

Working with Life Scripts in Art Therapy with Adults
Affected by Complex Trauma

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A Research Paper
in
The Department
of
Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montréal, Québec, Canada

April 2016

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CONCORDIA UNIVERSITY

School of Graduate Studies

This research paper prepared

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Entitled: Working with Life Scripts in Art Therapy with Adults Affected by Complex
Trauma

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Creative Arts Therapies; Art Therapy Option)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality as approved by research advisor.

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April 2016

Abstract

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In this theoretical research paper, we explore how art therapy may inform life scripts analysis in Transactional Analysis (TA) through a prism of the modern trauma recovery model developed by Judith Herman (1992, 1997). Based on analysis and synthesis of existing literature, we suggest an integrative model for the work with adults who have experienced trauma, sensitive to the specifics of the severe consequences of complex trauma. This theoretical study has the goal of filling the gaps in the TA theory and practice of life scripts through combining TA and art therapy within a modern trauma recovery model. Moreover, we suggest that incorporating the creative process phases within the stages of trauma recovery could enlighten the therapeutic process. Each stage of recovery is described from the positions of Herman, TA, creative process and art therapy, and provided with examples of art therapy interventions. Finally, we discuss limitations of this study and propose implications of the suggested integrative model in future research.

Keywords: art therapy, complex trauma, creative process, life scripts, transactional analysis, trauma recovery.

Acknowledgements

I would like to thank the very important people in my life who made it possible for me to be where I am now. First, I wish to thank family for their unconditional love and faith in my endeavors. Without you, I would have never been able to go through this journey. Thank you to Sylvain for being so patient and caring.

I would like to extend my gratitude to Josée Leclerc, who supported me through my internship and the process of writing this paper, providing her guidance, care, and encouragement. Thank you for normalizing and validating my experience on the path of becoming a therapist, for your expertise and wisdom; you have been a model for me all this time.

I also wish to thank my cohort for making these two years so valuable and treasurable for me. I had found true friends, and your dedication and support mean a world to me.

Thank you Sam, you are my rock.

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Figure 1 The original structure of the three ego states (p. 11, Berne, 1961).

Introduction

The idea for this theoretical paper emerged from my personal experience of life script analysis. Learning about TA model, the analysis of my life script was a turning point, which helped me to develop a new perspective on my thoughts, feelings and actions, to make sense of some important aspects of my childhood and of life in general. The experience of TA as a therapy was enriching and life-changing for me. However, throughout the process, multiple times I found myself unable to provide any verbal formulations of my experience; I thus started creating “illustrations” for each session, such as “portraits” of my ego states, drawings of my life path, reflecting on each and only eventually verbally interpreting them. I realized how empowering and helpful was my intuitive decision to incorporate art in my process, which inspired me to learn about art therapy.

This theoretical research attempts to answer the question of how art therapy could inform the work with life scripts of individuals affected by complex trauma in Transactional Analysis (TA) frame, based on Herman’s model of trauma recovery. According to multiple authors, complex trauma presents a big challenge for our society (Erskine, 2008, 2010; Herman, 1992, 1997; Levine, 2005, 2010, 2015; Malchiodi, 2012, 2015; Schimmenti & Caretti, 2016; van der Kolk, 2014). The percentage of children that are being exposed to abuse, neglect, domestic violence, or being emotionally maltreated, increased in the last decade and continuously grows (Perry, 2008; Herman, 1992, 1997; van der Kolk et al., 2009; van der Kolk, 2014).

Research shows that chronic exposure to traumatizing events during the developmentally sensitive periods creates structural and functional changes in the child’s nervous system (Herman, 1997; Perry, 2008; van der Kolk, 2014). Chronic exposure to traumatic experiences leads to difficulties in self-regulation, behavioural issues, affect instability and other symptoms that are being viewed separately as individual diagnoses, instead of a complex disorder, which would require a different integrative approach (Perry, 2008; van der Kolk, 2014). Nevertheless, even if the proposal developed by van der Kolk and his colleagues of adding the complex trauma stress disorder under a name of “Developmental Trauma Disorder” was approved, it had not appeared in DSM-5 due to its complexity and overlapping with other disorders (van der Kolk et al., 2009; van der Kolk, 2014). Other pioneers in trauma recovery, such as Judith Herman (1992, 1997), advocate for a need of changing the posttraumatic stress disorder (PTSD) category for adults, by distinguishing complex PTSD as a separate disorder.

In this theoretical paper, we seek to explore what approaches are commonly used in work with adults affected by complex trauma, and how TA approach in combination with art therapy could be applied within Herman's trauma recovery model. In the first chapter, we explain briefly the current situation in regards to the diagnosis of complex trauma and its impact on physiological, emotional, and cognitive levels. Further, we introduce the approaches used in trauma recovery and present a model for work with individuals affected by trauma, developed by Judith Herman (1992, 1997). In the second chapter, we introduce to the reader an approach of TA, founded by Eric Berne (1961, 1972), and describe its major concepts of life scripts, ego states, and existential positions. We present the original ideas developed by Berne and address modern perspectives on TA in general, and particularly, on work with individuals affected by complex trauma and their life scripts. In the third chapter, we apply Herman's recovery model as a structural base for a synthesis of TA work with individuals with complex trauma and art therapy (Herman, 1992, 1997). Finally, we present to the reader with the limitations of the newly combined model in work with clients affected by complex trauma, discuss recommendations and future research implications, and emphasize the importance of work with individuals affected by trauma in modern world.

Method

A theoretical methodology is chosen for this qualitative research paper with the purpose of providing an analysis and synthesis of existing literature on life script analysis and on the use of art therapy with individuals affected by complex trauma within Herman's model for trauma recovery. The main goal of this research paper is to synthesize the two approaches and demonstrate how art therapy could enrich the work with individuals affected by complex trauma in a TA framework. Such theoretical methodology is suitable because there have not been, to our knowledge, any trauma recovery models that have incorporated the work with life scripts in Transactional Analysis (TA) and art therapy.

In this research study, we firstly formulate the hypothesis that art therapy could inform life script analysis in TA with individuals affected by complex trauma. Secondly, we collect the relevant data, which will be evaluated afterwards. Furthermore, we analyze and interpret the collected information, creating a synthesis of addressed approaches within a framework of Herman's trauma treatment model.

As stated by Walsh and Downe (2005), in preparation for constructing such a framework, it is essential to unify theoretical and empirical literature on the addressed topics. In the first two chapters of this research paper, we include a literature review, which is done through the methodology steps described by Creswell (2013), such as identifying and locating literature applicable to the research question, reading and evaluating the relevance of it, and organizing it in logical units that would be easy to manipulate when writing a literature review. Firstly, we collect the relevant literature on complex trauma and trauma treatment approaches, TA, and art therapy with individuals affected by trauma. The literature includes peer-reviewed articles, books, and online resources. Moreover, we chose the literature that reflects viewpoints of multiple investigators instead of use of multiple works by only one author; by doing that, we may provide different perspectives on the addressed topics (Walsh & Downe, 2005).

Secondly, the collected literature was systematically organized through assigning codes and creating a coding book (Saldana, 2012). The data analysis included separating the literature into three categories: literature on the life script analysis, the complex trauma and treatment models, and art therapy interventions in trauma treatment. In the data analysis, coding was an essential part of the process, which was done manually. After all the sources are separated into content units and the information is integrated, we aim to create a bridge between TA approach and art therapy, interrelating it with the stages of Herman's trauma recovery model (Herman, 1992, 1997).

Thirdly, having identified the main ideas and gaps in theory and practice of life scripts, we synthesize the approaches of art therapy and TA in work with complex trauma, using Herman's trauma recovery model. This leads to developing a new integrative perspective on work with complex trauma, with the aim to make a meaningful contribution to the art therapy field (Creswell, 2013), including recommendations and limitations of this approach.

Chapter One: Complex Trauma

The notion of complex trauma has been well defined by multiple authors (Ford & Courtois, 2009; Herman, 1992, 1997; Levine, 1997, 2005, 2010, 2015; Perry, 2008; van der Kolk, 2014), yet it has still not been included in the DSM-5 regardless of the attempts to change the category of post traumatic stress disorders, which does not cover complex trauma symptoms. As defined by Ford and Courtois (2009), complex psychological trauma is caused by a prolonged or repetitive severe and harmful influence coming the primary caregivers during developmentally

sensitive periods of a person's life. The examples of traumatic events include childhood abuse, witnessing violence, neglect or disrupted communication with caregivers. Complex trauma leads to changes on multiple levels and "represents extreme forms of traumatic stressors due to their nature and timing" (Ford & Courtois, 2009, p. 14).

One of the leading specialists in trauma treatment, Judith Herman (1992) says that dissociation, somatization, and affect dysregulation are quite common parts of the complex trauma syndrome, emphasizing that they are not merely symptoms, but more consequences of the prolonged exposure to neglect or abuse. The aftermath of the complex trauma involves behaviours and functioning that do not fit the classical picture of PTSD with symptoms, which are commonly intrusive re-experiencing, avoidance of the potential triggers, and hyperarousal (Ford, 2009; Ford & Courtois, 2009; Herman, 1992; van der Kolk, 2014). Complex trauma is not a newly discovered notion and could be seen as overlapping with concepts such as cumulative trauma (Khan, 1963), developmental trauma (van der Kolk, 2014), relational trauma (Schoore, 2012), attachment trauma (Mucci, 2013), and others.

According to multiple authors, neglect and repetitive abuse lead to chronic states of emotional stress and impair the capacities to identify, express and regulate these affects (Cicchetti, Toth, & Lynch, 1995; Ford, 2009; Ford, Courtois, & Cloitre, 2009; Levine, 2005, 2010, 2015; Schoore, 2000, 2012; van der Kolk, 2014). In addition, as the authors emphasize, individuals affected by complex trauma have difficulty recognizing and identifying emotional states, but also their body sensations, frequently perceiving the latter as menacing and triggering. As a result, a disconnection between mind and body appears, shattering one's trust in one's own physiological reactions. Such disconnection could also lead to persistent affective states, such as anxiety, rage, sadness (Ford & Courtois, 2009). Herman (1997), Levine (2005) and van der Kolk (2014) indicate that somatization and psychosomatic reactions, dysregulation of the basic functions, such as sleeping and eating, as well as harmful behavioural patterns, for example, risk taking, and development of addictions could be observed often as a part of the complex trauma repercussions.

Overall, the severe repercussions of complex trauma affect all aspects of trauma survivors' existence, incorporating not only physiological and affective disturbances, but also influencing negatively the development of the self and the ability to create intimate interpersonal

connections, while limiting capacities to process and evaluate information, and behave accordingly to the reality (Herman, 1997; van der Kolk, 2014).

Complex Trauma and the Body

Traumatic exposure in childhood leads to multiple functional and structural alterations in the body, as the child's developing nervous system shifts from being focused on learning to being focused on surviving.

