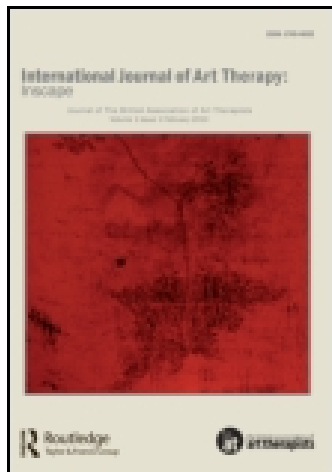


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## The invisible wound: Veterans' art therapy

JANICE LOBBAN

### Abstract

On Armistice Day 2011, BBC2 broadcast a *Culture Show* special, entitled 'Art for Heroes', about art therapy with veterans who have post-traumatic stress disorder (PTSD). It involved the filming of an art therapy group at a Surrey treatment centre for veterans. This article is based on the transcript of that group and takes a thematic analysis approach towards understanding the benefits of art therapy for those veterans. It also explores the neurobiological processes involved in PTSD and in art therapy, examining how the latter might assist recovery on a structural level. Through examination of recent studies and the observations made by those who have participated in the process of art therapy, it is hoped that this article will add to the discussion about the effectiveness of art therapy as a treatment for veterans' PTSD.

**Keywords:** *Art therapy, veterans, PTSD, Art for Heroes, Culture Show special, neuroscience*

### Introduction

With the closure of specialist military hospitals in the UK, treatment of ex-forces personnel who have been psychologically injured through service is the responsibility of the National Health Service (NHS). Combined with this, there has been an increase in the number of combat-related casualties due to UK involvement in the Iraq and Afghanistan conflicts in recent years. Consequently, it is likely that many therapists will receive veteran referrals. One aim of this article is to provide an overview of the use of art therapy with veterans based on the author's experiences of working with them at a charity called *Combat Stress*. It is hoped that this will assist practitioners in the community in understanding veterans' presentation and needs.

*Combat Stress* was established in 1919 in the aftermath of World War I to help those returning home traumatised by war. Originally named the *Ex-Forces Mental Welfare Society*, it has provided treatment and welfare support for approximately 100,000 veterans. Currently, there are more than 4,800 veterans receiving active treatment from the society, with 1,443 new referrals received in 2011 alone. The veterans have left the services, and come from all ranks of the three British Forces as well as the Merchant Navy, the Territorial Army and the Reserves. Ages range from 20 to 95 and the male to female ratio is roughly 97:3. Between them, they have served in operational duties from World War II, Korea and Malaya through to Northern Ireland, the Falklands, Cyprus, the Balkans and Rwanda, and both the Gulf Wars and Afghanistan. The society comprises three treatment centres and an office in Northern Ireland which collectively serve the entire UK.

They offer short-stay in-patient admissions, but treatment can be available for a number of years according to individual needs. There are also 14 small outreach teams who work within their respective communities. The profile of the average veteran is a 43-year-old male who served 11 years in the army, has a diagnosis of post-traumatic stress disorder (PTSD), who self-referred and first came for assessment 13 years after leaving the Forces. This delayed diagnosis means that symptoms are chronic and there can be co-morbid conditions as well as the early onset of physical problems to contend with.

Traumatic experiences affect systems of attachment and meaning, the basic assumptions of life, leaving the victim feeling abandoned and disconnected (Herman, 2001). However, there seems to be a common bond that connects 'warriors' throughout time (see Figure 1), an understanding that can be restorative. The group art therapy session that was broadcast on television and described in this article provides a glimpse into that process in action. Indeed, in the years since *Combat Stress* began, and the effects of war trauma started to be recognised and treated, the war wounded have played a vital part in the development of group therapy. In his pioneering work at Hollymoor Hospital, Birmingham, Wilfred Bion conducted the first of the Northfield experiments in 1942 using group dynamics to promote coping and rehabilitation with traumatised troops returning from combat. 'The experiments were an important landmark in the evolution of theory and practice in group psychotherapy and in the therapeutic community movement' (Harrison & Clarke, 1992, p. 698). However, Bion's methods were not well received

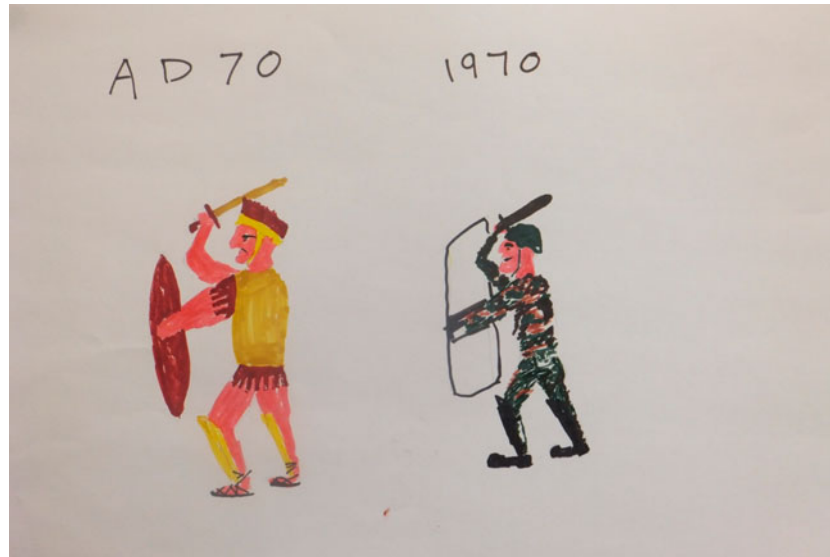


Figure 1.

within the military system at the time and the experiments were closed after six weeks. The more successful second Northfield experiment, led by S.H. Foulkes and others, was geared towards getting people back to the front line for action. Foulkes' team focused on the group rather than the individual, encouraging mutual support and forming communities from wards. Although this reads as an event in the distant past, at *Combat Stress* veterans from that era are still coming for treatment—men who served at Monte Cassino, in the Atlantic convoy and on the beaches of Normandy on D Day. Such is the indelible nature of trauma.

