International Advances in Art Therapy Research and Practice

International Advances in Art Therapy Research and Practice:

The Emerging Picture

Edited by
Val Huet and Lynn Kapitan

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INTRODUCTION

VAL HUET AND LYNN KAPITAN

In these difficult times of environmental, political, and social upheaval, how do we conceive of a meaningful role for art therapy? How can we better prepare for current challenges, as well as for future realities we cannot foresee? Among our many tools are the healing relationship, reflexive practice, research evidence, and art in service of the emancipation and realization of human potential. However, the landscape in which art therapists live and work is not fixed in position; it is fluid and ever changing, as our world is ever changing. Consider an art therapist in the Netherlands who perceives the need to add a visual, art-based element to a standard trauma protocol and thereby empowers trauma survivors to re-script their nightmares. Or Indonesia's six art therapists who reached out across the vast, diversely-populated archipelago to document how they adapted art therapy upon return from training abroad. As these and other innovations of research and practice described in this text affirm, art therapy's ability to evolve practice greatly differs by locale, based in part on available infrastructure to support research, practice, and training. As new problems and opportunities arise, art therapists must be able to cross boundaries of difference, in spaces of connection rather than division.

This understanding was recognized at the inaugural International Art Therapy Practice Research Conference in London where, on the 11th of July 2019, 700 delegates from 36 countries gathered. Art therapists the world over came together, not solely as a profession but a community of practice (Wenger, 1998) with a common sense of purpose within a diversity of practices, resources, and perspectives. Many were from countries where art therapy was well established, benefitting from academic training, registration/licensure, formal posts, professional bodies, and an overall strong professional identity. Those who did not share this experience lived in places with fewer resources and opportunities, yet were courageously and painstakingly developing art therapy, one small step at a time. As all delegates exchanged ideas, questions, innovations, and evidence, a nascent practice/research network was seeded.

Practice/research networks originated with medical practitioners who knew they needed evidence-based research but were also time-poor and often worked on their own (Huet et al., 2014). Art therapists, similarly, are confronted with the question "Where is your evidence?" We know that the testimonies of clients, families, carers, and friends on art therapy's significant positive impact does not constitute robust enough evidence. As Huet et al. (2014) explained, one solution is to access and disseminate research through networks of peers and colleagues, and to identify areas for common research collaboration. This model was used to establish a research network for British art therapists in 2000, providing the organizing framework for the conference.

Research networks can introduce collaboration and bridge seemingly insurmountable distances between professional associations. For the American Art Therapy Association (AATA) and the British Art Therapy Association (BAAT), the conference resulted from their first-ever collaboration. A small working group was formed that included Donna Betts, Sarah Deaver, Val Huet, Girija Kamal, Lynn Kapitan, Neil Springham, and Tim Wright. The conference aim was to build a culture inclusive of all levels of expertise and experience in research and, importantly, to help address the gap between research and practice. We proposed to attract not only experienced researchers but also inspired clinicians who were developing evidence-based practice innovations. Another aim was to break down certain research myths, including the notion that research is only conducted by experts

rather than by practitioners, or that there always must be a strict delineation between researcher and participants.

De-Centering the Conversation

Early discussions within the working group produced awareness that to truly create an ethos of inclusivity within an international gathering of art therapists there must be opportunity for diverse perspectives to be voiced, particularly in the planning process. An invitation went out to representatives of art therapy throughout the world to open up collaborative, co-participation in shaping the conference structures. What came back, almost immediately, were entwined concerns about power and privilege in research, training, and practice formats—especially for art therapists working outside of dominant cultures. A robust discussion highlighted an urgent need to de-colonize and re-think/re-design art therapy training and approaches to practice, and to develop culturally-relevant training worldwide. Discussants emphasized the incapacitating effects of professional isolation, which is particularly acute in locales where there is no profession or professional organization, credentials, or standards.