Ford and Courtois (2009) explain that the learning mode and survival mode encompass the same system and processes; however, the survival mode keeps the nervous system in a state of stress and forces the person to survey the environment for potential threats and danger, mobilizing the body resources for the future response, such as flight, fight or freeze. In contrast, the learning mode focuses on discovering new information and supporting homeostasis of the body and is characterized by openness to new experiences (Ford & Courtois, 2009). Furthermore, during the developmentally sensitive periods, children discover not only their external world, but also learn about themselves, in particular, how to react to stress and self-regulate, fluctuating between the states of tension, during potential danger, and relaxation, after the situation is resolved (Ford & Courtois, 2009; Levine, 2005, 2015).

From a physiologically informed point of view, the mechanism that occurs within the nervous system in individuals affected by complex trauma is that the state of relaxation or expansion does not follow the tension state of freeze after the danger is gone (Levine, 2005, 2015). Levine concludes that people affected by complex trauma are in a constant state of contraction; they are being trapped in their own bodies, feeling helpless and hopeless, with a sense of despair, perceiving their physiological reactions as betrayal of the body. As explained by Ford and Courtois (2009), if the survival mode starts from birth, or during other developmentally sensitive periods, an individual would have limited opportunities to learn how to self-regulate and reestablish sense of safety after stressors disappear.

Complex Trauma and Behaviour

Multiple authors (Herman, 1992, 1997; Levine, 1997, 2005, 2010; van der Kolk, 2014) demonstrate that the information processing suffers as much as emotional regulation. Since basic safety is shattered in individuals with complex trauma, they dwell in a state of chronic hypervigilance, as they scan the environment for potential danger and keep both body and mind

in constriction, blocking any opportunities for exploration and learning (Herman, 1997; van der Kolk, 2014).

As Levine (2005) states, this rigidity as consequences of unresolved trauma could affect one's habits, system of beliefs, interpersonal relationships. In her writings, Herman (1992, 1997) contends that the gravity of consequences of complex trauma is reflected in a sense of isolation, "disempowerment, and disconnection from others" (p. 133). She emphasizes that the behaviour of the trauma survivor, even in new relationships, would be influenced by the difficulties of establishing basic trust and sense of competence and adequacy (Herman, 1997). As a severe consequence of complex trauma, the capacity for intimacy and autonomy is endangered by the intrusive past of the survivors as well (Lourie, 1996).

As Lourie (1996) indicates, people affected by complex trauma often conclude that they are not lovable or inadequate, which severely damages their ability to establish and sustain long lasting and close relationships. Similarly, Levine (2005) explains that trauma survivors often have a tendency for reenactment of the traumatic experiences, making an impact on the relationships and social situations. The author adds that complex trauma could lead to self-destructive behaviours and even trigger appearance of somatic diseases. The effect of complex trauma is summarized by Levine (2005) as being "about loss of connection – to ourselves, to our bodies, to our families, to others and to the world around us" (p. 9).

Modern Treatment Models for Complex Trauma

As van der Kolk (2014) explains, there are three main types of approaches in the practices oriented towards work with trauma. He suggests that the first way of treatment would relate more to the field of psychiatry and pharmacology, and its essence is oriented towards shutting down the inappropriate responses from the nervous system by taking various medication or by reorganizing neurotransmitters and hormone production/exchange in the body. According to the multiple authors, on itself, this approach to treating consequences of trauma exposure neither solves the problem nor brings any resolutions to the individual affected by trauma; however, it may help the person to regain stability, decrease certain symptoms, and prevent overwhelming states (Levine, 2005, 2010, 2015; Herman, 1992, 1997; van der Kolk, 2014). As Levine (1997) puts it, "drugs may be useful in buying time to help the traumatized person stabilize" (p. 38).

Van der Kolk (2014) introduces a second path, a top down approach which focuses on retelling the traumatic story, reorganizing and processing memories, creating system of interpersonal support and reconnecting to the community.

The third approach is a bottom up approach, which appears to be the most fruitful for those people who had prolonged traumatic experiences early in their childhood, as it initially addresses with basic safety and body experiences (Levine, 2005, 2010; van der Kolk, 2014). However, van der Kolk (2014) emphasizes that most people “require a combination of the approaches” (p. 3). He highlights that universal formulas for work with people affected by complex trauma simply do not exist.

In his writings, van der Kolk (2014) proposes that a combination of approaches should be used when dealing with complex trauma. The author himself gravitates towards using a bottom up approach in his work with people affected by complex trauma, suggesting body-oriented techniques with a goal of establishing basic safety and healthy self-regulatory patterns.

As explained by van der Kolk (2014), the functional changes in the nervous system could be transformed with help of different therapies, such as neurofeedback, yoga, eye movement desensitization and reprocessing, some mindfulness techniques, creative art therapies and others, and not necessarily requiring medication and/or top down approach. He encourages the use of expressive therapies; however, emphasizes that simple outplaying and expressing trauma with non-verbal means do not automatically lead to health, and that trauma recovery requires verbal processing in order to find resolution and renegotiation of trauma. The author argues that the essential part of the work should be done through restoring sense of connection, ownership, and safety of one’s body; otherwise, any following work on reconstruction of the traumatic memories would lead to retraumatization and merely add to the vicious circles of reenactment and repetition (van der Kolk, 2014).

Judith Herman’s Trauma and Recovery

Judith Herman (1992, 1997), one of the pioneers in the work with complex trauma or complex PTSD as she calls it, describes the stages of recovery from trauma. Her integrative model appears to gravitate towards top down approach, but incorporates elements from bottom up approach as well (Herman, 1997). She states that the two main principles of the trauma recovery model are empowerment and affiliation. Herman (1997) emphasizes the importance of safety and self-regulation as a base for future recovery, upon which arises the opportunity to

recall, process, and mourn for the traumatic past in a contained and secure way. Furthermore, the author stresses the importance of reconnection with community, establishment of healthy interpersonal relationships and behavioural patterns, and acquirement of social support, which becomes one of the most valuable resilience factors for trauma survivors (Herman, 1992, 1997).

Herman (1997) argues that naming the problem and escaping the wordless world of trauma is an essential aspect of the recovery process, and her integrative model is based on the premise that “the conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of the psychological trauma” (p. 1).

First stage: Safety and stabilization. The first stage of the trauma recovery model is establishing safety and stabilization, which is based on the core principle of empowering the client (Herman, 1997). The empowerment principle in the first stage for people affected by complex trauma implies taking control over their life, in other words, regaining power over their inner and outer worlds. Since one of the main struggles of people affected by complex trauma relates to sense of not trusting their own sensory experiences, being overwhelmed by them, thus, not being secure in their own bodies, the reestablishment of the control over the physiological functioning seems essential (Herman, 1997, p. 160). She suggests that use of medication, as well as behavioural and cognitive techniques, could help with reestablishment of control over the body, through fostering healthy biological cycles of sleeping and eating, reducing self-harming behaviours, increasing awareness, and focusing on the body (Herman, 1997).

In the first stage, Herman (1997) also addresses establishing safety and control over the environment, such as stabilization of the living situation, planning for future self-protection, creating system of social support, and avoiding stressors. Even through the three stages of recovery overlap and may require addressing safety over and over again, a gradual transition towards a sense of higher independence and ability to take care of oneself would mark the first stage completion.

Second stage: Memory reconstruction and mourning. In the second stage of the recovery, the story of trauma is being formulated and told, after which a mourning process could begin. As Herman (1997) states, the “reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor’s life story” (p. 175). According to the author, the story reconstruction follows three general steps.

The first step is the review of the life story before the trauma in order to reclaim the client's sense of flow and continuity. However, in the case of early complex trauma it might not be easily reachable.

The second step, according to Herman (1997), is the reconstruction of the traumatic event which may include both verbal and non-verbal means of communication, since the closer the client gets to the unbearable moments, the harder it is to continue using words. The author suggests that the objective of this step is to create a cohesive narrative out of the words, images, and symbols that the client expressed about the traumatic experiences; therefore, use of expressive art therapies could be appropriate and sometimes more helpful than verbal therapy techniques.

Herman (1997) proposes that the next step is to reread and "relive" the traumatic narrative in a safe environment and in the presence of the therapist, after which the possible meaning making process could begin. Herman also emphasizes that cathartic reliving of trauma without going through the first stage of establishing safety is very dangerous, as the therapist would then become the instigator of the overwhelming experiences, instead of a containing and safe person; in this case the experience of reliving trauma would be triggering and re-traumatizing (Herman, 1997). Furthermore, the author suggests that after multiple repetitions and transformations of the story, trauma loses its vividness and stops being the dominating part of one's life.

After the reconstruction of the trauma narrative, a mourning process could take place. As Herman (1997) explains, the mourning process that follows the reconstruction of the trauma is the most difficult part of this stage and represents a point of stagnation of recovery because of the resistance. For individuals affected by complex trauma, the grieving process appears even more complicated, since they have "a task of grieving not only for what was lost but also for what was never theirs to lose" (Herman, 1997, p. 193). Moreover, this stage of recovery includes an important task of creating new meaning and internal perspectives on the world functioning and survivor's experience.

Third stage: Reconnection. The third stage of the recovery process, according to Herman (1997), represents the future-oriented phase, in which a restructuring of one's life happens. A person continues creating a new system of beliefs, builds new identity and new interpersonal connections through meaning making. If, as Levine (2005) states, the trauma is about loss of connections, then this last stage of recovery process is about restoring or building new ones. Herman contends that during this stage the therapist helps clients to expand their self-awareness,

to learn how to fight instead of freeze, to reconnect with themselves and their bodies, as well as with the community, and build strong system of social support.

Herman (1997) summarizes that the principles of empowerment and affiliation should follow the survivors of trauma, as even after a successful course of treatment, the client might regress under stress and “relapse”, which makes the goals of the reconnection stage vital for trauma survivors.

The main goals of the trauma recovery model are to provide individuals with traumatic past with ways to find empowerment, process trauma, and build a system of social support through healthy and strong interpersonal relationships (Herman, 1997). The social network of the individuals affected by complex trauma becomes the main resilience factor after therapy, as in moments of stress and despair the holding hands of others provide support and encouragement, assisting the survivors of trauma to remain stable and safe. Nevertheless, building a support system for the individuals affected by trauma is a long and difficult process, as they have to challenge behavioural patterns that prevent development of strong relationships.

As van der Kolk (2014) explains, one of the main goals of therapy with individuals affected by complex trauma is in life re-scripting, switching it from being based and focused on trauma to a more healthy and full life. He suggests that re-scripting happens on the level of body and experience and, in therapy, a trauma survivor learns how it is to be taken care of and to be safe.

Similar ideas were suggested by Berne (1961, 1964, 1972), who sees one the main goals of therapy in reaching self-awareness and coming closer to autonomy from the pathological behaviours developed as a result of cumulative effects of traumatic events in childhood and unhealthy parental programming. Berne (1961, 1972) developed an approach called Transactional Analysis, within which the final phase emphasizes re-scripting of life as an important step on the path to full and healthy existence, as will be described below.

