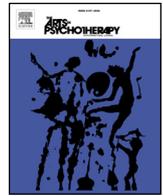




ELSEVIER

Contents lists available at ScienceDirect

## The Arts in Psychotherapy

journal homepage: [www.elsevier.com/locate/artspsycho](http://www.elsevier.com/locate/artspsycho)

## Research Article

## Understanding the role art therapy can take in treating veterans with chronic post-traumatic stress disorder

Janice Lobban<sup>a,\*</sup>, Dominic Murphy<sup>a,b</sup><sup>a</sup> *Combat Stress, Tyrwhitt House, Leatherhead, Surrey, UK*<sup>b</sup> *King's Centre for Military Health Research, King's College London, London, UK*

## ARTICLE INFO

## Keywords:

Art therapy  
Veterans  
PTSD  
Avoidance  
Self-awareness  
Trauma therapy

## ABSTRACT

Individuals who are highly avoidant and/or have dissociative post-traumatic stress disorder (PTSD) presentations may be less likely to engage in evidence-based trauma treatments, and consequently are more likely to drop out of therapy. These individuals may benefit from approaches that provide alternatives to verbal or cognitive processes to achieve therapeutic outcomes.

In recent years, a number of research studies have been undertaken at the UK veterans' mental health charity Combat Stress to try to understand the role art therapy can take in treating veterans with chronic PTSD. An overview of the findings is presented, along with suggested treatment and ethical guidelines, and recommendations for innovative ways to conduct research on the value of art therapy for veterans. Art therapy is shown to offer promise as a treatment for the overcoming of PTSD-related avoidance symptoms and for increasing self-awareness. Furthermore, the work created in sessions captures snapshots of meaning that veterans can use as a form of communication outside of the art therapy space, as active working documents. In this way, art therapy can assist veterans to understand and communicate their inner experiences, and to engage in trauma therapy.

## Introduction

Since its emergence in the regeneration that followed the Second World War, art therapy has a history of helping war wounded to express and work through traumatic experiences. Adrian Hill, one of the founding figures of art therapy in the UK, was a commissioned war artist during the First World War. He worked with war wounded at King Edward VII Hospital, Midhurst from 1941. Hill focused on the restorative qualities of art-making and from first-hand experience he realised how art could help to get to the root of problems (Hogan, 2001). Hill encouraged patients to paint and also to enjoy the benefits of art-viewing. Concurrently, the psychiatrists Wilfred Bion and later Sigmund Foulkes were involved in the Northfield Experiments at Hollymoor Hospital, Birmingham. The aim of this project was to enable war wounded to return to active service. Through the Northfield Experiments the development of group therapy was undertaken (Harrison & Clarke, 1992). Art-making was also taking place in the art hut at the same hospital, from 1944. Sergeant Laurence Bradbury was tasked with facilitating free expression for groups of wounded veterans. The approach taken was to use "all the relationships and activities of a residential psychiatric centre to aid the therapeutic task" (Bridger, 1990,

p. 68). It seems tension built up through Bradbury's free art-making sessions, and sometimes strong feelings emerged. Bradbury did not take the lead or any responsibility for dispelling anxiety, or clearing-up any mess that was made. It has been recorded that sometimes mayhem ensued (Bradbury, 1998; Harrison, 2000; Lobban, 2017a). Hill and Bradbury's work is representative of two contrasting approaches in the early days of art as therapy with war wounded in the UK.

Although little has been written about the role of art as therapy in the military context, there is a seam that connects the legacy of early developments to present day. In 1987, an innovative, new post-traumatic stress disorder (PTSD) programme was introduced at the Royal Hospital Haslar, Hampshire for armed forces and emergency services personnel. It incorporated creative art as a way of expressing pre- and post-trauma experiences, as well as the trauma itself. Participants were filmed explaining their images, and the video was then shared with family and friends to involve them in the recovery process (Lobban, 2017a). Around the same time, the profession of art therapy was introduced at the Queen Elizabeth Military Hospital, Woolwich for serving military personnel, where it became part of the treatment available until the hospital closed in 1995 (Lobban, 2017a). In 1991, the hospital began receiving war casualties from the first Gulf War, which included

\* Corresponding author at: Combat Stress, Tyrwhitt House, Oaklawn Road, Leatherhead, Surrey, KT22 0BX, UK.

E-mail address: [janice.lobban@combatstress.org.uk](mailto:janice.lobban@combatstress.org.uk) (J. Lobban).

those with psychological injuries.

In 2001, art therapy became part of treatment at the veterans' mental health charity Combat Stress, which is the context for this study. At that time the veterans receiving inpatient treatment included those who had served during the Second World War (1939–45); the Korean War (1950–53); the conflict in Aden (1963–67); the Falklands War (1982); the Bosnian War (1992–95); and the troubles in Northern Ireland (1969–98). Although the conflicts may have become consigned to history in the public eye, for those who had been psychologically affected by service experiences, the aftershock continued. The culture predominating at that time amongst the veterans, particularly those involved in the earlier conflicts, was "we don't talk about it." Art therapy was to provide an alternative to verbal expression. In due course, the *War on Terror* that followed the attacks made by the militant Islamist group al-Qaeda on 11 September 2001 in the US was to have a significant effect on treatment at Combat Stress that continues to be relevant to present day practice.

Although many veterans who have engaged in art therapy at Combat Stress have reported that it has played a vital part in their recovery, anecdotal evidence alone is not enough to secure an evidence-base for this form of treatment. Consequently, over recent years a number of research studies have been undertaken at Combat Stress that explore the role that art therapy can play in the treatment of veterans with chronic PTSD. This paper presents the findings of those studies with the aims of consolidating the work done so far, and contributing towards the growing body of literature that is increasing the understanding of art therapy's particular relevance to this area of work. Firstly, an outline of the impact of PTSD on veterans is presented to highlight the challenges being faced.

### Impact of PTSD on veterans

The majority of service personnel make successful transitions out of the military, but a portion of veterans experience mental health difficulties. However, a substantial minority of ex-service personnel leave with either symptoms of PTSD or go on to develop these difficulties in later life (Fear et al., 2010; Hoge, Riviere, Wilk, Herrell, & Weather, 2014; Sundin et al., 2014). Evidence from American studies suggests that between 12% and 20% of US veterans who had deployed to the conflicts in Iraq or Afghanistan went on to report symptoms of PTSD (Hoge et al., 2004; Milliken, Auchterlonie, & Hoge, 2007). In addition, as the passage of time increases since the end of these deployments, prevalence rates of PTSD has also increased (Cabrera, Hoge, Bliese, Castro, & Messer, 2007; Milliken et al., 2007). To date, within UK veteran populations, similar increases have not been witnessed (Fear et al., 2010). However, in the UK there has been a sizeable expansion in the numbers of veterans seeking help for PTSD over recent years (Murphy, Weijers, Palmer, & Busuttil, 2015). It has been estimated that the cost to society as a result of PTSD is over and above that of other military-related mental health difficulties (Brunello et al., 2001; Francois, Depiegel, Maman, Saragoussi, & Auguier, 2010).