The challenge of diversifying and de-centering art therapy research and practice can only be met by holding different points of view in dialogue. Connecting with one another also strengthens resilience, providing needed flexibility and adaptation for art therapy to thrive. The conference vision thus shifted from "research expert" to "research connector" across the global art therapy community, and initiated a more open, self-organizing network of researcher-practitioners than imagined. The attendees connected—by engaging, re-imagining art therapy through multiple pathways and standpoints, and realigning themselves with new ideas, solutions, and connections (Kapitan, 2014). When embraced within a transformational community of practice, we may find that historic differences are no longer a problem. We may become more flexible, permeable, and able to accommodate all the ways art therapy is practiced and all that motivates art therapy researchers.

Structure of this Book

In any healthy network the greater the linkages, the greater the potential impacts of actions taken through them. To join research with practice and vice versa, each contributor to the conference was asked to articulate implications for practice from research study and for research from practice innovation. We welcomed presentations that included co-production between art therapists and clients, diversity of lived experiences with art therapy, and socially-relevant practices that addressed such global imperatives as trauma, community resilience, and marginality. This publication reflects the dynamism and creativity that defined the conference, as well as its cultural and practice diversity.

We have organized this book to reflect these central features. Each section is comprised of select research and practice chapters positioned dialogically to link and enhance the reading experience. Part I illustrates how art therapists are using research and practice innovations to address trauma and related social ills. Part II is an exploration of how art is being used to advance knowledge by meaningfully capturing both the researcher's and participants' experiences—whether as the focus of study (art-informed research) or by actually performing or driving the method of inquiry (art-based research). Part III describes the inroads art therapists have made in establishing their practices in countries new to art therapy. In Part IV readers will learn how art therapists are breaking down barriers of culture and marginality within the art therapy encounter. Finally, Part V focuses attention on the lived experience of art therapy, and how it supports participants in finding a voice of empowerment in particular. Although several chapters could easily have been placed in more than one section, an important thread common to all is a genuine sense of care and compassion towards people who, for a multitude of reasons, have come to art therapy having experienced deep distress.

To Our Readers

Art therapists who come together with diversity in unity are leading the way in the formation of resilient communities of practice that are responsive to changing contexts. As this book attests, diversity and connectivity ensure that new alliances will form, with different talents and perspectives to take up new challenges. By integrating research into our daily practice, we can produce more effective impacts. By sharing the results of our work, we multiply these impacts toward a greater range of possible solutions and responses. We hope that this book will inspire art therapists, artists, and people interested in therapeutic art and, importantly, make a positive contribution to our clients' lives.

Acknowledgements

Many thanks to the members of the collaborative, cross-national teams that devoted their time and energy in planning the inaugural International Art Therapy Research Conference in London, 2019. We thank Neil Springham and Tim Wright who, with Val Huet, represented the British Association of Art Therapists, and Donna Betts, Sarah Deaver, Girija Kaimal, and Christianne Strang who, with Lynn Kapitan, represented the American Art Therapy Association. We also thank the AATA and BAAT staff members, particularly Cynthia Woodruff, Barbara Florence, Abimbola Badiora, Alex McDonald, Bettina Jensen, Nicky Sutton, and Ioanna Xenophontes, whose work was essential in making the event a success.

We are grateful as well to the more than 50 representatives of art therapy associations and locales throughout the world who responded to our invitation to join the International Advisory Group in the planning process. Their diverse perspectives and focal concerns helped shape the conference direction, themes, and content. Without them, the breadth of the conference—and this text that emerged from it—would not have been possible. Collectively, the planners, advisors, volunteers, and all participants and attendees helped realize the goal of strengthening art therapy on a global scale.

