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Beyond Resistance and Resilience: The Altered Book in Adolescent
and Young Adult Complex Trauma Recovery, a Method

Capstone Thesis

Lesley University

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Art Therapy

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Abstract

The method detailed in this paper was developed to explore the potential positive impacts altered bookmaking could have on adolescents and young adults with complex trauma histories. The paper describes the literature supporting the use of art therapy in trauma treatment and using altered books with adolescents to explore identity and assist in treating depression and anxiety. Trauma is typically not communicated linearly or with words; art therapy is effective in treating individuals with trauma, as the modality allows the client to communicate symbolically. By externalizing the story onto an object, a book, clients create space from their thoughts, memories, and emotions. To expand upon these findings, I created trauma-informed interventions for adolescents and young adults with complex trauma histories to explore the potential value of an altered book art therapy intervention with this population. My observations of the clients' positive responses have supported the need for future research of providing an altered book intervention to assist in the progression through trauma recovery.

Keywords: complex trauma, art therapy, altered book, trauma-informed

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Introduction

Healing from trauma is a multifaceted journey. Often more difficult to detect than a single event trauma, complex trauma manifests within the internal psyche while the individual's external presentation is confusing to both personal and clinical relationships. In particular, individuals with childhood trauma histories are often treated for their presenting behavioral issues (Fisher, 2019), leaving the wound of the trauma to fester and become further internalized into adulthood. Treatment for this level of trauma-induced disorganization is complicated and requires the clinician to establish safety, hold unconditional positive regard for the client, maintain consistency, and actively involve the client in goal setting (Naff, 2014). The challenges mental health clinicians face in treating complex trauma lie in first needing to address the presenting behaviors, which Fisher (2019) identified as "secondary symptoms,"

Traditional talk therapies...can often sufficiently manage the secondary symptoms to ensure patient safety, desensitize individuals to the traumatic memories, and help them process the resulting emotions, but traditional psychotherapy models generally lack techniques that directly treat the autonomic and somatic effects that perpetuate the psychophysiological symptoms. (p. 158)

Art therapy is an effective treatment method for individuals with trauma, as the modality allows the client to communicate symbolically and access the nonverbal memories and unconscious material from the trauma. Part of trauma recovery is the integration of self, which can be achieved safely and effectively through a variety of art therapy directives (Chong, 2015; Naff, 2014). Specifically, an altered book intervention can help the client build a greater sense of self

and the individual can take ownership of their story, both literally and metaphorically. An altered book is a reconstruction of a published book through the visual arts including painting, collage, drawing, writing, and blackout poetry. The use of the altered book in art therapy provides a unique physicality to externalizing the internalized trauma memories. Staying in metaphor is often necessary for traumatized clients to maintain safety and “the therapist and client can discuss problems within the context of the book, instead of discussing them as being a part of the client” (Cobb & Negash, 2010, p. 61). In particular, altered bookmaking with traumatized adolescents in art therapy is especially relevant, as the issue of identity development is already prevalent for typical adolescents (Chilton, 2007) and is further amplified when a trauma history is present (Spinazzola, van der Kolk, & Ford, 2018). The altered book as an art therapy intervention for traumatized adolescents and young adults promotes safety, gives the individual control, and provides a creative outlet to externalize their trauma narratives onto and into a repurposed object.

While there are several pieces of literature outlining the benefits of treating complex trauma with art therapy, there are none that establish an altered book art therapy intervention or its merits for treating individuals with complex trauma. I found no articles that referenced using altered bookmaking and complex trauma using the following terms in Lesley University Library’s catalog and Harvard Library’s catalog: *complex trauma*, *complex ptsd*, *developmental trauma*, *altered book*, *altered bookmaking*. On the other hand, the literature does indicate the effectiveness of the altered book when working with adolescents on themes such as identity exploration. This further piqued my interest to investigate and demonstrate how the altered book can be useful when treating complex trauma symptoms, specifically integration. Integration in trauma therapy is understood as the therapist helping to bring out the client’s stronger aspects of

their personality and reinforce them, as well as looking to their future (Mooren & Stöfösel, 2014). My development of a method will be incredibly valuable to the field, as it builds the vital bridge between the current evidence for the effectiveness of both art therapy in complex trauma treatment and for altered bookmaking in art therapy with adolescents. It is my hope that by learning a new skill and dedicating time to building a sense of self, my clients experienced a sense of personal growth. The capstone thesis to follow outlines how the exploration and establishment of an altered book art therapy intervention, informed by a rigorous review of the literature, can illuminate clinical practice with adolescents and young adults who have a complex trauma history.

Literature Review

The following is a robust review of the available literature on the history of complex trauma in the field, how complex trauma manifests and impacts an individual across the lifespan, and the effective treatments. Furthermore, research findings on the effectiveness of treating complex trauma with art therapy are identified and articulate the ways in which art therapy can be more suitable for traumatized individuals than traditional talk therapy. The altered book and its applications in therapy, specifically working in metaphor, provide a clear path for utilizing the art intervention when treating individuals with complex trauma histories.

Complex Trauma

To properly identify and understand complex trauma, its differentiation from posttraumatic stress disorder (PTSD) must be established. PTSD is a recognized mental disorder in the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual, 5th Edition (DSM-5)*, while complex trauma is a term that has only been adopted by specialized traumatic stress clinicians and researchers. The external presentations of PTSD and complex trauma are

markedly different, van der Kolk (2005) explained, “Isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma...Chronic trauma interferes with neurobiological development...the capacity to integrate sensory, emotional and cognitive information into a cohesive whole” (p. 402). To date, no consensus has been reached on a clear definition of the symptomology or diagnostic criteria of complex trauma. However, upon a review of the concept of enduring personality change after catastrophic events (EPCACE) and W. John Livesley’s model of personality development, Mooren and Stöfösel (2014) defined complex trauma as,

a coherent cluster of traumatic reactions to extremely overwhelming – predominantly multiple and chronic – acts of violence. It includes problems associated with emotion regulation, attention and concentration, identity, trust, and functioning within relationships ...The essence of the symptomology of complex trauma is the trauma symptoms associated with PTSD combined with alterations in cognition, affect, personality, and relationships. The symptoms are often accompanied by an overall sense of malaise, which means that complex trauma lies somewhere at the juncture between trauma and personality disorders. (p. 15)