Research exploring treatment outcomes in veterans has been conducted in a range of countries (Chard, Schumm, Owens, & Cottingham, 2010; Currier, Holland, Drescher, & Elhai, 2014; Forbes, Lewis, Parslow, Hawthorne, & Creamer, 2008; Morland et al., 2014; Murphy, Palmer, & Busuttil, 2016; Murphy, Spencer-Harper et al., 2016; Richardson et al., 2014). Generally the outcomes from these studies show that whilst there are significant reductions in the severity of PTSD symptoms post-treatment, there is often still evidence of a significant burden of symptoms.

Comparisons of PTSD treatment outcomes between veterans and non-veteran groups suggest that veterans have poorer responses (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Kitchiner, Roberts, Wilcox, & Bisson, 2012). It is unclear why this might be, though a number of factors have been suggested. These include pre-trauma risks, for example high rates of childhood adversity have been linked to more

severe PTSD presentations (Iversen et al., 2007; Iversen et al., 2008). Peri-traumatic risk factors include the fact that veterans who have served in conflict zones may have been exposed to multiple traumatic experiences which could increase the complexity of presentations (Richardson, Pekevski, & Elhai, 2009). Post-trauma exposure factors could be that only a minority of veterans with PTSD are able to engage in treatment, and for those who do engage, it can take significant periods of time to get support (Murphy & Busuttil, 2014). In the UK it was found that veterans took approximately 11 years to seek help (Murphy, Palmer et al., 2016). The influence of stigma, in particular self-stigma, has been shown to impact on treatment-seeking behaviours. In addition, alcohol misuse within serving and ex-services personnel is more common than in the general public, and has been shown to negatively impact PTSD treatment (Fear et al., 2007; Murphy, Palmer et al., 2016; Murphy, Spencer-Harper et al., 2016).

It would be pertinent to explore the influence of these factors on treatment response in further studies. Findings might be used to more accurately predict which subgroups of veterans are at risk of not responding to current treatments, and those who might benefit from alternative interventions, such as those specifically developed to treat complex PTSD including Dialectical Behaviour Therapy (DBT), coupled with Prolonged Exposure or Skills Training in Affect and Interpersonal Regulation (STAIR; Cloitre & Schmidt, 2015; Harned, Korslund, & Linehan, 2014). However, while STAIR and DBT aim to address emotional dysregulation and interpersonal difficulties, it is important to support those with more complicated PTSD at pre-engagement. In particular, clinical experience suggests that individuals who may be highly avoidant and/or have dissociative PTSD presentations are less likely to engage in evidence-based trauma treatments, and then more likely to drop out of treatment. These individuals may profit from approaches that are less reliant on verbal or cognitive processes. Art therapy could provide a platform to support such individuals and to prepare them for more verbal types of trauma-focused therapy (for example trauma-focused cognitive behavioural therapy; Palmer, Hill, Lobban & Murphy, 2017).

### Art therapy research with veterans

#### Literature review

In the UK, published art therapy research with the veteran population is scarce. A contributing factor is that, unlike in the US where there is a healthcare system in place specifically for veterans, in the UK the care of veterans comes under the umbrella of the National Health Service (NHS). Specialist NHS veteran mental health services have only emerged since 2011, and currently art therapy is not routinely available as part of these services (Lobban, 2016b). Although art therapists might work with veterans occasionally when they are referred through services such as for substance misuse, the Criminal Justice System, or generic adult mental health, it tends to be in isolation rather than as a specialty. This does not enable detailed study of particular factors and trends associated with this client group. Consequently, it has been necessary to look to work being undertaken overseas to explore ideas and discoveries, and to investigate any resonance there might be with UK practice.

In her literature review of studies related to art therapy with veterans with PTSD, Smith (2016); Smith & Lobban, 2017) identified 11 papers of particular relevance (Avrahami, 2005; Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001; Collie, Backos, Malchiodi, & Spiegel, 2006; Gantt & Tinnin, 2009; Johnson, Lubin, Miller, & Hale, 1997; Kopytin & Lebedev, 2013; Lobban, 2014; Lyshak-Stelzer, Singer, St. John, & Chemtob, 2007; Nanda, Gaydos, Hathorn, & Watkins, 2010; Pifalo, 2002; Rademaker, Vermetten, & Kleber, 2009). In a thematic analysis of the content, Smith distinguished six key themes emerging though the studies that suggest the mechanisms of change. These being: the group; externalising the image and symbolic expression; from non-

verbal to verbal processes; integration and processing of memory; containment; artistic pleasure and mastery (Smith, 2016; Smith & Lobban, 2017). However, Smith highlighted that further research into art therapy with veterans as a stand-alone intervention is necessary, as the standard treatment approach tends to be within multi-modal packages, which makes it harder to distinguish the specific contribution of art therapy to treatment outcomes.

Recent research that has shed further light on art therapy with military populations includes studies by Campbell, Decker, Kruk, and Deaver, (2016); Howie (2017); Jones, Walker, Masino Drass, and Kaimal, (2017), and Walker, Kaimal, Koffman, and DeGraba, (2016). These collaborative studies give an indication of the parallel desire between our countries to understand the part that arts therapies can play in treating military populations recovering from psychological and physical injuries.

### Detailed review of Combat Stress published research studies

An adaptive art therapy model has been developed at Combat Stress that is: (1) driven by the short-term nature of inpatient hospital admissions; (2) informed by a phasic model for working with trauma; and (3) based on an awareness of military culture (Lobban, Mackay, Redgrave, & Rajagopal, 2017). Art therapy has been part of all the treatment programmes, which include a one-week preparation for therapy programme and a six-week intensive PTSD treatment package. The body of this paper is dedicated to reviewing the UK research that has emerged from work at Combat Stress.

In 2011, a BBC film crew recorded an art therapy group facilitated by the lead author. It spotlighted five veterans and the part that art therapy was playing in their treatment for PTSD. The full, uncut recording of the UK art therapy group was later transcribed verbatim and used as the basis for a thematic analysis of the experience (Lobban, 2014). The veterans identified shared problem areas as being a sense of disconnection from other people, reinforced by psychological defences in place to maintain distance; the presentation of a false-self to shield personal vulnerability; the avoidance of feelings; and the fixedness of their traumatic memories. By contrast, participants reported experiencing the opposite during the art therapy process and said that they had felt connected through a common bond, had been able to open up and share true feelings, and had been able to access unconscious material through the imagery thereby gaining new perspectives. For the participants in the filmed art therapy group, the common bond with its shared language, history, and culture enabled the veterans to feel less alone, normalising the post-traumatic stress reactions they had experienced. Recognising their own problems reflected in others helped to reduce isolation and to learn how others managed symptoms.

