TRAUMA-RESPONSIVE INTEGRATIVE ART AND DBT (TRIAD) AS AN ART THERAPY TREATMENT MODEL FOR ADOLESCENTS WITH COMPLEX POSTTRAUMATIC STRESS DISORDER (CPTSD) : A THEORETICAL INTERVENTION RESEARCH

JADE BRISSET

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By: Jade Brisset

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Research Advisor:

Bonnie Harnden, MA, RDT

Department Chair:

Cynthia Bruce, PhD, MTA

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ABSTRACT

TRAUMA-RESPONSIVE INTEGRATIVE ART AND DBT (TRIAD) AS AN ART THERAPY TREATMENT MODEL FOR ADOLESCENTS WITH COMPLEX POSTTRAUMATIC STRESS DISORDER (CPTSD) : A THEORETICAL INTERVENTION RESEARCH

JADE BRISSET

This research paper explores the integration of Dialectical Behaviour Therapy (DBT) and art therapy in a trauma-informed approach as a theoretical intervention for adolescents (ages 13–17) with Complex Post-Traumatic Stress Disorder (CPTSD). Given the efficacy of DBT and art therapy as clinical psychiatric treatments on their own, as well as their shared therapeutic goals—emphasizing emotional regulation, distress tolerance, and self-exploration—this research proposes a DBT-informed art therapy model that may provide a comprehensive and multimodal approach for adolescents with CPTSD. The proposed intervention program incorporates Judith Black's (2004) three phases of treatment for individuals with PTSD into a DBT-informed art therapy framework, offering a structured and phased approach to trauma recovery. This qualitative theoretical intervention research follows Fraser and Galinsky's (2010) intervention research model, focusing on the initial stages: developing problem and program theories and designing program materials. By synthesizing existing literature and identifying gaps at the intersection of DBT, art therapy, CPTSD, and adolescent mental health, this study aims to lay the groundwork for a structured intervention program. The proposed framework seeks to address chronic stressors, trauma-related dysregulation, and maladaptive coping mechanisms in this vulnerable population, ultimately contributing to future clinical applications and research.

Keywords: trauma, complex posttraumatic stress disorder (CPTSD), dialectical-behavioural therapy (DBT), trauma-informed care, art therapy, adolescents, intervention research

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Chapter 1. Introduction

This paper explores the integration of dialectical behaviour therapy-informed art therapy (DBT-AT; Clark, 2016) and trauma-informed care (Herman, 1992) as a potential intervention treatment for adolescents with CPTSD using Steps 1 and 2 of Fraser and Galinsky 's (2010) intervention research model. The focus of this research is on problem formulation and theory development, providing a conceptual framework that addresses the unique needs of this population. By analyzing challenges unique to CPTSD and adolescence (through problem theories) and by articulating how Trauma-Responsive Integrative Art and DBT (TRIAD) can facilitate change (through program theories), this paper seeks to develop a foundational understanding of how these modalities can work synergistically to provide innovative interventions for adolescent trauma.

Significance and Need

Despite being a relatively new addition to the diagnostic world (International Classification of Diseases; ICD, 2018), complex posttraumatic stress disorder (CPTSD) is an increasingly recognized issue in mental health, highlighting a critical need for effective, trauma-informed interventions. Trauma's overwhelming impacts on physical and mental health has been recognized as 'a hidden epidemic' (Lee, 2022), drastically impairing interpersonal and social functions (Maercker et al., 2022). Unlike Posttraumatic Stress Disorder (PTSD), Complex PTSD encompasses pervasive symptoms of emotional dysregulation, interpersonal difficulties, and disturbances in self-identity, which can profoundly impact social and cognitive development (Cloitre, 2020).

Complex posttraumatic stress disorder (CPTSD) in adolescents presents further significant challenges, particularly in emotional regulation, distress tolerance, and attachment security (Lofthouse et al., 2024). A study using logistic regression analysis found that trauma-related negative self-perceptions were the most significant factor in diagnosing CPTSD (Karatzias et al., 2018). Given that adolescence is a critical period for identity development and the formation of self-perception (Erikson, 1968, 1998), it is important to address these negative self-beliefs through therapeutic intervention before they become more entrenched and challenging to modify. Additionally, adolescents with CPTSD have heightened severity of comorbid depressive and panic symptoms than adolescents without CPTSD, along with an

increased prevalence of negative post-traumatic cognitions (Lofthouse et al., 2024). Dialectical Behaviour Therapy (DBT) has been shown to effectively address emotional dysregulation (Linehan, 1993), while art therapy embodies the elements of a trauma-informed and strengths-based approach by offering a creative, non-verbal outlet for processing difficult experiences and emotions (Malchiodi, 2015; Grame, 2022).

Statement of Purpose

With traumatic experiences underlying a majority of mental health-related diagnoses and accounting for nearly 80% of clients seeking support in mental health clinics (King & Strang, 2025), it is imperative to provide specific therapeutic services which tailor to those needs. The purpose of this research is to explore current research and literature and create a theoretical DBT-informed art therapy intervention program which would address chronic stressors and trauma symptoms in adolescents aged 13-17 experiencing CPTSD, which would in turn foster healing and growth in this population. There is a gap in the literature when it comes to the intersection of these themes (DBT, art therapy, CPTSD, trauma-informed approaches, and adolescent mental health), which is what my research aims to address. By making links between the topics and creating a research-informed intervention programme, I hope that it may one day evolve into a clinical research trial to further develop the collection of therapeutic resources for this population.

Personal Relationship and Motivations

In addition to the growing body of literature supporting the effectiveness of these therapeutic approaches, I bring a deeply personal understanding of their healing potential. As someone with lived experience of both art therapy and Dialectical Behaviour Therapy (DBT), each accessed independently during different phases of my own recovery journey, I have witnessed firsthand how profoundly transformative these modalities can be in navigating and healing from complex trauma. My personal encounters have instilled in me a strong belief in the power of creative expression and skills-based emotional regulation as complementary paths toward recovery.

Furthermore, my second-year internship placement in an outpatient child and adolescent psychiatry hospital setting significantly deepened my commitment to this work. Engaging directly with youth in a therapeutic context was not only fulfilling, but also profoundly

enlightening. It affirmed my desire to build a career dedicated to supporting individuals, especially children and adolescents, as they work through the many challenges of life.

Defining Key Terms

Adolescence is identified by the World Health Organization (WHO; n.d.) as "the phase of life between childhood and adulthood, from ages 10 to 19", which represents "a unique stage of human development and an important time for laying the foundations of good health." Throughout this period, individuals experience puberty, develop more complex thinking skills, form a sense of identity, gain independence, and begin to establish deeper social relationships (Siegel, 2014).

Trauma is defined by the American Psychological Association (APA) Dictionary of Psychology as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning" (APA, 2018). World-renowned trauma expert Dr Gabor Maté (2023) more recently added that "Trauma is not what happens to you but what happens inside you" (p. 20), shifting the focus from the traumatic incident(s) to the internal happenings within a person who has experienced such adverse circumstances.

Complex Posttraumatic Stress Disorder (CPTSD) is a mental health condition that arises after prolonged or repeated exposure to traumatic events, often from which escape is difficult, such as childhood abuse and domestic or community violence (International Classification of Diseases; ICD-11, 2018). CPTSD includes the core symptoms of PTSD—re-experiencing the trauma, avoidance of reminders, and a heightened sense of threat—alongside additional disturbances in self-organization, which includes affective dysregulation, a negative self-concept, and difficulties in forming or maintaining relationships (Maercker et al., 2022).

Art Therapy is a specialized form of psychotherapy that merges creative artmaking, such as imagery, color, and shape, with psychotherapeutic techniques to promote self-exploration, emotional expression, and personal growth (Canadian Art Therapy Association; CATA, n.d.). According to the Canadian Art Therapy Association (CATA, n.d.), when art therapy is properly facilitated by a trained art therapist it can draw on "our innate creativity to help us heal, grow and transform" by enabling individuals to articulate thoughts and feelings that might otherwise be difficult to express.

Dialectical-Behaviour Therapy (DBT) is an evidence-based form of psychotherapy created by American psychologist Marsha Linehan (1993). At the core of the therapeutic model is the concept of dialectics, which promotes the belief that the opposing strategies of acceptance and change can be true at the same time; the client's behaviours and experiences are valid, but they also have the responsibility to create change in order to manage their emotions in a healthier way (Centre for Addiction and Mental Health; CAMH, 2025).

A *Trauma-Informed Approach* is a framework which acknowledges the widespread impact of trauma and prioritizes physical, psychological, and emotional safety for trauma survivors (Substance Abuse and Mental Health Services Administration; SAMHSA, 2023). Applying therapeutic work with a trauma-informed approach means advocating for non-pathologizing, survivor-centered care that understands trauma in the context of power, oppression, and interpersonal violation (Herman, 1992). Trauma-informed care can be applied across diverse settings such as in health care, education, social services, and various mental health facilities to support trauma recovery through compassion, dignity, and responsiveness.

Chapter 2. Literature Review

Dialectical Behaviour Therapy (DBT), originally developed to address suicidality and persistent emotional instability in Borderline Personality Disorder (BPD) (Linehan, 1993a, b; Linehan et al., 2006), has shown promise in treating trauma-related symptoms (Bohus et al., 2013; Oppenauer et al., 2023), yet adaptations are essential to meet the specific needs of adolescent populations with CPTSD. Art therapy, as a complementary modality, offers a non-verbal avenue for trauma processing and emotional expression, potentially enhancing DBT's efficacy by addressing complex trauma symptoms through creative means (Clark, 2016). Through a synthesis of relevant research and case-based insights, this literature review examines the theoretical alignment between DBT and art therapy, the unique advantages of integrating these approaches for adolescents with CPTSD, and the broader developmental implications of DBT-informed art therapy as a promising clinical intervention model for trauma work.

Trauma and its Impacts on Health and Functioning

Trauma refers to a deeply distressing or disturbing experience that overwhelms an individual's ability to cope, leaving a lasting impact on their psychological, emotional, and

sometimes physical well-being (American Psychological Association; APA, 2018). Traumatic experiences can vary widely, either resulting from a single event or a series of events that are perceived as threatening and which have profound effects on a person's sense of safety, trust, and belonging in the world. Groundbreaking research in the neurobiology of trauma has demonstrated that the psychological effects of trauma produce actual physiological changes in the brain, "[…] including a recalibration of the brain's alarm system, an increase in stress hormone activity, and alterations in the system that filters relevant information from irrelevant" (Van der Kolk, 2014, p. 4).