Art therapy also has roots in the regeneration following World War II. Adrian Hill, who is often credited with coining the term 'art therapy', was a war artist on the western front during World War I. While convalescing from tuberculosis in a sanatorium in Sussex in 1938, he used art to aid his own recovery. In 1939, when he was an outpatient, he was invited by the sanatorium to help returning war wounded soldiers by teaching them art. Hill and contemporaries such as Marie Petrie believed that art could restore health (Waller, 1991).

There is a body of research that has identified the firm neurobiological basis of PTSD (e.g. Rauch et al., 1996; Van der Kolk, 1994) and now, through the work of people like Lusebrink (2004) and Belkofer and Konopka (2008), who used brain imaging in their research, we are able to observe neurobiological activity associated with art-making and to consider *how* art therapy assists healing. Alongside this, art therapists around the world have been undertaking studies to gain a better understanding of the processes

involved. This article offers a brief synopsis of some of the current studies.

### Post-traumatic stress disorder and veterans

The diagnostic criteria for PTSD were first set in 1980 as a result of research in the US following the Vietnam War. Prior to that the condition had been referred to in many ways, including 'shell shock' during World War I, but the symptoms have been recognised throughout history, with descriptions dating back from the ancient Greek civilisation, through the writings of Shakespeare, the American Civil War and onwards. Currently, the diagnostic criteria are outlined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). In broad terms, there has to have been a recognisable stressor that was outside the usual range of human experience, which caused a response involving intense fear, helplessness and horror. The resulting symptoms are clustered into three categories: re-experiencing, arousal and avoidance. Re-experiencing might take the form of nightmares, intrusive thoughts or flashbacks, during which sensory material is replayed as the brain tries to make sense of the event. Arousal symptoms include hyper-vigilance, exaggerated startle response, difficulty concentrating and sleep problems. Avoidance might take the form of emotional numbness, a feeling of detachment or estrangement from people, a sense of futility regarding the future or avoiding activities, places or people that remind them of the trauma. The three categories of symptoms all feed into one another, creating a vicious circle which is hard to break.

DSM-V will soon be published with the additional recognition of negative alterations in cognitions and mood associated with the traumatic event and the presence of depersonalisation (experiences of feeling detached from one's mental processes or body) and/or derealisation (experiences of unreality of one's surroundings).

With PTSD, traumatic memories become dysfunctionally stored and do not naturally diminish in intensity over time but remain vivid, raw and unprocessed, disconnected in the system and taking on a life of their own. Veterans sometimes refer to the past as being more real than the present, describing how past trauma can be heard, smelt, seen and felt whereas the present can seem foggy and numb. As veteran Eddie Gray describes it:

*... the re-enactment of disturbing experiences, this at times has been so strong that I have almost been transported back in time, people I see seem so real that you feel as if you could touch them, others I swear I could hear them calling out or screaming. I have sometimes found it hard to breathe, my eyes water and my face burns and becomes sore as if I have been gassed. (Gray, 1994, p. 1)*

In essence, PTSD is a disorder of information processing, storage and retrieval. Traumatic memories take different pathways than normal memories through the brain and are stored in the central nervous system, ready to be triggered by sensory stimuli reminiscent of the trauma. Dual Representation Theory (Brewin, Dalgleish, & Joseph, 1996) describes how normal memories are declarative or verbally accessible and manifest as coherent words and stories. They are fluid and updateable, linked with other memories in the context of a whole life story with a time tag. They happened there and then in history and they are usually recalled on purpose. Traumatic memories, however, are non-declarative or situationally accessible, being triggered automatically by trauma-related cues. They are formed of vivid sensory information and are static and frozen in time. They are isolated and stand alone, being very much in the here and now rather than in the past. If expressed verbally, they may be disorganised, fragmented and incoherent. Traumatic events produce lasting changes in psychological arousal, emotion, cognition and memory. The hippocampus, part of the brain's limbic system that is involved in verbal declarative memory and the consolidation and modulation of memories, becomes damaged by the stress hormone cortisol and studies have shown that its

volume can shrink by up to 26% with combat-related PTSD (Bremner, 2005; Gurvits et al., 1996). The brain's danger recognition centre, the amygdala, also in the more primitive limbic system, goes on permanent red alert, sensing threat everywhere, and so the PTSD becomes self-sustaining with every false alarm becoming a re-enforcement. Consequently, sufferers tend to avoid crowds and social situations, might find it hard to use public transport, suffer panic or anxiety attacks, and often get very depressed.

The language centres in the brain close down in high arousal states and all energy becomes focused on survival. This can cause a speechless terror with an inability to capture the experience in words, and subsequently interferes with the development of narratives to process the experience. A study by neuropsychologist Bessel van der Kolk (1994) showed decreased activity in Broca's area of the left hemisphere of the brain during traumatic memories (the region involved in translating subjective experiences into speech), and increased activity in regions of the right hemisphere that are associated with visual imagery and emotions. A further study by Rauch et al. (1996) using PET scans had similar findings, demonstrating how people with PTSD re-experience emotions as physical states rather than declarative verbal memories.

According to contemporary psychoanalytic theory, thought is affected due to the breakdown of the capacity to symbolise. Symbolic thinking allows for a symbol, such as a word, to stand for something else but to be differentiated from it. Then it is possible to have space for creativity and flexibility of thought (Garland, 2002). However, memories of trauma are dominated by the symbolic equation (Segal, 1957) so that, for example, a firework becomes the sound of gunfire, evoking the same physiological and psychological responses as the trauma itself. There is no 'as if' but rather a concrete association or re-enactment. During this reliving of the trauma, or flashback, the ego is overwhelmed by the raw sensory material such as the smells, tastes, sights and sounds it is receiving. Drawing on Bion's theory of containment (1967) regarding a mother's ability to tolerate, detoxify and transform her infant's unbearable anxiety, Garland suggests that a flashback can be viewed as 'the experience of loss of container: the internalised place... intimately connected with good early care, in which thinking-about-something can occur' (Garland, 2002, p. 110).

Understandably there is reluctance on the part of the client to go near the trauma as the memory is frozen in its original anxiety-provoking state in

the sensory-motor system, non-verbal, unprocessed and ready to be triggered. The goal of therapy, then, is to help the client to create a narrative of the experience, to be able to think about it and process the material so that it can be stored in the narrative memory system along with reason and meaning.