The study opened a number of other possible directions for research follow-up through both individual and group work. Avoidance is an aspect that comes up time and time again, and so it has become a major thread running through the studies. The following two research papers were mixed methods studies that explored issues relevant to the development of art therapy at Combat Stress, but the findings were also of wider significance.

In a subsequent study (Lobban, 2016a), two surveys were completed by veterans on six-week Intensive PTSD Treatment Programmes. The first was designed to understand why veterans dropped out of group art therapy sessions or were unable to engage with the treatment. Data analysis revealed that barriers to engagement included pre-session apprehensions such as concern about having no artistic ability; anxiety about revealing too much; and fear of losing control of emotions. The actual experience of art therapy took some participants out of their comfort zone; caused them to feel vulnerable; and brought out things they did not want to think about. The data revealed that the majority of respondents who found it difficult to engage in art therapy had low capacity for tolerating the distress of others and preferred to keep emotionally-charged work for individual sessions. However, responses

showed that many veterans were able to overcome an element of avoidance. In contrast, the second survey which was with a different sample of veterans, focused on self-rated benefits of the art therapy groups. With this sample, all respondents found the atmosphere relaxing and reported that the art therapy process had brought out things in them that they did not know were there. Furthermore, the vast majority agreed that art therapy had stimulated alternative ways of thinking, and reported learning more about themselves. Overall, the surveys revealed how art therapy was helpful in terms of group bonding as veterans saw a different side of each other through the imagery created. The majority were surprised by what emerged during the sessions. Participants valued seeing and hearing other interpretations of the group themes, which helped to promote new perceptions and universality, which in turn reduced their sense of isolation.

The surveys provided 'gold dust' for research purposes and generated further studies. At the time, veterans were asked to complete an evaluation at the end of each therapy group at Combat Stress. Consequently, 547 art therapy group questionnaires were amassed from the three treatment centres across the UK over the course of a year (2015). These surveys provided the data for a cross-disciplinary paper (Palmer, Hill, Lobban & Murphy, 2017). The aim of the study was to explore the acceptability of art therapy as a treatment for mental health problems experienced by veterans. Quantitative measures gauged an overall rating of acceptability through the construct of usefulness, and qualitative measures were used to elicit the nature of acceptability. Through inductive content analysis of the evaluation data, three major themes emerged in the study: sharing within the group as a bonding and normalising experience; unlocking and expressing difficult feelings that are hard to verbalise; and the significance of environmental aspects that facilitate calmness and choice (Palmer, Hill, Lobban, & Murphy, 2017). Respondents rated the usefulness of art therapy highly, with a mean overall rating of 4.43 out of a maximum of five. Accordingly, the study supports the inclusion of art therapy in treatment plans for veterans with mental health presentations.

So far, all the research studies focused on group art therapy as part of multi-modal inpatient treatment packages, with common factors becoming apparent. For the next study, the aim was to explore individual art therapy in an outpatient context in order to tease out the specific contributions of art therapy as a stand-alone treatment. The previous research had highlighted that many veterans were surprised by the material that emerged through their art therapy imagery and their unexpected ability to express emotions. Consequently, the study (Lobban, 2017b) set out to explore in what ways art therapy might be able to assist the overcoming of avoidance and facilitate engagement.

A small sample of veterans ( $N = 5$ ) completed a series of twelve individual art therapy sessions (Lobban, 2017b). During the course of sessions, participants expressed what life was like for them. Figs. 1 and 2 were made by the same participant in different sessions. Fig. 1 is a symbolic representation of how powerless and anxious the veteran was feeling at that time. The veteran is shown as having no control over the metaphorical lava flow and avalanche of toxic material heading his way. He awaits its impact in a prison cell, unable to get out of the way of its destructive path. Moderating powerlessness with increased self-awareness, in Fig. 2, the veteran underlines the resonance between past trauma and current emotional responses whilst under stress, and how perceptions become affected. This insight helped to make sense of reactions whilst articulating some of the complexities of experience. Significantly, in the middle of the image is a key. The veteran explained that he had realised that there was a way to escape this situation, and that art therapy was the key that could unlock his escape route.

Figs. 3 and 4, which were created by another veteran, also convey the lived experience of PTSD, as well as co-morbid depressive symptoms (Lobban, 2017b). Fig. 3 represents feeling detached from the world in the form of a bee caught behind the glass of a framed picture. The veteran described how at times whilst being able to see the world around him, he does not feel part of it. Fig. 4 charts the breakdown in



Fig. 1. Stuck.

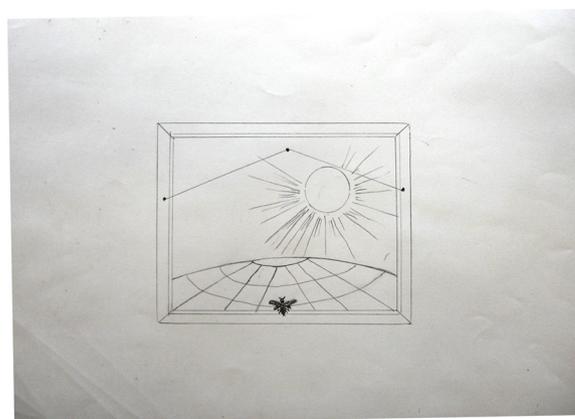


Fig. 3. Bee behind glass.



Fig. 4. xxx.



Fig. 2. Then and now.

communication with others that is associated with a fall into a black hole of depression. However, the image also provides tools to escape from that position—lights shone into the darkness, and a rope to use to climb out—that represent management strategies he had gained that moderate a sense of powerlessness.

Participants' comments made during the semi-structured interviews at the end of the study clustered around having regained a sense of control; surprise at unplanned exposure; coding/disguising material in the images; gaining insight; increasing tolerance of difficult material; and recognition of inner conflict whereby resistance was made manifest through the imagery (Lobban, 2017b). The psychometrics used to measure outcome, the PTSD Symptom Scale-Interview (PSSI) and Dissociative Experiences Scale II (DESI), revealed a decrease in the frequency and severity of avoidance on subscales related to engagement with life goals, and the ability to experience a whole range of feelings. Dissociation scores also decreased. However, there was a slight increase

in hyper-arousal and physical symptoms in some cases, which might have been associated with reduced avoidance.

In 2016, the lead author of this article was awarded a Churchill Research Fellowship, which enabled her to spend six weeks in the US visiting art therapists across the nation who work with veterans and active duty military personnel. Links were established with the art therapy team at the Giant Steps Program, VA Connecticut Healthcare System. This led to two ground-breaking transatlantic art therapy groups being held via video-conferencing between veterans at Giant Steps and Combat Stress in 2016 and 2017 (Lobban & Spinelli, 2017). The aims of these groups were to explore commonality and universality of experience through art therapy expression. The groups began with introductions, each participant coming closer to the screen and saying a little about themselves. This in itself was a significant step for those who might have struggled with social avoidance. The common bond of being a veteran seemed to facilitate this exchange. Later, as participants shared their images, their counterparts across the ocean were seen to nod their heads in quiet camaraderie. Many of the pieces had a resonance in meaning but astonishingly, some images also held strong similarities in form. The mirrored groups, live through the television screens, provided the chance to share experiences through a common language of imagery and to recognise shared wounds.