Trauma is directly connected to our autonomic nervous system, a subsection of the peripheral nervous system which regulates involuntary body processes such respiration, heart rate, digestion, and pupillary response (Schore, 2012). A traumatized nervous system is dysregulated; it is either hyperaroused in a sympathetic state, interpreting everything around as an imminent threat, or hypoaroused in a parasympathetic state and completely disengaged with its surroundings (Schore, 2012). This is not only the case for adults, as "interdisciplinary evidence indicates that the infant's psychobiological response to traumatic stress is comprised of two separate response patterns: hyperarousal and dissociation" (Schore, 2012, p. 78) as well. Additionally, the long-term effects of the hormonal surplus brought on by chronic stress and chronic rage have devastatingly tangible outcomes. Dr. Gabor Maté (2023) informs that this can:

> Make us anxious or depressed; narrow blood vessels, promoting vascular disease throughout the body; encourage cancer growth; thin the bones; impair essential cognitive and emotional circuits in the brain; elevate blood pressure and increase blood clotting, raising the risk of heart attacks or strokes. (p. 47)

These distressing findings highlight the importance of developing evidence-based treatments for all sorts of traumas, at the risk and peril of our overall health. Additionally, it has been found that trauma lived by parents may change their children's biology (Curry, 2019), with recent research showing that "the impacts of collective, historic, intergenerational, and racial traumas have been found to alter gene expression for offspring of the traumatized" (King & Strang, 2025, pp. 3-4).

Trauma-Informed Care

The recommended treatment guidelines for trauma-informed approaches focuses on a multimodal treatment method (Cloitre et al., 2012; Herman, 1992). The three sequential phases of a trauma-informed care are identified as: (1) establishing a sense of safety while fostering

emotional awareness and expression, (2) exploring recollections of trauma to aid in the rearrangement and reintegration of the trauma into memory, and (3) integrating aspects of treatment to transition into life (Herman, 1992).

Complex Trauma

Differentiating CPTSD from PTSD

Experts in the field have categorized two different forms of trauma: Type I trauma, referring to a single episodic event causing great distress, such as a physical or sexual aggression, a natural disaster, an accident, or the sudden loss of a loved one, and Type II trauma, encompassing relentless stressor events such as childhood neglect, domestic violence, discrimination, racism, or battling a life-threatening illness (Ford & Courtois, 2020; Mahoney & Markel, 2016; Terr, 1991). Whether Type I or Type II, all traumatic experiences can lead to a range of psychological responses, such as flashbacks, nightmares, anxiety, depression, emotional numbness, and difficulties in interpersonal relationships (Lee & Bowles, 2023).

Posttraumatic Stress Disorder (PTSD) is typically associated with Type I trauma, as it often develops after a single traumatic event or a series of isolated traumatic incidents, such as an accident, assault, war, or natural disaster (DSM V-TR, 2022). In contrast, Complex Posttraumatic Stress Disorder (CPTSD) is usually considered a type II trauma as it results from prolonged, chronic exposure to trauma, often during prime developmental stages or in situations where escape isn't possible, such as long-term abuse, neglect, or captivity (Maercker et al., 2022; Horesh & Lahav, 2024).

While Complex Posttraumatic Stress Disorder (CPTSD) is recognized in the 11th revision of the World Health Organization (WHO)'s International Classification of Diseases (ICD-11, 2018), it is not a distinct diagnosis in the most recent American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR, 2022). Additionally, although complex trauma is acknowledged in the DSM V-TR (2022), it is only done so in the context of childhood diagnoses and is instead referred to as developmental trauma disorder. While the official emergence of CPTSD made its debut in the 11th revision of the WHO's International Classification of Diseases (ICD) in 2018, the concept of complex trauma was named decades ago by Judith Herman (1992), who laid the groundwork for CPTSD to be understood as a distinct condition requiring specialized, trauma-informed care. As per the ICD,

Complex PTSD includes the core symptoms of PTSD but also involves additional challenges such as difficulties with emotion regulation, troubled interpersonal relationships, a persistently negative self-image, and, sometimes, dissociation (ICD-11: World Health Organization [WHO], 2018).

Trauma-focused Cognitive Behavioural Therapy (TF-CBT) is the current recommended treatment for PTSD according to the National Institute for Health and Care Excellence (NICE) guidelines (NICE, 2018). A recent study evaluating clinically significant posttraumatic stress symptoms (PTSS) concluded that this treatment (TF-CBT) is indeed effective in reducing PTSS, while also providing empirical evidence for the distinction between PTSD and CPTSD; although the PTSD-only group and the CPTSD group both received the same treatment, the CPTSD group ended the treatment with far more symptoms than the PTSD-only group of the same age range (Sachser, Keller, & Goldbeck, 2017). This demonstrates the need for age-appropriate, CPTSD-specific treatment, and that "as a relatively new diagnosis, research into CPTSD could be useful to better understand the phenotype and experience of trauma-exposed youth." (Lofthouse et al., 2024, p. 822).

Incidence and Prevalence

Global and regional data consistently show that a significant proportion of children and adolescents are exposed to violence, either as witnesses or direct victims, which both consist of traumatic experiences. According to the most recent statistical profile for family violence in Canada, children and adolescents (aged 17 and under) made up 19% of all victims of police-reported family violence in 2021, amounting to 24,504 victims, which is a 13% increase from 2020 and a 25% increase since 2009 (Conroy, 2021). This is especially alarming considering that one of the strongest risk factors for developing psychopathology, notably depression and suicidal ideation, is child maltreatment (Dunn et al., 2022). Additionally, it was reported that between 60–80% of children living in homes with intimate partner violence are also witnesses to the abuse (Conroy, 2021).

More broadly, approximately 16.5% of children have witnessed physical domestic or family violence by the age of 18, with estimates in low-income and high-income regions being similarly high (Stoltenborgh et al., 2014). It is estimated that over 1 billion children worldwide aged 2–17—over half of the global child population—have experienced some form of violence in the past year, including physical, emotional, sexual violence, or peer bullying (Hillis et al.,

2016; World Health Organization [WHO], 2020). When moderate forms of violence such as spanking or emotional maltreatment are included, this number rises to nearly 76% (Hillis et al., 2016).

The prevalence of children being direct victims of violence is equally alarming. Globally, about 17.3% of children report experiencing physical domestic or family violence before the age of 18 (Stoltenborgh et al., 2013), and nearly one in four children experienced some form of violence during the COVID-19 pandemic, including 11% who were physically abused (Baron et al., 2020; UNICEF, 2021). In Canada, police-reported incidents of family violence against children and adolescents under 18 increased by 32% between 2018 and 2023, affecting 26,777 victims, with girls representing 62% of that demographic (Statistics Canada, 2024). The prevalence of child sexual abuse is also significant, with global estimates ranging from 12.7% to 18% for girls and 7.6% for boys (Stoltenborgh et al., 2011). In both Canada and the United States, approximately one in three students report being victims of bullying at school (Centers for Disease Control and Prevention [CDC], 2022).

Though relatively recent, these statistics do not fully capture the breadth and intensity of traumatic experiences that children are currently enduring across the globe. For example, as of 2024, over 19,000 Palestinian children in Gaza have been killed or injured, and virtually every child in the region has been exposed to extreme levels of violence, loss, displacement, and prolonged psychological trauma due to the ongoing conflict and humanitarian crisis (UNICEF, 2024; Save the Children, 2024). Similarly, children in Ukraine continue to face the chronic stresses of war, with thousands displaced, separated from caregivers, and subjected to frequent shelling and military aggression (UNHCR, 2023). In Iran, youth have also been affected by state violence, political unrest, and the suppression of protests, including the arrest and abuse of minors involved in pro-democracy movements (Amnesty International, 2022). These examples underscore the urgent need to recognize and address the complex, layered trauma experienced by children in both conflict zones and politically unstable environments— trauma that is likely underrepresented in current prevalence data, and which will, unfortunately, likely be passed down inter-generationally in the future. All these statistics underscore the widespread and multifaceted nature of violence experienced by children and adolescents and emphasize the urgent need for trauma-informed, developmentally appropriate interventions.

Complex Trauma in Adolescence

Adolescence is a period of profound transformation, marked by rapid changes in the brain, body, and sense of self. This stage is characterized by a natural drive towards independence, increased emotional intensity, and a deepening focus on peer relationships, with youth beginning to explore questions of identity, belonging, and meaning, often by pushing against parental influence and seeking autonomy (Erikson, 1968). These developmental shifts are not only normal, but they are also essential for healthy identity formation and the transition into adulthood (Siegel, 2013).

Adolescence is also marked by what Blos (1967) described as a pivotal "second individuation." The first occurs in early childhood, when the infant gradually differentiates from the primary caregiver and begins to develop an autonomous sense of self (Mahler et al., 1975). In adolescence, this second individuation involves forming a distinct identity while renegotiating relationships with caregivers, ultimately moving toward psychological autonomy (Blos, 1967). When this process unfolds smoothly and is supported by secure attachment and a stable context, the adolescent emerges with a coherent self-concept and adaptive autonomy. However, if the separation–individuation process is disrupted by factors such as trauma, attachment ruptures, or inconsistent caregiving, the adolescent may experience profound insecurity, identity diffusion, or emotional instability. Consequently, failure in this second individuation phase is linked to heightened risks of psychopathology, including anxiety, borderline or narcissistic symptoms, and reliance on maladaptive coping such as substance use (Stavrou, 2022).

Furthermore, neuroplasticity—the brain's amazing capability of developing and adapting in response to lived experiences—has been proved to be highest in children and adolescents (Tau & Peterson, 2010), facilitating the 'rewiring' of the brain. This makes adolescence an optimal time to consciously change thinking processes (Siegel, 2014), including maladaptive coping mechanisms brought on by posttraumatic stress symptoms. Although youth often develop adaptive coping mechanisms for their situations, this frequently comes at the expense of their ability to learn and concentrate, making it additionally challenging to develop a healthy self-image and control their impulses (National Child Traumatic Stress Network, 2015).

While these developmental shifts are critical for teenage development, they also leave adolescents particularly vulnerable, especially in the context of trauma. In their attempt to cope with posttraumatic stress symptoms (PTSS), adolescents with CPTSD experience a particularly

greater severity of comorbid depression, panic symptoms, and more negative posttraumatic cognitions (Lofthouse et al., 2024; Daniunaite et al., 2021), as well as an increased susceptibility to addictions (Jannini et al., 2024). Adolescence is a particularly appropriate time to address complex experiences of trauma because the youth are already involved in a formative period of change, with the process of identity-formation centering around issues of existentialism (Erikson, 1968, 1998).