For decades and most especially in the last fifteen years, clinicians and researchers within the mental health field have more closely examined the systemic failure to identify individuals with complex trauma histories. Relational trauma, ongoing neglect, and abuse in childhood are all etiologies of complex trauma that are difficult to quantify, detect, and, ultimately, to treat. Furthermore, the managed care medical model takes the focus away from the trauma work, which often requires longer term psychotherapy, and requires clinicians to focus on treating the presenting behaviors within a specific timeframe. Due to the secondary symptoms (Fisher, 2019)

taking precedence, it can also lead to mental health professionals' oversight of the trauma history altogether, particularly in childhood.

Developmental trauma disorder (DTD). Left untreated, children who experience trauma often later develop complex trauma in adolescence or adulthood. In recent years, researchers have put these complex trauma histories in children and adolescents at the forefront. This included Dr. Bessel van der Kolk (2005) proposing a new diagnosis for the *DSM-5*: developmental trauma disorder (DTD), which is “predicated on the notion that multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults or witnessing domestic violence have consistent and predictable consequences that affect many areas of functioning” (p. 406). The Complex Trauma taskforce of the National Child Traumatic Stress Network (van der Kolk, 2005) established the diagnostic criteria for DTD, which focused on exposure, repeated emotion and affect dysregulation patterns triggered by trauma memories, loss of expectations and trust in others or systems to protect them, and functional impairments in multiple settings (see Appendix A for full criteria). Little to no meaningful data on childhood trauma has been gathered, which has led to the overall lack of focus on the childhood trauma itself, and much more on the presenting behaviors. Van der Kolk (2005) elaborated,

their symptomatology tends to be pervasive and multifaceted, and is likely to include depression, various medical illnesses, as well as a variety of impulsive and self-destructive behaviors. Approaching each of these problems piecemeal, rather than as expressions of a vast system of internal disorganization runs the risk of losing sight of the forest in favor of one tree. (p. 402)

As a result, the severity of the symptoms and external behaviors reach an acute level of care before childhood trauma is detected, if detected at all. Nonetheless, the trauma and its connection

to the child's behaviors are not prioritized within the mental health system, despite 92% of the youth in residential treatment programs had experienced multiple traumas (Kagan & Spinazzola, 2013). These massive systemic oversights of childhood trauma and its impacts on neurobiological development are correlated with poor adult health outcomes, contributing to increased use in public services (medical, mental health, correctional, social, etc.). An official diagnosis like developmental trauma disorder would provide the proper funds, research, professional and community supports to match the scale of the crisis.

Impacts of complex trauma on the brain and body. Researchers have identified trauma's impact on the brain and how an individual's neurobiology can better explain their incongruent affect, acting out or acting in behavior, and challenges in emotion regulation. An effective and healthy stress response system in the brain involves the amygdala and medial prefrontal cortex (MPFC) working together to differentiate a false alarm from actual danger (van der Kolk, 2015). Trauma disrupts this partnership; specifically, the amygdala is thrown into disarray and overresponds, while the hippocampus loses its ability to mediate the MPFC and amygdala (Chong, 2015). Communication between the left and right hemispheres of the brain are critical for proper linear memory processing: the left recalling facts and vocabulary of the event while the right storing memories of sound, touch, smell, and the emotions the events activate. The left side of the brain often temporarily shuts down when emotions are high. Human beings typically respond primarily with emotion via the right hemisphere by expression (crying, yelling, etc.), but once the experience has passed, those without a trauma history can successfully reflect on their response and make any necessary amends. In his book, *The Body Keeps the Score*, van der Kolk (2015) explained what happens for a person with a trauma history when their present-day experience reminds them of the past, "their right brain reacts as if the traumatic event were

happening in the present. But because their left brain is not working very well, they may not be aware that they are reexperiencing and reenacting the past” (p. 45). The poor connection between the two hemispheres prevents emotional memory and verbal consciousness (Chong, 2015) from collaborating to properly regulate emotions and impulses.

Since the mind cannot differentiate what happened in the past from the present, the body reacts with a fight, flight, or freeze arousal, triggering a sudden spike in stress hormones. The hormones reach elevations disproportionate to the initial stimuli and also take longer to dissipate, contributing to issues with appropriate heart rate and respiration (Fisher, 2019), memory and attention, irritability, and sleep (van der Kolk, 2015). With complex trauma in particular, this arousal response state occurs more frequently and with more, seemingly unrelated, mild triggers. Fisher stated, “the body and nervous system develop habitual responses (e.g., automatic obedience, hyperactive fight/flight responses, hypervigilance, loss of sensation, heightened tolerance for pain) once adaptive in a traumatogenic environment but now maladaptive or even dangerous” (2019, p. 157). Proper resources and treatment methods can help mediate these responses when they are identified for what they are: a body and mind doing its best to cope with ongoing complex trauma.

Attachment and complex trauma. John Bowlby’s theory of attachment is centered around an infant’s inclination to develop strong attachments with others, particularly their primary caregivers, in order to survive. Today, researchers also believe that attachment style has a “longstanding impact on the development of identity and personal agency, early working models of self and other, and the capacity to regulate emotions” (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005, p. 426). A healthy attachment with the primary caregiver sets the stage for an internal working model of support and care from others is accessible as needed,

which is understood to be true to that individual across their lifespan. Corcoran and McNulty (2018) suggested that adult attachment styles endure as a result of the person's attachment history and included an example of an adult who had numerous rejections in childhood relationships "will be more sensitive to cues of rejection in future relationships. This hypersensitivity will likely result in behavior that elicits rejection, which would in turn confirm his/her negative internal working model" (p. 298). The cycle described suggests that childhood trauma like neglect or an insecure attachment style can lead to future traumatic incidents by their very nature.