A subsequent article (Lobban & Murphy, 2017) follows leads from the earlier outpatient discourse and presents four case studies. Four veterans with chronic PTSD and avoidance presentations were invited to participate in a bespoke two-week art therapy-focused, inpatient admission. The aim of these case studies was to see how art therapy might help the participants to overcome, or cope with, limitations associated with PTSD-related experiential avoidance. Again, group bonding was seen as a crucial therapeutic factor. The group dynamic

became a strong container for the expression of previously evaded feelings. In this way, participants recognised that exposure of feelings and difficult psychological material through art therapy was tolerable and something that need not be avoided. The art work created a safe distance from which to explore content, and to find personal and shared meaning.

A key discovery that emerged through the group sessions was participants' willingness to begin to challenge hitherto rigid perceptions (Lobban & Murphy, 2017). There was discussion around social perceptions and assumptions that necessitated re-evaluation. Inspired by viewing Grayson Perry's *Map of Nowhere* (2008) during a gallery visit, which depicts the artist's internal world within a globe-like body, the group creatively explored inner experience as represented through a range of potent symbols. The symbols included barbed wire, a poppy, an opened can of beans, and the back of a figure's head looking into darkness. The group acknowledged that they were opening up and revealing their inner worlds, but this was manageable.

### Summary of findings

The art therapy studies were completed with the full support of the veteran participants. When invited to take part in research, invariably participants readily consented to take part out of a desire to help other veterans. This reflects the common bond that has come across so clearly throughout the studies. It also echoes the findings of Yalom (1995), who underlined key therapeutic factors that are relevant to group therapy such as cohesion, universality, interpersonal learning, and guidance. These factors are familiar to veterans, as they resonate with military training and culture. Trust is soon built within veterans' art therapy groups, which enables the removal of symbolic masks, revealing concealed and shared vulnerabilities. Personal isolation becomes moderated by the knowledge that individuals are not alone in their responses to trauma, thereby normalising and de-shaming the experiences.

The creative process, the very essence of art therapy, has been seen to help veterans access, express and make sense of hitherto unconscious, avoided, or suppressed material. Bypassing the censorship imposed by conscious thought and rigid perceptions enabled participants to achieve increased self-awareness. This in turn promoted new ways of seeing, interpreting, and responding to situations. The process was often experienced as surprising by the veterans because it had not been an intentional or planned act. The created art objects were able to hold and convey meaning that could be decoded through subsequent reflective discussion, sometimes providing undeniable proof of inner conflicts or resistance that participants had been unable or unwilling to recognise previously.

Veterans can be slow to ask for help or to admit to having mental health problems. Even after seeking help, there may be further barriers to overcome before they are ready to engage in treatment. Art therapy can help veterans to overcome avoidance and increase self-awareness, thereby enabling them to make better use of trauma therapy and other components of multi-modal programmes. The work created in art therapy sessions captures snapshots of meaning that veterans can use as a form of communication outside of the art therapy space, as active working documents. The artwork might be shared by the veteran with significant others, such as a partner or psychologist, in order to convey what hitherto had been impossible to put into words. Working together in this way can enable 360-degree perspectives.

### Recommendations for the use of art therapy with veterans

#### Treatment and ethical guidelines

Based on feedback from veterans who have participated in art therapy, advances in research and practice, and clinical experience, we propose that the following areas be considered by art therapists when

treating veterans with chronic PTSD.

#### Awareness of military culture

Busuttil highlights that "military culture is unique" (2017, p. 73). He proposes that the cultural features shaped by military training, exposure to operations, and the severing of secure attachments on leaving the forces affect subsequent approaches to help-seeking and engagement in treatment. He emphasises that an understanding of these aspects is crucial when treating this client group.

According to developmental theorists such as Erikson (1959), the late teenage years and early twenties are a time when people develop a sense of identity through trial, error and discovery. However, those are the very years when many enlist into the armed forces and acquire a military identity, along with its culture and jargon (Murtagh & Lobban, 2017). Awareness of military codes of conduct, written and unspoken, as well as the role of hierarchies, expectations, and conformities can help to inform understanding and practice. In the military context, the needs of the individual become secondary to group objectives. There is an emphasis on not letting down the team or being the weakest link. Furthermore, the UK military 'macho' culture can foster a 'work hard, play hard' approach that promotes excessive use of alcohol (Busuttil, 2017, p. 76). These factors can contribute to the suppression and maintenance of mental health problems.

In combat and peacekeeping operations, services personnel might be exposed to ethical dilemmas that violate personal beliefs. For example, rules of engagement might mean that it is not possible to intervene when presented with atrocities such as ethnic cleansing (Busuttil, 2017). This can result in a deep sense of guilt and/or shame that undermines recovery, whereby the person does not consider that he/she deserves to feel better. The conceptual model of Moral Injury (Litz et al., 2009) provides a framework for understanding the cumulative effects of such internal conflicts, and offers a treatment approach.

Busuttil (2017) notes the use of *collective defence mechanisms* that serve to protect service personnel psychologically, such as the use of banter and black humour. The use of humour is often present in art therapy groups, and therefore is something to be considered and worked with (Kopytin & Lebedev, 2013; Kopytin & Lebedev, 2015). It is likely that therapists will also encounter splitting in the form of attitudes towards military and civilian approaches. The military structure is often viewed as fostering a hard-working ethic, reliability and high performance, whereas the civilian world might be viewed as untrustworthy, slack, and unclear. The sense of belonging to this respected ex-military group might affect motivation towards fully integrating into the civilian community. Furthermore, those who were young recruits might experience challenges readjusting into a culture that has become unfamiliar. Some veterans paraphrase a popular saying by commenting that "you can take the soldier out of the army but you can't take the soldier out of the man".

#### Understanding the neurobiology of PTSD and of art therapy

As a result of advances in research into the neurobiology of PTSD, there is a wealth of information available to inform our understanding of the processes involved. It is an advantage to know how trauma memories are encoded and stored, and the part art therapy can play in recovery from PTSD by accessing and processing non-verbal material. For instance, studies such as those by Lusebrink (2004); Hass-Cohen and Carr (2008), and Kravits (2017) are informative reading for those seeking to work with veterans who have PTSD.