Trauma-Informed Art Therapy

Trauma-informed art therapy integrates principles of a trauma-informed approach with creative expression, providing a nonverbal, embodied means to process and regulate the complex emotional and physiological impacts of trauma (Hass-Cohen & Findlay, 2015). A trauma-informed approach acknowledges the neurobiological impacts of trauma, particularly how traumatic memory is often stored in nonverbal parts of the brain (van der Kolk, 2014), making art an effective bridge to access, integrate, and transform implicit trauma narratives.

Trauma-informed art therapy prioritizes safety, choice, collaboration, trustworthiness, and empowerment, which is then translated into creative processes that emphasize client autonomy and self-awareness. Emerging research supports that trauma-informed art therapy can reduce symptoms of PTSD, increase emotional regulation, and foster resilience (Lyshak-Stelzer et al., 2007; Haeyen et al., 2018). Thus, unlike traditional talk therapies, art therapy allows clients, especially those with complex trauma, to externalize inner experiences in a safe, symbolic form that may bypass the need for immediate verbalization, which can be difficult or retraumatizing (Malchiodi, 2020).

A more holistic Trauma-Informed Expressive Arts Therapy (TIEAT) model has been established by Malchiodi (2022), which recognizes the potential of diverse expressive arts treatments—including art therapy, drama therapy, music therapy, play therapy, dance and movement therapy—to address the effects of trauma, drawing on recent research from trauma-informed care practices. The model's fundamental tenets include strength-based interventions influenced by neurobiology and neurodevelopmental theory, the use of creative arts therapies to support regulation, the normalization of physical distress, embodied adaptive coping, and an emphasis on resilience, positive interpersonal interactions, safety, and agency (Malchiodi, 2022).

Malchiodi (2020) also previously highlighted five essential trauma-informed principles, which are as follows: (a) trauma contributes to a variety of challenges and disorders across all

ages, (b) trauma is a mind-body experience, (c) trauma responses and symptoms denote adaptive coping mechanisms rather than pathology, (d) therapy is inherently relational and reflects broader sociocultural worldviews and, (e) the therapeutic approach is one that recognizes the potential for hope, resilience, and growth in survivors (p. 40-42).

The Neurobiological Role of Art Therapy in Complex Trauma Recovery

As trauma is shown to be linked to "impaired recall of episodic memory due to the release of cortisol in stressful situations to shut down unnecessary processes and activate the amygdala for a primitive fight/flight response" (Armstrong, 2013, p. 281), traumatic memories may be temporarily uncoupled or encoded in a deteriorated form that would make them more difficult to retrieve, preventing them from being available consciously. Some traumatic memories are even entirely encoded in images, such as pre-verbal trauma, which refers to traumatic experiences occurring before a person develops the ability to process and express experiences verbally (Malchiodi, 2020). With art being closer to the unconscious than words—because our visual perceptions predate our capacity for verbal expression—research surrounding art psychotherapy, neurobiology and trauma have found "significant findings for art therapists engaged in accessing traumatic memory through image making" (Talwar, 2007, p.26).

Art therapy (AT) embodies the elements of a trauma-informed and strength-based approach (Grame, 2022) and plays a crucial role in trauma treatment by offering a non-verbal, creative outlet for individuals to process and express complex emotions that may be difficult to articulate through words alone (Hass-Cohen & Findlay, 2015; Malchiodi, 2020; King & Strang, 2024). When working with traumatized individuals, neuroscience principles have been used to show that art therapy:

> (1) facilitates the organization and integration of traumatic memories; (2) reactivates positive emotions and serves as a vehicle for exposure and externalisation of difficult content; (3) reduces heightened arousal responses; (4) enhances emotional self-efficacy and maintains a space for the exploration of self-perception and psychic integration; and (5) enhances the development of identity (King & Strang, 2025, p. 8)

For trauma survivors, especially those with Complex PTSD, traditional exposure-based talk therapies can feel overwhelming or even retraumatizing, as direct verbal recall of traumatic events is incredibly difficult to express and can trigger intense emotional responses (Heijman et al., 2024), at times resulting in premature termination of the therapy (Imel et al, 2013). Trauma

can disrupt the functional connectivity of brain networks, particularly those involved in emotional regulation, memory, and attention (King & Strang, 2024). These disruptions in neural connectivity are correlated with the symptomology of people with CPTSD; this is where AT comes in to foster a stronger sense of self-identity, relational skills, and emotional resilience, seeing as "a new manner of knowing oneself can prevail when creative experiences are internalized from self-actualizing growth, even growth after trauma" (Hinz, 2020, p. 159).

Art Therapy Relational Neuroscience (ATR-N)

Emerging as a meticulously crafted bridge between art therapy and interpersonal neurobiology, the Art Therapy Relational Neuroscience (ATR-N) model provides a powerful lens for understanding and facilitating creative relational change in therapeutic settings (Hass-Cohen & Findlay, 2015). The CREATE framework—Creative Embodiment, Relational Resonating, Expressive Communicating, Adaptive Responding, Transformative Integrating, and Empathizing and Compassion—provides a neuro-informed structure for therapeutic interventions using art (Hass-Cohen & Findlay, 2015).

Creative Embodiment engages the sensorimotor cortex and right hemisphere by emphasizing sensory interaction with art materials, helping adolescents access nonverbal emotional states and re-establish a connection with their bodies, which is critical for trauma survivors who experience dissociation or somatic numbing. *Relational Resonating* draws on the mirror neuron system and limbic structures to foster emotional attunement and attachment repair through co-regulated creative processes, promoting safety and trust within the therapeutic relationship. *Expressive Communicating* facilitates symbolic and metaphorical expression of complex inner experiences, supporting inter-hemispheric integration and memory reconsolidation by engaging the amygdala, insula, and language centers. This enables clients to safely externalize trauma that may be inaccessible through verbal dialogue alone. Building on these foundations, *Adaptive Responding* encourages cognitive flexibility and problem-solving by engaging the prefrontal cortex and downregulating the amygdala, allowing adolescents to reframe distress and experiment with new coping strategies. *Transformative Integrating* facilitates autobiographical coherence and identity formation through narrative-based art tasks that stimulate the hippocampus and default mode network, supporting memory integration and the repair of fragmented self-states. Lastly, *Empathizing and Compassion* promotes self-soothing and emotional regulation by activating the anterior cingulate cortex and oxytocin pathways,

encouraging the development of self-compassion and reducing shame. Together, by engaging both top-down and bottom-up pathways, the CREATE model addresses the neurobiological, relational, and expressive needs of adolescents with CPTSD, making it a stimulating theoretical component for integrating art therapy into DBT-based interventions.

Art Therapy with Adolescents

Art therapy can be especially valuable for adolescents as it can help them with the sensitive areas of their developmental challenges, provide them with empowering activities which help them progress interpersonally, and help them find answers to the complex identity questions which our culture challenges them with (Linesch, 2016). When working therapeutically with adolescents, one of the main challenges presented is resistance to treatment. This resistance "tends to be reduced in art therapy because the focus is on creative activity rather than an exclusive emphasis on the client-therapist encounter" (Briks, 2007, p. 3), which alleviates a lot of stress for the teenage client.

According to Judith Rubin's stages of artistic development (2005), the phase encompassing 12- to 18-year-olds is the *Personalizing* stage, where adolescents begin to personalize their work and explore their understanding of their own identity through experimentation with a variety of different mediums. Adolescence also demonstrates an increase in self-criticism and concern for aesthetic quality, which is concurrent with their growing egocentrism at this stage (Rubin, 2005). Art therapy can serve to explore the symbolic representation within these more self-centred artworks, starting a discussion between client and art therapist which allows the adolescent client to realize that their self-concept can also change. This period of life is "particularly ripe for the benefits of art therapy because adolescents are at their most creative, and they are very concerned with developing and expressing their individuality" (Beaumont, 2012, p. 8). Therefore, through artmaking and the reflective culmination of art therapy, it is likely that the client will eventually be able to achieve self-awareness as well as the abilities required to develop a flexible, adaptive self-identity (Beaumont, 2012).

Mindfulness-Based Art Interventions (MBAIs) have been shown to improve various mental health outcomes in youth, with a recent systematic review highlighting "the potential breadth of impact and the relevance of MBAIs in enhancing the overall psychosocial well-being of children and adolescents" (Javadian et al., 2025, p.1179). While most of the research in this

systematic review backed up the general efficacy of MBAIs, two studies in this meta-analysis discovered that older kids and teens actually showed greater improvement than their younger peers in terms of decreased PTSD symptoms, depression, and feelings of hopelessness (Staples et al., 2011) and in increased happiness, calmness, and concentration (Kelly, 2023).

Adolescents receiving inpatient mental health care described positive experiences with art therapy (Versitano et al., 2023; Nielsen et al., 2019), with 80% of adolescents reporting that "art therapy helped them learn how to express themselves safely" and 78% affirming that it helped them "understand how their thoughts related to their feelings" (Nielsen et al., 2019, p. 165). These reports validate that art therapy is an effective approach to encourage the safe expression of distress in adolescents. Moreover, since neuroplasticity proven to be highest in children and adolescents (Tau & Peterson, 2010), and it being theorized that "the positive effects of art therapy are related to changes in neuroplasticity" (King & Strang, 2025, p. 8), it would be logical to optimize this window of time in their life to engage in art therapeutic treatment.

Dialectical Behaviour Therapy (DBT) as a Treatment Framework

DBT Origins and Core Principles

Dialectical Behaviour Therapy (DBT) is a structured, evidence-based therapy originally developed by Marsha Linehan (1993) for individuals with Borderline Personality Disorder (BPD), specifically targeting symptoms of intense emotions dysregulation, suicidality, and self-destructive behaviors. Central to DBT is the concept of dialectics, referring to the balance between radically accepting oneself as they are and working toward positive change. DBT combines principles from cognitive-behavioural therapy (CBT) with mindfulness practices, focusing on helping clients manage difficult emotions, improve interpersonal relationships, and build a life they find meaningful (Linehan & Wilks, 2015).

DBT is structured in four sequential phases that support clients in moving from crisis stabilization to long-term emotional and relational well-being (Linehan, 1993). In Phase 1, the focus is on achieving safety and behavioural control by reducing life-threatening, therapy-interfering, and quality-of-life-interfering behaviors. Clients begin learning the four core DBT skills—mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness—to build a foundation for stability. In Phase 2, therapy shifts to addressing unresolved emotional pain and trauma through deeper emotional processing, while continuing to use DBT skills to

manage distress and maintain regulation. Phase 3 emphasizes "building a life worth living" (Linehan, 1993) by setting personal goals, improving relationships, and cultivating a sense of purpose, with DBT skills becoming more integrated into daily life. Finally, Phase 4 focuses on self-actualization, supporting clients in sustaining their gains, exploring identity, and living with greater meaning.