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PART I:

TRAUMA

1. CREATE, DESTROY, TRANSFORM: A BRAIN-BASED DIRECTIVE FOR TRAUMA TREATMENT

KRISTYN S. STICKLEY AND DENISE R. WOLF

Trauma occurs when a person experiences an event that overpowers their ability to cope (American Psychiatric Association, 2013). Traumatic events may involve threats to one's life, physical safety, or emotional well-being, and are often met with responses of terror or powerlessness (Sarid & Huss, 2010). When confronted with a dangerous situation, humans, like animals, respond by fleeing the scene, fighting the threat, or by freezing, resulting in a brain state focused on survival that inhibits areas of the upper brain like the prefrontal cortex (Levine, 2010). This reaction produces a transition in brain functioning to address pain and distress (Chong, 2015). Areas of the brain involved in survival (e.g., the brainstem, limbic system, etc.) are located in the "lower brain" and those involved in cognition reside in what can be called the higher or "upper brain." Survival-based reactions produce neural changes that interrupt the brain's state of homeostasis, replacing it with a state of fear-based, heightened arousal (Schore, 2003). Typical functioning of the lower areas of the brain also become disrupted and replaced with dysregulated neural activity, prolonging symptoms of trauma that affect emotional regulation, memory, and sensory processing (Schore, 2003, as cited in Chong, 2015). Until these symptoms are ameliorated, cyclical fear-based responses will continue, causing the individual dysregulation and distress (van der Kolk, 2014).

Emerging evidence supports treatment interventions that target such dysregulation of the lower brain. When individuals are asked to describe their trauma in therapy, they may feel unable to verbally recount it because the upper brain, which contains language centers, shuts down during traumatic event(s) (Schouten et al., 2015; Stace, 2014). Therapies that treat trauma without using words—that engage brain functioning upward from the bottom of the brain—may prove more effective in reducing symptoms by re-regulating the dysregulated lower brain (Chong, 2015; Hinz, 2009; Perry, 2009; Sarid & Huss, 2010). Among the frameworks that are useful in trauma treatment with art therapy, our work has been informed by three in particular: the Expressive Therapies Continuum (ETC; Lusebrink, 2010), Perry's (2009) tenets of trauma treatment, and Herman's (1997) three-stage approach to trauma treatment.

The ETC provides a model for tracking information processing systems that are engaged when using various art media and directives (Hinz, 2009; Lusebrink, 2010). It involves four levels: kinesthetic/sensory, perceptual/affective, cognitive/symbolic, and creative. The first two levels correspond with the lower brain, the third level corresponds with cognitive functions, and the creative level can be present in all levels of the ETC and throughout the brain (Lusebrink & Hinz, 2016). Varied experiences with art materials can target activation of brain functions important in the treatment of trauma.

Perry's (2009) Neurosequential Model of Therapeutics involves patterned and repetitive interventions to re-regulate dysregulated neural activity. Perry developed his tenets (the "5 Rs") to inform effective trauma treatment with tasks that are relational, relevant, repetitive, rewarding, and rhythmic as necessary for regulating the dysregulated lower brain (Perry, 2009). Homer (2015) demonstrated that many art therapy tasks have these features and can be utilized in a neurodevelopmental approach to trauma treatment.

Seminal work by Herman (1997) outlined trauma treatment that involves three stages: safety and stabilization, remembrance and mourning, and reconnection and integration. The first stage aims to establish physical and emotional safety within the therapy space; the second stage of treatment is

focused on sharing the traumatic event(s) and making meaning; and in the third stage of treatment, the individual is able to integrate their experience into their life story, recognize that it does not define them, and focus on redefining themselves (Herman, 1997).

Create, Destroy, Transform

We adapted an art therapy directive called "Create, Destroy, Transform" to promote trauma resolution, healing, and understanding after trauma. Kapitan et al. (2011) described the directive in a research report on their experience working with community leaders who engaged in shared, round-robin art making in the roles of a creator, destroyer, or transformer to process aspects of collective trauma. Wolf and King (2018) utilized the directive with art therapy conference attendees to illustrate trauma theory and to foster empathy.

Our contemporary practice innovation pairs the "create, destroy, transform" directive with clay. Clay was chosen as the primary vehicle for "bottom-up" and "top-down" neural regulation because clay can be molded, worked, and reworked while providing kinesthetic, cathartic, constructive, destructive, and aggressive outlets for the artist (Nan & Ho, 2017). Research suggests that clay may activate the lower brain (Elkis-Abuhoff & Gaydos, 2018). According to Ryan et al. (2017), neural dysregulation can be improved if an individual partakes in safe and predictable motor experiences, like sculpting with clay.