Chapter Two: Transactional Analysis

In this chapter, we introduce some of the core premises of Transactional Analysis (TA), an approach founded by psychiatrist and psychotherapist Eric Berne. Particular attention is given to the concept of *ego states* that serve as central building blocks of TA, as well as to original and modern perspectives pertaining to the concept of *life scripts*.

Coming from psychoanalytical and social psychology viewpoints, Berne developed TA as a model that seeks to unfold the nature of interpersonal relationships and personality (Berne, 1961, 1964, 1972). According to Berne (1961), TA is a system of psychotherapy that provides a path for personal growth and change. Berne (1972) defines it as “a theory of personality and social action, and a clinical method of psychotherapy, based on analysis of all possible transactions between two or more people, on the basis of specifically defined ego states” (p. 20).

The idea of developing a model of TA arose from Berne’s dissatisfaction with the psychoanalysis of his days; in addition to being available only to groups of people who had the financial means for such long treatment, he saw it as not necessarily successful, too complex, too rigid, and too slow (Berne, 1961). In addition, Berne expressed his disagreement with the psychiatric perspective of seeing patients from a negativistic point of view, such as in positions of weakness or illness. As a result, Berne strived to create an approach that, firstly, would be accessible and understood by all people and not only professionals; secondly, which the clients could apply independently throughout their life.

In fact, the main idea of TA is to seek true autonomy and independence, both internal and external, as defined by Berne (1961). Berne (1972) explains that it could be achieved through awareness of one’s behavioural patterns, as well as through an understanding of how other people affect one’s behaviour and decisions, starting from transactions between children and their parents that become internalized, ending with interpersonal interactions in adulthood. The author also suggests that people can be *autonomous* after rethinking their life script decisions, which were developed in childhood; they learn to become aware of their ego states functioning, their behavioural patterns, and their life scripts influences.

Deriving from Sartre’s existential philosophy, Claude Steiner (1974), Berne’s student and later colleague and friend, summarizes the three main premises of modern TA. The first premise is that people are born with a positive sense of self; the second one is that they are born with all the resources and potentials to become autonomous and face emotional difficulties; and according to the third premise, such difficulties are curable with the right approach.

Even though TA incorporates multiple concepts, due to the scope of the present research paper; the concept of life scripts receives most of our attention. However, before introducing this concept, two other important concepts of TA, namely existential positions and ego states or structural analysis, must be defined.

Existential Positions

Based on Erikson's notion of basic trust (1968), Berne (1962) believes that each child is born within a position of positive experience of self and of other, which he describes as "I'm OK, you're OK" (p. 23). This position is rooted in the prenatal mutuality between the mother and the child. According to several authors (Allen, 2010; Cornell, 2010; English, 1988; Erskine, 2010), the only explanation for a child to abandon this position and accept negative perceptions of self or others, or both, is the danger to the child's safety and sudden unpredictability of the reality. In this case, the child adjusts the impressions and expectations of the world accordingly to parental messages and her own experience, similarly to the development of a false-self personality (Winnicott, 1992).

Berne (1972) theorizes that since a child cannot accept herself the way the child is, and is implicitly forced to become someone else, the child would search for validation of this new self in an external model. Frequently, such external models would be founded on characters present in fiction, myths, fairy-tales, and other type of narratives, as described by Berne (1972) and his colleagues (Allen, 2010; Erskine, 2010; Steiner, 1974). As the authors indicate (Allen, 2010; Berne, 1972; Erskine, 2010; Steiner, 1974), the identification with a hero from a story brings not only relief and clear guidelines of interactions with the world, but also attempts to solve the internal cognitive conflict caused by contradictory information from the world.

Structural Analysis or Ego States

Berne was highly influenced by the psychosocial ideas of Eric Erikson and Ego Psychology in general (Berne, 1961, 1964, 1972; Erikson, 1968). He proposes a three part structural model of ego states, defined as follows: Exteropsyche, Neopsyche, and Archaeopsyche; these ego states correspond to what Berne describes as the Parent, the Adult, and the Child, respectively (see Figure 1). These three ego states serve as building blocks of TA. As defined by Berne in his latest writings, ego states are "coherent systems of thought and feelings manifested by corresponding patterns of behaviour" (1972, p. 11). In other words, every moment of a person's existence is in an ego state, which is reflected in one's feelings, thoughts, and behaviour. In addition, the author explains that each person's cathexis or mental energy will go from one state to another depending on the circumstances (Berne, 1972).

The Adult ego state. Steiner (1974), following Berne (1961, 1972), summarizes that Neopsyche or the Adult is an ego state that is led by rationality and logic; in this ego state, a

person receives and sends information, and, essentially, includes feelings, thoughts and behaviour located in here-and-now. As Harris (1969), another follower of Berne's ideas, writes, the Adult is "principally concerned with transforming stimuli into pieces of information, and processing and filing that information on the basis of previous experience" (p. 32). That is to say, the Adult responds accordingly to the current reality. For instance, if asked a question, a person in the Adult state responds to the information of the question and not to the implicit level of the incoming message.

The Child ego state. Berne (1961) described *Archaeopsyche* or the Child ego state as a state that develops in childhood. The author suggests that Child contain three other parts, namely the "Adapted Child", the "Little Professor", and the "Natural Child", each representing a different type of child behaviour.

As summarized by Goldhaber and Goldhaber (1976), the Little Professor is a small Adult, which in childhood represents the behaviours, which are related to discovering and learning. After a person grows up and develops a separate Adult ego state, the Little Professor stays as a part of the Child, which is responsible for "curiosity, creativity, originality, intuition, and manipulation" (Goldhaber & Goldhaber, 1976, p. 39). This part motivates person to explore and try new things, and to wonder about the functioning of the world and human relationships. From Ford and Courtois (2009) point of view, the Little Professor is the ego state of the learning mode.

As Berne (1961) defines it, the Natural Child is a carefree and spontaneous part of the Child ego state, which represents raw desires and demands; it is simultaneously affectionate and could be aggressive, if something does not go its way. According to Berne (1961), the Natural Child and the Little Professor are the ego states that are often repressed in people with traumatic childhood.

The third part of the Child ego state, as Berne (1961) theorizes it, is the Adapted Child, which represents an adaptation to caregivers' messages. In comparison with the Little Professor, this part of Child ego state is responsible for the aspects concerning the survival and adaptation to the world the child lives in. The Adapted Child is the part that follows the rules and norms, learns what is appropriate and what is wrong from a social perspective. In addition to the external control from caregivers, the Adapted Child is being controlled by the Parent ego state of the person. Moreover, the Adapted Child "modifies behaviour of the Natural Child in order to

confront to the wishes of parental figures” (Goldhaber and Goldhaber, 1976, p. 40). Berne (1961, 1972) theorizes that individuals affected by trauma would have a powerful Adapted Child with distorted perceptions of the norms and regulations, which would influence the Adult, creating cognitive distortions, as well suppress the Natural Child and the Little Professor, blocking playfulness, flexibility and capacity to be creative.

The Parent ego state. In his writings, Berne (1961) suggests that Exteropsyche or the Parent is an ego state that is mostly adopted by the person from the models presented by the parental figures. According to Berne, the Parent contains two parts: the “Controlling Parent” and the “Nurturing Parent”. The author contends that the Nurturing Parent is reflected in nurturing behaviours which aim to keep the Child ego state safe and comforted; for instance, being loving, protective, caring, showing concern, providing help. Furthermore, Berne theorizes that the Controlling Parent internalizes the critical messages from the primary caregivers, which are accepted by the child without bias, and then reproduces them in critical behaviours, such as punishing, bullying, evaluating, judging, teasing, etc. According to Berne and his colleagues (Cornell, 2014; Erskine, 2010; Steiner, 1974), such parental injunctions represent the force that would sculpt the formation of a life script, as it influences the development of the Adapted Child and is completely replicated in the Controlling Parent.

From a structural analysis point of view, as Steiner (1974) suggests, chronic traumatic experiences in childhood prevent the ego states from developing fully. One of the trauma repercussions is the repression of the creativity, curiosity, flexibility, and spontaneous expression (for which the Natural Child and the Little Professor are responsible) as the child focuses on survival mode instead of learning mode (Ford & Courtois, 2009).

Another consequence of the trauma is the influence of the Adapted Child’s emotions and the Controlling Parent’s injunctions on the Adult ego state. As Berne (1961, 1972) and Steiner (1974) explain, in the cases when the Adapted Child or the Controlling Parent influence the Adult, the Adult responds not to the current reality, but to the situation from the past which was triggered by the current reality. For instance, if a present situation elicits a traumatic memory, the Adult reacts to the memory, and not to the actual situation. In the case of the influence from other ego states, the Adult would filter and distort the external information in order for it to fit previous traumatic experiences and lead to reenactment of them in relationships with other people (Steiner, 1974). Hence, one of the goals of TA with people affected by complex trauma

would be to exempt the Adult from the influences of the Adapted Child and the Controlling Parent, and allow the expression of the Natural Child, the Little Professor, and the Nurturing Parent (Steiner, 1974).

Origins of Life Scripts

The concept of life scripts is one of the major concepts in TA, and according to Berne (1961, 1972), the goal of TA therapy is in gaining an awareness of scripts' influence on behaviours, decision-making, and system of beliefs. Berne suggests that a life script is a limiting "extensive unconscious life plan" (1961, p. 23). He states that a life script could be formed in childhood as an adaptation model giving meaning to one's experience in concordance with parental injunctions. In this sense, the notion of life scripts find correlates in the ideas of internal working models introduced by Bowlby (1969), repetitive compulsion as defined by Freud (2011/1920), as well as styles of life theorized by Adler (2010/1927).

Berne (1972) explains that a life script is "based on childhood decisions and parental programming which is continually reinforced" (p. 233). The script decision is made by the child under the influence of his or her emotions and reality testing, and represents the best possible strategy of surviving. Berne (1961, 1972) theorizes that these patterns present themselves in rigid schemata, which serves as a set of preconscious guidelines for the person to follow throughout the course of life in order to get a payoff, which is seen as a resolution of the script.

Essentially, as summarized by Steiner (1972), a combination of childhood events and caregiver's implicit and explicit messages regarding these events and life in general would serve as a base for formation of a life script. As Berne (1972) conceptualizes, the "life scripts are based on parental programming" (p. 59), and the parents pass on their knowledge, including not only useful information, but also their own life programming, which sometimes supports a vicious circle of intergenerational trauma, while in other cases provides their child with resilience and success.

In his writings, Berne (1961, 1972) describes three main aspects of a life script: protocol, script proper, and adaptation. He defines protocol as the earliest level of a life script, which is unconscious and is based mostly on implicit communications between the child and caregiver in infancy. Script proper, on the other hand, is conceptualized as a level of life script that evolves parallel to the development of language and speech in a child; it is often pre-conscious. Berne

describes adaptation as a compromise between the script directives and the opportunities to outplay those directives in reality.