DBT has shown to have high efficacy and great promise in treating many psycho-behavioural problems, such as emotional dysregulation, self-harming behaviours, and suicidality in people with BPD (Linehan, 1993; Linehan et al., 2006; Linehan & Wilks, 2015), posttraumatic symptoms in people with PTSD (Harned, 2022; Oppenauer et al., 2023), substance use disorders (McCool et al, 2023), and eating disorders such as binge-eating disorder (Telch et al., 2001; Safer et al., 2009; Lammers et al., 2022) and bulimia (Wiser & Telch, 1999; Safer et al., 2001; Hagan & Walsh, 2021). With the treatment being flexible to adaptation and "based on principles rather than on highly structured protocols" (Linehan & Wilks, 2015), DBT creates a balanced and compassionate therapeutic approach through which clients can heal by finding the delicate equilibrium between radical acceptance and necessary change.

The CPTSD / BPD Debate

Since the emergence of the CPTSD diagnostic criteria, it has been a pertinent topic of discussion for trauma experts to debate whether BPD and CPTSD are two different diagnoses for the same presentation of symptoms (Cloitre et al., 2014; Knefel et al., 2016; Hyland et al., 2019; Fung et al., 2024). This debate stems in the similar nature of the disorders; they are both closely associated with dissociative symptoms, exposure to trauma, and exhibit overlapping features such as affective dysregulation, negative self-concept, and disturbances in relationships. But CPTSD and BPD share more than just diagnostic symptoms— they also have some neurophysiological similarities, such as abnormal volume or activity in the amygdala, the hippocampus, the anterior cingulate cortex and the prefrontal cortex, areas which impact emotions, memory, and personality (Ford & Courtois, 2014). These neurophysiological findings help us understand the reasoning behind certain pathological behaviours in people with CPTSD and BPD, mapping out the ways in which trauma can disrupt the functional connectivity of brain networks. Despite research leaning towards the fact that PTSD, CPTSD, and BPD are "potentially comorbid but distinct syndromes" (Ford and Courtois, 2020), with such similarities in the defining symptomology of these disorders, it would be rational to hypothesize that, since

DBT is a highly effective evidence-based treatment for BPD (Hernandez-Bustamante et al., 2024), it also has the potential to be effective for CPTSD, with certain tailored adaptations.

DBT for Trauma-Related Disorders (DBT-PTSD)

Research on the effectiveness of DBT tailored for PTSD (DBT-PTSD) in adults who experienced childhood sexual abuse has demonstrated significant mean change in posttraumatic diagnostic scale between baseline and follow up, as evaluated by the Clinician-Administered PTSD Scale (CAPS) and the Posttraumatic Stress Diagnostic Scale (PDS), as well as recorded improvements in the reduction of trauma symptoms, depression, and anxiety (Bohus et al., 2013; Steil et al., 2011). With DBT-PTSD providing evidence-based results of high efficacy in the treatment of posttraumatic stress symptoms (Wagner et al., 2007; Harned, 2022; Oppenauer et al., 2023), a large part of the work to adapt DBT into a more trauma-informed treatment has already been done. The next step would be to (1) adapt the DBT-PTSD program to make it more generalizable to include Complex PTSD, or (2) to create a new DBT-CPTSD treatment approach to form a distinct program with tailored therapeutic goals to best support people with CPTSD specifically. The good news is that the inherent modularity of DBT allows for skills to be added, modified, or deleted depending on the curriculum or need (Linehan & Wilks, 2015; Chapman et al., 2011), making DBT a rather versatile tool.

DBT Adapted for Adolescents

Adolescence presents with unique challenges, such as heightened emotional vulnerability, change in family dynamics, and behavioural impulsivity (Siegel, 2014). DBT for adolescents (DBT-A) is a tailored framework which integrates youth-specific adaptations while preserving the model's core principles, addressing the developmental and contextual needs of adolescents. Miller et al. (2021) list key adaptations as being: the incorporation of caregivers through family skills training and parent coaching, modifying skills-training to focus on age-relevant challenges such as managing impulsivity, peer dynamics, and self-criticism, and enhancing crisis management strategies to address high-risk behaviors like self-harm. Therapists often design DBT-A with experiential activities to maintain engagement while integrating dialectical strategies to help families balance validation with change, support adolescent autonomy, and create a supportive context for growth (Harvey et al., 2023; Miller et al., 2021).

DBT-Informed Art Therapy

DBT-Informed Art Therapy is a therapeutic approach that integrates the principles, structure, and core skills of Dialectical Behaviour Therapy (DBT) with the expressive and experiential methods of art therapy (Clark, 2016). This approach combines DBT's emphasis on the core skills of emotional regulation, distress tolerance, mindfulness, and interpersonal effectiveness with creative, non-verbal modes of expression to support clients in accessing, processing, and transforming overwhelming internal experiences (Huckvale & Learmonth, 2009). DBT-Informed Art Therapy is particularly well-suited for individuals with complex trauma, as it provides both containment and emotional access through structured art-making processes that promote self-awareness, skill acquisition, and a sense of mastery (Clark, 2016). The integration of DBT and art therapy facilitates both bottom-up (somatic and sensory) and top-down (cognitive and behavioural) therapeutic processing. Moreover, "the pairing of a kinesthetic modality like art therapy with the verbal nature of DBT seems to expand activation of bi-lateral integration, the linking of left to right brain functioning" (Heckwolf et al., 2014, p. 335), fostering greater engagement, safety, and neurobiological integration.

Conclusion and Implications for Future Research

By combining DBT's structured skill-building methods with the expressive, non-verbal benefits of art therapy, the research explored proposes that the intersecting combination of trauma-informed care, DBT, and art therapy is a promising avenue that could address the intricate challenges which are central to youth with CPTSD. The blend of these theoretical frameworks highlights how a combined multimodal approach can enhance self-awareness, build resilience, and foster a sense of agency, supporting adolescents in their journey toward healing from complex trauma. This research hopes to contribute to the growing field of trauma treatment by proposing a compassionate and practical model for clinical settings, offering valuable insights for art therapists and expanding options for youth in need of tailored, trauma-informed care.

Chapter 3. Methodology

Research Question

The primary research question in this theoretical intervention research is: *How can DBT-informed art therapy be adapted and conceptualized in a trauma-informed approach as an effective intervention for adolescents with CPTSD?* Through the guidance of this primary inquiry, the research will also answer a subsidiary question: *What would a trauma-responsive DBT-informed art therapy program specifically designed to support adolescents with CPTSD look like?*

Intervention Research Methodology

Fraser and Galinsky's (2010) intervention research model is well-suited for answering the research question because it provides a structured framework for developing and refining theoretical interventions, clarifying mechanisms of change in treating Complex Posttraumatic Stress Disorder (CPTSD). This methodology provides a controlled process for understanding complex interventions like DBT-informed art therapy, which has its roots in the already elaborate therapeutic theories of art therapy and dialectical behaviour therapy (DBT). The structure of the intervention research framework supports the integration of different theoretical approaches while simultaneously advocating for the adaptation of interventions to meet the needs of diverse settings and specific populations, such as adolescents with CPTSD.

There are five steps in the intervention research framework outlined by Fraser and Galinsky (2010): "(1) develop problem and program theories; (2) design program materials and measures; (3) confirm and refine program components in efficacy tests; (4) test effectiveness in a variety of practice settings; and (5) disseminate program findings and materials" (p. 459). Since this research is theoretical, with the focus being on conceptualizing rather than empirically testing an intervention, only the first two steps of the model are followed in this inquiry.

Step 1: Develop Problem and Program Theories

The first step initiates the development of problem theories and program theories, which are interconnected yet distinct components. Problem theories are formed through the analysis of literature to find the problem's risk, protective, and promotional variables, while program theories consist of malleable mediators that explain how an intervention will address the problem

and achieve the desired outcomes (Fraser & Galinsky, 2010). In this context, problem theories would explain why adolescents with CPTSD experience distinct difficulties, focusing on the dynamic interplay between the biological development of adolescents and the underlying mechanisms of the trauma response which makes youth particularly vulnerable to CPTSD, such as emotion dysregulation, disorganized attachment or fragmentation of the self. The program theories then explain how the intervention (Trauma-Responsive Integrative Art and DBT; TRIAD) produces change in the population (adolescents with CPTSD) by directly addressing the problems identified in the forementioned problem theories. In addition, risks, protective factors, and mediators of the problem will be highlighted and the level of intervention design, which can either be on an individual, communal, or social level, will be chosen (Fraser & Galinsky, 2010).

Step 2: Specify Program Structure

Step two of Fraser and Galinsky's (2010) intervention research protocol consists of specifying the program design based on the research findings from step one to construct a pilot program which includes the rationale for the intervention, as well as the objectives and the more detailed implementation processes. In other words, this step will integrate and analyze data to make relevant links amongst the literature found about DBT-informed art therapy benefits, trauma-informed approaches, and complex posttraumatic stress in adolescents, to yield key features of an intervention structure which addresses the identified needs, risks, obstacles, and specific problems of this population (Fraser & Galinsky, 2010). The program design includes the translation of the raw data collected in the identification of problem theories and program theories into distinct themes to be addressed in each phase of the TRIAD for CPTSD treatment program. Art therapeutic goals and interventions are then suggested for each phase according to the findings of the current literature and research. The program structure will outline the population demographic, intake process, setting, themes, goals, objectives, art therapist's role, and session descriptions to present a 12-week intervention program (Fraser & Galinsky, 2010).

Validity, Reliability, and Limitations

The validity and reliability of this methodology is usually assessed in the third and fourth steps of intervention research, when the program is put to the test in different settings and the outcomes are assessed to measure efficacy (Fraser & Galinsky, 2010). Regarding steps one and two, overall validity is higher with more recent and more international resources. Internal

validity will hinge on how thoroughly existing research is explored and how well the findings are integrated, while external validity is high in natural, real-world contexts, despite not being very generalizable (Creswell, 2013).

The reliability of qualitative research tends to be lower than it would be for quantitative research, due to the lack of standardized procedures and numerical data in qualitative research. Both methods have distinct strengths and weaknesses, and the choice of which method to use often depends on the research question, goals, and context. For example, flexibility and richness of data is higher in qualitative research due to the method being adaptable to emerging insights and exploring detailed human experiences (Creswell & Creswell, 2018).

Limitations include the theoretical nature of the research, therefor lack of measurable, tangible data, as well as the fact that findings may not be widely generalizable across different settings or populations beyond adolescents with CPTSD. Additionally, my role as the sole researcher in this project could mean that that my biases may subconsciously influence data findings, as data interpretation is subjective and often reliant on personal insights, despite my efforts to remain objective.