In the case of the veterans who come to *Combat Stress* for treatment, there have often been multiple and prolonged traumas, so they have a lot to deal with. There are a number of additional factors to take into account with military PTSD. Conditioned to overcome the impulses to flee or freeze in the face of threat, and instead to fight, the veterans tend to respond to threat with anger, and then become afraid of losing control of their anger. This might mean that they avoid situations that could lead to confrontation, making them reclusive, or to them turning the anger inwards and becoming depressed. Having been part of a cohesive group whilst in the military, all with a role to play, clear directives and a sense of belonging, adjusting to civilian life can be problematic for some veterans, and this can compound difficulties. Because of past training, there might be a desire to do a job perfectly, which can result in a fear of failure that prevents tasks being undertaken or disillusionment with a civilian culture that seems not to care about standards, leaving veterans feeling alien. Battle-mind preparation to face attack means that their threat system was already keyed up prior to the trauma, and safety procedures that were necessary whilst in action might persist in everyday life, such as checking under their car for bombs. Involvement in peacekeeping operations might have meant they were witnesses to atrocities but were unable to intervene, leaving them feeling powerless and contaminated by the experience. Some veterans might be left with feelings of guilt and shame related to events they were involved in during the extraordinary circumstances of warfare. Being part of a close, cohesive group can leave some people with survivor guilt when comrades are killed, which might prevent them from moving forward with their own life. The use of alcohol to numb feelings and to try to block out intrusive memories of trauma can cause further difficulties and mask the root of the problem. Additionally, a sense of stigma with the fear of being thought of as weak might prevent veterans from admitting they are struggling. Humour is often used both as a way of coping with and disguising the effects of PTSD.

An important factor to bear in mind when working with veterans is what some of my colleagues and I have come to think of as, the

'Band of Brothers' concept (Lobban, Hobbs, & Jordan, 2006). I have lost count of the number of times veterans have said to me that 'the best therapy is being with the lads'. At first I was a little deflated by that comment, but soon came to realise and respect the truth in it. Trauma affects an individual's ability to relate to others. It severs bonds and shatters beliefs, leaving the person feeling abandoned, vulnerable and disconnected from those around them. As van der Kolk (1987, p. 155) puts it, 'One of the most urgent tasks facing therapists of traumatized individuals is the re-creation of a sense of human interdependence and community'. Van der Kolk moves on to refer to 'the essential qualities of human existence: belonging, being useful to others and sharing a common culture and past' (ibid., p. 156).

Becoming part of *Combat Stress* provides veterans with the opportunity to reconnect with a familiar peer group and bonds are rapidly formed. There are unwritten rules of mentoring whereby newcomers are welcomed and guided by their peers, who offer practical advice and the benefits of their experience of treatment. Veterans are used to looking after those under their charge or looking up to those with more experience. Sometimes people find others from their own regiment or the same theatre of operation, which can be a great reassurance that they were not the only one to have sustained a psychological injury and can help to manage stigma and shame. There is a shared language with the use of nicknames and service jargon, and shared experience that makes them feel understood by each other. This forms a good basis for group therapy, with the advantage of having a cohesive peer group ready to listen to and learn from each other. The therapeutic implications of the 'Band of Brothers' are that they are able to learn how others manage and by forming mirror relationships they can recognise their own struggles reflected in others. The overwhelming sense of isolation and disconnection becomes modified and they begin to regain confidence as they work towards mastery of their PTSD symptoms.

### Filming 'Art for Heroes'

In the spring of 2011, I was contacted by BBC director Liam McArdle who had been commissioned to make a documentary about art therapy with veterans. Surprised, delighted and a little apprehensive, we set a date for him to visit the treatment centre to discuss possibilities. I described how the groups are in two sections with an hour of image-making followed by an hour of

discussion. The first hour is spent in introspection, with individuals using **creative self-expression**, the channelling of emotions, exerting energy, movement, moderating distance from the content, exposure to trauma-related material, and finding symbols. During the second hour the veterans come together and reflect, verbalising, naming, conceptualising, discussing, conveying to others, processing, **making connections** and using words. In this way **all areas of the brain are used for processing, from the emotional, intuitive right hemisphere to the verbal, analytical left hemisphere.**

We agreed in principle to the BBC filming an actual art therapy group the following June, depending on whether any veterans would be willing to participate. I wrote to five veterans from the Rolling Programme who I thought might be interested and robust enough to tolerate the demands of being under the spotlight. They all agreed to participate.

Treatment admissions on the *Combat Stress* Rolling Programme tend to be for two weeks twice a year, with some veterans arriving and others departing on a daily basis. This means that the groups are constantly changing and the veterans might never meet again, although there can be an overlap of future admissions and some veterans do keep in touch outside of *Combat Stress*. The catchment area for the Surrey treatment centre is from Cornwall across to Kent and Hampshire up to the Midlands. I invited veterans who were familiar with the **art therapy process**, having participated several times before. However, they had never all been in the same art therapy group together, came from different geographical locations and they did not all know each other. Due to the staggered nature of admissions, it was not until the day before filming that they were all in house. I had not seen them individually for about six months but we had corresponded by letter, email and telephone.

The morning before filming, I met with the veterans to discuss their thoughts and to answer any queries. Naturally, there was apprehension but they were all absolutely committed to seeing it through. If it could help other veterans, promote *Combat Stress* and **spotlight the usefulness of art therapy**, then they thought it would be worth the challenge. They preferred to have a suggested theme as a focus for the group but did not want to know what it would be in advance. That afternoon the director and the presenter Tim Samuels, along with a camera operator, came to observe an art therapy group with the veterans in order to plan for the recording, that is, where to site the cameras and so forth. The veterans were able to

ask questions and clarify certain points. It was important for them to know what to expect, as they do not like surprises. I set the theme *Ways of Seeing* and we had a typical two-hour group. The feedback from the BBC team afterwards was that they were 'blown away' by it. They had not realised how powerful the process is and what raw emotion is unleashed. They felt privileged and humbled by being a part of it.