Table 1.1

Stages of "Create, Destroy, Transform" with Corresponding Frameworks

Stages of the Directive	The Expressive Therapies Continuum	Perry's Tasks (the 5 Rs)	Herman's Stages of Trauma Treatment
Create	-Kinesthetic/Sensory -Perceptual/Affective -Creative	-Rhythmic -Repetitive -Rewarding	-Safety and Stabilization
Destroy	-Kinesthetic/Sensory -Affective -Cognitive/Symbolic	-Relevant -Rewarding	-Remembrance and Mourning
Transform	-Perceptual -Cognitive/Symbolic -Creative	-Relevant -Relational -Rewarding	-Reconnection and Integration

Our directive aims to assist individuals toward brain-based healing and trauma resolution grounded on a synthesis of theories (Table 1.1). We posit that our directive, when used with clay, may simultaneously regulate the lower brain while cognitively processing traumatic experiences in the upper brain. Thus, the individual may be able to integrate their trauma into their life story and experience trauma resolution through this approach.

Case Vignettes with Each Stage

The development of the directive was part of a graduate capstone project with first author Stickley in the role of facilitator and second author Wolf as her advisor. The setting was a community mental health center with adults who had histories of trauma and were experiencing related symptoms. A diverse sample of three participants (identified with pseudonyms) was selected based on their voiced desire to process their trauma. Participants who had not yet reached a level of stabilization of symptoms that allowed them to function independently in the community without a higher level of care were not include in the directive.

The directive, which was introduced as optional, was implemented with each individual over the course of several 50-minute sessions. Participants were told that the directive had three stages (to create a piece of art, to destroy it, and then to transform it) with the goal of regulating the lower brain. I (Stickley) explained the neurological changes that occur after trauma and answered questions about the directive, elaborating on each stage of the process. Each session was structured with a 10-minute check-in, a breathing exercise, art making for as long as the individual wanted, verbal processing of the artwork, and a second breathing exercise before the session ended. I also explained the structure of each session before beginning. Polymer clay, clay tools, safety goggles, hot glue, and other materials in the art therapy space were provided to the participants throughout this directive.

Create

The "create" stage invited sensory and kinesthetic responses from the participants, as all three participants noted the sensory qualities of the clay. They felt the temperature and texture of the clay. Brandon spoke at length about how the clay was "cool" and "hard," and how he wanted to "warm it up." They all became kinesthetically involved with the clay as they held, rolled, and pounded the clay without prompting. While creating their piece, they experienced two of Perry's 5 Rs: rhythm and repetition. Taylor's breathing appeared to slow and become more regular as she shaped the clay to form the figure of a cat (Figure 1.1), commenting that the task was "relaxing." Brandon initially presented with shaking hands, but as he rolled the clay into a long coil (Figure 1.2), he stated that his hands had become "less shaky" and his breathing slowed. All participants verbally recounted their trauma while working, without prompting. As Taylor began to work on her cat, she spontaneously spoke about her abuser and her experience of domestic abuse. Brandon spoke about his siblings, noting the traumatic impact of his ongoing isolation from them. Similarly, Dana, who created Figure 1.3, began to speak about losing both of her children.

Figure 1.1

Create: Multiple Views of *Cat* by Taylor

Figure 1.2

Create: *Nautilus Shell* by Brandon

Figure 1.3

Create: *Clover* by Dana

Destroy

In response to the next prompt, which was to "destroy" their hardened clay pieces, there seemed to be an increase in physical exertion along with expression of fantasies of retaliation against the aggressor. All participants experienced difficulty in their first attempts to destroy their art, as baked polymer clay is strong. When their pieces did not break, they increased their physical force. After his first attempt to break his piece with a heavy object, Brandon chose to use only his hands to do so, which required a large amount of force (Figure 1.5). Struggling to break her piece, Dana stated, "that's hard to crack; you'd have to be really angry to crack that," then used more force to break it (Figure 1.6). Fantasies of retaliation that seemed to be against their aggressors arose; Taylor laughed as she broke the cat and stated that it did not matter if "he" was destroyed because "he's ugly" (Figure 1.4). Afterwards, she shared that the experience had been "fun" for her. Dana seemed to

express a similar desire to retaliate, saying that a person would have to be “really angry” to break her piece, as she then demonstrated.