Data Collection and Analysis Procedures

Data was gathered from various search engines and databases including Google Scholar, the Concordia University Library Software (*Sophia*), PsycINFO, PubMed, ProQuest, ScienceDirect, and the PsychiatryOnline (POL) Core Package, which includes the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-V-TR). Key search terms included *adolescence, youth, mental health, trauma, complex trauma, art therapy, creative arts therapies, Complex Posttraumatic Stress Disorder (CPTSD), Dialectical behaviour therapy (DBT), DBT-informed art therapy, mindfulness, emotional dysregulation, trauma-informed care,* and *posttraumatic growth*. Although searching for the most recent academic resources available in these categories, no concrete inclusion/exclusion criteria were determined timewise. Excluding findings published before a certain date seemed counterintuitive seeing as many of the primary sources for these theories or date from the 20th century (Linehan, 1993; Herman, 1992, Erikson, 1968).

Data was analyzed through a qualitative synthesis of diverse literature, though not a full-fledged systematic review, to identify patterns and themes. Theoretical analysis of the literature is then synthesized to refine the intervention framework, based on literature and research

regarding trauma, CPTSD, art therapy, DBT, and adolescent development. Fraser & Galinsky (2010) highlight the importance of using sequential experimentation in throughout the steps of the research to refine programs, and stress that a robust research design is critical to establish causal relationships in intervention research.

The conclusions drawn from theoretical intervention research are more conceptual than empirical, seeing as the intervention program will not be tested in this research. The most prominent hypothesized conclusion is that the integration of DBT skills (e.g., emotion regulation and mindfulness) and trauma-informed care within an art therapy framework addresses core symptoms of CPTSD.

Ethical Considerations

This research, being theoretical and non-empirical, presents minimal risks of participant harm but nonetheless requires careful ethical reflection, particularly in accurately representing the population and therapeutic practices. A major ethical responsibility is to ensure that cultural sensitivity and trauma-informed care are at the core of the conceptualization process of a DBT-informed art therapy intervention program for adolescents with CPTSD. Researchers have a responsibility to avoid reinforcing stereotypes or perpetuating harm by misrepresenting populations or oversimplifying complex clinical needs, which applies in this theoretical research circumstance as well.

Position of the Researcher

Self-reflexivity also plays a vital role in maintaining ethical rigor; researchers must remain aware of their personal biases, motivations, and positionality, acknowledging how their background, education, and identity may influence the conceptualization process. This is especially important in qualitative research, where data interpretation is subjective and often reliant on personal insights (Creswell, 2013).

I recognize my own potential biases as someone who has personally benefitted from both art therapy and DBT during adolescence, which may inform my perspective despite efforts to maintain objectivity. I also situate myself within a position of considerable privilege as a graduate student pursuing higher education in a Western context, and I acknowledge the influence of Eurocentric frameworks and ideologies embedded in the academic discourse I have been exposed to while attending an anglophone university in North America.

Chapter 4. Results: Intervention Design

Introduction to Intervention Design

The Trauma-Responsive Integrative Art and DBT (TRIAD) art therapy intervention model for youth with CPTSD presented in this paper merges the healing mechanisms of art therapy with Marsha Linehan's (1993) four-stage DBT model and the trauma-informed, three-phase treatment model established by Judith Herman (1992). Phase 1 of the TRIAD intervention program focuses on the first step of trauma-informed care—safety and stability—while integrating DBT Stage 1's emphasis on behavioural control and mindfulness. Phase 2 centers on the emotional processing and grief which takes place in the second stage of trauma-informed care, combined with DBT Stage 2's structured work on emotional suffering. Finally, Phase 3 merges DBT's life-building and existential deepening (Stages 3 and 4) with Herman's third and final phase, emphasizing reconnection, autonomy, and integration. This intervention model is theoretically grounded and developed in response to the complex emotional, psychological, and developmental needs of adolescents living with Complex Posttraumatic Stress Disorder (CPTSD). For a visual layout of the proposed TRIAD intervention framework and its merged multimodal approach, please refer to Table A1 in Appendix A.

The design of this intervention follows Steps 1 and 2 of the Fraser and Galinsky (2010) intervention research model. These steps include problem and theory analysis, as well as the development of a program theory, laying the groundwork for the conceptualization of a treatment model prior to empirical testing. Informed by a comprehensive review of the literature and grounded in trauma theory, developmental theory, and contemporary adaptations of DBT, the intervention proposes a structured, three-phase program that uses the creative process as a core modality to support emotion regulation, trauma integration, and posttraumatic growth.

Problem Theories

Identification of the Problem

Complex Posttraumatic Stress Disorder (CPTSD) in adolescence poses unique and serious challenges, both clinically and developmentally. Unlike PTSD, which often develops after a single traumatic event, CPTSD is linked to prolonged, repeated trauma—particularly interpersonal trauma such as chronic abuse, neglect, or exposure to domestic violence—occurring during critical periods of emotional and psychological growth (Cloitre et al., 2014;

Ford & Courtois, 2020). The process of separation and individuation can be challenging even under the best circumstances, but for those who have experienced trauma, it can be profoundly destabilizing. Adolescents living with CPTSD often struggle with severe emotional dysregulation, difficulties in relationships, negative self-concept, and coping behaviors such as self-harm or emotional numbing (Lofthouse et al., 2024; Daniunaite et al., 2021). These symptoms are further complicated by the neurodevelopmental changes of adolescence, a time when identity formation, emotional processing, and social belonging are especially vulnerable (Siegel, 2014; Tau & Peterson, 2010). Additionally, actively trying to make sense of their lived experiences and establishing a strong sense of self becomes far more challenging for adolescents if they have experienced complex trauma, as trauma disrupts self-concept (Van der Kolk, 2017; Maté, 2023).

Although evidence-based treatments like Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) have been widely used, research suggests that they may not fully address the complexity of symptoms experienced by youth with CPTSD (Sachser et al., 2017). Without appropriate, developmentally sensitive care, these adolescents face increased risk for long-term psychological distress, social isolation, academic disruption, and maladaptive coping strategies such as substance use (Jannini et al., 2024). The severity and breadth of these challenges highlight the pressing need for flexible, integrative, and trauma-informed interventions tailored specifically to the developmental needs of adolescents.

Risks, Protective Factors and Malleable Mediators

In accordance with Fraser and Galinsky's (2010) intervention research framework, identifying the risks, protective factors, and mediators is essential to understanding the mechanisms that contribute to and can potentially alleviate the challenges experienced by adolescents with CPTSD.

Risk Factors. Among the key risk factors are chronic relational trauma, such as prolonged abuse, neglect, or exposure to violence, which disrupts core developmental processes (Ford & Courtois, 2020) and leads to profound difficulties in emotional regulation (Cloitre et al., 2014) and attachment security (Lofthouse et al., 2024). Adolescents with CPTSD also commonly struggle with low distress tolerance, heightened impulsivity, and a diminished capacity for verbal emotional expression (Miller et al., 2021; Heijman et al., 2024), all of which complicate engagement in traditional talk-based therapies. These challenges are compounded by trauma-

induced neurobiological alterations, including hyperactivation of the amygdala and under-functioning of regulatory brain regions (Van der Kolk, 2014; Malhotra et al., 2024), increasing vulnerability to reactivity and dysregulation. Individuals from minority groups, those with limited education, and those with low socioeconomic status are at increased risk of developing CPTSD, as the condition has been linked to such sociodemographic factors (Daniunaite et al., 2021). Research has also consistently shown that women are more likely than men to develop both PTSD and CPTSD (Cloitre et al., 2019). These disparities highlight the need to incorporate culturally and socially responsive considerations when designing therapeutic programs for youth who fall within these at-risk categories.

Protective Factors. Known protective factors that can buffer these effects include the establishment of safe, structured, and stable therapeutic environments (Cloitre et al., 2012), the presence of consistent caregiver involvement (Miller et al., 2021), and access to creative, non-verbal modalities such as art therapy (Malchiodi, 2020). Adolescents also benefit from developmentally appropriate interventions that account for their heightened neuroplasticity and identity formation processes (Siegel, 2014; Tau & Peterson, 2010), as well as therapeutic models that emphasize strengths, self-efficacy, and narrative meaning-making (Hinz, 2020). The trauma-responsive integration of DBT and art therapy leverages these protective factors while targeting the unique symptomatology of CPTSD.

Malleable Mediators. The hypothesized mediators of change in this DBT-informed art therapy model include mindfulness and present-moment awareness, which support attentional and emotional regulation (Linehan & Wilks, 2015; Clark, 2016), symbolic and sensory-based expression to facilitate trauma processing (Avrahami, 2006; Hass-Cohen & Findlay, 2015), and co-regulated relational attunement through the therapeutic alliance (Hass-Cohen & Findlay, 2015). Additionally, the creative challenges inherent in art therapy parallel DBT's distress tolerance practices (Huckvale & Learmonth, 2009), while the structured skill-building in DBT directly targets maladaptive coping mechanisms and emotion dysregulation (Bohus et al., 2013; Harned, 2022). Together, these mediators form the conceptual mechanisms through which the proposed intervention may promote resilience, integration, and posttraumatic growth in adolescents with CPTSD.

Program Theories

Rationale for Integration: DBT and Art Therapy as Complementary Approaches

Both Dialectical Behaviour Therapy (DBT) and art therapy have demonstrated efficacy in the treatment of trauma-related symptoms, and each brings unique strengths to therapeutic work with adolescents experiencing Complex PTSD. DBT offers a structured, skill-based approach rooted in cognitive-behavioural principles and mindfulness, aiming to balance radical self-acceptance with the pursuit of positive behavioural change (Linehan & Wilks, 2015). In contrast, art therapy provides a psychodynamic and sensory-based modality through which individuals can safely explore and reframe traumatic experiences using imagery and metaphor (Malchiodi, 2011). When combined, these approaches offer a multimodal intervention that can support both top-down cognitive restructuring and bottom-up somatic processing.

Von Daler and Schwanbeck (2014) advocate for this type of integrative work, suggesting that while DBT fosters behavioural and emotional stabilization, expressive arts can deepen emotional engagement and transformation through imagination, sensory exploration, and creativity. This synergistic relationship offers an especially meaningful pathway for adolescents who struggle with verbal processing or are easily overwhelmed by traditional talk-based modalities (Clark, 2016).