At 10 o'clock the next morning we all reassembled, along with a further camera operator and a sound engineer, ready for filming. I set the theme of *The Invisible Wound*, which I had never used with them before, and the usual art therapy group format was recorded with the presenter by my side. The veterans worked for an hour creating individual responses to the suggested theme, sitting apart at different tables, silently in their own thoughts. When the group came together for the reflection time, they were invited to say something about how the process had been for them. They took turns to show their work, allowing time for discussion around each piece before moving on to the next. As soon as the group finished, the presenter interviewed the veterans while we were all still sitting together in the discussion space. Some of this material was broadcast in the documentary.

#### *The transcript—taking a thematic analysis approach*

I was given a copy of the full, uncut version of the recording by the BBC, which provided invaluable material to use for research purposes. Thematic analysis, a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006, p. 79), provided a helpful framework to employ, so I transcribed the recording verbatim then began searching for themes, primarily on the semantic-explicit level but also in an attempt to understand the broader meanings and implications.

**In the following section, relevant excerpts of the recording using the participants' own words illustrate that art therapy with veterans who have PTSD, in a group setting, enables them to communicate on an emotional level which is usually avoided by employing both conscious and unconscious defences. This tends to support the theory that in art therapy unconscious, unprocessed material is expressed through image-making, then decoded using cognitive appraisal mechanisms, which involves reduced avoidance and increased tolerance of emotions and leads to improved insight. When done in a group setting this reduces isolation by promoting a sense of reconnection.**

As the group discussion took place around the images made in response to the topic *The Invisible Wound*, several themes emerged.

**1. The group identified problem areas around disconnection, control/avoidance of feelings, wanting to present a mask/false self to the world to protect their vulnerability and the stuckness of traumatic memories**

*Disconnection*

The veterans describe how they feel detached from people around them and how they put up defences to maintain distance. Traumatized people can feel like aliens, with the normal bonds of human interdependence severed. Isolation can become a way of protecting oneself. Emotional numbing can act as an anaesthetic but it has an effect on relationships. Traumatic experiences shatter the basic assumptions of life such as safety, trust, personal value and a sense of meaning. 'When trust is lost, traumatized people feel they belong more to the dead than the living' (Herman, 2001, p. 52).

*We don't know how to communicate properly. You shut yourself away; you ain't coming in It's a rejecting of people. My comfort zone becomes my prison; you build the walls to protect yourself and then you can't get out. The trouble is you push them away and then they don't bother any more. The inability to talk to them, the inability to try and explain. If I don't make friends and I don't show anything then I can't do any harm... I can be happy in my own misery. A lot of people sort of turn away because they can't understand what's going on. You're acting in strange ways... they don't want to know. I have a very hard job with the physical contact with people, hugging people and that, because I feel that I might implode or melt into a big blob on the ground and never be able to get back up again. Umm, so we tend to keep people [gesture with arm] physically at arm's length, don't we? And mentally. There is an invisible barrier and it's horrible. People turn away because they don't know what's going on. They stop listening because it's going further from the events [in time].*

*Issues around control and avoidance of feelings*

Traumatic events involve situations beyond anyone's control. The resulting memories,

associated emotions and physical sensations are replayed internally without choice. Consequently, the veterans attempt to remain in control or avoidant of their emotions at all times, fearful that discussing the past will result in overwhelming reactions that might cause further damage to the self and others.

*I find I direct my anger inwards because in the long run it's far less damaging than if I direct it outwards. The worse that could happen is someone might get damaged. You're afraid to let it out. They won't be able to cope with it. [I don't want to] contaminate these people. You feel like you're gonna totally explode... it's gonna, you know, spill everywhere. The possibility that I could explode... is frightening. I don't want to lose control. Every time you have to relive the things you damage yourself a bit more. It's very difficult to talk about even when you need to because you get used to not saying. It's very hard to communicate that. Sometimes it feels like when you knock a glass over and it all spills out... we're bottling it up. I wasn't giving it out... I say things which is the tip of the iceberg.*

*The mask/false self to protect vulnerability*

**PTSD causes structural dissociation of the personality (Nijenhuis, Van der Hart, & Steele, 2004) with an apparently normal personality presenting to the world, getting on with functional daily life but with a split-off emotional personality (or more than one) caught in the trauma time.** The veterans describe the dichotomy of hiding the emotional self behind a coping mask, the effort involved and the fragility of the man inside.

*... I try to act the way I think people want me to act... becoming a people-pleaser and they're getting a false image. You tend to isolate and hide within yourself. I move among people and they don't notice I'm there. I just blend in to the background. We don't know how to project ourselves properly to fit into society... we put this front up. I find it hard work to socialise... there's always this sense of threat... to come out of hiding. Coming out of the shadows is revealing yourself... you don't like to expose yourself to anything because... inside you feel very fragile and you have to wear a mask and body armour just to give the illusion of normality. You keep it deep inside because it's yours and you don't want anyone else to know. You*

*know you're a really strong figure but inside you're so fragile and complex.  
You shut yourself away.  
It takes a lot of strength to keep it all inside.  
If you get inside that barrier you are going to hurt me.  
You can get to the barrier but you won't get any closer.  
Sometimes they just see you for what they think you are . . . big and strong.  
The grey man in the shadows.  
They see the swan on the water gliding along, (not the) . . . paddling just to hold where we are . . . having to work so hard just to stay still because everything is coming towards you.*

#### Stuckness of traumatic memories

The veterans describe being prisoners of time, with the trauma memories continuing to replay without any new, adaptive information being added. Society moves on but part of them remains in a time warp.