Spinazzola, van der Kolk, and Ford (2018) hypothesized that attachment adversity and interpersonal trauma were antecedents to DTD and complex trauma. Results found the combination of attachment adversity and interpersonal trauma, "was particularly strongly associated with self/relational dysregulation, independent of the effect of PTSD. Consistent with these results, in adults, self/relational dysregulation has been identified as a core feature of a complex variant of PTSD that is distinct from traditional PTSD" (p. 638). The distinction from traditional PTSD is especially notable, as it emphasized the significant diagnostic differences and where effective treatment for the complex trauma specifically is lacking. Focusing on attachment styles and how they manifest across the lifespan are crucial components to better understanding complex trauma and its antecedents.

Differential diagnosis. The diagnosis of PTSD is often not given to children or adults with complex trauma histories, in part due to the traumatic memories living in the nonverbal hemisphere of the brain (van der Kolk, 2015) and their presenting behaviors, what Fisher (2019) describes as secondary symptoms. A child with a trauma history can display difficulty with "unmodulated aggression and impulse control, attentional and dissociative problems,

and...negotiating relationships with caregivers, peers, and, later in life, intimate partners” (van der Kolk, 2005, p. 405). The absence of an appropriate diagnosis like DTD leads to other diagnoses in childhood including separation anxiety disorder, oppositional defiant disorder, phobic disorders, PTSD, and attention-deficit/hyperactivity disorder (ADHD) (van der Kolk, 2005). In turn, the mental health system has prioritized treating “high-risk” behaviors without addressing or treating “youth’s exposures to trauma, trauma reactions, and how trauma is linked to the youth’s problems” (Kagan & Spinazzola, 2013, p. 706).

As previously discussed, untreated complex trauma in childhood is predictive for its impacts to extend into adolescence and adulthood. In making the case for the addition of DTD into the DSM-V, van der Kolk (2005) cited diagnostic issues in properly identifying complex trauma, “history of childhood physical and sexual assault is associated with a host of other psychiatric diagnoses in adolescence and adulthood. These may include substance abuse, borderline and antisocial personality, and eating, dissociative, affective, somatoform, cardiovascular, metabolic, immunological, and sexual disorders” (p. 405). Within the area of personality disorders, particularly borderline personality disorder (BPD), there is an ongoing, contentious debate amongst professionals about reclassifying BPD as complex trauma, which has been met with much resistance. Ferguson (2015) explained, “the majority of those diagnosed with BPD have a history of complex trauma, for example, repeated extreme interpersonal trauma resulting from adverse childhood events” (p. 208). The stigma long associated with BPD frames the disorder as untreatable, leading to the individual’s trauma history being inappropriately addressed or not addressed at all. As a result, the interpersonal trauma cycle can perpetuate itself throughout the individual’s life, including treatment, given the frequent transference and countertransference that often emerge between client and clinician in treating both complex

trauma and BPD (Ferguson, 2015). Part of van der Kolk's (2005) call for a new diagnosis addressing complex trauma was based in the challenge clinicians face with insufficient diagnoses and treatment interventions. Shifting the focus from "inappropriate" external behaviors that are often used to describe BPD to a trauma-informed, compassionate approach would address the trauma response-based behaviors and interpersonal challenges in a meaningful way. Herman (2015) articulated the impact a new approach would have on treating individuals diagnosed with BPD,

Understanding the role of childhood trauma...provides the basis for a cooperative therapeutic alliance that normalizes and validates the survivor's emotional reactions to past events, while recognizing that these reactions may be maladaptive in the present. Moreover, a shared understanding of the survivor's characteristic disturbances of relationship and the consequent risk of repeated victimization offers the best insurance against unwitting reenactments of the original trauma in the therapeutic relationship. (p. 127)

Reframing BPD as complex trauma also creates the opportunity for the clinician and client to examine how the presenting symptoms were developed and used for survival in the context of their trauma history. Ferguson (2015) argued that this recognition, "leaves the room open for recovery, for the rebuilding of a sense of self, and of relationships...By comparison, approaches that minimize the connection with trauma lose the opportunity to powerfully address stigma as one of the implications of trauma" (p. 210). When complex trauma is properly recognized and diagnosed, finding an appropriate treatment method becomes much more viable.

Trauma-informed Care

An effective treatment program for individuals with a trauma history must operate from a trauma-informed lens. While there are effective evidence-based treatment methods for PTSD, van der Kolk (2005) found that traumatized children do not typically meet the diagnostic criteria for PTSD, as interpersonal trauma does not fall under the DSM's definition of a traumatic event. Furthermore, the difference between an isolated trauma event that typically leads to a PTSD diagnosis from complex trauma has significant treatment implications on how to obtain best outcomes. As previously stated, there is still no present diagnosis for developmental trauma disorder or complex trauma, however, leading professionals of institutions, agencies, and hospitals have articulated appropriate guidelines in both treating PTSD and complex trauma, both of which do not necessarily overlap. Specifically, recommendations have tended to state that sequence-oriented protocols are most effective in treating complex trauma, as they minimize unintended harm or retraumatization (Kagan & Spinazolla, 2013). Within the proposal for the new diagnosis of DTD, van der Kolk (2005) outlined three phases of treatment, which include “establishing safety and competence, dealing with traumatic reenactments, and integration and mastery of the body and mind” (p. 407). For traumatized children and younger adolescents, it can be useful to include the parents/guardians in the treatment process when appropriate, which involves the child and parent/guardian establishing self-regulation skills (Kagan & Spinazolla, 2013).