Theory of Change: Why Art Therapy Works in Trauma Treatment

Art therapy enables clients to bypass verbal defenses, externalizing inner experiences through symbols, metaphors, and sensory engagement. This non-verbal access is particularly valuable in trauma treatment, where verbal recall of events may be fragmentary or triggering (Avrahami, 2006; Heijman et al., 2024). The physical, tangible process of art making helps individuals re-establish a sense of agency and safety, while engaging brain systems linked to memory, emotion regulation, and sensory integration (Hinz, 2020; Malhotra et al., 2024). As Malchiodi (2008) notes, “for a person’s experience of trauma to be successfully ameliorated, it must be processed through sensory means” (p. 21). This somatosensory processing is a key feature of trauma recovery and is uniquely facilitated through art interventions and materials that evoke embodied responses, activating specific neurobiological pathways. For example, clay sculpting has been shown to support regulation and narrative reconstruction in trauma survivors by engaging both tactile and symbolic modalities (Hass-Cohen & Findlay, 2015).

The Body-Mind Model

The Body-Mind Model (Czamanski-Cohen & Weihs, 2016) frames art therapy as a therapeutic platform where integrated somatic and cognitive processes converge to foster psychological change. According to Czamanski-Cohen & Weihs (2016), artmaking engages the body through tactile interaction with materials, activating sensory, motor, and proprioceptive systems. This embodied form of engagement facilitates the activation and reorganization of implicit bodily experiences, such as unintegrated emotions or traumatic somatic memories, and supports their translation into explicit, symbolic forms. As clients work with art materials in the safety of the therapeutic relationship, these bodymind processes promote growth and reintegration of the self by enabling shifts in awareness, emotional regulation, and perspective-taking. The model also emphasizes the therapeutic container—the relational and material context provided by the art therapist—as a foundation for this transformation. It is within this scaffolded environment that clients can externalize internal experiences, experience mastery and agency in their creative efforts, and integrate new meanings and self-concepts which arose throughout the therapeutic process (Czamanski-Cohen & Weihs, 2016).

The Instinctual Trauma Response

In their contribution within King and Strang (2025)'s innovative book *Art Therapy and The Neuroscience of Trauma*, Gantt and Tripp (2025) discuss the importance of processing preverbal trauma prior to tackling other subsequent traumas. The clinicians present the Instinctual Trauma Response (ITR) as a short-term treatment to process foundational traumas occurring preverbally in infancy. The ITR treatment is composed of the following components: the Graphic Narrative (GN), the re-representation of the GN, and the Externalized Dialogue (ED). When explaining to clients how these components influence psychological change, Gannt and Tripp (2025) provide the following simplified description of the ITR process:

> The GN allows for the emotional brain to deal with bits and pieces of trauma memory that have previously gone around in a repetitive "limbic loop" (the amygdala, the hippocampus, and the cingulate gyrus). The GN stops the looping and shows the logical brain what happened. These pieces get rearranged in a linear sequence, and are time-stamped, thus logically stored in explicit memory as past history. The re-presentation tells what happened during the trauma and includes thoughts, feelings, and

> body sensations. This gives the whole brain a new and much more integrated way to understand the full story with a beginning, middle, and end. Finally, accessing parts in the ED, the whole brain can now communicate about past experiences and create healthy new patterns of reactions and responses to use for situations in the future (p.86).

This explanation can be used as a psychoeducational base to help clients break down and better understand some of the complex components of trauma work.

Shared Foundations: Theoretical Compatibility of DBT and Art Therapy

There is notable theoretical overlap between DBT's core skills and the goals of art therapy. DBT emphasizes four primary skill domains: Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness (Linehan, 1993a), each of which can be supported and reinforced through creative expression. For instance, art therapy can cultivate mindfulness through the embodied focus of image-making, promote distress tolerance by inviting clients to sit with emotional discomfort during the creative process, support emotion regulation through externalization and meaning-making, and foster interpersonal effectiveness through projects focused on communication, boundary-setting, and relational themes (Clark, 2016; Heckwolf et al., 2014).

This alignment is underscored by Heckwolf et al. (2014), who identified multiple shared principles between DBT and art therapy, such as validation, self-expression, and the development of adaptive coping strategies. As Huckvale and Learmonth (2009) observe, "it is the synergistic and catalytic processes between art, learning, and therapeutic understandings that are the difference that makes a difference" (p. 62). Together, these modalities offer an integrated, experiential framework for emotional and relational healing.

Merging Multimodal Approaches: A Trauma-Informed Integration

This theoretical research presents a 12-week Trauma-Responsive Integrative Art and DBT (TRIAD) intervention model for youth with CPTSD which combines the healing mechanisms of art therapy with the trauma-informed three-phase treatment model developed by Judith Herman (1992) and Marsha Linehan's (1993) four-stage DBT model. With the unification of these two multimodal approaches, the following three phases have been created for the proposed TRIAD intervention program: Phase 1: Building Basic Stability / Safety and

Overcoming Dysregulation, Phase 2: Addressing Emotional Suffering / Remembrance and Mourning, and Phase 3: Building a Life Worth Living / Reconnection and Integration.

This phased, multimodal approach addresses both the regulatory and narrative dimensions of trauma recovery, while ensuring adolescents can engage creatively, safely, and developmentally appropriately. The integration of art therapy further enhances this trauma-informed framework by offering non-threatening, developmentally appropriate methods of expression, grounding, and narrative repair (King & Strang, 2024; Malchiodi, 2020).

Program Description and Purpose: TRIAD for CPTSD

This merged approach, drawing from the conscientious narrative approach of trauma-informed work, the structured emotional literacy of DBT, and the sensory-symbolic depth of art therapy, helps meet the unique needs of adolescents with CPTSD. It supports the development of insight, self-compassion, and emotional resilience, while offering a safe, creative container for exploring past experiences. As Malchiodi (2011) writes, "images are a bridge between body and mind" (p. 20); a concept which sits at the heart of this intervention's capacity for integration and healing.

Population Demographic/Identification

While adolescence is typically defined as being between the ages of 10 and 19 (WHO, n.d.), to narrow down the research focus and specify age-appropriate treatment goals, this intervention will only consider youth in the middle phase of adolescence aged 13 to 17. More specifically, this intervention model is created for adolescents who are presenting with pervasive posttraumatic stress symptoms and meet the following criteria: must be between 13-17 years old, must have a CPTSD diagnosis or chronic CPTSD symptoms which cause significant functional impairment across various areas of their life, and must not have an active substance use disorder or eating disorder.

Counter-indications. Counter-indications for this intervention would include people whose trauma is very recent, as exploring the trauma in-depth too soon may have the opposite effect, causing further distress and worsening the client's psychological state. Additionally, people with an active substance use problem or an eating disorder requiring weight management are excluded from the research because they are unlikely to benefit from the intervention, due to

the biological implications of their disorders which require immediate medical attention and tailored support.

Location

This intervention program would be conducted in an outpatient hospital context in association with the child and adolescent psychiatry department. An outpatient psychiatry approach feels most appropriate because of the clinical nature of the program, with the outpatient component allowing the youth to keep living their lives while receiving treatment without the major disruption of an inpatient hospitalization.

Role of the Art Therapist

The role of the art therapist is to helps individuals externalize internal experiences safely and sensitively through visual and creative processes. This includes guiding clients in engaging with materials, exploring symbolic content, and integrating insights from the art into their broader therapeutic goals. Art therapists are trained to understand both psychological theory and the therapeutic use of art, and they work collaboratively to support emotional regulation, trauma processing, self-awareness, and resilience (Malchiodi, 2008). The art therapist should foster a supportive environment, which is defined by Hinz (2020) as "one that is facilitated by an attuned art therapist and contains diverse art media; it […] fosters curiosity, encourages perceptual openness, and stimulates all the senses" (p. 215).

The art therapist must set the therapeutic frame at the very beginning of the intervention program by talking about confidentiality, boundaries, goals, and expectations, while remaining open to questions and comments from the client. Additionally, to assure a culturally sensitive approach, the art therapist has a duty to recognize trauma with a wider lens in relation to social and political oppression, examining any privileges and assumptions they personally hold (Karcher, 2017). They must acknowledge that "the intersections of one's identity can complicate the experience of trauma, and produce additional barriers to care, negatively affecting the healing process if not addressed" (Karcher, 2017, p. 124). By acknowledging systemic factors that contributed to the trauma, the therapeutic process aims to provide a more inclusive perspective and understanding of the client's lived experience.

There are unique aspects in art therapy that affect transference, which refers to the client's perception of and feelings towards the therapist. For example, the offering art

materials—which can be seen as abundant or meager—the providing of art instruction for an intervention—which can be interpreted as supportive or intrusive—and how the preserving of art products is handled—conscientiously or carelessly (Hinz, 2020).

Art Materials

To foster an inclusive environment for all participants, the art therapist must be aware of personal media biases and culturally sensitive art materials that they provide for the clients to identify with (i.e., diverse types of magazines for collage).

Expressive Therapies Continuum. The selection of art materials in this DBT-informed art therapy program is intentionally aligned with the Expressive Therapies Continuum (ETC), a framework that maps how different art processes engage specific cognitive, emotional, and neurological systems (Hinz, 2020). Each level of the ETC is divided into complementary functions that reflect hemispheric specialization in the brain: left-hemisphere processes (e.g., kinesthetic, perceptual, and cognitive) emphasize structure, movement, and logic, while right-hemisphere processes (e.g., sensory, affective, and symbolic) support emotional attunement, bodily sensation, and intuitive, nonlinear processing.

A case study on two young boys who experienced childhood sexual abuse demonstrated how, with use of the ETC, art therapy in trauma treatment can either be a 'bottom-up' approach or a ‘top-down’ approach (Hinz & Lusebrink, 2025, p.59). A ‘bottom-up’ approach engages the body and sensory systems first to regulate the nervous system and access implicit, nonverbal trauma memories through kinesthetic/sensory experiences, while a 'top-down' approach starts with cognitive processes such as reflection, language, and narrative to promote insight, meaning-making, and emotional regulation through more symbolic/perceptual levels of artmaking (Hinz & Lusebrink, 2025). The brothers created very different images in their first art therapy sessions, which indicates differences in their underlying brain functions and preferred implicit processing strategies (Hinz & Lusebrink, 2025). One brother’s traumatic memories seemed to be encoded on the kinesthetic/sensory level of the ETC as sensory-motor memories, which denotes “predominant encoding in the posterior cortex” (Hinz & Lusebrink, 2025, p. 71), while the other brother demonstrated that his traumatic memories were stored on a more cognitive/symbolic level, “indicating the predominant involvement of the limbic system and amygdala” (p. 72). This case study revealed how trauma survivors can respond so differently to their experiences—even in brothers who share the same trauma—and that the therapeutic approach must be tailored to

each client, depending on how they are arriving and where they are in their processing of the trauma. In both cases, the bilateral organization of the ETC supports the integration of trauma across both cognitive and somatic systems, demonstrating how "integration of information processing using all of the different levels of the ETC can contribute to healing and posttraumatic psychological growth" (Hinz & Lusebrink, 2025, p.59).

