed on the therapeutic interventions I describe later, I stress to the patient that she is in control of the session (unlike in the past traumatic events). She can ask me to stop (by raising her hand or saying so) the process at any time, should she feel uncomfortable or too overwhelmed.

This felt safety and control offers a stark difference to the experience of the original trauma, where feelings of powerlessness and intense disruption were present. It also helps the patient to feel different from their past self, as they witness the past traumatic memories while grounded in present control and safety, and do not get overwhelmed by the past emotions, risking re-traumatisation.

Van der Kolk (2014) writes:

> [V]isiting the past in therapy should be done when people are, biologically speaking, firmly rooted in the present and feeling as calm, safe and grounded as possible… Being anchored in the present while revisiting trauma, opens the possibility of deeply knowing that the terrible events belong to the past. Therapy won't work as long as people keep being pulled back into the past. (p.70)

A strong therapeutic alliance

As Rose gradually discloses her traumas, I am genuinely bewildered by what she has endured and deeply moved by her story. Therapist empathy is important in most approaches to therapy, and is particularly central to treatment of survivors of childhood abuse because of the need to counteract the lack of empathy experienced as a result of maltreatment at the hands of an attachment figure (Little, Akin-Little, & Somerville, 2011). To ensure the alliance is strong throughout the session, I draw inspiration from Scott Miller's (2008) brief alliance measures. I regularly enquire if Rose is feeling heard, if what we are talking about is relevant to her and if she feels we are making good use of the session.

While not the central focus of this paper, it is important to state that I believe, with many others, that a strong therapeutic alliance is more important to therapy success than techniques (Duncan, Hubble, & Miller, 2008; Lambert & Hills, 1994; Horvath & Symonds, 1991; Norcross, 2010; Martin, Garske, & Davis, 2000). I always do my best to be attuned and sensitive to my patient, but this patient made it very easy. What was particular about her was her total trust in my interventions, and her absolute readiness for change from our first meeting. As we say, 'it takes two to tango'. Rose's high motivation and readiness for change were

important factors in the success of this therapy. (Such predictors of positive treatment outcome were documented as early as 1976 by Mallan, and later by Lambert in 2004 and Norcross in 2010.) This makes it therefore easy to showcase the techniques below as there was not much resistance to start with.

Quick positive changes

One of the first matters she wishes to work on is the relationship with her husband, which she deems unsatisfactory. She feels victimised and rejected by him. There has been no intimacy between them in the last five years. She is overcome with tears and often unable to assert herself in marital conflicts (mainly in relation to their differing views on their sons' upbringing).

Neuroscience has shown that following trauma, the prefrontal cortex is unable to optimally regulate affective processing and this seems to be congruent with Rose's experiences (Garfinkel & Liberzon, 2009; Glover, 1992; Ogden, Minton, & Pain, 2006; Siegel, 1995; van der Kolk, 2006).

We first stay in the present and use reality testing (Beck, 1963; 1967; Beck & Weishaar, 2008) to work on her confusing thoughts. She challenges her husband's view that she is over-reacting to her 16-year-old son smoking cannabis and coming home late, and realises that she has a right to worry. While knowing on a rational level that it makes sense, which gives her a sense of relief and clarity in her family interactions, she still feels very emotional. So to process these emotions further, we address some of the related traumas, starting with the most recent (van der Kolk, 1987; 2006; 2014), using the method described below.

After five sessions, she reports being more assertive with her husband and less emotional. She starts delegating house duties and taking weekend trips for herself.

These fast and positive changes strengthen the therapeutic alliance (Lambert & Hill, 1994; Miller et al., 2008; Norcross, 2010).

Description of the therapeutic process

I have divided the process into four steps for this paper, but in reality the succession of the first three steps is a fluid one, the patient remaining in a relaxed state with her eyes closed throughout.

Malchiodi (2015) states, "because trauma is stored as somatic sensations and images, it may not be readily available for communication through language, but may be available through sensory means such as creative arts, play, and other experiential activities and approaches" (p.11).

This is our 25th session. We have addressed many of her traumas (using the same interventions as described below) and Rose continues to notice positive changes stemming from the therapy, so she feels engaged and motivated. In this session, we focus on the feeling of rejection that she has experienced lately. When we review the triggers, they seem out of proportion with the present. Rose is aware of this. This over-reaction often indicates that past feelings related to a similar situation need processing. So I suggest we look for the related past event and Rose agrees.