Moreover, Berne (1961, 1972) divides all life scripts into three categories, namely positive, banal, and negative or tragic scripts. Positive life scripts, according to Berne (1972), are the scripts of people who are highly self-aware and set adequate and challenging goals, and successfully follow through with their contracts with themselves and the world. Banal scripts are similar to positive scripts; however, people who follow banal scripts would not be able to set appropriate goals for themselves, and they see all of their achievements as “almost being good enough” (Berne, 1972, p. 234). In terms of negative or tragic scripts, people with such scripts are distinguished by a deep sense of not being good enough, which often is a severe consequence of cumulative trauma, which includes not only abuse, but also neglect and chronic misattunement from their caregivers.

Despite the colossal amount of work on life script analysis, as Erskine (2010) describes, Berne had not finalized his perspective on this topic. He died before the ongoing discussion between him and his followers regarding the nature and potential “cure” (Erskine, 2010, p. 13) of life scripts was resolved. After half of a century of neuroscience development, the viewpoint on life scripts in TA had changed, and many of the modern transactional analysts (English, 2010; Tosi, O’Reilly-Knapp, Napper, English, & Stuthridge, 2011) consider Berne’s definition of life scripts to be deterministic and limiting, suggesting that more open and positive viewpoints are needed.

Modern Perspectives on Life Script Analysis

As mentioned above, the paradigm shifted from the original notions of TA with the development of neuroscience and social sciences. Multiple authors (Allen, 2010; Cornell, 2010; Stuthridge, 2010) turned to neuroscience to explain the formation of life scripts, which brought a new perspective in regards to the question regarding which parts of life scripts are conscious, pre-conscious and unconscious constructs. With the aim of bringing back the power to clients and putting them in a proactive position, Berne (1961, 1962, 1964, 1972) unwillingly underemphasized the importance of implicit communications between the caregivers and children, as well as significance of unconscious, non-verbal, and physiological experiences, which could be out of the reach of clients consciousness. As Erskine (2010) comments, the modern perspective on life script incorporates a possibility that a script could be “held within the

body as a self-protective, inhibited, and rigidified physiological reaction” (p. 11). This idea validates the importance of body-oriented work with individuals affected by complex trauma.

Several authors (Bucci, 2001; Erskine & Trautmann, 2003; Erskine, 2008; Lourie, 1996; Tosi et al., 2011) agree that a life script formation could be connected to early childhood events, even before the child’s language apparatus fully develops. Furthermore, as the authors suggest, since the experiences happened before the speech development, such experiences reside in one’s memories in a non-verbal form; therefore, some life scripts have a non-narrative format and could not be verbalized easily (Bucci, 2001; Erskine & Trautmann, 2003; Erskine, 2008; Lourie, 1996; Simonds, 1994; Tosi et al., 2011). Erskine (2010) states, “implicit script conclusions may represent early childhood pre-verbal or never verbalized experiences that, because of the lack of relationship, concept, and adequate language, remain unconscious” (p. 7).

Moreover, Erskine (2008, 2010) argues that early childhood experiences that would influence the formation of life scripts would include not only trauma, such as neglect, abuse, or separation, but also misattunement that may cumulatively impact the formation of unconscious relational patterns and influence the script decisions. He highlights that a substantial part of life scripts is expressed on affective and sensorimotor levels, and could be observed through the specifics of self-regulation processes and unconscious somatic responses (Erskine, 2010).

Similarly to Erskine (2008, 2010), Tosi et al. (2011) argue that “life scripts being composed of subsymbolic and procedural memory, implicit experiential conclusions, and self-regulating patterns” (p. 255), they are partly unconscious and thus, not as easily accessible, as it was suggested by Berne. Multiple transactional analysts (Allen, 2010; Cornell, 2010; English, 1988, 2010; Erskine, 2008, 2010; Heiller & Sills, 2010; Noriega, 2010; Widdowson, 2010) propose that the modern work with life scripts should incorporate cognitive, creative, physiological and other dimensions of therapy in order to help clients raise awareness about their unconscious experiences, instead of residing within purely cognitive-oriented model. According to several authors (Erskine, 2010; Hargaden, 2010; Tosi et al., 2011), this new perspective provides various ways of working with life scripts for adults affected by complex trauma, even if some of their experiences could not be easily transformed into an autobiographical narrative.

This new perspective, informed by neuroscience, incorporates not only the traditional verbal and cognitive therapeutic practices of work with life scripts, but also various non-verbal

techniques, as applied by Allen (2010) and his colleagues (Erskine, 2008; Erskine, 2010; Erskine & Trautmann, 2003; Cornell, 2008, 2010, 2014).

For instance, Cornell (2010) emphasizes the somatic relations in life scripts and, especially, in script protocols, as the earliest level of life scripts. Cornell follows the structure of life scripts developed by Berne (1972), but highlights the significance of the somatic part of the protocol, which Berne called the “tissue level” (1972, p. 111). In his critique of Berne, Cornell (2010) claims that somatic component is not being addressed in the classical TA work, which is a big oversight because many of the issues brought in the therapy are rooted on the tissue level. He further states that the cognitive-interpretive approach may not reach the origins of the protocol; thus, it could not become the shifting power for the client affected by childhood traumatic experiences.

Multiple codes model. In his TA practice, Cornell (2010) applies the model of multiple codes developed by Bucci (1997, 2000, 2001), highlighting the differences in the systems of mental representation. Bucci (2000) presents four levels of information processing: symbolic verbal, subsymbolic verbal, symbolic non-verbal, and subsymbolic non-verbal levels.

The *symbolic verbal* level mode, which is expressed in language and words and is easily accessible, is considered a mode of cognitive-interpretive communication (Bucci, 1997, 2000). Concerning the *symbolic non-verbal* level, Bucci suggests that it incorporates images, object representations and information from other senses. She proposes that the *subsymbolic non-verbal* level operates in sensorimotor modality and is dominant in the emotional information processing, which would pertain to various experiences, such as empathy and intuition. Whereas, the *subsymbolic verbal* level, which is studied the least, incorporates the musical aspects of language, such as intonations and rhythms (Bucci, 1997, 2000).

Cornell (2010) concurs that the original TA proceeds on *symbolic verbal* level similarly to any type of verbal therapy, emphasizing the language cognitions of the client. According to this author, there is a need to address the other levels as well in work with people affected by complex trauma, since their experiences may not reside on the symbolic verbal level. In modern TA, many authors (Allen, 2010; Cornell, 2010; Erskine, 2010) are starting to apply this knowledge in order to provide optimal care for clients. Cornell (2010) agrees with Bucci’s (2000) point of view that the optimal goal of therapy should be a reorganization and reinforcement of all those modes of processing and experiencing information. He also finds that

the multiple codes model informs the work with life scripts and behavioural patterns in TA, establishing a valid parallel between Bucci's model and TA concepts (Cornell, 2010). Most importantly, he emphasizes that trauma would be experienced on the *subsymbolic* levels, which corresponds to the earliest level of the life script characterized by implicit communications with caregivers.

From a modern TA perspective, the concept of negative life script formation is tightly linked with trauma theories and notions (Allen, 2010; Cornell, 2008, 2010; Erskine, 2010; Steiner, 1974, 2010; Tosi et al., 2011; O'Reilly-Knapp & Erskine, 2003, 2010). As defined by Erskine (2010), there are striking similarities between the elements of tragic life scripts and the repercussions of complex trauma, such as embodiment and reenactment of the traumatic events, self-regulatory problems, somatic dysregulation, and disorganized attachment problems. All of the above lead to the view that the optimal therapeutic goal would be to create an integrative approach to therapy in order to provide care and tools suitable for various clients (Erskine, 2010). Modern approaches to trauma therapy would thus incorporate not only narrative and cognitive aspects of work, but also creative art therapies, body-oriented work and others, in order to provide a person with a sense of empowerment, foster self-regulation and resilience, in addition to accessing unconscious material and working through it in a non-threatening way.

Chapter Three: Art Therapy Informed Life Script Analysis from the Perspective of Herman's Trauma Recovery Model

As highlighted in the literature review presented in the first two chapters, modern transactional analysts, such as Erskine (2003, 2010), English (1992, 2010), Trautmann (2003), Tosi et al. (2011), all have reviewed Berne's ideas, emphasizing the lack of his attention towards the physiological and implicit experiences in work with life scripts. They argue that besides the explicit and conscious decisions regarding one's behaviour, there are multiple factors over which individuals with complex trauma do not have control; thus, they would require assistance in achieving awareness about the potential influences on their life and restoring ownership over their life (Erskine, 2010; English, 1992, 2010; Erskine & Trautmann, 2003; Tosi et al., 2011).

Furthermore, in the case of complex trauma, the authors assert that clients would have to address self-regulation and fragmented triggering traumatic memories before creating a cohesive narrative and sharing their full story, and prior to making connections amongst their experiences

and their behaviours, values, choices, and coping strategies (Erskine, 2010; English, 1992, 2010; Erskine & Trautmann, 2003; Tosi et al., 2011). As stated by the eminent professionals who work with trauma, such as Herman (1992, 1997), Levine (2005, 2010, 2015), and van der Kolk (2014), the first important step in trauma recovery is to establish basic safety, starting from a sense of security of one's body, following a bottom up approach. Thus, in work with trauma survivors, modern TA, being originally a top down approach or psychotherapy, slowly becomes an integrative approach that addresses the physiological and implicit experiences of clients (Erskine, 2010).

In this paper, we suggest to incorporate art therapy and creative process throughout the course of work with life scripts, as well as body-oriented work. In combination with life scripts analysis, art therapy would make it possible to address not only the symbolic verbal level, but also subsymbolic and symbolic non-verbal levels, according to Bucci's model (1997, 2000, 2001).

In order to synthesize this new proposed theoretical piece of knowledge, Judith Herman's (1992, 1997) three-stage model of recovery is used as a core structure for integration of TA and art therapy approaches. Furthermore, the four creative process phases introduced by social psychologist Graham Wallas (1926) are incorporated within Herman's recovery model, as well as in Rollo May's (1975) perspective on the creative process.

Art Therapy and the Creative Process

Art therapy. Moon (1994) defines the basic premise of art therapy, suggesting that art mediums serve as intermediates between thoughts and emotions. As Lusebrink (2004, 2010) explains, the use of art materials provides a path to affective processes, which are not accessible through verbal therapy techniques. Besides, art therapy is seen as a less threatening way of addressing, exploring, and transforming emotionally charged expressions. As multiple authors (Gantt & Tinnin, 2009; Hass-Cohen, 2003; Hass-Cohen & Carr, 2008; L. Herman, 1997; Malchiodi, 2012a, 2012b, 2015; Malchiodi & Miller, 2012; McNamee, 2005; Meekums, 1999; Rappaport, 1998, 2015; Silverman, 2004, 2006) describe, by using art materials, metaphors and artistic creations clients can often gain a healthy distance from the affective content of their traumatic experiences, without the latter becoming overwhelming. Moreover, because of the tangible nature of the created artworks, clients may gain a sense of consistency and stability; also, they can return to the objects they created throughout the course of therapy, interact with

them, changing their meaning and transforming them (Gantt & Tinnin, 2009; Hass-Cohen, 2003; Hass-Cohen & Carr, 2008; Rappaport, 1998, 2015). Hass-Cohen and Carr (2008) explain that art therapy helps create links between the past fearful memories with new positive images, decreasing anxiety. Art therapy thus assists clients affected by trauma in finding a sense of empowerment and control; it also reactivates their creativity and playfulness, provides means for reconnection with the body, contains overwhelming emotions, and makes available the paths for accessing the non-verbal levels of individuals' experiences.