Throughout all phases, the creative level of the ETC allows clients to move flexibly between modes of engagement as needed. A client may begin with grounding sensory tasks, move into emotional expression, and eventually reach symbolic integration, reflecting a natural arc of trauma recovery (Malchiodi, 2020; Hass-Cohen & Findlay, 2015). This flexibility is also culturally contextualized through Megan Kanerahtenhá:wi Whyte's (2023) reimagining of the ETC as a more wholesome approach grounded in Indigenous knowledge systems. Her *Expressive Therapies Continuum Wheel* links the body, heart, mind, and spirit to the somatic, affective, cognitive, and creative levels, challenging hierarchical, Western constructs of healing and promoting a more holistic, relational, and culturally responsive approach (Whyte, 2023). This adaptation supports the values of balance, interconnection, and cyclical growth that are foundational to trauma-informed practice, particularly for Indigenous and culturally diverse youth.

Confidentiality

The artwork created in art therapy is an expression of the self and therefore an extension of the client, meaning it needs to be respected as such. Therefore, keeping the artwork in a safe, confidential way is crucial (Rubin, 2011). Confidentially storing artwork would mean keeping all images and objects created in a locked cabinet, only accessible to the art therapist. The art therapist keeps all artwork safely confidential, and once the therapy has come to an end the client will receive all their art to take home and have the choice to do with it as they please. The therapist also must assess for suicidal, violent, or dangerous thoughts that the client may have towards themselves or others and act accordingly, only breaching confidentiality if they believe someone to be in immediate danger. Suppose the therapy is being carried out as part of a research project— in that case, the art therapist has the ethical duty to be transparent about what will be divulged to the research team and obtain informed consent before revealing what was shared in the therapy space, even if the information will be anonymized.

Referral and Intake Process

Initial screening before the commencement of the program is important to assess suitability for the intervention. For the patients' whose trauma is too recent, the risk of re-traumatizing runs high, and the program may wind up harming rather than helping the youth. While this program could potentially benefit adolescents who suffer strictly from PTSD as the aftermath of a major traumatic event, it is designed for adolescents who live with CPTSD and the multifaceted symptoms which stem from pervasive interpersonal trauma. Therefore, the intake process will triage the adolescents who present with PTSD and those who present with CPTSD, accepting only the latter. Youth presenting solely with PTSD who do not meet the criteria for inclusion and youth with comorbid diagnoses that impede on the experience of the program will be referred to appropriate psychosocial/therapeutic support services. To ensure the suitability of the intervention program, an interview process will be conducted with adolescents who meet the inclusion criteria. As identified earlier, the criteria being (1) having a CPTSD diagnosis or chronic CPTSD symptoms which cause significant functional impairment across various areas of life, (2) no active substance use disorder or active eating disorder, and (3) must be between 13-17 years old.

Structure of Sessions

The stability of the structure of sessions is an important factor of the intervention treatment process. Art therapist Carmen Richardson (2015) in explains in her book *Expressive Arts Therapy for Traumatized Children and Adolescents* that "creating structured, consistent, and predictable experiences increases the chances of creating a strong therapeutic alliance" (p.70), which is the necessary baseline for any psychotherapeutic work (Cabaniss et al., 2011). Knowing what to expect from the therapist and the session provides a sense of security and stability, which is especially important when working with people who have experienced trauma.

Each session will last approximately one hour and will occur once a week over three months, resulting in a 12-week individual program. Sessions will begin with a brief (maximum 10-minute) art-based warm-up or check-in, during which the adolescent client is invited to share how they are arriving emotionally and mentally. This check-in may involve various art prompts such as a bilateral scribble, selecting a color and creating a line or shape to reflect current feelings, transforming a spontaneous scribble into an image, identifying a "rose-bud-thorn" from

the week, responding visually to a chosen song, or engaging in expressive mark-making. Following the check-in, the art therapist will introduce a weekly concept of trauma-related psychoeducation, offering insight to help the client better understand their experiences on a cognitive level. The psychoeducation component of the session will taper out as the intervention program advances and the client makes sense of their experience. After a brief discussion of the psychoeducational topic, the therapist will guide the client into the main intervention of the session, as outlined below. To conclude, the session will close with a reflective invitation for the adolescent to share thoughts or feelings about their artwork and experience, with prompts such as, “How are you feeling as we come to the end of our time today?” or “Is there anything you’d like to leave here or carry with you?”.

Structure of Intervention Program and Breakdown of Sessions

Please refer to Appendix A for the tabular layout of the full proposed *Trauma-Responsive Integrative Art and DBT (TRIAD) Intervention Framework* [Table A1], as well as for the *Session Overview of Trauma-Responsive Integrative Art and DBT (TRIAD) Intervention Program* [Table A2], which are formulated according to each phase of treatment and their associated goals.

Phase 1: Building Basic Stability / Safety and Overcoming Dysregulation

This first phase of treatment focuses on building safety and containment in the art therapy space, because participating in this intervention without forming a strong therapeutic alliance before the exploration of traumatic events could result in distress, seeing as “the foundation of treatment is the safety of the therapeutic relationship” (Van der Kolk, 2007, p.18). Establishing a sense of security is crucial, with the therapeutic relationship playing a vital role in fostering a feeling of safety for the client (Malchiodi, 2008). The art therapist nurtures this by providing empathic attention to the individual, rather than solely focusing on the traumatic event, and validating the client's experience, reassuring them that their reactions are normal given the abnormality of the situation they experienced. The psychoeducation component of the session will be the longest in this phase, as Black (2014) specifies that by explaining stress, PTSD, its effects, symptoms, and what to expect during the recovery process, the therapist works to reverse the client's sense of powerlessness. Goals in this first phase are to stabilize emotional and behavioural dysregulation (1a) and to develop foundational coping and relational trust (1b). These goals are addressed in the first four sessions.

Session 1 – Depict a Safe Space. In this introductory session, the adolescent is invited to create a visual representation of a personal "safe space" using collage and mixed media. Collage proposes already-produced images and words for the client to choose from, rather than having to express themselves from a blank page, which can be intimidating in a first art therapy session. Through the selection of images that resonate with them, individuals may also discover aspects of themselves that contribute to their sense of self-worth and autonomy (Landgarten, 1993). The imagery may reflect a real or imagined environment—internal or external—that evokes feelings of calm, protection, and emotional refuge. The art therapist introduces the studio space and available materials (e.g., magazines, glue, scissors, colored pencils, and textured papers), framing the activity with gentle prompts to support grounding and self-reflection. This intervention is adapted from Tripp et al.'s (2019) clinically tested and trauma-informed art therapy protocol, serving multiple purposes: to establish psychological containment, to reduce early-session anxiety, and to assess readiness for trauma therapy. The safe space collage becomes a visual anchor that can be returned to in moments of dysregulation. It aligns with DBT's distress tolerance and mindfulness modules by encouraging present-moment focus, observational awareness, and the cultivation of internal safety. As a trauma-informed intervention, it respects the client's window of tolerance, emphasizing safety, pacing, and relational trust at the outset of the therapeutic process. Although this first intervention is currently proposed as a single session, maintaining flexibility in response to each client's comfort and needs is essential in trauma-informed work. Upon implementation, it may become necessary to extend this intervention across two sessions to avoid rushing participants in establishing a sense of safety and comfort.

Session 2 – "I feel, I need, I have, I hope". In this session, the adolescent is invited to complete a guided art response structured around the four-part reflective prompt: "I feel, I need, I have, I hope". Using drawing or mixed media, the client separates a large piece of paper into four quadrants and represents each of these statements visually through images, symbols, words, or color. Seeing as trauma can lead to dissociation and shame surrounding the experience or event (Maté, 2023; Van der Kolk, 2007, 2014), individuals may find it challenging to express themselves verbally when it comes to their current situation. The art therapist introduces the exercise as an opportunity to explore internal states while reinforcing a strengths-based orientation by highlighting resources ("I have") and future orientation ("I hope"). This session

builds on the previous one by offering emotional expression within a structured, manageable format. It encourages the client to identify and organize affective experiences and unmet needs—an essential DBT emotion regulation skill—while also fostering psychological containment. The structure of the prompt supports cognitive organization and reduces emotional overwhelm, making it appropriate for adolescents with complex trauma who may struggle to verbalize or prioritize their internal experiences. This intervention also reinforces the trauma-informed principle of pacing by offering a scaffolded and client-directed entry into self-expression, promoting the integration of thoughts and feelings in a visual, tolerable format.

Session 3 – Mindful Portrayal of a Positive Memory. This session invites the adolescent to mindfully recall and depict a positive memory from either the recent or distant past, using art materials of their choice. The memory may be a moment of joy, connection, calm, pride, or safety and can be rendered through imagery, color, or symbolic representation. The therapist gently guides the client to remain present with the memory during the art-making process, using grounding language to support regulation. This intervention serves to build relational trust by honoring the client's strengths and resilience, foster positive affect and internal safety, and reinforce DBT's mindfulness practice by teaching the adolescent to observe and describe a memory with attention and curiosity (Clark, 2016, p.186). From a trauma-informed lens, the session helps widen the client's emotional range by balancing negative affect with moments of resource and stability, without dismissing their pain. This also supports the development of a trauma narrative that includes not just what hurt, but also what helped, thus hoping to restore a more coherent and hopeful sense of self.

Session 4 – Inside-Out Masks. In this session, the adolescent creates a two-sided mask or split-face artwork that represents two contrasting layers of self: what is shown externally to others versus what is felt internally. The art therapist encourages the use of symbols, colors, facial features, or abstract marks to represent each side, and may offer prompts such as "What do you think people see when they look at you?" and "What do you keep inside? What don't people see?" This intervention is designed to promote self-awareness, emotional articulation, and give insight into emotional masking or dissociation, which are common defences in adolescents with complex trauma. It provides a safe, symbolic container to explore any dissonance between how the adolescent feels versus how the act, while giving the therapist a meaningful glimpse into the client's relational and emotional world (Clark, 2016, p.179). Therapeutically, the process

reinforces DBT's mindfulness and interpersonal effectiveness skills by helping the client identify emotional incongruences, which can guide them to better understand how their behaviors may differ from their internal states. It also supports trauma-informed goals of relational safety, identity development, and expressive freedom, all within a non-verbal medium that allows for pacing, control, and choice.