Essentially, in high arousal states such as a traumatic experience, the language centres of the brain close down so that all energy can be turned towards survival (Rauch et al., 1996). This means that the experience is not captured in words but in emotions, sensations and visual imagery. In turn, this affects the ability to create a coherent narrative of the experience to assist the recovery process. The non-verbal,

unassimilated, and unprocessed trauma memory becomes frozen in its sensory form, un-date stamped, and re-experienced as happening in the here-and-now. The brain becomes sensitised to threat with associated hard-wired physical and psychological responses. Art therapy is well-placed to create a thinking distance from the experience through symbolic expression, and to facilitate meaning-making. It can enable expression of the non-verbal trauma-related material which can then be thought about, translated into words, contextualised and reintegrated (Lobban et al., 2017).

Providing veterans with basic psycho-education about the mechanisms of PTSD can help to empower them through increased knowledge and understanding. It might also help to challenge barriers to recovery such as self-perceptions of weakness. Such information-sharing groups are often part of multi-modal packages, but therapists working independently could consider integrating psycho-education into the early stages of treatment.

#### *Tailoring practice to context*

A phasic approach that paces exposure to the trauma material is generally accepted as the recommended model in this context (Collie et al., 2006; Foa et al., 2009; Herman, 1992; NICE, 2005). The initial phase involves establishing safety, whereby a foundation of affect management techniques is laid. This might necessitate the therapist being familiar with grounding, breathing, and relaxation techniques. It is important to equip clients with strategies to enable them to remain within an optimal level of distress tolerance. Art therapy can reach deeply very quickly with the risk of causing decompensation if balancing and containing strategies are not established: first, do no harm. This may mean that therapists are required to adopt a more pragmatic approach than in some other contexts.

Once safety is established, the subsequent phase of treatment provides an opportunity to explore the traumatic experience/s, or to work on particular symptoms such as isolation, anger or nightmares. This phase might entail remembrance and mourning (Herman, 1992), and the challenging of long-held, trauma-related perceptions that have blocked recovery. Avoidance is one of the clusters of PTSD symptoms and always present to a greater or lesser degree. By discussing treatment objectives, it is possible for the client to choose whether or not they want to revisit trauma memories, or perhaps focus on improving quality of life whilst living with unresolved trauma memories. Once avoidance is overcome, it is necessary to ensure that sufficient support and treatment is in place.

During the final phase, sometimes termed 'reintegration', thoughts turn towards incorporating new perceptions and understanding into everyday life. This might mean implementing practical changes such as finding a new, less stressful job; or letting people get close again. Art therapy can help by 'rehearsing on paper'. Studies into the use of prospective imagery suggest that it can foster optimism and help to facilitate change (Holmes, Lang, Moulds, & Steele, 2008; Lobban et al., 2017). It can also help to recognise underlying apprehensions or pre-conceptions that might require attention.

#### *Effects on the therapist*

Before entering into this field of practice, it is appropriate to take time to consider possible effects of witnessing trauma stories through images and words. Vicarious traumatisation is an acknowledged phenomenon in this area of work (Pearlman & Saakvitne, 1995). Becoming aware of horrors or injustices outside of usual life experiences can affect how the world is viewed and challenge the therapist's own belief system. It is important to ensure that sufficient supervision is in place to enable reflective practice, including being self-aware regarding warning signs of any negative effects and having self-care in mind (Lobban, 2017a).

It is also worth considering any underlying motives or prejudices

related to working with this client group. Although this applies in all contexts, the military can arouse extreme responses. For example, there might be a strong desire to rescue the rescuers, or offer succour to the peacekeepers. On the other hand, military action past and present might not always sit well with strongly held moral or political views, which might affect the therapeutic alliance.

#### *Developing innovative ways to conduct research on the effects of art therapy for veterans*

##### *Use of the image*

We have yet to identify a quantitative outcome measure that captures the value of art therapy with veterans who have chronic PTSD. Various psychometric measures have been employed that chart changes in specific symptoms, such as the Generalised Anxiety Disorder Assessment (GAD-7) for anxiety, the Patient Health Questionnaire (PHQ-9) for depression, and Dissociative Experiences Scale (DESI) for dissociation. Also well-being measures such as the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). Qualitative interviewing of individuals tends to elicit the most fertile material for investigation. However, it could be apposite to develop a drawing measure to demonstrate change. Although drawing measures are not often used as part of art therapy practice in the UK, they are sometimes employed in the US. For instance, the bird's nest drawing (BND), developed by Kaiser (2009), is recognised as a useful tool for assessing secure attachment.

In the outpatient study mentioned earlier in this paper (Lobban, 2017b), participants were invited to make a creative response to the theme 'mask' at baseline and end of treatment. The art work created proved to be completely different at the beginning and end points, providing visual evidence of change in perceptions. It was helpful for participants to recognise personal movement in this way. The challenge will be devising a measure that ensures validity and reliability.

Another way to use art therapy images to monitor change, from a qualitative perspective, would be to collate photographs of the work into a book of images accompanied by text. Often, valuable material is lost when a client describes the meaning of an image in a session. The therapist is only able to retain key points and not the subtleties of emphasis or the exact words used. Furthermore, the discourse is unavailable for significant others outside of the therapy space to hear should the client wish to include them in the process. Regularly veterans provide feedback that they cannot remember exactly what they said about the work. By recording the description, the client could then replay the narrative and use it to shape text to accompany photographs of the art therapy images pasted into a book format. This replaying, planning, and selection process could aid cognitive and emotional processing of the material, increase emotional regulation, and improve distress tolerance. The completed book could be used a point of communication with others as the individual shares their story.

##### *Research partnerships with museums*

Museums and galleries are gaining increasing attention as alternative venues for healthcare, with opportunities for taking therapy out of the hospital or treatment centre and into a public space (Chatterjee & Camic, 2015). Progressively in the UK, museums are being thought of as spaces for wellbeing, and initiatives such as 'arts on prescription' and 'social prescribing' are providing an alternative to medicalised health care. Clinical Commissioning Groups have health and wellbeing agendas, and museums are seeking working partnerships. This is great news for art therapy, as our training and clinical objectives lend well to fostering research partnerships with museums.

Gallery visits have been incorporated into art therapy programmes at Combat Stress since 2009, with feedback that this has been an enriching experience for veterans (Lobban & Ellis, 2017). Extending treatment beyond the therapy room can help to facilitate social integration and reduce isolation. Art collections that represent our diverse

cultural heritage are often accessible free of charge, within a safe and stimulating environment. Gallery work can also reconnect art therapists with their creative roots, revitalising and nourishing our practice.

#### Charting post-traumatic growth

Entering into the art therapy room for the first time can be a step into the unknown for some veterans. They may not have made art since their school years, with differing associations of success or failure. There might be apprehensions about getting in touch with feelings, or concern about being thought of as a “tree-hugger.” However, the fact that they have come to the session is testament to their willingness to ‘give it a go’ in the hope that it might help with their problems. Accessing creativity can be a turning point for some veterans.