Attachment, self-regulation, and competency (ARC). ARC is a component-based treatment intervention for children and adolescents who have experienced complex trauma. Kinniburgh et al. (2005) elaborated on the framework as being, “grounded in theory and empirical knowledge about the effects of trauma, recognizing the core effects of trauma exposure on

attachment, self-regulation, and developmental competencies” (p. 425). They emphasized ARC’s individualized approach and encouraged clinicians to refer to the client’s assessment, “child-in-context,” and to utilize and trust their own clinical judgment when selecting the variety of activities and interventions listed. With an emphasis on the phases of the treatment, the researchers underline the importance of first establishing safety with the client before beginning explicit trauma work. Kinniburgh et al. (2005) explained that trauma impacts, “intrapersonal competencies, such as development of positive self-concept, awareness of internal states, realistic assessment of self-competencies, and capacity to integrate self-states” (p. 429). The competency component of the ARC treatment model promotes the client’s current strengths and ability to continue to grow, which is a part of the goals of integration. This strengths-based, phase-oriented, and individualized treatment protocol informed both the rationale for and eventual development of my method.

Art Therapy in Trauma Treatment

Art therapy is a modality of mental health counseling that incorporates a range of artmaking mediums. The art therapist promotes creativity and expression, regardless of artistic ability or experience. Art therapy is an effective treatment modality for a variety of populations, including individuals who have experienced trauma. Clinicians have articulated art therapy’s unique ability to prevent a client from utilizing defense mechanisms that are typically employed in everyday encounters and in talk psychotherapy. Skeffington and Browne (2014) articulated how art therapy improves a client’s ability to “engage with the processes that produced the image, enabling interaction with previously slippery and elusive parts of themselves...Images allow unspeakable traumatic experiences to be acknowledged and explored...facilitate change by moving clients towards thresholds and edges within themselves” (p. 116). Additionally, an

externalization of traumatic experiences has the potential for the client's internal world to be confronted safely and limit the risk of harmful and counterproductive triggers. Skeffington and Browne (2014) argued that imagery created allows for a safe pathway to "confront and engage with the uncomfortable material" (p. 119) while easing therapeutic change.

Art therapy vs talk therapy. Trauma lives and persists in the body and in one's mental life; due to the lack of its integration into the brain's verbal consciousness, trauma is not experienced or communicated in a linear, verbal process. Gantt and Tinnin (2009) explained that without guidance from the brain's dominant verbal conscious to establish a timeline, "The nonverbal mind...loses the capacity for narrative memory for the duration of the trauma experience. Perceptions and thoughts are stored in nonverbal memory as fragmentary states of experience without temporal order" (p. 150). Talk therapies have limitations in treating complex trauma, especially when ongoing trauma memories and responses are stored in early childhood and manifest in the nonverbal part of the brain, the right hemisphere. Fisher (2019) argued that a client must first mindfully observe their physiological trauma responses before being able to verbally process them. In turn, art therapy's nonverbal nature and varying sensory-based materials can aid in the discovery of physiological trauma responses. Utilizing "neuroscience findings, developmental theories and psychodynamic views, with the heuristic illustration of clinical vignettes" (p. 118), Chong (2015) highlighted the importance and efficacy of treating early relational trauma with art psychotherapy over verbal and cognitive behavioral approaches. Noting the challenges individuals with trauma histories have with traditional talk therapy, Chong identified the role of art therapy, a nonverbal-based therapy, in treating early relational trauma symptoms, such as splitting, aggression, and dissociation.

Arts-based research findings. Kruger & Swanepoel (2017) conducted research on the effectiveness of “digital metaphoric imagery” (p. 92) in treating complex trauma. The frameworks of CBT trauma treatment, art therapy, and technology informed the researchers’ method: digital art trauma therapy. They argued that externalizing metaphors are helpful when treating trauma, due to trauma memories not being integrated into the brain like other memories. Specifically, they stated that by creating a narrative using metaphor, the client is likely to feel less threatened by re-experiencing symptoms, while also providing access to sensory experiences. Their meta-model had three phases: alliance formation and stabilization, trauma processing, and functional reintegration conducted over ten sessions. For example, a stage two trauma processing session consisted of:

Work with two software programmes to explore trauma memories and feelings.

Participants think of their past, specifically their trauma memories and accompanying feelings, and depict those in an artwork...Psychoeducation on trauma...Trigger awareness in the environment to address flashbacks or intrusive negative feelings on a cognitive level...Distress reduction and affect regulation training. (p. 96)

The research method used is known as social constructionism, which is rooted in the belief that knowledge is not objective. Utilizing this approach, the researchers stated that their “data analysis reflects the intersubjectively shared constructions through the cycles of coding in which we...had to reach agreement among each other as well as member checking when the participants had to agree with our attribution of meaning” (p. 94). The analysis consisted of interviews between researcher and participant, image data with enquiry from the researcher to the participant, and observation by the researchers. “Using the transcribed text and scanned image data, we undertook thematic analysis to organise, code...and categorise the data...The

best approach to the perceived problem of coding visual data ‘is a holistic, interpretive lens guided by intuitive inquiry and strategic questions’” (p. 96). Results from their holistic coding, which included the participant in the analysis process, revealed that all of the participants experienced positive change. Three out of four participants experienced post-traumatic growth, according to criteria defined by Richard Tedeschi and Lawrence Calhoun in their 1996 Posttraumatic Growth Inventory; Mooren and Stöfösel (2014) illustrated, “Posttraumatic growth or benefit finding...addresses the positive consequences of going through a traumatic experience...Positive consequences can only be present if there is enough stability and harmony in the client’s life” (p. 139).

Altered Book Intervention

Given the medium’s inherent opportunity for self-expression and personal narrative, altered books are often utilized by art therapists to promote a client’s sense of self and a healthy rebellion against the status quo (Chilton, 2007). The altered book is a powerful metaphor in and of itself, as a client can rewrite, cover up, or recreate a story on each page over a period of time. “Symbolically, books can represent knowledge, illumination, learning, wisdom, revelation, and both the universe and the self...Dusty old books may represent...an earlier ‘chapter’ of one’s life. Opening or closing a book may symbolize opening or closing a stage in one’s life” (Chilton, 2007, p. 60). For individuals with complex trauma, the ability to work in metaphor and begin to integrate the “end” of the trauma within their mental life is a powerful process with the potential for long-lasting results.