*Time passes from the events that caused the injury and they pass further into history and into people's memories.*

*You become preoccupied . . . start having flashbacks.*

*It's a long way in the past to the public but to us . . . it can be quite dreadfully fresh.*

*In a very real sense I think to all of us, it's just happened and it always stays that way but to other people the time goes on and it was ten years in the past, twenty years in the past, how can that still be giving you a problem?  
I can still smell it.*

2. **During the art therapy process the group described and demonstrated being connected, working spontaneously and opening up, and to having begun processing material**

#### Connected

Through art therapy, the veterans are able to translate their emotions and body sensations into words and in so doing to make sense of experiences and to find meaning. They are able to articulate their observations to others and to feel less detached. **Discussions take place and a network of connections is being made internally and externally with others. They link with each other's imagery and apply aspects to themselves, discovering new insights.**

*The unconscious is trying to communicate with your conscious brain and say 'that's what's worrying me'.*

*You are looking at yourself . . . through the images. If you have trouble communicating . . . it's another form of communication.*

*It's easier to communicate like that than sitting eyeball to eyeball with someone. That's easier because there is a focal point there (the image). When you are in a group . . . you can see a lot of stuff is tied together.*

*It's stuff you normally wouldn't talk about.*

*There's a common bond between people who have been in conflicts because they have all seen the same thing but in a different place.*

*It's the group setting that is important because I find I feel less lonely afterwards because I recognise so many of the things in me are in the other people as well.*

*There's a common bond . . . it's a shared experience . . . I'm not alone.*

#### Spontaneous

**Images are made as a creative response to a set theme. The veterans describe working without prior planning and allowing material to emerge freely.** This process contrasts to how they described needing to avoid feelings and to keeping issues controlled and bottled up inside.

*I don't know the subject beforehand and it's surprising what it actually brings out.*

*It's not a time to think . . . you get the subject and before you know it you're putting things down on paper.*

*My mind is empty of thoughts really because I don't know what I am going to do when I go in there, and I pick up the art materials and it's as though the drawing starts making itself.*

*The important thing is to just let the pictures flow out of the head and right down to the hand to get the symbols and concepts down.*

*I don't have any preconceived ideas . . . something flashes into my head and I have to get it down very fast.*

*I can sort of see my hands moving and I'm thinking about it but I'm sort of not forcing them to do it.*

*You have to get it down very quickly in case you lose that train of thought because there are intrusions all the time.*

*Sometimes I, um, I feel I'm getting out of breath because I'm trying to do it so quickly. Although you know you've got an hour, sometimes you finish in 15 minutes/half an hour because you are in such a rush to get it down.*

#### Opening up

**Once made, the images are symbols of internal states that can be reflected upon—tangible objects that can be stepped back from and**



observed. As opposed to the inner personality that needs to be hidden and protected, these externalised symbols are seen as useful expressions with the power to stand alone.

*It's amazing what's actually in there you didn't realise . . . it just comes out.  
What amazes me is always how much comes out of nothing in these sessions.  
You can get things out because there is a focal point.  
If you have trouble talking and expressing your feelings and if you can't make head nor tail of it . . . .  
This is the one that opens the doors.  
That's right very quickly. The other ones open doors slowly.  
I think it's so powerful.  
The other thing is the talking therapies they, they use language. So everything that is in the back of your mind, the images, the emotions has to come out and to be processed through that left brain into the speech areas and turned into speech. So you are removed one big stage from the pictures.  
Umm, with art therapy the picture just goes down direct and so you don't have that, umm, filtering and editing going on. It is just there and it pulls things out so fast and deep that, umm, yeah I think it's the most powerful of the therapies I've tried, for me anyway.  
You can be yourself here [at Combat Stress]. You don't have to keep your guard up. You can be exactly the person you are and not be judged either.  
A snapshot of what's in my head at the time, my emotions, my feelings at the time.*

#### Processing material

The veterans describe how processing continues beyond the art therapy session. The creative process stimulates new ways of articulating and thinking about experiences that break away from rigid thought patterns. This suggests that new neural pathways are being formed.

*It takes a while to actually sit down, a couple of fags and a couple of cups of tea to actually mull over . . . the things it brings out.  
When those symbols go down they aren't speaking language . . . and I think it takes a long time to finally assimilate all those ideas that have come out.  
You're still trying to decipher what's going on.  
You can bounce off the artwork.  
This is [the therapy] that does a lot of work.  
If you are given an idea it almost instantaneous takes you to something and then I have to work with that.  
It helps because . . . it's the hidden bits of the mind,*

*you know, as we said it just opens the door to other things.*

*It starts a chain reaction.*

*It [art therapy] brings . . . you get this little niggling thing [gestures with both hands to side of head] at the back of your head. You don't know what it is. It's the fidgeting, the uncomfortableness, the something wrong, the something just niggling . . . let's pull this thread [gestures of pulling with both hands] and all of a sudden instead of having a big ball of strands . . . it gives me a little understanding.*

*It brings an understanding of what is happening inside you . . . and makes it easier to cope with the symptoms.*

*It's got me out of my little box and activated.*

*It opens up things that explain an awful lot.*

*It's like when you are cleaning house you know, you might come into an attic that you've crammed all your rubbish in . . . you'll move it about a bit and you've got a clear space and you sit down and you go 'Oh, that's comfortable'.*

#### Discussion

The art therapy group was in two sections: (i) image-making/expression; and (ii) image-viewing/exploration. These are now discussed in turn with reference to the relevant processes and themes encountered.

##### (i) *Image-making/expression*

The veterans worked alone, occasionally moving around the room to gather materials and sometimes exerting bursts of energy into moulding clay or moving pastels across large areas of paper. They appeared to be completely immersed in their work, with no eye contact or verbal exchange with others. When describing this experience later on, the veterans commented, 'It's not a time to think . . . you get the subject and before you know it you're putting things down on paper'; 'my mind is empty of thoughts really because I don't know what I am going to do when I go in there, and I pick up the art materials and it's as though the drawing starts making itself'.