In the mid-1990s, the concept of post-traumatic growth emerged, whereby adversity and suffering was recognised as stimulating positive change in some cases (Tedeschi & Calhoun, 1996). This might be seen through the enhancement of relationships; personal acceptance, and re-evaluated priorities (Joseph, 2012). Art-making can help to optimise recovery by fostering post-traumatic growth. In a recent study (Murtagh & Lobban, 2017), a veteran described how painting helped him to stop binge drinking after discovering an interest and ability in art for the first time: “Drinking became a burden. How could I paint if I was drunk or hung-over?” (p. 220). Therefore, another rich area for art therapy research could be charting post-traumatic growth through longitudinal studies made over time. In this way, it would be possible to discover any long-term and enduring benefits of creative approaches to therapy.

#### Summary of recommendations

It is vital to consider the impact of military culture when working with veterans as it will have influenced their perceptions and identity. It can also be helpful to become familiar with military terminology, as well as the history and characteristics of different theatres of operation. For instance, the particular qualities of long wars of attrition; peace-keeping missions; or unresolved conflicts. Awareness of the neurobiological underpinnings of PTSD assists practice, and also helps veteran clients to feel more in control through knowledge gained about the symptoms they are experiencing. When this approach is tailored to context by adopting a phasic model, it can foster safe, paced exposure to trauma material that is experienced as more manageable. Throughout practice it is important that the therapist is self-aware and mindful of any detrimental effects that require reflection during supervision, or the implementation of self-care strategies.

Suggestions have been made for ways of researching the effects and value of art therapy with veterans. The art therapy images produced have provided invaluable material for measuring outcome, which might be achieved through a specific drawing measure; comparing theme-based imagery produced over time; or the creation of a story book. Research partnerships with museums and galleries offer potential for collaborative work to return art therapy to its cultural roots. Charting post-traumatic growth offers a way of capturing the long-term effects of accessing creativity through art therapy; a quiet process with a slow-burn effect.

#### Declaration of interest

None.

#### References

Avrahami, D. (2005). Visual art therapy's unique contribution in the treatment of post-traumatic stress disorders. *Journal of Trauma & Dissociation*, 6(4), 5–38. [https://doi.org/10.1300/J229v06n04\\_02](https://doi.org/10.1300/J229v06n04_02).

Bisson, J., Roberts, N., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, (12), 1–242. <https://doi.org/10.1002/14651858.CD003388.pub4> 2013.

Bradbury, L. (1998). *Interview by Blakeway Associates [Tape recording]. The science of war – Battle of the mind (Interview rushes Part 1 of 4)*. Retrieved from London, England: Blakeway Associates, Imperial War Museum Archives. <https://www.iwm.org.uk/collections/item/object/1060035898>.

Bridger, H. (1990). The discovery of the therapeutic community: The Northfield experiments. E. Trist H. Murray The social engagement of social science Vol. 1 London, England Free Association Retrieved from [www.moderntimesworkplace.com/archives/ericssess/essvol1/Bridgerp68.opd.pdf](http://www.moderntimesworkplace.com/archives/ericssess/essvol1/Bridgerp68.opd.pdf).

Brunello, N., Davidson, J. R., Deahl, M., Kessler, R. C., Mendlewicz, J., Racagni, G., ... Zohar, J. (2001). Posttraumatic stress disorder: Diagnosis and epidemiology, comorbidity and social consequences, biology and treatment. *Neuropsychobiology*, 43(3), 150–162. <https://doi.org/10.1159/000054884>.

Busuttill, W. (2017). Military culture effects on mental health and help-seeking. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 73–88). London, England: Routledge.

Cabrera, O., Hoge, C., Bliese, P. D., Castro, C., & Messer, S. C. (2007). Childhood adversity and combat as predictors of depression and post-traumatic stress disorder in deployed troops. *American Journal of Preventive Medicine*, 33(2), 77–82. <https://doi.org/10.1016/j.amepre.2007.03.019>.

Campbell, M., Decker, K. P., Kruk, K., & Deaver, S. P. (2016). Art therapy and cognitive processing therapy for combat-related PTSD: A randomized controlled trial. *Art Therapy: Journal of the American Art Therapy Association*, 33(4), 1–9. <https://doi.org/10.1080/07421656.2016.1226643>.

Chapman, L., Morabito, D., Ladakakos, C., Schreier, H., & Knudson, M. (2001). The effectiveness of art therapy interventions in reducing Post-Traumatic Stress Disorder (PTSD) symptoms in pediatric trauma patients. *Art Therapy: Journal of the American Art Therapy Association*, 18(2), 100–104. <https://doi.org/10.1080/07421656.2001.10129750>.

Chard, K., Schumm, J., Owens, G., & Cottingham, S. (2010). A comparison of OEF and OIF veterans and Vietnam veterans receiving cognitive processing therapy. *Journal of Traumatic Stress*, 22(1), 11–19. <https://doi.org/10.1002/jts.20500>.

Chatterjee, H. J., & Camic, P. (2015). The health and well-being potential of museums and art galleries. *Arts & Health*, 7(3), 183–186. <https://doi.org/10.1080/17533015.2015.1065594>.

Cloitre, M., & Schmidt, J. A. (2015). STAIR narrative therapy. In U. Schnyder, & M. Cloitre (Eds.). *Evidence based treatments for trauma-related psychological disorders* (277–297). Cham, Switzerland: Springer.

Collie, C. A., Backos, A., Malchiodi, C., & Spiegel, D. (2006). Art therapy for combat-related PTSD: Recommendations for research and practice. *Art Therapy: Journal of the American Art Therapy Association*, 23(4), 157–164. <https://doi.org/10.1080/07421656.2006.10129335>.

Currier, J., Holland, J., Drescher, K., & Elhai, J. (2014). Residential treatment for combat-related posttraumatic stress disorder: Identifying trajectories of change and predictors of treatment response. *PloS One*, 9(7), e101741. <https://doi.org/10.1371/journal.pone.0101741>.

Erikson, E. H. (1959). *Identity and the life cycle*. New York, NY: International Universities Press.

Fear, N. T., Iversen, A., Meltzer, H., Workman, L., Hull, L., Greenberg, N., ... Jones, M. (2007). Patterns of drinking in the UK armed forces. *Addiction*, 102(11), 1749–1759. <https://doi.org/10.1111/j.1360-0443.2007.01978.x>.

Fear, N. T., Jones, M., Murphy, D., Hull, L., Iversen, A. C., Coker, B., ... Greenberg, N. (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. *The Lancet*, 375(9728), 1783–1797. [https://doi.org/10.1016/S0140-6736\(10\)60672-1](https://doi.org/10.1016/S0140-6736(10)60672-1).

Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (Eds.). (2009). *Effective treatments for PTSD: Practice guidelines from the International society for traumatic stress studies* (2<sup>nd</sup> ed.). New York, NY: Guilford.