The literature review outlined the current research on complex trauma, its impact, and how a phase-based and individualized treatment protocol is most effective. Art therapy offers a unique pathway in trauma treatment, as it allows the therapist and client to utilize the art medium

to remain in metaphor, which maximizes safety and aids in overall stabilization. Altered bookmaking is an art medium used by art therapists; the literature revealed its use is primarily with adolescents and exploring identity. These findings informed the development of my method, which implemented altered bookmaking for adolescents with complex trauma histories.

Method

The method introduced adolescents with varying developmental, relational, and complex trauma histories to altered bookmaking to promote a sense of self and integration. I am defining integration as finding and reinforcing the stronger aspects of the adolescents' personalities, as well as looking to the future.

Participants

The participants were all students at a public high school in MetroWest Boston. The students' ages ranged from 15 to 18 years old and identified as female, male, or nonbinary. All participants are students I meet with for individual counseling as a part of their Individualized Education Program (IEP). I will refer to the participants as Student 1, Student 2, Student 3, and Student 4.

Materials

Books were provided by the public high school and all participants were able to select from a wide variety of books in terms of their content, size, and overall style. All sessions were held in the expressive arts therapy room, where participants had access to an array of materials, including paint, pastels, markers, drawing materials, collage materials, decoupage, and other mixed media. Participants were given the option to work on their altered book outside of the sessions, but most opted to leave the book in the art room.

Procedure

With a trauma-informed approach, I conducted interventions that were focused on building a sense of self and also promoted integration. To establish and maintain safety and stabilization, I largely relied on metaphor and did not talk with my clients about the trauma directly. Operating from this clinical stance is in line with the literature reviewed; specifically, the treatment protocol for DTD established by van der Kolk (2005) who emphasized, “Complexly traumatized children need to be helped to engage their attention in pursuits that do not remind them of trauma-related triggers and that give them a sense of pleasure and mastery” (p. 407). Each session was catered to the individual’s needs, with some specific prompts given, while others were left open for participants who benefited from autonomy and self-direction. Altered books allowed for a narrative to emerge on each page and the externalization of thoughts, emotions, and relational dynamics (Cobb & Negash, 2010).

Record Keeping

To keep track of my progress, I recorded what I experienced in a written document that I updated following each session. Additionally, I responded to the sessions by making art in my own altered book. The altered book acted as an external object of both my clients’ stories and my own inquiries, discoveries, and responses. The act of art making in response to leading an intervention of my method provided a personal piece of data that is not replicable by other forms of record keeping. Chilton (2013) explained, “my sensory knowledge cannot be discovered by proxy...Emotions—not traditionally honored by the academy—yet crucial to me, to my learning, and to who I am” (p. 465). Furthermore, engaging in artmaking helped me build awareness of and process any transference and/or countertransference and vicarious trauma. Additionally, I had weekly individual and group supervision where I had the time and space to process, sought

consultation, and gained further clarity of what I have noticed throughout the development and execution of my method.

The development and execution of my method, altered book art therapy interventions with adolescents and young adults with complex trauma, will contribute to the clinical practice of expressive therapies by establishing additional literature and interventions that outline the benefits that art therapy and altered bookmaking bring to treating this challenging population. My method is intended to further emphasize the unique and vital role the art therapy modality can play in treating the internal disintegration that complex trauma brings and not just the presenting behaviors or secondary symptoms (Fisher, 2019).

Results

The vignettes in this section detail the experiences I had with the participants while they created their altered books. I focus on the themed directives I facilitated, as well as observations from the open-studio format. Additionally, I discuss my observations and artistic responses to each session.

Directives

For some participants, providing a specific prompt was useful to better build therapeutic rapport and create and maintain structure throughout the session. The directives were designed and selected to promote self-expression, exploration, and value identification, all of which are in service of the participant building their sense of self and integration.

Powerful vs. powerless. Using collage-making materials, the participant, Student 1, was prompted to create a two-page spread comparing the powerful and the powerless. Materials provided included magazines, scissors, glue, and bins of precut collage materials separated by people, places, things, and words. The student was intrigued by the prompt and thoughtfully

selected materials from the bins and eventually looked through the magazines for more. She carefully separated the collage materials before pasting them to the pages. Her topic of conversation and overall presentation shifted throughout the session. The student began by talking about what Fisher (2019) would categorize as secondary symptoms, but eventually reported feeling like her family is not proud of her and her desire for new connections and meaningful friendships. The two-page spread was filled with photographs, words, and illustrations, and she said that her selections were focused on feminism, empowerment, politics, and questioning the society's status quo. The student thanked me for our session and was receptive to my suggestion of advocating for herself with her family and friends. Following the session, I was struck by Student 1's parents' resistance to trusting her judgment when selecting a college. I responded by creating a collage in my own altered book with only images from my undergraduate school's magazine (Appendix B, Figure 1.1). I filled the page with the exception of one word, "restrictions."

Emotions landscape. With acrylic paints, Student 2 was introduced to the directive, "create a landscape that reflects your current emotional state." Student 2 was open to the directive, but they asked if they needed to talk about their emotional state, to which I responded that they did not. Notably, Student 2 has rejected the use of acrylic paints outside of their altered book in previous sessions. The participant worked quietly, but with purpose, throughout the session, making careful strokes in their altered book and utilizing the blending of colors. They reported liking the outcome of their emotions landscape. While I had many questions for Student 2 about their emotional state, to promote safety and autonomy, I felt it was important to allow them to decide what to share with me. Furthermore, the art itself was giving me information about their emotional state, which was a big, vulnerable step for them to take in our session.

Student 2 asked to leave their altered book in the art room to dry, allowing for distance from what was expressed in their art. A few sessions later, Student 2 returned to working in their altered book and flipped through the pages, pausing at their emotions landscape and stating how much they liked how it turned out.