The creative process is an essential part of art therapy practice. As Winnicott (1971/2012, 1992) explains, the creative process represented in play, art making and other expressive activities, is an encounter of the inner and outer worlds, which does not happen purely in one's imagination nor in the reality, but in a transitional space or intermediary realm of experience. This encounter provides an opportunity to shape the external world without experiencing overwhelming feelings and in a contained form – through symbolic expression.

Phases of the creative process. In his writings, Wallas (1926) describes that the creative process rest on four phases namely preparation, incubation, illumination, and verification. As Wallas explains, the *preparation* phase is characterized by a conscious immersion into a question or concern, during which a person collects information and increases the knowledge related to the question. The preparation phase of creative process could be seen as parallel to the initial stage of therapy, where the initial contact occurs, preliminary goals of therapy are being defined, contract and frame are being established. Within Herman's model of recovery (1992, 1997), the preparation phase would underline the establishment of safety and stabilization.

In the *incubation* phase, all the collected information has been examined, but the solution has not yet appeared. Wallas (1926) characterizes the incubation phase as a state where the unconscious mind is involved in the solution search. The incubation phase is filled by struggles to find the answer to the question, during which the person withdraws his or her focus from the problem. In the therapeutic process, the incubation phase may be seen similar to the exploration process, where the defined problem is being explored and processed, but the client has not yet reached realizations about the core issues, and the therapist waits before the client is ready for the interpretations (Coppolillo, 1987). The incubation phase could be also seen as a point of stagnation in therapy.

As Wallas (1926) explains, given time, the incubation phase is usually followed by *illumination*, commonly a short phase in which the person suddenly gains an insight and a sense of clarity, receiving the answer to the question or coming up with an idea. From a therapeutic perspective, illumination appears when the client gains insights and when the therapist makes timely and accurate interpretations, bringing sense of relief to the client and feeling of being understood.

Finally, the *verification* phase represents a process of reexamining and reevaluating the solution. As Rollo May (1975) suggests, the creative process is almost never linear, having a cyclical form; in addition, the author emphasizes that the creative process requires “*alternating work and relaxation*” (p. 66). In therapy, this could be the stage of reevaluation of the reached outcomes, reestablishing goals, and making changes according to the gained insights.

Frequently, clients in art therapy represent their experiences symbolically or through metaphors without making direct links to real life events at first (Cox & Theilgaard, 1987). In this sense, a visual transformation happens through the symbolic or metaphoric expressions of the art process, which could be seen as preparation and incubation phases. When ready, clients are then able to recognize the connections with real life experiences, going through phases of insights followed by verification, leading to deeper self-awareness and development of new perspectives.

The next section is devoted to a more detailed integration of Herman’s model of trauma recovery (Herman, 1997), life script analysis, and art therapy. A brief introduction to each stage is followed by art therapy perspective and interventions suitable for the goals of the particular stage. TA process, and, mostly, life script analysis is briefly introduced for the stages as well. The three stages described below follow Herman’s model of recovery, as well as the knowledge from the recent trauma research (Levine, 2005, 2010, 2015; Schore, 2000, 2012; van der Kolk, 2014). In establishing basic safety and stability the focus is on the reconnection with the body, which is followed by memory reconstruction and mourning, thus, “reconnecting” with the mind, and, finally, building relationships with the community, simultaneously facing existential questions, “reconnecting” with the souls—spirit, meaning making.

Three Stages of Trauma Recovery: Reconnecting with the Body, the Mind, and the Soul

First stage: Containment. As mentioned above, one of the central issues affecting people with complex trauma pertains to self-dysregulation and disconnection from the body, as

the experience of trauma is overwhelming and menacing to an extent that an individual affected by complex trauma does not feel safe in his or her own body (van der Kolk, 2014). For the first stage of therapy, it is important to establish the therapeutic alliance, a trusting relationship between the client and the therapist, and to provide a holding environment and safe space before exploring traumatic memories and creating a trauma narrative. Therefore, in a combined treatment model for complex trauma, it seems essential to start from the body and go up towards cognitive acceptance and integration (van der Kolk, 2014).

Many individuals affected by complex trauma hesitate naming their problems, talking about traumatic past, and seeking help. Herman (1997) explains that if people affected by PTSD have a sense that they “may be losing their minds”, people affected by complex trauma “often feel that they have lost themselves” (p. 158). A sense of not being able to name what is wrong with them leaves individuals affected by complex trauma incapacitated by hopelessness. Moreover, a feeling of shame and pride may prevent them from asking for help, as it might be seen as acknowledging the omnipotent power of the perpetrator. As Herman (1997) suggests, often therapists have to explain that “accepting help is an act of courage” and that “taking action to foster recovery, far from granting victory to the abuser, empowers the survivor” (p. 159).

According to Herman (1997), the first stage of recovery must address safety and stabilization, thus providing grounding and structure for the client. The author highlights the importance of safety for the client affected by complex trauma in and out of the therapy. With individuals affected by complex trauma, the first stage may take up to a few months, and requires partial focusing on the pragmatic aspects of trauma repercussions, aiming at restoring safety on different levels, starting from structuring daily routine, encouraging healthy sleep and eating habits. Herman (1997) also underlines the importance of helping clients to stabilize their living, social and financial situations.

Levine (1997, 2005) and van der Kolk (2014) highlight that people affected by complex trauma experience difficulty trusting their physiological reactions, as well as knowing their bodies. Multiple authors (Erskine, 2010; Cornell, 2010; Levine, 2010, 2015; van der Kolk, 2014) suggest body-oriented work as a first step in therapy, addressing the somatic consequences of complex trauma, giving the client tools to decrease the tension, relax, and bring awareness to the body. However, it is important to remember that mindfulness techniques and meditation based on retrospective gaze may be overwhelming for individuals affected by complex trauma;

thus, it is essential to provide some external elements for grounding during relaxation, for example, concentrating on a calming inner image while keeping one's eyes open (van der Kolk, 2014). Several art therapists suggest incorporating meditation and breathing exercises with use of sensory-motor interventions, emphasizing the regulatory function of the art making process (Echterling & Stewart, 2015; Elbrecht, 2015; Hass-Cohen, 2003; Hass-Cohen & Carr, 2008; Hinz, 2009; Malchiodi, 2012; Malchiodi & Rozum, 2012; Malchiodi & Miller, 2012).

For instance, Hinz (2009) proposes to concentrate on breathing while squeezing piece of clay, imitating the lungs expansion and contraction. Malchiodi and Miller (2012) suggest various activities, such as “drawing your breath”, bringing clients' attention to their respiration, exploring their breathing patterns, and teaching how to inhale and exhale slowly and deeply. The authors propose to make images of correct breathing with lines and shapes, providing clients with sensory-motor activity, reconnecting clients with their bodies (Malchiodi & Miller, 2012). Furthermore, they describe that through scribbles and various abstract shapes, clients may express and explore their overwhelming emotions, such as sadness, anger, and anxiety. In addition, repetitive, soothing activities, such as sewing, quilting, constructing, colouring could bring relief and “positive sensory experiences” (Malchiodi & Miller, 2012, p. 342) to the clients affected by complex trauma. As Hass-Cohen (2003) explains, the sensory-motor aspect of the art making process helps clients to modulate their emotional and physiological experiences.

From a TA perspective, similarly to Herman (1997), Erskine (2010) suggests for therapists to model how to take care of oneself and structure daily life, providing elements of psychoeducation in order for clients to gain clarity of their goals and restore control, fostering their Adult ego state. In TA practice, the initial sessions covers several important aspects, such as initial assessment, building a therapeutic relationship, setting goals for therapy, defining client's role in the therapeutic process, creating an assessment of the ego states functioning, and motivation and expectation enhancement (Widdowson, 2015).

The first step in TA therapy is creating a contract, which, on one hand, is similar to conventional therapeutic contracts, but, on the other hand, expands and implies a bigger responsibility and immediately puts the client in a more proactive position, meaning that the client, by agreeing to the contract, agrees for a change (Berne, 1961). Realistic preliminary outcomes of the therapy and goals are being established from the very beginning, even if they could be changed throughout the course of therapy; in TA, the potential future achievements are

also incorporated in the contract (Steiner, 1974). The initial goals may also incorporate the pragmatic aspects of dealing with trauma consequences, such as fostering healthy habits, avoidance of self-harm behaviours, stabilizing social situation (e.g. leaving an abusive partner, transferring to a shelter). Similar to Herman (1992, 1997), Widdowson (2015) explains that the practice of TA includes assigning “homework”, which allows the client to gain self-awareness not only in sessions, but also in daily life outside of therapy. Essentially, the therapist provides questions, skills, and techniques that help clients to pause and observe their patterns and reactions, which eventually become internalized and applied in everyday life.

However, self-awareness requires clients to have a certain degree of insight, which may not be easy for the individuals affected complex trauma, as their experiences, due to the physiological and non-verbal nature, can be overwhelming. In this case, art therapy interventions might be a suitable choice, since clients may complete their “homework” in a visual form, creating tangible objects, which they bring to therapy and explore with the therapist. Having a sketchbook, which would incorporate both images and texts, could help contain the experiences outside of therapy, simultaneously allowing the client to learn how to take time for introspective activities that could be safer than meditation or mindfulness techniques. Spontaneous art making presents an unconscious material, which could be reflected upon later, while during the process, helps to release tension and channels the expression. The tangible nature of the artwork provides grounding, the client controls the art process, taking pauses and modifying the way of interactions with art materials at any time, if it becomes overwhelming. As art therapist Laury Rappaport (1998) suggests, art making provides a safe distance through the creation of an object, which also contains and holds emotionally charged experiences.

In art therapy, the establishment of the therapeutic frame and contract also sets an external structure for the client, as the art therapist addresses confidentiality, treatment of artworks, use of materials, as well as the structure of the sessions in terms of time, space, and frequency of meetings (Rappaport, 1998, 2015). As in any type of therapy, containment and safety are essential aspects of art therapy. First contact, therapeutic contract and other elements of establishment of the frame help create a containing environment. During the first stage of recovery, Rappaport (1998) proposes interventions that help foster resilience and a sense of safety in the art therapy space; she also addresses the inner resources of the clients. For instance, she asks them to imagine a safe space, and create an image of a symbolic protector. She

encourages clients to find a comfortable distance between their artwork and themselves within the space. In addition, Rappaport asks her clients to create maps of feelings and move along them to foster boundaries and find safe distance from overwhelming emotions.