Forbes, D., Lewis, V., Parslow, R., Hawthorne, G., & Creamer, M. (2008). Naturalistic comparison of models of programmatic interventions for combat-related post-traumatic stress disorder. *The Australian and New Zealand Journal of Psychiatry*, 42(12), 1051–1059. <https://doi.org/10.1080/00048670802512024>.

Francois, C., Depiegel, N., Maman, K., Saragoussi, D., & Auguier, P. (2010). Anxiety disorders, major depressive disorder and the dynamic relationship between these conditions: Treatment patterns and cost analysis. *Journal of Medical Economics*, 13(1), 99–109. <https://doi.org/10.3111/13696991003591321>.

Gantt, L., & Tinnin, L. (2009). Support for a neurobiological view of trauma with implications for art therapy. *The Arts in Psychotherapy*, 36(3), 148–153. <https://doi.org/10.1016/j.aip.2008.12.005>.

Harned, M. S., Korslund, K. E., & Linehan, M. M. (2014). A pilot randomized controlled trial of Dialectical Behavior Therapy with and without the Dialectical Behavior Therapy Prolonged Exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD. *Behaviour Research and Therapy*, 55, 7–17. <https://doi.org/10.1016/j.brat.2014.01.008>.

Harrison, T. (2000). *Bion, Rickman, Foulkes and the Northfield experiments*. London, England: Jessica Kingsley.

Harrison, T., & Clarke, D. (1992). The Northfield experiments. *The British Journal of Psychiatry*, 160(5), 698–708. <https://doi.org/10.1192/bjp.160.5.698>.

Hass-Cohen, N., & Carr, R. (Eds.). (2008). *Art therapy and clinical neuroscience*. Philadelphia, PA: Jessica Kingsley.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror*. New York, NY: Basic Books.

Hogan, S. (2001). *Healing arts: The history of art therapy*. London, England: Jessica Kingsley.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine*, 351(1), 13–22. <https://doi.org/10.1056/NEJM040107>.