Belkofer and Konopka (2008) used electroencephalography (EEG) to measure patterns of electrical brain activity before and after art-making. Their findings showed higher frequencies of brain activity in the temporal lobes after art-making. They refer to the research of Persinger (1983) and Newberg, D'Aquili and Rause (2001), which has shown that the temporal lobes play an important role in 'experiencing a profound sense of meaning, connections to a higher power, deep feelings of peace, and a loss of time' (Newberg et al., 2001, p. 61). It is



Figure 2.

suggested that there is potential for people to reach a deeper level of self-awareness in this way. An interview with Dr Lukasz Konopka, Director of Clinical Neuroscience at one of the largest veterans' hospitals in the US, featured in the BBC2 documentary 'Art for Heroes'. Dr Konopka has worked extensively with Vietnam veterans who have PTSD, and has done scientific research into the effects of art therapy. When asked what role art therapy has in treating someone with PTSD, he stated that he considers it essential because it taps into primitive brain networks and helps to establish new neural pathways that could alter function and be long-lasting. This view is shared by Lusebrink who suggests that art therapy is 'uniquely equipped' to take advantage of 'alternate paths for accessing and processing visual and motor information and memories' (Lusebrink, 2004, p. 133). Art expression activates the tactile-haptic, visual-sensory and perceptual channels with subsequent processing of the material through the verbal and cognitive channels to find associations and meaning. Lusebrink describes how the motor action and movement of image-making can be used to express energy while stimulating emotional responses. Art therapy is an action therapy that combines movement, tactility, vision, memory and imagery in the creative process (Riley, 2004) and which addresses the non-verbal core of traumatic memories (Talwar, 2007).

Comments were made by the veterans about the nature of the materials, such as clay and how it was possible to convey a body sensation through that medium: 'a sort of tightening in my chest... a pain' (Figure 2). In addition, pastels enabled one veteran to get his thoughts down on paper very fast in a colourful way when something

flashed into his head, thereby capturing that moment for further exploration, the tactile and visual qualities of the materials adding another dimension to expression.

The image-making/expressive part of the group enabled the veterans to access non-verbal, emotional, intuitive and sensory material, then to step out of the experience by the use of symbol and metaphor, thereby creating a thinking distance. In so doing they demonstrated increased tolerance of difficult feelings and body sensations. This is consistent with the findings of a US study that found that 'art therapy shows promise as a treatment for combat-related PTSD that can reduce immediate symptoms [and] can help overcome avoidance and emotional numbing' (Collie, Backos, Malchiodi, & Spiegel, 2006, p. 161).

In their review of the empirical literature on the therapeutic implications of artwork for war veterans with PTSD, Nanda, Gaydos, Hathorn and Watkins (2010) observe how visual imagery might be necessary for the symbolic processing involved in creating a trauma narrative. They also refer to a study of specialised PTSD programmes where 'Researchers found that art therapy was the most effective of 15 different programs for veterans with the most severe PTSD symptoms' and concluded that this was because 'it combined pleasurable distraction with exposure to difficult content (Johnson, Lubin, James, & Hale, 1997)' (Nanda et al., 2010, p. 382).

### (ii) Image-viewing/exploration

During the second section of the art therapy group, the veterans gathered together again away from the art-making space to reflect on the

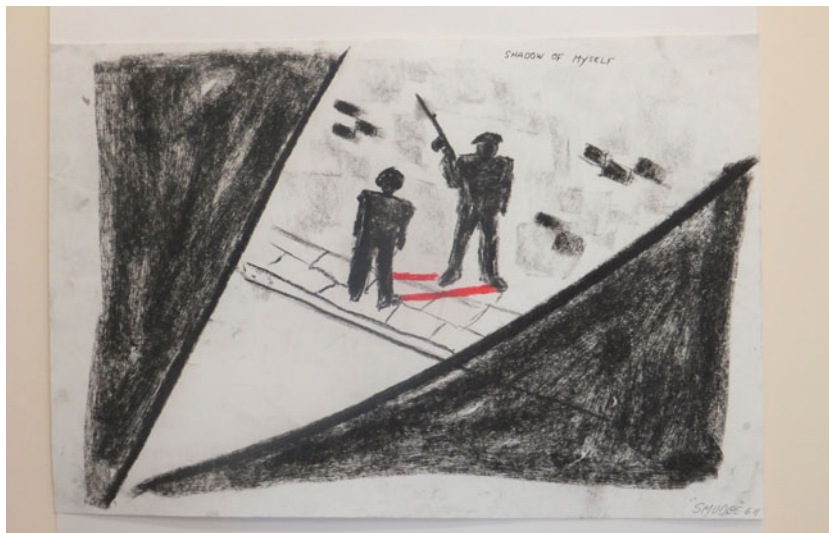


Figure 3.

process, each bringing their work with them. In turn, they laid their image on the floor in the centre of the group as the focus for attention and discussion. Comments were made by the veterans on the usefulness of having a focal point and its role in processing material: 'You can bounce off the artwork'; 'opens the doors'; 'you can get things out because there is a focal point'; 'a snapshot of what's in my head at the time, my emotions, my feelings at the time'.

The images revealed a number of contrasts and dilemmas, for example between past and present self, inner experience and outer presentation, society and the veteran, or whether opening up and connecting with others would be beneficial or more harmful. Some work has clear dividing lines with no middle ground.

Smudge was the first to show his image, entitled *Shadow of Myself* (Figure 3). He finds himself caught in headlights and confronted with a shadow of himself as a soldier, then a capable and powerful figure holding a rifle, but one who is also compassionate and protective and who asks him, 'What is the matter Smudge, don't you feel well?'. Smudge remembered the time he used to look after the men in his section, commenting that now he is barely able to look after himself. This was a moving moment for the group as we looked at the image together and connected with his feelings. The other veterans picked up the analogy of being a shadow of the former self and also living in the shadows, hiding from perceived threat, feeling vulnerable and exposed.

Alex's response to the word 'wound' had involved a body reaction, and he created an image using clay (Figure 2). Through his use of a binding around the chest of the figure, he described struggling with the dilemma of holding it (emotions/sensations/PTSD) all in or letting it out.

However, the binding constricts and causes pain too. He was unsure whether tearing off the straps might provide release or create vulnerability, but by holding it deep inside the restraints pull tighter and tighter. This has a resonance with the physicality of PTSD as an anxiety disorder, which the veterans all identified with. When the threat system is activated, cortisol and adrenaline are released. There is chest pain, pressure or tightness, pounding heart, feeling smothered or finding it hard to breathe and palpitations. A comment was made about the strap appearing to be a bandage, which seems to reflect how avoidance might serve as an immediate solution that does not resolve the problems in the long term. The group explored the complexity of the symbolic meaning of the image and the dilemma around treatment potentially being more painful than the symptoms.