Malchiodi and Miller (2012) emphasize the importance of the initial establishment of safety as well, and propose various interventions in order to provide the survivors with experiences of recognizing the links between their body reactions and the triggering situations. They underline the positive orientation of the interventions, aiming at empowerment, strengths, and exploration at the first phase of therapy. Addressing pragmatic aspects, such as creating safety plans and having a clear understanding of trauma survivors' social support, is essential for the clients. As Malchiodi and Miller describe, a therapist may ask clients to represent a "safety net" (p. 339), creating a map of social support. Furthermore, in their work with domestic abuse, the authors suggest creating a collage of the cycle of violence visually depicting "tension build-up, incident of abuse, making up, and calmness" (Malchiodi & Miller, 2012, p. 344). Such approach provides containment and structure, allowing the survivors of abuse to see a larger picture and patterns of the traumatic experiences, leading to increasing self-awareness.

Linking Herman's recovery model (1997) and the creative process phases (Wallas, 1926), this stage could correlate with the phase of preparation, as the establishment of the therapeutic relationships requires gathering information for the therapist and the client, gaining stability, and building the base for the future work. The preparation phase of the creative process is an investigation (May, 1975). From a therapeutic point of view, it would include assessment, interviews and introduction to the therapeutic approach and setting the stage for the client. Choosing the direction of therapy and establishing short-term and long-term goals would be viewed through the preparation phase as well. Although the preparation phase of the creative process could be seen as parallel to the initial stage of therapy, it is important to remember that the creative process is a cyclical activity (May, 1975). In the first stage of recovery, client may go through multiple phases of preparation, incubation, insight, and verification.

As indicated above, the first stage of therapy emphasizes structure and stability, which are essential components in work with complex trauma, as they are the building blocks of future sense of safety and control over the body and the environment. It is a preparation phase for both therapist and the client, allowing both parties to learn about the future working relationship and initiate the therapeutic process. Having clear and cohesive organization of therapy is extremely

important, and the therapist's role might be more proactive at this stage. However, even if the therapist almost provides an exoskeleton for the client, he or she focuses on strengths and creates an environment that would help the client to feel secure and empowered, see potential benefits from changing, and find motivation and resources for future work. Furthermore, agreeing and signing a contract is the first step in building a working relationship; it also symbolizes stability and grounding. A contract and a clear understanding of the therapeutic process are meant to bring sense of clarity and safety to the client.

Summarizing the highlighted parts in this section, it seems that TA approach, by addressing symbolic verbal mode of expression and communication provides high level of structure and helps clients to self-organize. On the other hand, given that art therapy functions in both symbolic verbal and non-verbal modes, it is liable to provide containment through tangible forms of expression for often overwhelming, non-verbal experiences, as well as help clients to modulate their affects related to traumatic memories (Bucci, 1997, 2000, 2001; Hass-Cohen, 2003). A therapist at the first stage of therapy would help clients to start organizing not only their inner experiences, but also the external circumstances, habits, living conditions, etc. The introduction of relaxation and breathing techniques, addressing the physiological aspects of a traumatic experience, would provide clients with a sense of control over their body, empowerment, normalization of the rhythms of nervous system activation, and increases the level of basic trust.

Second stage: Telling the story. During the stage of memory reconstruction and mourning, creation of a cohesive autobiographical narrative is seen an important part of the therapeutic process, making it possible to process the experience cognitively and to share the survivor's story with the world. However, some of the memories and experiences are not expressible by verbal means, especially if the trauma does not have an easily identifiable, concrete cause or origin, such as in cases of neglect and misattunement (Herman, 1997; van der Kolk, 2014).

At that stage, after safety and stabilization are established, trauma survivors could start unraveling the traumatic past. According to Herman (1997), one of the objectives of this stage is the desensitization to the trauma story. After the fragmented experience is verbalized in a cohesive and narrative form, the story is being told multiple times until it is no longer triggering. The ultimate goal of the first part of this stage is to translate all the trauma story parts into a

verbal form. Initially, however, they could be expressed in various ways, through art making, body movements, and use of metaphors. The full completion of traumatic narrative would provide a possibility for the mourning process to begin.

From a TA point of view, one of the goals for this stage would be to begin the decontamination of the Adult from the influences of the Adapted Child and the Controlling Parent (Steiner, 1974). Moreover, addressing restoration of the positive existential position is an essential part of the healing process (Berne, 1972; Steiner, 1974). Finally, similar to Herman's model, creating a narrative of trauma is an essential objective in therapy with individuals affected by complex trauma (Erskine, 2010).

In individuals affected by complex trauma, the Adapted Child represents the system of meaning that provides justifications for caregivers' abusive actions in order to preserve an inner object of a good caregiver, a sense of hope, and power. In other words, it is essential for a child to keep the belief in a good parent intact; since the survival depends on the powerful adult, the child is more likely to sacrifice her own "goodness" than the parent's one, and to develop a powerful Adapted Child or, in Winnicott's theory, a false-self (Winnicott, 1961/2012). Eventually, a child, by concluding that his inner badness might be the cause of the perpetrator's actions, suppresses the Natural Child and the Little Professor (Steiner, 1972). In adulthood, triggering situations would raise the emotions and sensations similar to his childhood experiences, which from a TA viewpoint is explained through the idea that the Adult instead of reacting to reality, reacts to the past situations and emotions that the Adapted Child elicits. Decontamination of the Adult ego state from the Adapted Child reactions happens through the empathetic and holding work of the therapist, who gently addresses various behavioural patterns and communications, raising self-awareness of the client. In addition, art therapy provides a unique opportunity to help the Natural Child and the Little Professor to bring playfulness and creativity, instigate curiosity and desire of discoveries, and foster the Adult ego state.

At this stage, Herman recommends recreating the autobiographical narrative directly; however, another path for it is through a use of metaphor. As mentioned above, life script analysis is based on analysis of the messages that were imposed and reinforced by caregivers during the childhood in combination with various life events, which led to a decision about the life course and behaviour made by the child in order to make sense of the world. Quite often, in their attempts to make sense of reality, children find validation of their experiences in fairy-tales,

stories, myths, movies, etc., and adopt the sequence of events in the story as part of their own life script (Berne, 1961; 1972).

Life script analysis could be based on work with a narrative and its different parts, whether it is an autobiography or a fairy-tale told by the person. The important element is how one tells the story, which version is chosen, which words are used to describe the events in the story, and its content. Berne (1972), English (1992), and Karpman (1968) believe that fairy tales and myth depict the rhythms of life in all its forms. Essentially, all stories are connected to the collective imagination and people take from it what they believe is relevant to their experience. The amount of exposure to the stories would influence the narration as well, so there might be cultural differences; however, the essence of each story, especially of the tragic negative scripts would resemble one another quite vividly (Berne, 1972; Steiner, 1974).

For the narrative analysis, fairy-tales, myths, movies, dreams, and others can be used. One of the ways of working with life scripts is to ask a person to tell the very first fairy-tale that the person could remember from the childhood; while the client narrates the story in their own words, the therapist would transcribe it (Berne, 1972; Tosi et al., 2011; Steiner, 1972). The client's memories and interpretation of the story is much more important than accurate details of the original take. After, the therapist and the client would highlight the keywords and elements of the story, the characters present, and the moments that were emphasized during the narration. The client may choose a character from the story to identify with, and try to retell the story, but from the character's position. If the story feels like it is the right one, it could be explored and retold from the positions of different personages, and potential roles and positions of antiheroes, helpers, and obstacles could be explored, similar to narrative techniques in art therapy (Harris, 2009; Herman L., 1997; Karpman, 1968). By analyzing the characters from the story, a person may understand not only the similarities between the hero and oneself in reality, but also of the hero's interactions and ways of problem solving, which may reflect the model that the person chose for herself in childhood. Moreover, the characters in the story would find correlates with the different ego states of the person, for example, a good and warm godmother who may be a projection of the Nurturing Parent, simultaneously, could represent a good enough grandmother in real life (Steiner, 1974).

In creative arts therapies, there are many ways of working with narratives, and one of them is Silverman's therapist-guided approach called *The Story Within* (Silverman, 2004, 2006). In

her approach, she incorporates all the modalities of the expressive arts therapies. Silverman explains that when client chooses a story, it serves as a container for his or her personal experiences, and that a real life challenge could be worked through metaphors of the story, as the client identifies with the chosen character(s). Her approach is based on the principle of empowerment, and the client takes decisions regarding the story, character, use of materials, and interpretation of the process. The therapist functions as a guide, providing containment, validation, and experience of being witnessed. Additionally, the response of the therapist may have an art format, which provides another deep level of validation in addition to verbal validation, reflections, and interpretations. Multiple authors (Fish, 2012; Moon, 1994; Silverman, 2004, 2006) advocate for use of art-response (or other expressive response) as a way of validating and reflecting clients' material. *The Story Within* provides safety in exploring difficult themes and internal conflicts; clients through addressing the core conflicts of their characters work through their own challenges, by interpreting their process from a personal position and making links with their real life.

In a group work, Silverman (2004) encourages interactions between peers on a symbolic level, who become witnesses of each other's creative transformations. The whole process requires clients to start attuning to their intuition and inner experiences, as they choose the story, character, and moment of the story pre-consciously. Throughout the course of therapy, clients create masks, costumes, environments for their chosen characters, they play the roles of their personages, explore their mission, helpers and obstacles on the way to it. The creative transformation happens through a final presentation of the character's journey, during which the client starts to recognize more the connections between the process of the character and the real life (Silverman, 2004). This allows clients to start mourning process and come to terms with their traumatic past.

Similar to TA, Silverman (2004, 2006) uses the capacity of the clients for identification with characters from the stories. She suggests a total immersion in the process, so clients do not have to prematurely face the anxiety of being confronted by the problems and traumatic past, whereas in life script analysis, there is a fluctuation between being immersed in the metaphor and cognitive understanding and interpretations.

It appears to be possible to use life script analysis in a less threatening way if the creative process and art making are parts of the therapy, as suggested by Gantt and Tinnin (2009),

McNamee (2005), Talwar (2007), Silverman (2004, 2006) and others. Throughout the course of art therapy, the client can restore the narrative through use of words and pictures allowing the experience to be seen from different perspectives or angles. The life script analysis of a story could be enriched by art therapy interventions, such as creating internal maps of the ego states, identifying each of them as different characters and making portraits of those, or images or sculptures to represent somatic and non-verbal experiences. Visual representation may provide larger perspective on the patterns of interactions, which could be overseen in verbal analysis. Artwork representing obstacles and helpers in the story helps identify the main characters of the traumatic experiences with the safe distance of a metaphor.