- 1056/NEJMoa040603.
- Hoge, C., Riviere, L. A., Wilk, J., Herrell, R., & Weather, F. W. (2014). The prevalence of post-traumatic stress disorder (PTSD) in US combat soldiers: A head-to-head comparison of DSM-5 versus DSM-IV-TR symptom criteria with the PTSD checklist. *The Lancet Psychiatry*, 1(4), 494–505. [https://doi.org/10.1016/S2215-0366\(14\)70235-4](https://doi.org/10.1016/S2215-0366(14)70235-4).
- Holmes, E. A., Lang, T. J., Moulds, M. L., & Steele, A. M. (2008). Prospective and positive mental imagery deficits in dysphoria. *Behaviour Research and Therapy*, 46(8), 976–981. <https://doi.org/10.1016/j.brat.2008.04.009>.
- Howie, P. (Ed.). (2017). *Art therapy with military populations: History, innovation, and applications*. London, England: Routledge.
- Iversen, A. C., Fear, N. T., Simonoff, E., Hull, L., Horn, O., Greenberg, N., ... Wessely, S. (2007). Influence of childhood adversity on health among male UK military personnel. *The British Journal of Psychiatry*, 191(6), 506–511. <https://doi.org/10.1192/bjp.bp.107.039818>.
- Iversen, A. C., Fear, N. T., Ehlers, A., Hacker, H. J., Hull, L., Earnshaw, M., ... Hotopf, M. (2008). Risk factors for post-traumatic stress disorder among UK Armed Forces personnel. *Psychological Medicine*, 38(4), 511–522. <https://doi.org/10.1017/S0033291708002778>.
- Johnson, D., Lubin, H., Miller, J., & Hale, K. (1997). Single session effects of treatment components within a specialized inpatient Post-Traumatic Stress Disorder program. *Journal of Traumatic Stress*, 10(3), 377–390. <https://doi.org/10.1002/jts.2490100304>.
- Jones, J. P., Walker, M. S., Masino Drass, J., & Kaimal, G. (2017). Art therapy interventions for active duty military service members with post-traumatic stress disorder and traumatic brain injury. *International Journal of Art Therapy Inscape*, 23(2), 70–85. <https://doi.org/10.1080/17454832.2017.1388263>.
- Joseph, S. (2012). *What doesn't kill us: A guide to overcoming adversity and moving forward*. London, England: Piatkus Little Brown.
- Kaiser, D. H. (2009). Assessing attachment with the Bird's Nest Drawing: A review of the research. *Art Therapy: Journal of the American Art Therapy Association*, 26(1), 26–33. <https://doi.org/10.1080/07421656.2009.10129312>.
- Kitchiner, N., Roberts, N., Wilcox, D., & Bisson, J. (2012). Systematic review and meta-analysis of psychosocial interventions for veterans of the military. *European Journal of Psychotraumatology*, 3(1), 1–16. <https://doi.org/10.3402/ejpt.v3i0.19267>.
- Kopytin, A., & Lebedev, A. (2013). Humor, self-attitude, emotions and cognitions in group art therapy with war veterans. *Art Therapy: Journal of the American Association*, 30(1), 20–29. <https://doi.org/10.1080/07421656.2013.757758>.
- Kopytin, A., & Lebedev, A. (2015). Therapeutic functions of humour in group art therapy with war veterans. *International Journal of Art Therapy Inscape*, 20(2), 40–53. <https://doi.org/10.1080/17454832.2014.1000348>.
- Kravits, K. (2017). The biological basis of Post-traumatic stress disorder and recovery. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 43–60). London, England: Routledge.
- Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., ... Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, 29(8), 695–706. <https://doi.org/10.1016/j.cpr.2009.07.003>.
- Lobban, J. (2014). The invisible wound: Veterans' art therapy. *International Journal of Art Therapy Inscape*, 19(1), 3–18. <https://doi.org/10.1080/17454832.2012.725547>.
- Lobban, J. (2016a). Factors that influence engagement in an inpatient art therapy group for veterans with Post-Traumatic Stress Disorder. *International Journal of Art Therapy Inscape*, 21(1), 15–22. <https://doi.org/10.1080/17454832.2015.1124899>.
- Lobban, J. (2017a). The development and practice of art therapy with military veterans. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 9–25). London, England: Routledge.
- Lobban, J. (2016b). *Art therapy for military veterans with PTSD: A transatlantic study* Retrieved from <https://www.wcmt.org.uk/sites/default/files/report-documents/Lobban%20J%20Report%202016%20Final.pdf>.
- Lobban, J. (2017b). Bypassing the sentinel. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 152–166). London, England: Routledge.
- Lobban, J., & Ellis, L. (2017). Cultural collaborations. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 183–201). London: Routledge.
- Lobban, J., & Murphy, D. (2017). Using art therapy to overcome avoidance in veterans with chronic post-traumatic stress disorder. *International Journal of Art Therapy Inscape*, 23(3), 99–114. <https://doi.org/10.1080/17454832.2017.1397036>.
- Lobban, J., & Spinelli, L. (2017). *Transatlantic art therapy group. Newsbriefing*. January/London, England: The British Association of Art Therapists 24–25.
- Lobban, J., Mackay, K., Redgrave, M., & Rajagopal, S. (2017). An adaptive art therapy model for working with traumatised veterans. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 103–125). London, England: Routledge.
- Lusebrink, V. J. (2004). Art therapy and the brain: An attempt to understand the underlying processes of art expression in therapy. *Art Therapy: Journal of the American Art Therapy Association*, 21(3), 125–135. <https://doi.org/10.1080/07421656.2004.10129496>.
- Lyshak-Stelzer, F., Singer, P., St. John, P., & Chemtob, C. (2007). Art therapy for adolescents with Post-Traumatic Stress Disorder symptoms: A pilot study. *Art Therapy: Journal of the American Art Therapy Association*, 24(4), 163–169. <https://doi.org/10.1080/07421656.2007.10129474>.
- Milliken, C. S., Auchterlonie, J. L., & Hoge, C. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*, 298(18), 2141–2148. <https://doi.org/10.1001/jama.298.18.2141>.
- Morland, L. A., Mackintosh, M. A., Greene, C. J., Rosen, C. S., Chard, K. M., Resick, P., ... Frueh, B. C. (2014). Cognitive processing therapy for posttraumatic stress disorder delivered to rural veterans via telehealth: A randomised noninferiority clinical trial. *The Journal of Clinical Psychiatry*, 75(5), 470–476. <https://doi.org/10.4088/JCP.13m08842>.
- Murphy, D., & Busuttill, W. (2014). Reviewing PTSD, stigma and barriers to help-seeking within the UK Armed Forces. *Journal of the Royal Army Medical Corps*, 161(4), 322–326. <https://doi.org/10.1136/jramc-2014-000344>.
- Murphy, D., Weijers, B., Palmer, E., & Busuttill, W. (2015). Exploring patterns in referrals to Combat Stress for UK veterans with mental health difficulties between 1994 and 2014. *International Journal of Emergency Mental Health and Human Resilience*, 17(3), 652–658. <https://doi.org/10.4172/1522-4821.1000250>.
- Murphy, D., Palmer, E., & Busuttill, W. (2016). Exploring indices of multiple deprivation within a sample of veterans seeking help for mental health difficulties residing in England. *Journal of Epidemiology and Public Health Reviews*, 1(6), <https://doi.org/10.16966/2471-8211.132>.
- Murphy, D., Spencer-Harper, L., Carson, C., Palmer, E., Hill, K., Sorfleet, N., ... Busuttill, W. (2016). Long-term responses to treatment in UK veterans with military-related PTSD: An observational study. *BMJ Open*, 6(9), e011667. <https://doi.org/10.1136/bmjopen-2016-011667>.
- Murtagh, D., & Lobban, J. (2017). Reclaiming life through art. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 215–226). London, England: Routledge.
- Nanda, U., Gaydos, L., Hathorn, K., & Watkins, N. (2010). Art and post-traumatic stress: A review of the empirical artwork for veterans with Post-Traumatic Stress Disorder. *Environment and Behaviour*, 42(3), 376–389. [10.1177/01511177093516510361874](https://doi.org/10.1177/01511177093516510361874).
- NICE (2005). *Post-traumatic stress disorder: Management*. Retrieved from [www.nice.org.uk/guidance/cg26/chapter/1-Guidance](http://www.nice.org.uk/guidance/cg26/chapter/1-Guidance).
- Palmer, E., Hill, K., Lobban, J., & Murphy, D. (2017). Veterans' perspectives on the acceptability of art therapy: A mixed-methods study. *International Journal of Art Therapy Inscape*, 22(3), 132–135. <https://doi.org/10.1080/17454832.2016.1277250>.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Counter-transference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: Norton.
- Perry, G. (2008). *Map of nowhere. Etching*. Retrieved from <http://visualarts.britishcouncil.org/collection/artists/perry-grayson-1960/object/map-of-nowhere-perry-2008-p8194>.
- Pifalo, T. (2002). Pulling out the thorns: Art therapy with sexually abused children and adolescents. *Art Therapy: Journal of the American Art Therapy Association*, 19(1), 12–22. <https://doi.org/10.1080/07421656.2002.10129724>.
- Rademaker, A., Vermetten, E., & Kleber, R. (2009). Multimodal exposure-based group treatment for peacekeepers with PTSD: A preliminary evaluation. *Military Psychology*, 21(4), 482–496. <https://doi.org/10.1080/08995600903206420>.
- Rauch, S. L., van der Kolk, B. A., Fisler, R. E., Alpert, N. M., Orr, S. P., Savage, C. R., ... Pitman, R. K. (1996). A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script-driven imagery. *Archives of General Psychiatry*, 53(5), 380–387. <https://doi.org/10.1001/archpsyc.1996.01830050014003>.
- Richardson, D., Pekevski, J., & Elhai, J. (2009). Post-traumatic stress disorder and health problems among medically ill Canadian peacekeeping veterans. *The Australian and New Zealand Journal of Psychiatry*, 43(4), 366–372. <https://doi.org/10.1080/00048670902721061>.
- Richardson, D., Contractor, A., Armour, C., St Cyr, K., Elhai, J., & Sareen, J. (2014). Predictors of long-term treatment outcome in combat and peacekeeping veterans with military-related PTSD. *The Journal of Clinical Psychiatry*, 75(11), 1299–1305. <https://doi.org/10.4088/JCP.13m08796>.
- Smith, A. (2016). A literature review of the therapeutic mechanisms of art therapy for veterans with Post-Traumatic Stress Disorder. *International Journal of Art Therapy Inscape*, 21(2), 66–74. <https://doi.org/10.1080/17454832.2016.1170055>.
- Smith, A., & Lobban, J. (2017). Research and evaluation. In J. Lobban (Ed.). *Art therapy with military veterans: Trauma and the image* (pp. 167–179). London, England: Routledge.
- Sundin, J., Herrell, R. K., Hoge, C. W., Fear, N. T., Adler, A. B., Greenberg, N., ... Bliese, P. D. (2014). Mental health outcomes in US and UK military personnel returning from Iraq. *The British Journal of Psychiatry*, 204(3), 200–207. <https://doi.org/10.1192/bjp.bp.113.129569>.
- Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3), 455–471. <https://doi.org/10.1002/jts.2490090305>.
- Walker, M., Kaimal, G., Koffman, R., & DeGraba, T. J. (2016). Art therapy for PTSD and TBI: A senior active duty military service member's therapeutic journey. *The Arts in Psychotherapy*, 49, 10–16. <https://doi.org/10.1016/j.aip.2016.05.015>.
- Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4<sup>th</sup> ed.). New York, NY: Basic Books.