Open-Studio Format

I utilized an open art studio format with all participants while conducting my method. Upon reviewing the literature, researchers underlined the importance of promoting autonomy in complex trauma treatment, while also maintaining a clear, contained structure (Kinniburgh et al., 2005). For Student 1, she has responded well to this approach, but has difficulty starting on a new, blank page. She typically used pastel or paint to go over what she previously worked on but did respond to redirection to work on a new page. When in an open art studio format, Student 1 tended to make abstract art, with careful attention to blending. Moments of pause in conversation were much more present for Student 1 when she was fully engaged in the artistic process, especially when focused on getting the exact shade of paint she envisioned. After our session, I used the left-over paints Student 1 had mixed for her artwork and created my own painting into my altered book (Appendix B, Figure 1.2). I reflected on how applying these dark, cool colors felt and started to think about how Student 1 ruminates on thoughts and feelings she has around interactions with others, especially with peers, going as far back as elementary school. I started writing “amygdala” over and over on the page, as I thought about how the amygdala is responsible for perceiving emotions, making sense of memories, and identifying patterns to determine potential threats (van der Kolk, 2015). Student 2 also responded to the freedom that an open studio model allows. I introduced them to decoupage with tissue paper and they responded with indifference at first. Following my modeling of using the medium (Appendix B, Figure 1.3),

Student 2 selected 3 colors of tissue paper and cut out small triangles, carefully placing each on the page before pasting the triangles down with Mod Podge. Each artistic creation was done with intention, precision, and care.

I utilized an open art studio model for Student 3 over the course of several sessions. He expressed interest in altered bookmaking when I agreed that he could rip up one of the books in the art room. Student 3 quickly opened the book and started ripping the pages out rigorously. He alternated between ripping out large sections at once to one page at a time. He encouraged me to participate, adding, “it’s fun!” When I asked Student 3 how he felt about tearing out pages from an old book, he responded that he was getting something out of it and that it was therapeutic. In our next session, Student 3 quickly chose a book and began ripping out pages, crossing out words with markers, and made a collage of different photos of an American politician. Energetically, he used a marker to write a few words one letter per page. Student 3 then asked to put baby oil on the pages, with my flipping quickly through the pages. Afterwards, he apologized and said that it was a “stupid idea” to put baby oil on the book. I reassured him that in our sessions there are no stupid ideas and that I welcome his creativity, to which he was somewhat receptive. Student 3 presented slightly agitated and quickly left the art room when the bell rang. I thought about the high energy and pace Student 3 put into his altered book and wondered what it must have felt like to scribble on the pages with markers. Using the exact markers Student 3 used, I created my response art (Appendix B, Figure 1.4) after our session to better empathize with him. At the beginning of our next session, I explained to Student 3 that an altered book could be something he worked on throughout the school year, to which he expressed indifference in, but was open to altering a book in our session that day. I provided Student 3 with collage materials and he quickly looked through magazines, only cutting out a few photographs. After a

few minutes, he said that he wanted to be honest with me, that he was not enjoying this art medium anymore. I reflected to him that I appreciated him voicing how he was feeling to me and that we would explore other kinds of artmaking. Having built rapport and established safety with Student 3, he felt comfortable and secure in voicing his opinions and preferences to me, which further highlights the importance of the stages of trauma treatment (Kruger & Swanepoel, 2017).

Student 4 asked if she could make an altered book upon seeing my altered book in the art therapy room and was incredibly enthusiastic to get started. She smiled and reacted when completed each page, stating, "I love this!" During our first session with Student 4's altered book, she filled several pages of collages she made of previous paintings she had done in our individual sessions. Student 4 worked quickly and applied generous amounts of Mod Podge and paint to the pages as she spoke about a frustrating and upsetting interaction with a school friend. She successfully noted that nothing about it was "her fault," a frequent challenge of hers, but was more frustrated by how much of an emotional reaction she had to it. In the next session, Student 4 had previously disclosed that she wanted to discuss upsetting family events and dynamics but was then avoidant and hesitant to bring it up. She started cutting up more of her paintings in preparation for more collages in her book and, when prompted, was able to speak about the dynamics and how they impacted her. Student 4 added generous amounts of black paint to the page before placing the collaged paintings on top of the paint, followed by Mod Podge. She was eager to see the page dry and continued to press down on the collage pieces. Student 4 was relieved to hear that I can leave her book out to dry overnight.

All four of the student participants were responsive to the altered bookmaking intervention and worked with the medium for a minimum of three sessions. 75% of participants utilized the art medium beyond three sessions and were receptive to both open-studio and

directive formats. Additionally, all participants verbally expressed a positive experience with the art medium. The volume of art created varied for each participant, with Student 1 and Student 2 focusing on an individual page each session, Student 3 altering an entire book each session, and Student 4 completing 3-5 pages per session.

Discussion

I developed the method of introducing an altered book as a part of individual therapy for adolescents who have complex trauma histories, as described in the literature review (Mooren & Stöfösel, 2014; van der Kolk, 2005). I selected the altered book as an art medium following research that outlined its effectiveness for adolescents, particularly in exploring identity. Chilton (2007) explained, “the transformation from uniform to unique—is an apt metaphor...Asserting individuality and identity is often a theme in the artwork of adolescents...healthy rebellion is one of the ways young people can discover their own selfhood and individual power” (p. 61). By applying the themes of self-discovery and empowerment through a trauma-informed lens, my students could take ownership of their stories and express challenging emotions through the artmaking at their own pace and with less pressure to “finish” their artwork by the end of the session, as they understood the altered book to be a project they return to. Chilton (2007) stated working in this medium is clinically significant, “the act of choosing a book to be altered is significant. By making any choice at all, the adolescents commit to working—with their therapist...and with their own inner artist. This decision reflects their desire for health, wellness, and creative growth” (p. 61). The students who returned to their altered books for several weeks displayed a commitment to the therapeutic process and a curiosity for what they may discover. The ability to close the book and eventually return to a difficult and vulnerable image in a contained, structured environment reveals the strengths of the altered book intervention for

individuals with complex trauma, as they often experience emotions at a higher intensity and can easily become flooded by emotions, thoughts, and memories (van der Kolk, 2015). The results described have several implications for how this intervention can be expanded upon in the future, while also having limitations to what conclusions, if any, can be drawn from my impressions.