Art processes may also address the neurological aspects of trauma. As McNamee (2007) suggests, bilateral art process, which involves the use of both hands, provides a unique way of integrating verbal and non-verbal memories of trauma through uniting the stimulation of the left and right hemispheres. In this case, the client is invited to use a sheet of paper divided in half and draw two images of a felt conflicting emotion, first with one hand, and then with the opposite hand. Similarly, in the *Art Therapy Trauma Protocol (ATTP)* developed by Talwar (2007), clients use both of their hands to create paintings, fluctuating between the use of dominant and non-dominant hands. The painting process in the ATTP is focused on the somatic and not easily verbalized traumatic memory, addressing the “affective distress experienced by client” (Talwar, 2007, p. 28). The theoretical standpoint of the ATTP is somewhat between client-centered therapy and cognitive-behavioural approach, and presents an integrative model.

In a similar way, Gantt and Tinnin (2009) emphasize that trauma has a non-verbal nature, thus art therapy presents an effective path for recovery for people affected by complex trauma. The authors argue that clients often may not find words to describe their experience, and by using art materials, they have an opportunity to express trauma related affects and experience that are not yet verbalized.

The primary task of trauma recovery during the stage of remembering and mourning is to build a complete trauma narrative in order for it to be integrated in the past memory. As Gantt and Tinnin (2009) explain, “a crucial task is to organize the traumatic state memories into a narrative form that will be comprehensible and acceptable to the verbal mind and to demonstrate in a concrete way that the event is over” (p. 151). Similar to other art therapists, Gantt and Tinnin use art for restoration of the traumatic narrative. They introduce an art therapy procedure

named *graphic narrative processing*, which is “a procedure of art making designed to tell the trauma story and imbue the state-dependent memories with words and historical context” (p.151). Providing elements of psychoeducation on the possible traumatic responses, the therapist helps the client to build a story of trauma “in pictures, labeling the pictures with appropriate survival instinct such as startle, fight/flight, freeze, altered state, submission, or self-repair” (pp.151-152). This procedure helps the client to take the position of an external witness to his or her own experiences through images, which are presented afterwards on a wall or a board, and reflected upon. As the authors highlight, it creates an “external dialogue with the part of the self that was frozen in trauma” (p.152).

Moreover, as Rappaport (1998) suggests, during this stage, the therapist may also ask clients to listen to “their felt experience” (p. 3), and to try to express those sensations in a visual form. She implies that through transformation of visual objects, a transformation of the inner experience may take place. Nevertheless, the creative process involved in artistic transformation may not be healing on its own, and the therapist should make timely and accurate interpretations, eventually, asking the client to tell the trauma narrative in an open autobiographical format. As Herman (1997) suggests, translating the illustrations of trauma events or images of the story, if it was done through a metaphor, to a verbal and direct form, is essential in order to start mourning process.

The stage of memory reconstruction and mourning appears to be similar to incubation and illumination stages of the creative process. A client requires a witness and an audience during this stage, someone who would be willing to emphatically listen to their story, help it to grow and expand, but in a safe environment, containing a potential overwhelming sense of hopelessness and helplessness. The narrative part of the life script could be done at this stage in order to analyze the roles of the characters, as well as help empower the Adult ego state, and bring clarity and control to the client’s mind. A mourning process starts after the narrative is reconstructed. However, during the second part of this stage, as Herman (1997) explains, a resistance towards the grieving process could occur, and it might take multiple forms:

Since mourning is difficult, resistance to mourning is probably the most common cause of stagnation in the second stage of recovery. Resistance to mourning can take on numerous disguises. Most frequently, it appears as a fantasy of magical resolutions through revenge, forgiveness, or compensation. (p. 189)

Herman (1997) further describes the core idea of the revenge fantasy, which is “often a mirror image of the traumatic memory, in which the roles of perpetrator and victim are reversed” (p. 189). Similar to the revenge fantasy, the fantasy of forgiveness is another path of empowerment for the victim. However, as Herman emphasizes:

...true forgiveness cannot be granted until the perpetrator had sought and earned it through confessions, repentance, and restitution. Once the survivor has mourned the traumatic event, she may be surprised to discover how uninteresting the perpetrator has become to her and how little concern she feels for his fate. She may even feel sorrow and compassion for him, but this disengaged feeling is not the same as forgiveness (p. 190).

The third common type of resistance described by Herman (1997) is compensation, which could take forms of material gains, and desires of “an acknowledgement of harm, an apology, or a public humiliation of the perpetrator” (p. 190). However, Herman indicates a paradox, stating “the patient may liberate herself from the perpetrator only when she renounces the hope of getting any compensation from him” (p. 190).

The mourning process, especially for the survivors of complex trauma, entails the difficult task of facing existential despair, accepting powerlessness in the face of the perpetrators, and grieving for “the loss of foundation of basic trust” (Herman, 1997, p. 193).

Third stage: Lifting the curse. As Herman (1997) contends, during the reconnection stage the client is no longer triggered by the traumatic memories, the whole narrative of the trauma is less vivid and more connected to the past than to the everyday life. The client is ready to reconnect and learn how to relate to others and build supportive interpersonal relationships. This is a stage, in which TA can be brought as a tool for dealing with daily routine and provide the client with tools which clients may apply throughout their life. By using TA terms and concepts, it might become easier for the client to recognize, name, and identify motivations, thoughts, emotions, ego states, and other aspects of daily experience, hence, it might help cope with stress and regressive states more effectively. Eventually, this internalized structure could become a resilience factor. In terms of TA, one of the transformations that could happen is that the client can become the Nurturing Parent to the Natural Child (Steiner, 1974).

From a position of life script analysis, the story finally finds its resolution, not in a dramatic ending, but in transformation of the content, lifting the curse of the trauma. In this sense, work with life scripts is very similar to the work with myth and fairy-tales described by

Silverman (2004, 2006), where the client starts making connections between the traumatic experiences and the character's journey, and is able to find deeper self-awareness through that experience. The creative transformation now is linked to the real experiences, and internalized as a source of power and resilience. In terms of the creative process, it could be seen as the phases of insight and verifications.

The art therapy process could serve as a path to empowerment, to building a new identity, visually representing and witnessing one's strengths and resilience, and consolidating the changes that have happened throughout the course of therapy. For instance, it could be done through making self-portraits of "before therapy and now" in order to reflect on the changes (Sarid & Huss, 2010). In combination with TA, such self-portraits may include images of the ego states before the therapy and after, highlighting the empowered creativity, trust in oneself, and ability for self-care of the Natural Child, the Little Professor, and the Nurturing Parent. Another way of reflecting on the changes could be done through creating artwork of the "healing path", as a review of the therapeutic process (Sarid & Huss, 2010). An adapted version of the exercise aiming at reframing beliefs related to trauma with adolescents through making visual representations of the concepts of "victim, survivor, and thriver" could be used with adults as well, as suggested by Richardson (2015, p. 160). Many art therapy interventions at this stage would aim at restoring a sense of belonging to the community, a sense of empowerment and hope; this is why group therapy may be beneficial throughout the whole course of therapy, and especially, at the stage of reconnection. As Silverman (2004) explains, the witnessing function of the group brings another level of validation and normalization.

Herman (1997) suggests that this final stage is focused on reconnection. It implies building a new structure of social support, fostering healthy relationships, based on intimate and honest communication. Moreover, it implies that reconciling with oneself is an essential part of the third stage. The traumatic past becomes only one part of the survivor's experience, and the person is "no longer possessed by her traumatic past; she is in possession of herself" (Herman, 1997, p. 202). The capacities to play and be creative fostered through the previous stages of recovery open the door for experimentation and making different choices that could lead to success instead of repetition of traumatic patterns. Moreover, reconnection with others becomes a successful and interesting journey, as the client "has a greater capacity for self-observation and a greater tolerance for inner conflict" (Herman, 1997, p. 205). Furthermore, many survivors

freed from shame and silence of the trauma, find their mission in helping other survivors and sharing their recovery process with others. The mission could take the form of public presentations, such as semi-closed art exhibitions or performances, with goals of confronting the society about the taboo of trauma, about the silence in regards to abuse, and showing the true courage and bravery of the survivors. The process of sharing and growing sense of belonging to a community empowers the survivors (Huss, Elhozayel, & Marcus, 2012). As Herman (1997) states “the survivor draws power from her ability to stand up in public and speak the truth without fear of consequences” (p. 210).

A re-scripting and transformation of the life course would happen during the third stage of the recovery process; however, it is important to remember that it is a long process. As Herman (1997) suggests, it appears that trauma recovery is not a linear and simple three-step process; it is best seen as having a cyclical nature, with moments of vicissitudes. As Herman mentions, a frequent part of the recovery process is regression under stress, which brings the client back to the first stages with a desire to establish basic safety and stabilize. However, moments of regression could be overcome, and the fact that clients may come back to seek further help should not be seen as a weakness, but as a power and will to change and get better. She suggests that the post recovery step would be in seeking commonality; sometimes as part of their mission, sometimes as part of fostering future resilience, trauma survivors may very well find support in various therapeutic groups. Herman (1997) states that by fostering their connection to the society, trauma survivors start belonging to it, having a role and place in “something universal” (p. 236), feeling sense of unity, validation, and being seen and heard.

Chapter Four: Discussion

TA is a flexible approach that could be combined with many other therapeutic approaches. It is a clear and accessible model that also has a high level of structure, as well as elements of playfulness and creativity. In work with people affected by complex trauma, TA may provide clients with support and understanding of interpersonal connections, as well as comprehension of the inner world. In combination with art therapy and the creative process in general, TA transforms from a top down approach to an integrative model which may provide an experience of change and become the shifting power for survivors of complex trauma, simultaneously,

bringing cognitive integration of the therapeutic experience that could be applied by clients after the therapy.

It appears that with people affected by complex trauma, an integrative approach to treatment is more beneficial and suitable because of the non-verbal nature of early childhood experiences and the repercussions of trauma on the body. Turning towards ideas expressed by Merleau-Ponty (1969), in an attempt to try to escape Cartesian dualism of mind and matter, it becomes essential to recognize how important it is for a person who experienced trauma to restore the connection with the body before reconnecting with others. From Merleau-Ponty's perspective, it is unfeasible to detach mind from body, from the emotional impressions, since the body serves a "place" for the person, from which he or she experience the world. In other words, the body becomes a subject instead of being an object of observation (Merleau-Ponty, 1969). In people who have experienced complex trauma, the body is often objectified and seen as weak, as unable to fight back, or as a "betrayers", hence as something that does not bring goodness to life (Herman, 1997). Through therapy, clients may regain ownership of their body and of their self, restoring their capacities to be creative, explorative and playful.