Frank created four images in quick succession, running with his train of thought. They all demonstrate divisions in the way he presents outwardly and feels inside. Figure 4 uses the metaphor of a swan gliding gracefully on the surface of the water to describe how veterans like to appear when in fact below the surface they are paddling like mad just to stay still and not get swept backwards. Calmness versus frenzy is elaborated in Figure 5, where the *serene happy* surface belies the threat response in action with the *FEAR* impulse of *F\*\*\* Everything and Run*. There is a stark contrast between the comfortable armchair surrounded by symbols of family life and the experience of self-imposed imprisonment in Figure 6, within 'a soulless room, blacked out windows, bare floorboards and a big padlocked door... you ain't coming in and you ain't getting out'. The group reflected on how the comfort zone/avoidance can become a prison. Figure 7



Figure 4.

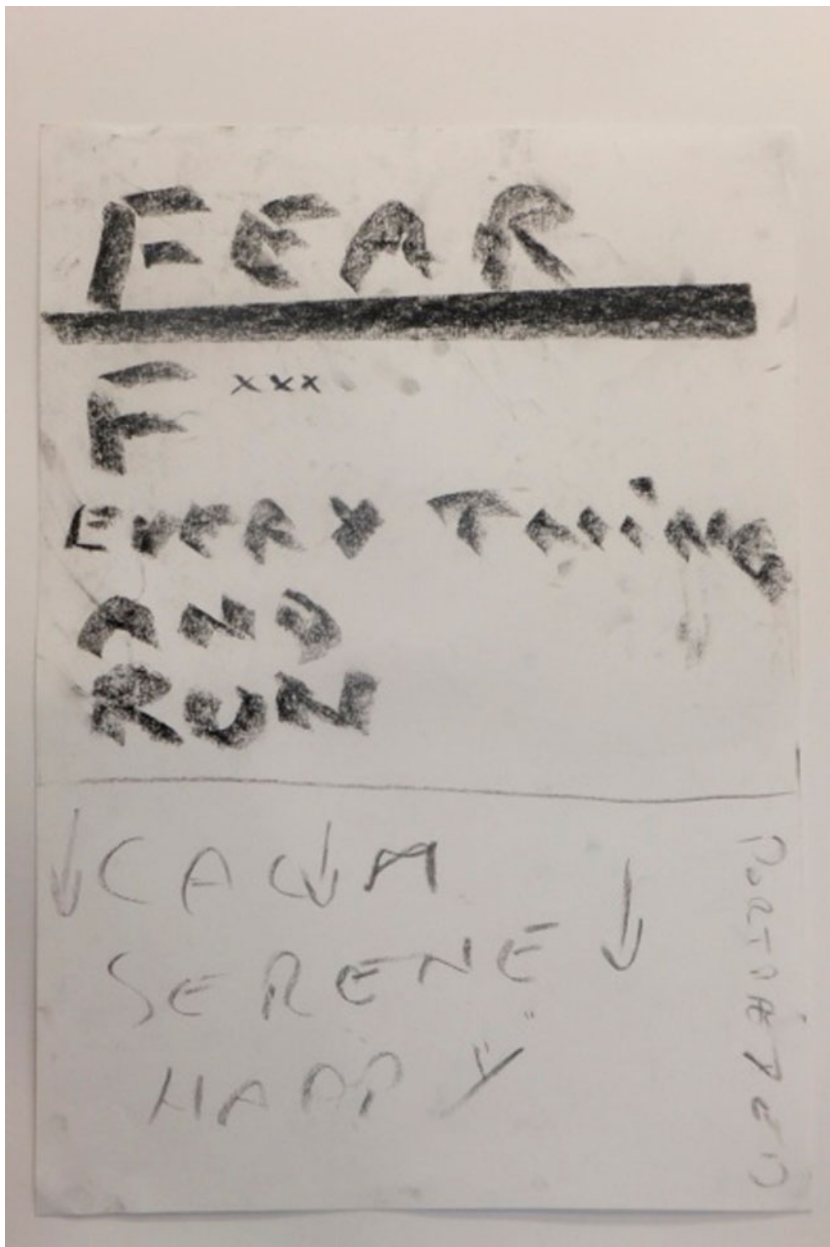


Figure 5.



Figure 6.

vividly shows a figure in anguish trying to keep those close to him away. Family and friends ask what the matter is, but the 'angry, confused man stood there in a rage' has erected a barrier and is afraid that if they get inside he will get hurt. The figure is sending out arrows and is in an aura or red mist of rage, the art materials being able to convey the sensory rawness and physicality of the experience. This led the group into discussing the impact on relationships.

Richard's work (Figure 8) is about the perceptions of society as well as the experience of having PTSD. It is in three sections but he explains:

*One of the things I find strange . . . the picture I created there with the three parts and a nice order, that isn't how it went down . . . I started on the left, then I did the right and then I was hopping back and forth . . . things were going down as they came*

*to me but what surprised me is that I found I'd left a gap where one was needed. So, somewhere inside in the silent region of the brain I must have had a finished picture, more or less, there. But I wasn't actually aware of it consciously. It was just that I only realised it when I found the gaps were in the right place to fill in.*

The left side shows a soldier with visible injuries being welcomed back by society as a hero. In the centre, invisible injuries start to manifest but because others cannot see them, people do not understand and stop looking and listening. Time has passed and events have gone into history. On the right is the 'grey man in the shadows', the lightning flashes symbolising how thinking has been affected. Flashbacks affect work performance and so the veteran becomes useless to employers, who point him towards the



Figure 7.



Figure 8.

scrapheap and turn away. Figures in society that hold the moneybags then want proof of the invisible injury but 'every time you have to relive the things you damage yourself that bit more'. However, there is hope in the form of an internal guardian angel/compassionate image, the little friendly dragon that holds its own sun, because the actual sun has become hidden behind the black cloud of depression. The image led the group into a rich discussion about the perception of time, depression, shame, isolation and hope.