Speculation and insights. Prior to describing the results, I feel it is useful to articulate my speculations and insights prior to beginning the altered book interventions. I anticipated that altered bookmaking would result in my clients building a greater sense of self, increasing their creative expression and understanding of their emotional experiences. For adolescents specifically, this medium provides portable stimulation and self-reflection, which could be achieved for my clients while remaining in metaphor. Chilton (2007) outlined the altered book's unique usefulness in therapy,

the art object acts as a metaphor for how our lives are altered by experiences. Our own core text—that blend of culture, childhood experiences, and inner spirit—can also be transformed by the material life presents us. The wisdom and revelation contained in the books we alter become our own, changed at times beyond recognition into the stuff of evolving personhood. The art concretizes a life transformed. (p. 63)

Furthermore, the distinctive nature of the altered book provides a container for the therapeutic work, which promotes and maintains the safety of the client, a crucial pillar in trauma treatment. When I began this inquiry, I believed that these interventions would serve my clients by helping them gain access to these unintegrated parts of self that are a result of their trauma histories.

Implications. Working within this art medium allowed for the process to unfold gradually and for a narrative to develop, both of which are crucial pieces of trauma treatment (Kruger & Swanepoel, 2017). I feel as though the results point to three out of four students

responding positively to the phase-oriented pace of the altered book. For example, Student 1 was able to express the role of power in her altered book and notably was less dismissive of her interpersonal challenges throughout the session. Furthermore, Student 2 responded positively to using a variety of mediums within their altered book, specifically acrylic paint, which they have rejected using outside of the book in other sessions. Due to the nature of complex trauma's nonverbal manifestation, working in a book format invited my participants to use their altered books' imagery and words to tell a new story (Cobb & Negash, 2010). It is evident that the open art studio format assisted in their exploration, with Student 1, Student 3, and Student 4 completing several pages in their books in one session. For Student 2, selecting the materials without the requirement of providing me with a verbal explanation about their creative expression was metaphorically beneficial to their treatment, as promoting and encouraging autonomy within a safe environment is an important part of trauma treatment (Kinniburgh et al., 2005).

While Student 3 did not continue his altered book beyond a few sessions, I feel as though I collected important information about the ways in which this intervention was useful for him. To begin with, he reported that tearing the pages directly out of a book to be especially therapeutic, perhaps pointing to him benefiting most from a process-oriented approach. How Student 3 interacted with the material was also informative for the potential for short term use of the altered book in trauma therapy. I feel as though the aspect of control and wide-ranging ability to expressive himself was cathartic for Student 3, at first, but the medium was unable to maintain his attention and interest. Furthermore, the altered bookmaking process led to Student 3 feeling the need to apologize to me for his "stupid idea," which I view as a deepening in our therapeutic work together. By Student 3 feeling safe and secure enough to vocalize an area of shame and

discomfort, he was beginning the healing process as outlined in several trauma-informed treatment protocols, such as ARC. Traumatized individuals' internalized emotional responses to everyday experiences are different than an individual without a trauma history, Kinniburgh et al. (2005) explained that they, "may be biased toward negative affect states (ie, shame, self-blame, isolation) due to...internalization of responsibility for their own traumatic exposures...emotions expressed by others may be misinterpreted as potential danger cues, or as negative emotions such as anger or blame" (p. 427). This art medium could provide the opportunity for individuals with complex trauma to begin to externalize their traumatic memories and responses. Additionally, the exploratory and autobiographical nature of the altered book moves the focus away from differential diagnoses' presenting behaviors that I outlined in my literature review, while still addressing the emotions and identity challenges often found in individuals given those differential diagnoses when a diagnosis of DTD or complex trauma would be more appropriate.

Limitations. Several limitations existed for this study. To begin with, I hold a bias in support of this art medium and its potential for incorporating it into complex trauma treatment. Importantly, my method was conducted with limited data collection and only came from my observations and insights. I ultimately cannot draw conclusions to the specific benefits altered bookmaking may have provided to all participants, especially because complex trauma work is a long process and I relied on metaphor to keep the participants safe within the therapeutic space, a public high school. The impacts of the method and whether or not it increased the participants' sense of self and integration are qualities to be measured over a longer period of time and not something I, the facilitator, could infer from a few therapy sessions.

Recommendations. For practitioners and researchers interested in exploring altered bookmaking in complex trauma treatment, I recommend relying on phase-oriented treatment, as

outlined in the literature. For any trauma work, but especially complex trauma, establishing safety and building a therapeutic alliance is crucial for effective care. Additionally, relying on metaphor, especially in the context of the altered book, is useful in building a narrative and empowering the individual. I am curious about whether a directive or open art studio approach is more beneficial and growth-fostering for individuals creating altered books. Ultimately, I recommend relying on the therapeutic relationship to be able to name and witness the challenging emotions, interpersonal dynamics, and responses within the room.

Concluding Remarks

The misunderstanding of complex trauma has led to harmful mischaracterizations of individuals with these histories and, in turn, ineffective treatment methods. The efforts from leading clinicians and researchers to move away from the surface behaviors and towards examining and processing how trauma impacts the brain, body, interpersonal relationships, and emotional responses is illuminating new avenues for both clients and new clinicians. Research findings reveal art therapy's important role in complex trauma recovery. Uncovering the nonverbal aspects of the trauma led me to the development of my method using altered books. Witnessing my clients engage in altered bookmaking was a humbling and inspiring experience. Each book was wonderfully unique and personal, and I am honored they were willing to share them with me. Furthermore, reviewing the literature and applying the altered book method has guided and will continue to guide my clinical practice and further develop my theoretical orientation.