Figure 1.4

Destroy: Multiple views of *Cat* by Taylor

Figure 1.5

Destroy: *Nautilus Shell* by Brandon

Figure 1.6

Destroy: *Clover* by Dana

All three participants connected to the experience of "being broken." After breaking her cat, Taylor shared that the cat was saying "help me because I'm broken and need to be pieced back together" and that the cat "want[ed] his life back." She spoke about how she felt "broken" each time her abuser had harmed her. Once his piece had been destroyed, Brandon reflected, "I was broken from [age] eight to thirty-eight," alluding to the multiple traumatic events he had experienced. Dana shared that she was "broken before" from having experienced a miscarriage and medical trauma. She added a second crack to her piece, stating that it represented her fissured relationship with her living daughter. Each participant directly compared the brokenness of their art to their own feelings of being broken, which appeared to parallel Herman's (1997) stage of remembrance and mourning.

Participants also connected the destruction of the artwork to their own processes of healing. Taylor said she had been broken like the cat but had since begun to heal. Brandon shared that, although broken, he had been "feeling better and finding [his] way" through treatment. Dana identified that she was "put back together now" as she was engaged in treatment.

Transform

The concept of "mistakes" arose multiple times in the third stage of the directive. Brandon transformed his piece by creating a vessel (Figure 1.8). He had wanted a certain number of pieces for each concentric circle he built up from the base, but reported that he was not successful. Instead of becoming upset he stated, "it's not perfect but nothing ever is . . . it's lopsided but so am I." He spoke about how his experience of trauma had changed him.

Another theme that emerged was a desire to reinforce or "fix" the art. Taylor shared that she wanted to "fix" the cat and therefore chose to reassemble it (Figure 1.7). This may have been a statement alluding to her own desire to heal. After having transformed his piece into a vessel, Brandon stated that he had "wanted to give the piece extra strength." Dana asked for a piece of string after she had finished her clover and tied it around its stem in the shape of a bow, seeming to want to further secure her reconstructed piece (Figure 1.9)