1. Setting the scene, grounded in safety

I first ask her to close her eyes and relax, guiding her briefly in feeling the contact and support of the chair with the different parts of her body. I let her know that I am also closing my eyes and I purposely use 'we' as I guide her, so that she may feel that I accompany her and that it is my authentic desire to be with her in what is most disturbing and difficult.

I give her some indications of sensations she may feel, as a guide. Sometimes people are not sure what sensations they should look for and this can create anxiety. Again, these suggestions are meant to have a reassuring effect and I also let her wonder about any other sensations she might feel.

After these few minutes of relaxing the body, I invite her to freely imagine a safe place, using Hinz's script (2006) to deepen this essential step. This is to reinforce safety in the session. I ask that the safe place include a designated area with a seat and a kind of screen to view past scenes later. When she is ready, I ask her to let me know by slightly raising her hand, giving her all the time she needs.

I was inspired by Smucker and Dancu (1999) for the screen idea, but I added a quick relaxation and safe place visualisation to promote safety, and a connection to a calm body. It echoes the essential idea in trauma therapy that the present is different from the past, that differentiation from now and then is key to the healing. Rose can be comfortable and relaxed in her safe place while remembering her younger self in painful situations.

2. Visualisation of a traumatic scene as witness

Once in the safe place, in front of an imaginary screen, I invite her to let a traumatic scene appear.

> *I might say: I wonder if a scene could appear where the young Rose felt rejected… if something comes up, please describe what is happening out loud.*

This is a delicate moment that could potentially be overwhelming for her. If the patient becomes emotional, or if no scenes come at all, it might mean that working on this area of focus is premature. This needs to be absolutely respected (not doing so could

be re-traumatising) and I usually guide the patient back to her safe place, where she can find some comfort, before bringing her back into the room with me. This reaction could mean that we need to work on stabilising the patient in her daily life and develop self-soothing abilities for a while, then return to it later. Resistances can be explored and the therapeutic alliance might need strengthening.

Sometimes patients say that a lot of scenes come up and they can't choose between them. This can be a sign of anxiety, and with gentle reassurance and a bit more time they are usually able to choose one. I encourage her to keep being grounded in the present and to just be the witness of the event happening to her younger self. After a few seconds, Rose (eyes closed) starts:

> *I was 9; I wanted to start a dance class. They (my great-grandparents) bought me everything for it. The dance teacher looked at me; she put her nails in my belly and said: "In any case, with a belly like yours, it is not going to be possible". I burst into tears. I was deeply hurt.*

3. Listening to the unprocessed emotions and responding to them appropriately

My next intervention is inspired by Imagery Rescripting and Reprocessing Therapy (IRRT), where traumatic memories are treated with a combination of prolonged imaginal exposure and imaginal rescripting (Smucker & Dancu, 1999). In this procedure, the adult (current) self of the patient comes to the rescue of the inner child (Capacchione, 1991).

> Me: *I wonder if it would be all right for you, as your adult self, to step into the scene.*

She nods yes (eyes closed). I encourage her to make visual contact with the young Rose. Once she has done this, I encourage the adult Rose to try and ask the young Rose more about what she is feeling.

> Rose: *She says that she is hurt. She feels rejected. She feels different. I am never at my place.*

I am never at my place: This sudden change from "she" to "I" may indicate that she is getting enmeshed with the memory and could risk becoming overwhelmed. It could also mean that she has reached a core belief that is central to many of her traumas. Internal Family Systems Therapy (Schwartz, 1995) names these painful emotions and negative belief the *burden*.

At this point, Rose starts to feel upset. When strong emotions and feelings are reactivated through imagery processing, I draw on Peter Levine's work on somatic experiencing (1997) and ask Rose to feel it in her body. She feels a pain in her heart and chest. Her facial expression indicates to me that this is quite painful so I suggest that she tends to the needs of the inner child quickly. In so doing, we reintroduce differentiation.

I invite her to ask the little Rose what she needs to feel better.

> Rose: *She doesn't know… but I want to take her out of here. And I want to tell the teacher that she is out of line, humiliating a child like that. I am taking the little Rose by the hand.*

I encourage her to do this in her imagination. Now, Rose is experiencing feelings of mastery and control essential to the healing of trauma (Malchiodi, 2015; Smucker & Dancu, 1999; van der Kolk, 2014). I give Rose time to imagine what is next.