Art therapy models of creative and visual expression play a meaningful role in achieving these goals and may prove to be efficient interventions within a TA frame as well. They are said to provide means for self-regulation and to reduce subjective discomfort levels through visual and creative transformation (Gantt & Tinnin, 2009; Hass-Cohen, 2003; Hass-Cohen & Carr, 2008; Hinz, 2009; Lusebrink, 1990, 2004, 2010; Malchiodi & Miller, 2012; Sarid & Huss, 2010; Talwar, 2007). Moreover, with the progress of neuroscience, multiple researchers in the art therapy field develop procedures that help unite the verbal and non-verbal traumatic memories that are "stored" in different hemispheres, through use of art materials (Hass-Cohen, 2003, Malchiodi, 2015; McNamee, 2005). For instance, McNamee (2005) proposes the use of bilateral art making, which activates left and right hemispheres through use of both hands in the art process. Gantt and Tinnin (2009) designed a procedure called *graphic narrative processing* as a safe way of recreating traumatic narrative, even if parts of the traumatic experience may be non-verbal. With the *Art Therapy Trauma Protocol*, Talwar (2007) proposes an integrative approach, which addresses the "non-verbal core of traumatic memory" (p. 22). Furthermore, as Sarid and Huss (2010) indicate, art therapy interventions seem to be as effective as cognitive-behavioural interventions, in that art therapy opens greater possibilities to address physiological aspects of

complex trauma through use of art materials. As for McNiff (1992), he advocates for multimodal approaches to include expressive arts therapies, seeing the creative process as necessary for healing.

Limitations

Before concluding this study, it is essential to recognize various limitations to this theoretical research. Firstly, due to the scope of the current study, the literature incorporated original and modern perspectives on life scripts and some TA concepts; however, it represented neither all of TA original concepts, nor all the branches of TA that had been developed in the past five decade. Furthermore, TA is a much more complex approach than the brief summaries introduced to the reader due to the scope of this research paper.

Additionally, this study provided neither a comparison of the approaches to trauma, nor evaluated whether bottom up or top down would be more effective, which might represent the bias of the author, who shares the views of van der Kolk (2014) who suggests that different clients might respond and benefit from different approaches and interventions.

Moreover, the study focused on people who were affected by complex trauma, which, on one hand, is a wide group of people, and on the other hand, might benefit from a different approach of recovery in comparison with individuals in crisis, people, exposed to traumatic events in adulthood, etc.

Furthermore, the literature used in this theoretical study was mainly proposed by North American authors, which societal development might influence the perspective on trauma (for instance, in some countries, because of the focus on community instead of individualistic culture, a person exposed to trauma might have wider social net and different social factors of resilience).

Implications and Recommendations

The goal of this research paper was to integrate art therapy and life script analysis with adults affected by complex trauma. It appears that art therapy, as a containing and non-threatening approach due to the tangible nature of the artwork, the use of metaphorical and symbolic forms of expression, which often creates a safe distance from painful and powerful affects, lends itself to a useful integration in TA in the work with people affected by complex trauma.

In terms of recommendations for future research and clinical implications, this theoretical model may serve as a base for development of an intervention program for people affected by

complex trauma. Because of the nature of complex trauma, such art therapy program may need to describe a long-term course of therapy, which could be divided into three stages according to Herman's model of trauma recovery. Combining art therapy and TA, the program may reach equilibrium needed to find a balance between cognitive orientation of recovery and its expressive side.

The future intervention program, may adopt a top-down approach, in which a therapist would, firstly, address the physiological repercussions of trauma through the use of art therapy interventions focused on stabilizing breathing, cycles of autonomous nervous system, meditation and relaxations techniques. Art therapy interventions may be adopted as a ritual throughout the course of therapy from the initial phases, in order to regain control over the physiological reactions, providing containment and stability for the client (Hass-Cohen, 2003). In addition, such constant use of meditation and relaxation, grounded by visual or sensory external anchors, would be aimed at decreasing the activation of the sympathetic nervous system, preventing hyperarousal (van der Kolk, 2014). After identifying sensations and feelings in their bodies, clients learn how to recognize and name them, which could be done through the use of art mediums, for instance by making abstract images of each feeling, as suggested by Malchiodi and Miller (2012). As seen above, the reconnection with the body is an essential aspect of trauma recovery.

Secondly, after the basic safety is established, the stage of memory reconstruction and mourning may occur with the client tolerating the emotional experiences the memories revive. As developed above, the mechanism of external projection plays a big role in trauma recovery and art therapy interventions allow the expression of traumatizing material in a safe and distancing way through the use of symbols, metaphors and analogies. Using art process could play a crucial role in creating a trauma narrative, which fragments might have a non-verbal form (Gantt & Tinnin, 2009). It appears that art therapy would be appropriate and beneficial at any stage of trauma recovery process, depending on the interventions, whereas, life script analysis seems to be suitable for the second and third stages of trauma recovery, after the client feels safe and stabilized enough to be able to reconstruct and share their traumatic past.

Throughout the course of recovery, art therapy may also be used to inform and enrich the TA practice through use of art making in the process of ego state analysis as visual exploration, in work with life scripts, where art could serve as a container for the experience, simultaneously

informing the process of building a narrative. A use of personalized fairytale or story may allow the person to tell the story through a hero's journey. In art therapy, this is done through combining narrative with visual means of communication, especially when verbal forms of experiences are not accessible. Depending on the client, it could be done through metaphor and prolonged immersion into symbolic process, for example, as Silverman (2004, 2006) proposes; with use of images and illustrations, addressing the somatic and affective aspects of traumatic memories, as Gantt and Tinnin (2009) describe, or more directly through cognitively oriented approaches, following Herman's model (1997). The reconstruction of the memories happens through piecing together the fragments of the past, expressed by client in words and images (as well as movements, and sounds).

Thirdly, a cognitive analysis of the transactions, programming, existential positions could be incorporated during the third stage of reconnection and renegotiation of the trauma. The third stage focuses on development of a new internal power for clients, helping them to readapt to society and learn how to trust themselves and others. Besides providing support and cognitive integration of the experience and transformation to the clients, it seems important to address existential questions, and focus on how the clients can come to terms with their experience through addressing existential questions and meaning making. During the reconnection stage, the therapist encourages reflections on the therapeutic and art processes, which help clients to consolidate the change, foster resilience, and provide resources to continue a trauma recovery process through establishment of connections with the community. Within the community, group art projects often can become a mission for the trauma survivors during the third stage, reflecting the long process of recovery, full of hope and empowerment.

To conclude, an expanded dynamic cyclical model of trauma recovery with the incorporation of an integrative art therapy approach may be added to already existing treatment models. As described above, the model may incorporate several phases, starting from work with body and self-regulation, establishing sense of safety, and going towards trauma reconstruction, mourning, and existential question resolutions.

Conclusion

The present research paper could not be ended without mentioning the importance of societal and political factors involved in trauma resolution. Trauma of any genesis is not a single-family issue, but always entails a collective responsibility that is often overlooked in our

society. The core issue of trauma, especially of complex trauma, is the disconnection between the mind and body, between the survivors and others in the society, between being able or not to feel safe, explore, learn and try to survive another day, and also between people who want to help but may re-traumatize and dismiss survivors' experience. One of the main resilience factors for trauma remains the social interpersonal connection that provides support and allows the person to process what happened. A chance to express one's traumatic experience and not be judged or pitied but fully received by an empathic witness is an important element that brings support, relief and sense of being understood. A chance to demonstrate courage and resilience in the battle against the silence imposed on survivors fosters their identity and power. Whereas, for therapists, who endorse a witness function for individuals affected by trauma in therapy, an important question may be whether to become proactive and raise their voice along, although differently, with the voices of survivors, publically advocating for social global changes that are needed in order to end the vicious cycle of trauma.

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Appendix

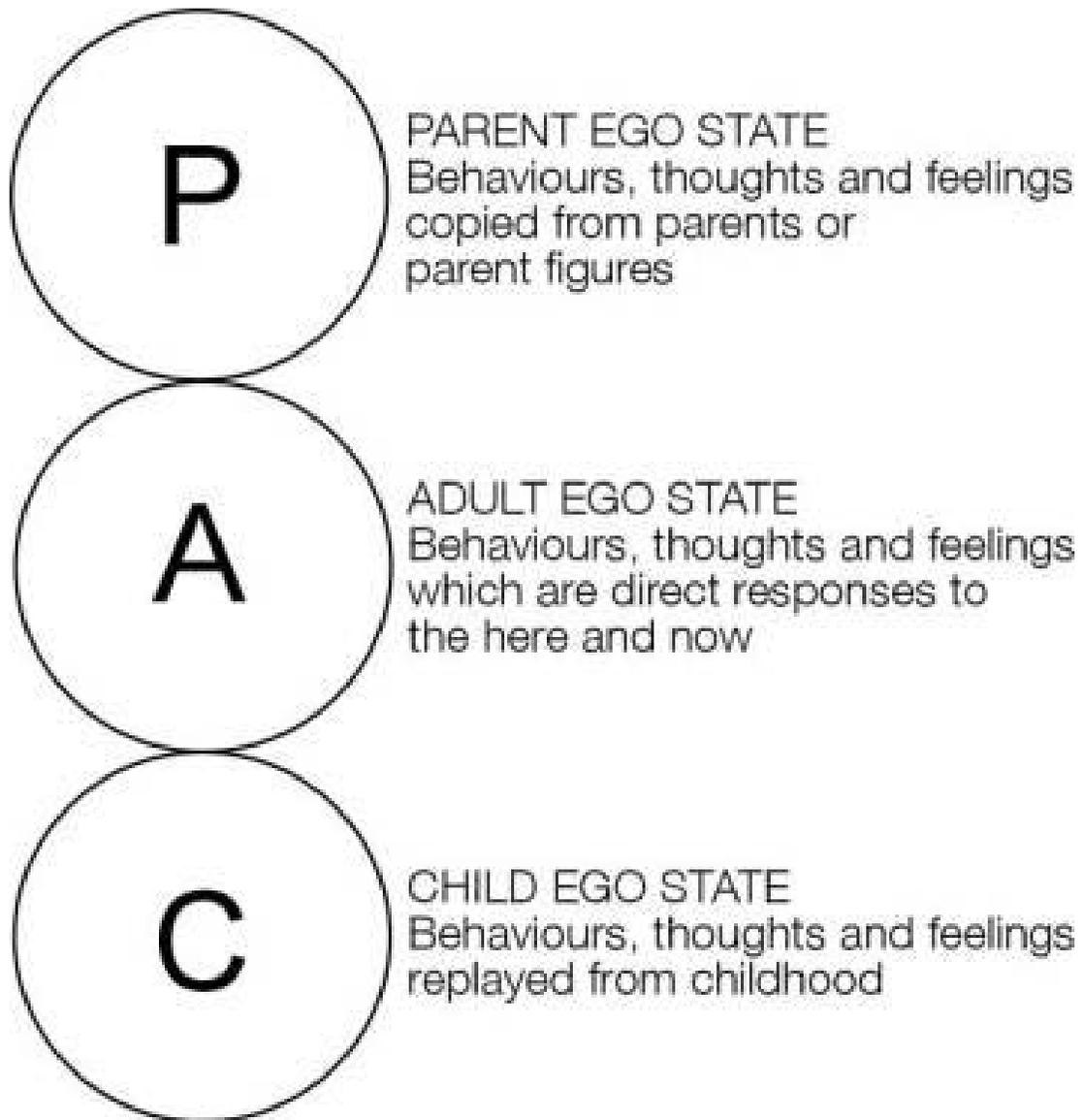


Figure 1. The basic ego structure (p. 11, Berne, 1961).