Figure 1.7

Transform: Multiple Views of *Cat* by Taylor

Figure 1.8

Transform: Multiple Views of *Reconstructed* by Brandon

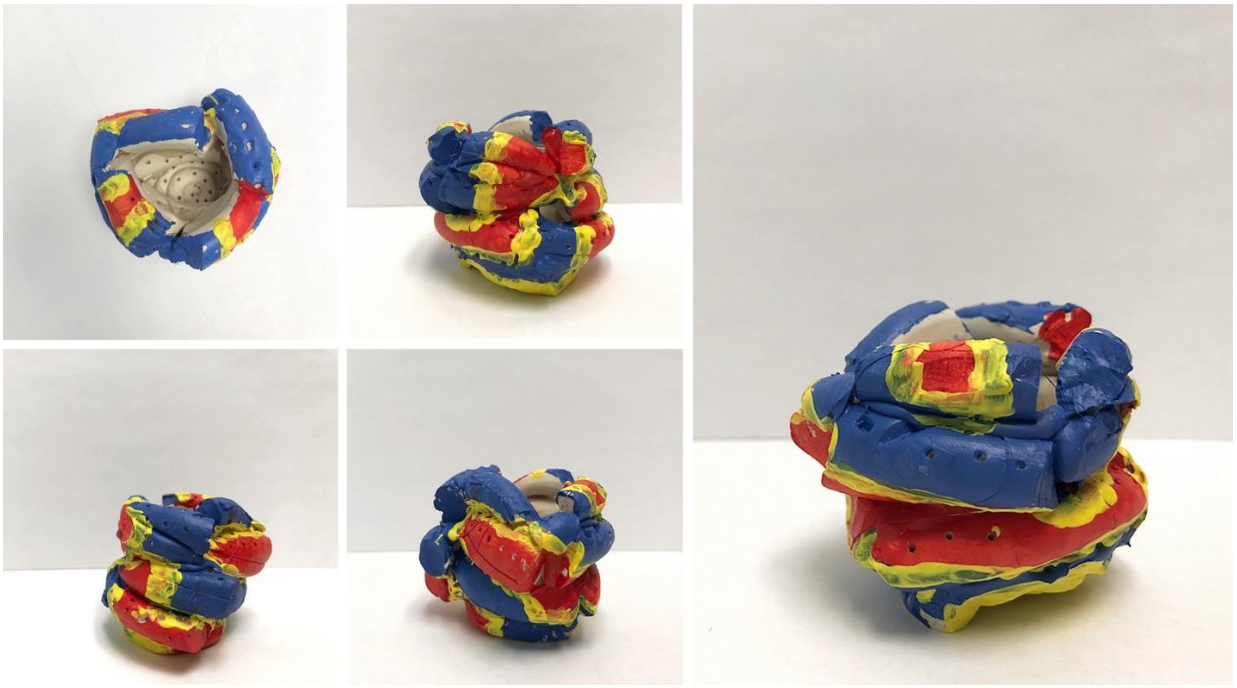


Figure 1.9

Transform: *Togetherness* by Dana

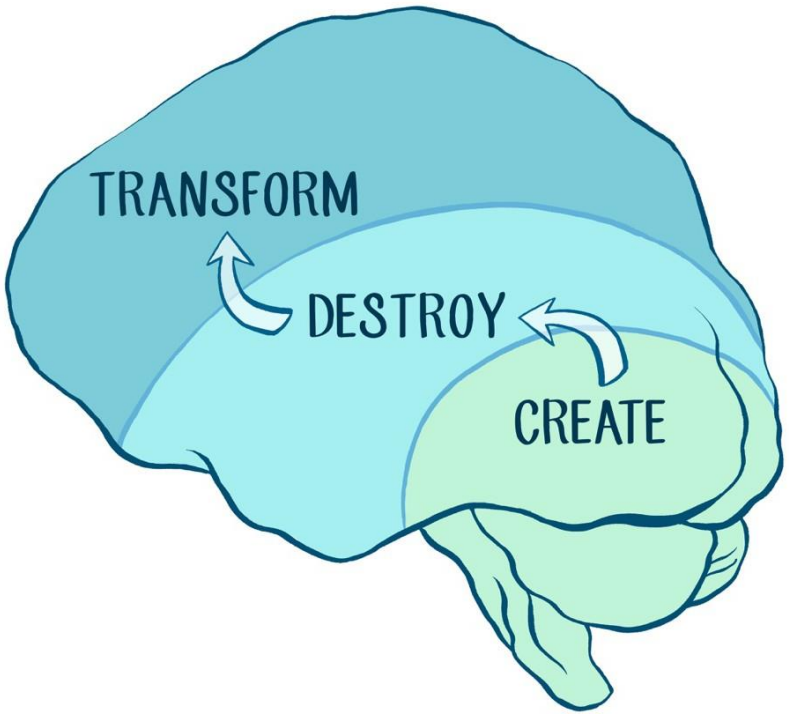
Participants may have begun to reintegrate their traumas into their life stories through the transformation of the clay. When prompted to respond to her repaired cat, Taylor stated: “He’s not broken no more; he’s new and improved and happy” and “he has scars . . . but they aren’t all he is.” She shared that her trauma will remain in her story but that it does not define her. Brandon stated that he had transformed his piece to mirror his “piec[ing] himself back together” and titled the piece “Reconstructed.” Dana compared her repaired clover to her desire to repair her family, stating, “I wish my family was patched up like this clover . . . I’m trying to put my family back together.” She titled the repaired piece “Togetherness.” All three participants directly compared this stage to their own transformation, understanding that they could not return to their life before their trauma but they could pick up the pieces and build something new.