After a few minutes, as her facial expression relaxes:

> Me: *What is happening now?*
>
> Rose: *I took her to another dance class… an African dance class… She loves it, she feels free and she is having lots of fun… I see that she is wearing comfortable clothes now.*

4. Externalisation of the remaining traumatic emotions and sensations through art therapy

I ask Rose what has happened to the pain in her chest. She says it has moved to her throat and is now quite painful. I ask her to imagine a shape, colour or form that would represent what she feels. She immediately sees a face made of mud.

I suggest that, if it is possible, she imagines putting the face made of mud outside of herself as further externalisation (Earley, 2009). She says it is really difficult and that the pain in her throat is becoming quite intense.

> Me: *I wonder if there is some sadness in your throat…*

Rose nods and sobs loudly for about ten minutes. During this entire time, I stay emotionally present, encourage her and let her know that she is safe. When the sobbing diminishes, she tells me how physically painful the process was.

She remembers always having to be nice and agreeable to everyone when she was young. I wonder how she felt crying in front of me. She says that she felt vulnerable showing something intimate about herself. I wonder how important it was for her to be so real in front of someone. She says it was difficult but all right as she feels this is exactly why she is here.

The ability of art therapy to contain raw emotions

Malchiodi (2015) states:

> [M]ost therapists using creative arts or expressive therapies in trauma intervention capitalize on the ability of art, music, play, and other comparable methods of expression to contain traumatic experiences rather than encourage cathartic communication of raw emotions or mere repetition of troubling memories. (p.15)

It seems that this is naturally happening in Rose's therapeutic process.

Malchiodi (2015) also speaks about the potential of art therapy to offer this differentiation from the past: "Externalization through visual means, play activity, movement, or other modalities may help shift traumatic experiences from the present to the past" (p.15, referring to Collie, Backos, Malchiodi and Spiegel, 2006).

In the next session (our 26th), Rose feels the urge to make a sculpture of the mud face (Figure 1) and says she has thought about it all week.

"Art therapy focuses on encouraging patients to become active, empowered participants in the therapeutic process" (Malchiodi, 2015, p.16). So in trauma work, art-making might be another externalising and empowering process for working through the memories and emotions felt during the traumatic experience (or burden to use the IFS term).

She chooses to use clay, and works silently and quickly. When she has finished she tells me that she just created what she saw as a kind of "flash image" in the previous session. She comments that it is ugly and that he looks angry. That he is full of pain and hurt.

The ability of art therapy to express and transform raw emotions

In the following session (our 27th), we continue the process of externalisation and containment of withheld emotions through a different creative mode – writing. Clay seemed to be the obvious choice for the sculpture, as it appeared in Rose's mind as a mud face.

What strikes her the most in this session is the angry expression on the mud face. I wonder with Rose what the mud face would say if it could speak. She feels like it would just shout and scream. I wonder with her about the possibilities of giving herself permission to shout her anger, either here or at home, in a pillow, underwater while swimming, or in the forest. Rose tells me that she just cannot see herself doing that, even though she would probably need to. I choose not to push Rose into more cathartic expression because she clearly expresses feeling uncomfortable with this. I suggest that she uses writing today as it validates her present skills as a teacher and cultured woman. It might empower her and help restore a feeling of control over the rawness of the previous sessions. I suggest she freely writes sentences starting with "I am angry because…", using her non-dominant hand. In her pioneering work on creative journalling, Capacchione (1988) proposes that the use of the non-dominant hand facilitates access to the right brain functions of feeling and intuition and even to one's inner child. Malchioldi (2013) states that it might not be an automatic doorway to the words of the inner child but can provide a "spontaneous form of expression that helps individuals let go of control and judgment about creative output" (Machioldi, 2013). As Rose has just admitted feeling uncomfortable with shouting her anger, I sense that writing with her non-dominant hand might facilitate her expressive process. Rose accepts this suggestion and flowingly writes six pages (Figure 2), and uses most of the session to do so.

With her permission, I stay next to her while she writes. I read with her as she writes and I can feel her pain with her. She cries while writing. At the end, she says she feels quite shocked seeing it all in one place, but is happy it is out.

Conclusion

Through this snapshot of part of a therapeutic journey I present core elements of my approach to trauma work, and make links to theories from psychologists, neuroscientists and art therapists to understand how and why this form of therapy was helpful to this patient.