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Appendix A
Proposed Developmental Trauma Disorder (DTD) Criteria

Criterion A: Lifetime of contemporaneous exposure to both types of developmental trauma

A1. Interpersonal victimization

A2. Disruption in attachment with primary caregiver(s)

Criterion B: current emotion or somatic dysregulation, 3 required for diagnosis

B1. Emotion dysregulation

B2. Somatic dysregulation

B3. Impaired access to emotion or somatic feelings

B4. Impaired verbal mediation of emotion or somatic feelings

Criterion C: Current attentional or behavioral dysregulation, 2 required for diagnosis

C1. Attention bias toward or away from threat

C2. Impaired self-protection

C3. Maladaptive self-soothing

C4. Nonsuicidal self-injury

C5. Impaired ability to initiate or sustain goal-directed

Criterion D: Current relational or self-dysregulation, 2 required for diagnosis

D1. Self-loathing or self viewed as irreparably damaged and defective

D2. Attachment insecurity and disorganization

D3. Betrayal-based relational schemas

D4. Reactive verbal or physical aggression

D5. Impaired psychological boundaries

D6. Impaired interpersonal empathy

(Spinazzola, van der Kolk, & Ford, 2018, p. 633)

Appendix B



Figure 1.1 Response to Student 1 after Powerful vs. Powerless directive

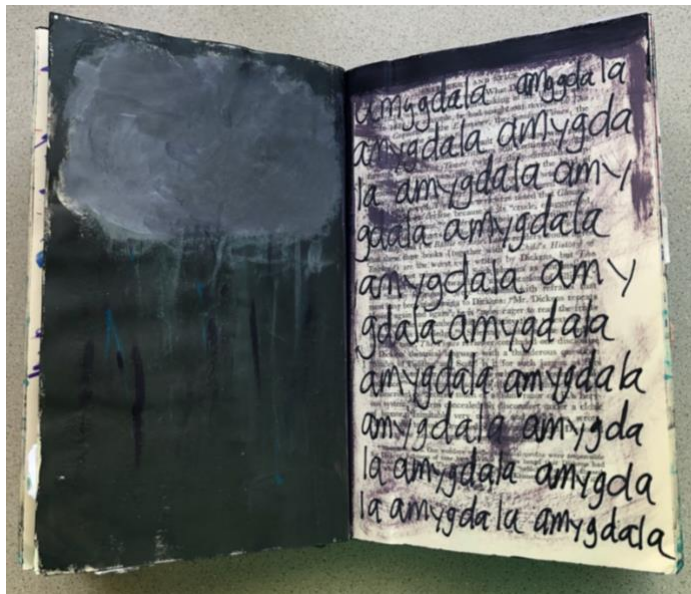


Figure 1.2 Response to Student 1 after open art studio format

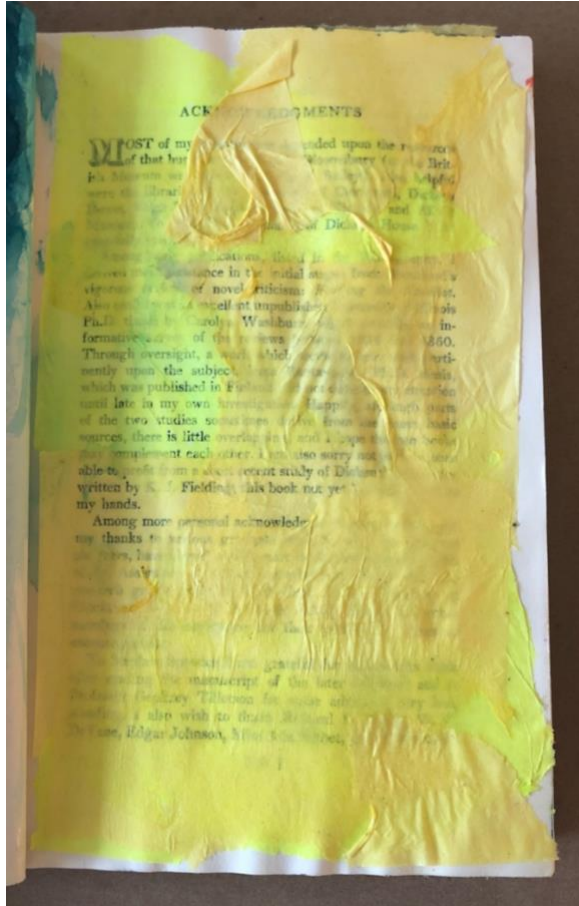


Figure 1.3 Response to Student 2 after open art studio format

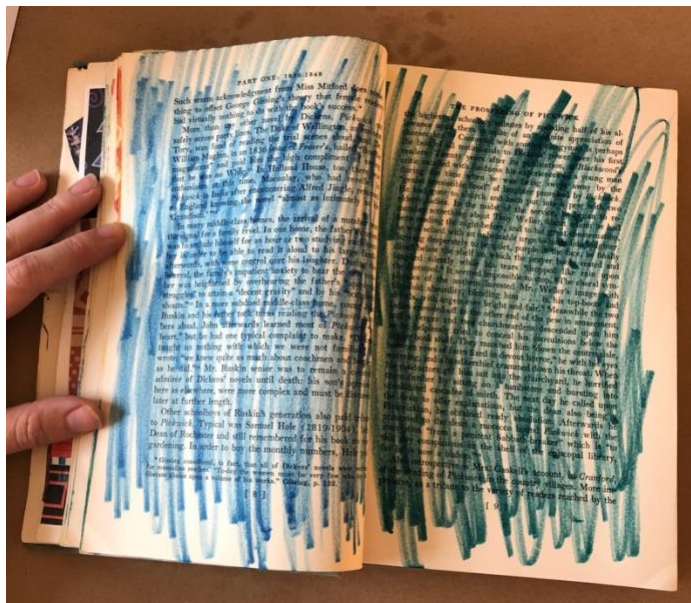


Figure 1.4 Response to Student 3 after 2nd session of open art studio format

THESIS APPROVAL FORM

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

Thesis Advisor: E Kellogg, PhD_____