Implications for Practice and Research

The “create, destroy, transform” directive was informed by parallels that were drawn among the ETC and its application to trauma treatment, Perry’s (2009) 5 Rs of neurodevelopmental trauma treatment, and Herman’s (1997) stages of trauma work. After parsing participant responses to the directive into themes and reflecting on clinical observations, it appears as though the research cited to support this method pairs well with its three-step approach. Through each stage of the method, a different area of the brain is targeted (Figure 1.10). The strength of the directive lies in its multifaceted approach to trauma treatment through brain-based, metaphorical, regulatory, and relational aspects of care.

Figure 1.10

Stages of Create, Destroy, Transform and Targeted Areas of the Brain



The number of positive responses to the directive suggests that additional explorations are warranted. One question that was raised and explored was whether the stabilization of symptoms must be in place prior to beginning to process trauma, as recommended by some theorists (Elbrecht & Antcliff, 2014; Herman, 1997). We continuously assessed participants throughout the sessions to ensure that only participants who were ready for such a directive would participate. Conversely, other theorists posit that assessing "readiness" for trauma treatment based on stabilization criteria can become a barrier to treatment. For example, Sweeney et al. (2018) questioned whether "extreme behaviors may be adaptions to past traumas rather than symptoms of a mental illness" (p. 327) and stabilization occurs as treatment begins. This is an ongoing question that warrants further exploration.

When used in practice or research, it is necessary to identify and consider that polymer and ceramic clays might elicit very different responses from participants. Polymer clay is unlike ceramic clay in that it is softer after it has been baked and does not leave a chalky residue on the hands. Compared to polymer, when broken, ceramic clay sounds louder and shatters into smaller, sharper pieces, making it more difficult to control the process of its destruction. Broken ceramic clay can become sharp, posing a physical risk. In this application of the directive, participants had a finished piece in which the cracks and mended pieces could be seen overtly. If the participants had used wet ceramic clay, this process could have been completed repeatedly, ongoing and unfolding, perhaps even in a single session.

The use of art materials that are not clay, such as, collage, fabric and textiles, paint, pastels, and found object sculpture, warrants further exploration. Other researchers utilizing two-dimensional materials have demonstrated the effectiveness of the "create, destroy, transform" metaphor for trauma and trauma resolution through the three-staged process (Kapitan et al., 2011; Wolf & King, 2018).

Cultural associations surrounding the symbols individuals create out of clay, as well as the meaning they assign to the breaking and transforming of these artifacts, holds significance. Therefore, we

recommend that exploration should focus on the ways in which cultural backgrounds and life experiences could affect outcomes. Subsequent research could be conducted to further understand the cultural connotations of the word "transform" and how the ways in which people transform their art pieces could be indicative of their process of healing.

The concept of "destroying" may be a challenge for some participants, as was evidenced by Dana's reaction when she broke her piece. I (Stickley) explained the "destroy" phase of the process before participants chose to engage in the directive; however, participants may react to destruction in different and unexpected ways. The difficulty of destroying their art can be a useful metaphor to explore in therapy. If the participant is resistant to destroying their piece, the art therapist should be sensitive to their own countertransference reactions and not shield the client from the hard work that can arise from the encounter. Another aspect of this directive is the mastery over the traumatic event that it can foster, given that participants get to control the outcome of the art and destruction. If there is resistance to destroy, the facilitator can change the language; for example, Nowell-Hall asked participants in her practice to "add something negative" to an art piece and then to "save it" (as recorded in Rubin, 2005, DVD section G, 6:10).

This discussion highlights the fact that art therapists must be attuned and responsive to the person seeking treatment and must always use flexibility based on a person's ever-changing presentation and needs in therapy. Before beginning any trauma work, the clinician should be sure that the participant is as stable and safe as possible. Stabilization should be continually assessed throughout treatment, balancing the effectiveness of treatment and desired outcomes with the treatment provider's comfort and ability to facilitate trauma work with a client who may be engaging in dangerous or life-threatening behaviors.