Like Smudge's picture, Steve's (Figure 9) includes an image of the soldier he once was, proud and confident. His moving personal story about the effects of setbacks that have overwhelmed his ability to cope and have affected all around him struck a chord with others and stimulated discussion around military conditioning

and delayed diagnosis of PTSD. In the image, most of the figures are looking at the viewer as though wanting a response, but two are looking away preoccupied with worry. There is a contrast between past achievements with a sense of purpose and uncertainty about the future with hidden wounds.

The images are externalised 'concrete' symbols of inner experience that help with the discovery of personal meaning as well as acting as a form of non-verbal communication that makes a connection with others and provokes a response. As the group worked together to decipher the codes and symbols in the imagery, they gained further insight through discussion. By constructing a narrative, discovering and articulating the meaning of the images, the group members used higher-order thinking with left brain hemisphere reasoning and analysis.



Figure 9.

By improving communication between both hemispheres of the brain, the art therapy process 'can facilitate the organization and integration of traumatic memories in ways that may not be possible with words alone' (Collie, Backos, Malchiodi, & Spiegel, 2006, p. 161). Many art therapists have written about similar observations. Klorer (2005) suggests how, through art therapy, clients can express feelings that are impossible to put into words and underlines that as traumatic experiences are stored in the non-verbal part of the brain it makes sense to use non-verbal forms of treatment. Avrahami (2005), Pifalo (2002), Gonzales-Dolgingo (2002) and others describe how art therapy communicates with the traumatic memory by using its own language of symbols and sensations and provides a flexible, multidimensional approach. Kapitan (2010, p. 158) reflects on neuroplasticity and how malleable and dynamic the brain is, 'shaped by experience not only in early life but also throughout the life span' and how art therapy can heal 'by introducing new learning at a structural level of the brain'.

In her 2004 paper, McNamee refers to Gazzaniga's split brain experiments (1998a, 1998b) whereby the function of each brain hemisphere was examined based on studies with patients whose corpus callosum had been severed to inhibit epileptic seizures. The brain hemispheres communicate primarily through the corpus callosum, so without this it was possible to identify hemisphere specialisation. The left side problem solves but the right side is poor at this. The left can use language whereas the right cannot, but what is said is not necessarily accurate as the left hemisphere can construct a meaning that can have little to do with reality. Gazzaniga suggests that the creative output of the right brain is a more reliable expression of experience and emotion (McNamee, 2004). McNamee posits that art therapy can capture the 'right brain truths' and has used scribble drawing to enable patients to identify their own truths 'facilitated by the safety of metaphor' and to integrate 'right-hemisphere experiences with left-hemisphere understanding' (McNamee, 2004, p. 141).

Both McNamee (2006) and Tripp (2007) have written about art therapy and bilateral stimulation in relation to neuroplasticity and the brain's ability to generate new neural pathways. Bilateral stimulation is used in eye movement desensitisation and reprocessing (EMDR) (Shapiro, 2001), an evidence-based intervention that is recommended in the National Institute of Clinical Excellence (NICE) guidelines for the treatment of PTSD. McNamee describes the use

of bilateral art and how it 'purposefully engages both left and right hemispheres of the brain, as well as multiple sensory systems in responding to client-identified conflicted elements of experience' with the aim of creating balance and integration by changing 'maladaptive neural organization' (McNamee, 2006, pp. 7–8). Tripp writes about her use of a modified version of EMDR combined with art therapy and how distressing memories become 'transformed with new associations to adaptive and positive information' (Tripp, 2007, p. 178) rather than remaining in a frozen state. Tripp has noticed a rapid shift in cognition and awareness in patients which has led to the resolution of trauma but she stresses that the method should not be undertaken without the necessary prior training in both treatment disciplines.

At the end of the group session, the veterans tried to convey to the BBC interviewer what makes art therapy such a powerful experience for them: 'You're looking physically at yourself [gestures towards the image on the floor in front of him] through the artwork'; 'if you have trouble talking and expressing your feelings'; 'it's another form of communication'; 'art therapy connects to a part of the brain that the other therapies don't touch'.

A rival explanation concerning the positive findings of this study might be that the veterans wanted to say the right thing as the documentary was to promote the use of art therapy. However, the art therapy images were a spontaneous response to an unknown theme and thereby a genuine expression of the veterans' associations at the time, which formed the basis of the discussion.

The group was staged in that the art therapist selected the participants, and extraordinary because it was filmed, but it represented as typical an art therapy group as there could be under such circumstances. Moreover, the analysis detailed in this article draws upon analogous everyday experiences in this line of work. The veterans had not all been in an art therapy group together until the previous day and some had never met before, so the discussion was not informed by a history of experiences together. They had all attended art therapy groups before and had engaged with the process, so they were familiar with the format.

## Conclusion

Research has shown that traumatic memories are held in the non-verbal right brain which can be accessed by art therapy using its own language of

symbols and sensations, then externalised and decoded in order to create a narrative. In this way, new neural pathways are formed that can alter function. Art therapy improves communication between the brain hemispheres, which assists in the processing of the trauma material.

This study does not determine the long-term effects of art therapy, but demonstrates observations made within a single session by what was said, done and shown through the imagery. Although the veterans identified the problems they struggle with in everyday life around disconnection, the desire to control/avoid feelings and to present a mask to the world, within the art therapy group setting they were able to behave differently by using the art materials spontaneously and exploring the content. In this way the group was able to connect on an emotional level, overcoming avoidance, with increased tolerance of difficult feelings, which promoted understanding and improved communication both with self and others.

Participants were able to share their deep fears and anxieties in a manageable way with the image acting as the focal point, thereby being able to drop 'the mask' and to gain insight as well as relief. The veterans described gaining a sense of achievement from having expressed themselves through the image-making and decoding its personal meaning: 'small victories . . . moving your parameters . . . If you can't run you walk. If you can't walk you crawl 'cos when you stand still it's a terrible place'. They identified that from their experience of art therapy, processing begins in the session and continues afterwards, thereby offering promise in terms of helping to shift the stuckness of traumatic memories and the accompanying negative cognitions. **An essential factor seemed to be the common bond of being veterans with PTSD—the Band of Brothers**—as this enabled them to speak openly about the imagery and its personal meaning in the knowledge that they would be understood and supported by their peers. This echoes the origins of group therapy and the work of Bion, Foulkes and others with the war wounded.

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