Eating disorders can be a coping mechanism to deal with unresolved emotions stemming from childhood trauma. To avoid re-traumatisation, it is paramount for the therapist to be particularly attentive to different aspects of safety:

- Is the patient stable and feeling safe in their present life?
- Is the patient feeling safe, heard and respected within a sound therapeutic alliance? The therapist's emotional and empathic response are key to counteract the lack of empathy experienced in the past.
- Does the patient feel in control of the session?
- Has the patient the ability to self-soothe and regulate their emotions? If not, the therapist should teach some of those skills.

I use a combination of techniques such as CBT, IRRT and art therapy to present safety, differentiation from the traumatic memories,

externalisation of traumatic emotions and sensations, and reparation.

I use imagery and visualisation because neuroscience research has confirmed that traumatic memories lack verbal narrative and context, and are encoded in the form of vivid sensations and images that cannot be accessed by linguistic means (van der Kolk & van der Hart, 1989; 1991). It therefore seems appropriate to work with visualisation and images to treat traumatic memories (Johnson, 1987).

The patient remembers the traumatic scene in a relaxed, calm, differentiated state using relaxation and safe place visualisation. She can then listen to and welcome the unexpressed emotions and sensations of the inner child and use her creativity to imagine a satisfying resolution. It is like opening a wound that has never quite healed and mending it properly.

Van der Kolk (2014) sums it up so well that I could not resist citing him again:

> [V]isiting the past in therapy should be done when people are, biologically speaking, firmly rooted in the present and feeling as calm, safe and grounded as possible… Being anchored in the present while revisiting trauma, opens the possibility of deeply knowing that the terrible events belong to the past. Therapy won't work as long as people keep being pulled back into the past. (p.70)

I mentioned my dual training as a psychologist and art therapist. It seems that the different approaches complemented each other well, each serving a different purpose at different key moments of the therapeutic process. The use of art therapy was present throughout, either through drawings to process emotions between sessions or through clay and creative writing during the last sessions. It seems that, after the more directive techniques used in CBT, creative expression came spontaneously from the patient, as an urge for palpable externalisation, mastery and closure.

The timing of these sessions towards the end of therapy might also have been important. Even though the scene discussed here may not seem to be the worst one compared to others she has endured, it did encapsulate the feelings of not belonging, rejection and a negative body image. It seems to be central to Rose's story and she might have been ready to work on it after building enough trust in me over time.

Rose said at the beginning of each session how satisfied she was with her therapy. How different she felt, how empowered she was in her relationship with her husband – for example, she felt less dependent on him to satisfy her emotional needs, and she described less frustration and fewer angry outbursts as a result.

At the 29th session, we reviewed once again her therapy goals and noted that her scores had improved:

- Feel more confident and able to assert herself with her husband (9/10).
- Respect her hunger and satiety and stop binge-eating (7/10).

She tells me that intimacy has returned in her marriage and that she would like to work more specifically on controlling her binge urges.

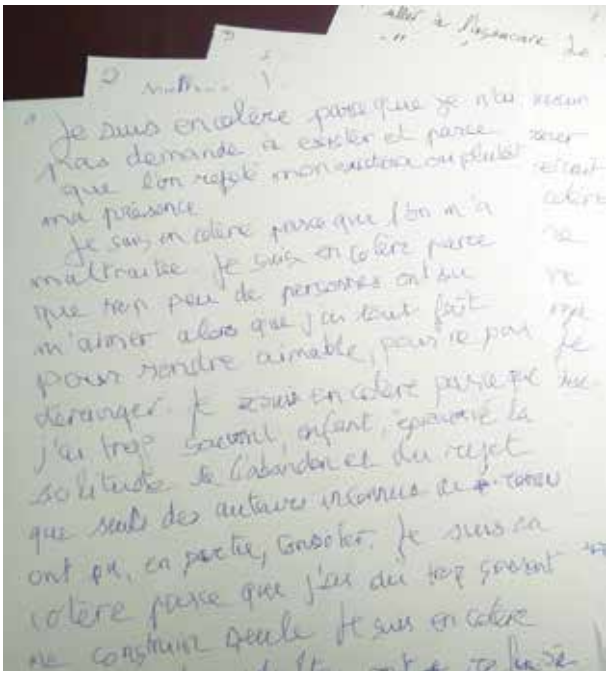

Figure 1: Rose, *untitled*, clay sculpture, 322 x 140 x 110mm.
Figure 2: Rose, *untitled*, pen on paper, 400 x 210mm.

Endnotes

1. Rose is not the patient's actual name. She has given written permission for the article and images to be published. The patient is French-speaking and the sessions took place in my private practice in Switzerland.

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