Increasingly, art therapy studies aim to identify the effectiveness of treatment as well as the mechanisms of change, in recognition of the potential of "contemporary neuroimaging technology [that] offers an accessible method of measuring brain dynamics in real world environments" (King & Kaimal, 2019, p.159). Using a tool such as functional magnetic resonance imaging (fMRI) would be valuable to implement with the "create, destroy, transform" directive in research that seeks to identify neurological changes pre and post art therapy trauma treatment (see, e.g., Walker et al., 2018). However, movement is inhibited when using this tool, which would pose a challenge particularly in the "destroy" process, which therefore may best be measured with such tools as Mobile Brain/Body Imaging (MoBI). Research using neuroimaging tools that would enhance this practice innovation requires further exploration.

Conclusion

Healing from trauma is not linear, and there is not one specific approach to treatment. The process of trauma resolution differs from person to person: no two participants had the same experience in completing the "create, destroy, transform" directive. This process offers rich metaphors for understanding trauma resolution. People cannot go back to being who they were before the trauma occurred, but they can pick up the pieces, consolidate their experience, and emerge with a stronger version of themselves. All of the participants commented on this aspect in some way. We are humbled to witness this conclusion offered by the participants' interactions with this method. Trauma resolution is a process of growing from and integrating one's experience.

Trauma has complex effects on people. Art therapy processes that employ brain-based techniques, verbal cues that inspire metaphor, and symbolic art making offer a rich opportunity for individuals to regulate their neural networks and integrate their experience of trauma into their life story. They are strong, resilient, and awe-inspiring when taking on the opportunity for healing and transformation.

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2. The Convergent Use of Images in Art Therapy and EMDR Therapy

Norma Irene García-Reyna

The combined use of art therapy and eye movement desensitization and reprocessing therapy (EMDR) may be effective when there is evidence that the client has a trauma in their life history (Breed, 2013; Urhausen, 2015). Attachment styles should be considered to determine how and when both approaches are applied. In my practice, the combination has proven useful and complementary, as well as convergent in the use of images, whether expressed physically in art therapy or mentally in EMDR.

This chapter summarizes my clinical experience with children and adolescents who had psychological trauma symptoms due to bullying directed at obesity. Clinical vignettes show how mental images, as analogous to physical images, have helped in the symbolization process. I have documented this practice innovation with clinical notes and postsession audio image recordings (AIR; Springham & Brooker, 2013) with clients. An AIR is an audio recording of a semi-structured interview accompanied by viewing still images created by the client during the art therapy process. The process obtains the client's views about the changes they have observed and the art therapy mechanisms that may have supported these changes.

The combined use of both approaches includes working at different times with each of them, in some cases within the same session. There are, however, art therapy protocols used with EMDR that describe satisfactory results in client recovery from traumatic symptoms, with their prevailing characteristic being the use of bilateral stimulation (McNamee, 2006; Talwar, 2007). I mainly use a non-directive approach and follow the themes that the client brings to the consultation. Art is important as an implicit way of working and interacting with the attachment system (Springham & Huet, 2018); therefore, art materials are always available to the client in the session. I turn to EMDR when, due to trauma symptoms, a client experiences memories or mental images that are distressing, repetitive, and disabling.

The Image as the Center of Reference in Art Therapy and EMDR

Mental images have always fascinated people as inherent to being human; internal images are those that originate in words and give life to personal history (Tobin, 2006). Traumatic events are not recorded mentally as but as images (van der Kolk, 2015). Damasio (1999) stated that mental images have a direct power over emotions, allowing an individual to invent new actions for use in different situations or future scenarios. This capacity of transmutation and combination of images is, according to Damasio, the source of creativity.

Art therapy is a process largely sustained by the non-verbal aspect of images which, along with the creative process, are the pillars of our work. Art therapists urge clients to use artistic creation as a bridge to access thought, feelings, sensations, and mental images in order to communicate and symbolize self-knowledge. EMDR also bases its practice on images. Its methodology consists of reprocessing traumatic memories (in the form of images) by means of bilateral stimulation (i.e., eye movements, sounds, gentle strokes, or vibrations) that desensitizes the intensity of the emotions felt while remembering the disturbing event (Shapiro & Forrest, 2007). Bilateral stimulation offers individuals the possibility of making associations on their own by identifying analogous events and relating them to the memory they are working on.