Phase 2: Addressing Emotional Suffering / Remembrance and Mourning

In the second phase of this intervention approach, the trauma-informed focus shifts to cognitive restructuring, now encompassing both past and present elements (Black, 2004; Herman, 1992), paired with DBT Stage 2's structured work on addressing emotional suffering. The goals for this second phase of the intervention are to facilitate safe exploration of trauma memories and emotional pain (2a) and to cultivate emotional resilience and meaning making (2b). A key objective in this phase is to enhance the client's ability to identify and tolerate a broad range of emotions, simultaneously working to reduce dissociative tendencies and feelings of shame. Seeing as "dissociation is an adaptation and emotional numbing, which causes the body to shut down when it feels too much pain" (Dass-Brailsford, 2007, p. 43), the therapist collaborates with the client to recognize and challenge distortions, misperceptions, and underlying beliefs which promote this extent of emotional numbing. In relation to addressing the impacts of trauma, van der Kolk (2014) suggested that self-awareness is a core aspect of recovery, and that conscious attention to one's inner experience can support an increased functional connection between neural systems and improve access to emotional regulation. Normalizing the client's reaction to their lived experiences helps in contextualizing their past, emphasizing that their identity is not defined by the traumatic event(s). Art therapy strongly benefits the treatment at this stage because "through art making clients are invited to reframe how they feel, respond to an event or experience, and work on emotional and behavioural change" (Malchiodi, 2011, p. 18). Self-esteem is fostered and strategies are implemented to decrease avoidance through desensitization techniques, promoting a gradual and controlled approach to confronting the distressing memories or situations.

Session 5 – Autobiographical Timeline. This session invites the adolescent to create a large-scale symbolic autobiographical timeline using drawing, painting, or collage to represent significant life events, transitions, or emotional moments. The timeline may be literal or metaphorical (e.g., a road, river, or spiral) and is created at the adolescent's pace, with

encouragement to include both painful and positive events as they feel safe to do so. The therapist co-regulates and scaffolds the activity with optional prompts such as "What are some moments that shaped you?" or "How would you illustrate important moments in your life?" The intervention supports trauma-informed care by providing structured, symbolic narrative formation without requiring detailed verbal disclosure. For adolescents with CPTSD, the timeline offers a visual structure that aids in organizing fragmented or dissociated memories, while also enhancing coherence and identity development. Artistic creation is a prime example of transforming memories, by reframing them in a manner which converts them from a static recording of events into a story written by the person who experienced them. The externalizing of the adolescent's life on paper facilitates autobiographical coherence and identity formation through narrative work (King & Strang, 2025), which sets the stage for the remaining art therapy interventions in this phase that address the restructuring of the trauma narrative.

Session 6 – Trauma Landscape. In this session, the adolescent is invited to create an abstract visual representation of what their trauma landscape "feels or looks like", using color, line, shape, and texture rather than literal imagery. The therapist introduces this activity as a way to externalize emotional pain symbolically and safely, emphasizing that the artwork does not need to depict specific events or recognizable forms; the focus is on expression of inner experience rather than narrative clarity. This non-verbal approach allows for safe emotional release while avoiding re-traumatization. By creating a visual narrative of an otherwise inexplicable event or experience to the brain, individuals are "tapping the left hemisphere's language centers, connecting words to experiences that may be nonverbal" (Malchiodi, 2008, as cited in Malchiodi, 2011, p. 20). The therapist remains attuned to signs of distress, helping the client stay within their window of tolerance through grounding strategies and attuned pacing. This intervention offers a powerful outlet for sensory and affective processing, especially for adolescents who may struggle to articulate their trauma verbally. It supports DBT skills such as observing internal states without judgment while reinforcing the trauma-informed principles of containment, titration, and emotional safety in the art-making process. This type of externalization facilitates making the unconscious conscious, an important part of the therapeutic process, though "merely uncovering memories is not enough, they need to be modified and transformed" (Van der Kolk, 2007, p. 19).

Session 7 – What I Lost / What I Keep. Building upon the trauma landscape from the previous session, the adolescent is guided to create a visual diptych or two-part artwork that reflects the duality of loss and survival. On one side, they depict what has been lost due to trauma, whether that be relationships, innocence, safety, or self-esteem. On the other, they represent what has endured, emerged, or been reclaimed, which could include values, strengths, relationships, or skills. The therapist may offer reflective prompts such as "What have you carried through the storm? What parts were lost in the storm?" or "What parts of you remain?" This intervention facilitates symbolic grieving and narrative integration by allowing the client to hold both pain and resilience in the same visual space. Clinically, it supports DBT's core dialectical approach: honoring the truth of suffering while affirming the possibility of growth (Linehan & Wilks, 2015). It also builds emotional flexibility and proposes essential reframing for posttraumatic meaning-making, as well as reinforcing identity cohesion in the face of fragmented self-perception, which is common with complex trauma.

Session 8 – Weathering the Storm. In this session, building off the storm metaphor introduced the previous week, the adolescent creates an expressive artwork using mixed media to depict themselves enduring or surviving a metaphorical storm. The storm may represent overwhelming emotions, memories, or past experiences, while the figure (explicit or symbolic) shows how they endure or protect themselves within it. Materials may include watercolor, tissue paper, charcoal, or collage to evoke movement, layering, and emotional intensity. The therapist helps the client explore how they've survived adversity and what internal or external resources they've drawn upon. This intervention brings emotional resilience to the forefront by helping the client reframe their experience of trauma from passive suffering to active survival. Symbolic imagery and metaphors such as this one are central to art psychotherapy, which aligns with DBT seeing as "Marsha Linehan encourages therapists to use metaphors and tell stories to help clients grasp the concepts of the skills" (Clark, 2016, p. 136). It also aligns with DBT's distress tolerance module by visualizing the concept of "riding the wave" or enduring emotional surges without being consumed by them. From a trauma-informed lens, the storm metaphor provides emotional distance, containment, and the opportunity to witness one's strength through imagery rather than exposure.

Phase 3: Building a Life Worth Living / Reconnection and Integration

The third and final phase of the treatment plan merges DBT's life-building and existential deepening (Stages 3 and 4) with the last trauma-informed step, which focuses on reintegration and encompassing the present and future aspects of the client's life to expand their capacity for insights into themselves and their experiences (Black, 2004; Herman, 1992). The goals in this final phase are to strengthen identity and future orientation (3a) and to support autonomy, community integration, and posttraumatic growth (3b). The foundation of this final phase is supporting the client in "building a life worth living"— a DBT phrase which serves as a reminder that healing is not only about reducing suffering, but about making life feel genuinely worthwhile (Linehan, 1993b). These final four interventions serve to assist the client in finding their own meaning in the aftermath of trauma, encouraging the establishment of realistic life goals based on their unique strengths and values. The art therapy process in this phase aims to reduce feelings of helplessness, simultaneously increasing hope and empowerment, while honouring the DBT premise that "the most profound change is often accepting oneself, and one's predicament, as we and it really are" (Huckvale and Learnmonth, 2009, p.53).

Session 9 – Symbolic Future Self Portrait. In this session, the adolescent is invited to create a symbolic portrait of their future self: someone they are becoming or striving towards becoming. The portrait may take any literal or metaphorical form, and can include symbols, colors, and/or settings that represent qualities, values, or aspirations. The art therapist supports this process by offering prompts such as "What does the future you want to say, feel, or do?" or "What strengths do you imagine yourself growing into?" The therapist may bring up metaphors on radical self-acceptance, such as Linehan's (2015) anecdote that "trying to be what others want a person to be is like a tulip trying to be a rose just because it happens to have been planted in a rose garden" (p. 292). This session marks a turning point in the therapeutic process where the adolescent shifts from exploring the impact of the past to envisioning possibility, autonomy, and purpose through the future. Like the previous session, it reinforces DBT's "building a life worth living" philosophy and invites clients to clarify their core values. Clinically, the symbolic portrait encourages agency, hope, and coherence by giving the youth the opportunity to externalize a resilient, self-determined facet of their identity. From a trauma-informed perspective, the activity supports posttraumatic growth and reconnection to self through future-oriented, embodied imagination.

Session 10 – Interpersonal Effectiveness Power Symbol / Coat of Arms. This session provides the adolescent with the choice between designing a visual "coat of arms" or an interpersonal effectiveness power symbol, both of which reflect key interpersonal values, boundaries, and internal strengths. Using drawing or collage, the client creates symbols which represent skills such as assertiveness, communication, empathy, or self-protection, depending on their personal needs and relational goals (Clark, 2016, p. 193). The therapist supports this process with reflective questions such as "What protects you in relationships?" or "What core values or beliefs do you want others to know about you?" The intervention integrates DBT's interpersonal effectiveness module by exploring how clients can engage more skillfully and confidently with others while maintaining healthy boundaries. It also affirms identity development through symbolic narrative construction, promoting pride, ownership, and clarity. From a trauma-informed lens, this activity empowers adolescents to reframe themselves not as passive or broken, but as active, capable agents in their relational world— it provides a tangible representation of their interpersonal growth and a visual reminder of skills they can carry forward.

Session 11 – Bridge Drawing. In this penultimate session, the adolescent is invited to draw a symbolic bridge that connects the past, present, and future. On one side of the bridge is where they've come from, in the middle is where they are now, and on the other side is where they're heading, while the bridge itself can reflect personal strengths, supports, or values that are carrying them across (Hays & Lyons, 1981). The therapist invites gentle reflection on transitions, turning points, and internal shifts, while validating the emotional complexity of leaving behind past identities or trauma-based roles. This intervention aligns with both DBT and trauma-informed frameworks by emphasizing continuity, integration, and symbolic transformation. It honors the dialectic of "I have been hurt" and yet, simultaneously, "I am healing", as well as supports the development of narrative cohesion once again. For adolescents with complex PTSD, the bridge becomes a powerful visual metaphor for recovery, helping them recognize growth and agency while remaining grounded in the therapeutic relationship as they prepare for the upcoming closure.

Session 12 – Vision Board of "A Life Worth Living". In the closing session, the adolescent creates a personal vision board that synthesizes the themes of their therapeutic journey and imagines a future grounded in hope, meaning, and self-determined values. Using

collage, drawing, text, and imagery, the client selects visual representations of goals, supports, values, practices, and aspirations that they want to carry forward. The act of piecing together different elements into a unified whole can be interpreted as a therapeutic metaphor for the healing process; it visually represents the journey of transforming fragmented experiences into a more cohesive and meaningful narrative. The therapist co-constructs meaning through gentle reflection, validating both the progress made and the strengths revealed. This final session serves as both a ritual of closure and a concrete integration of the client's healing narrative. It encapsulates DBT's emphasis on value-driven action and post-treatment planning, while honoring the trauma-informed principle of client agency. The vision board becomes a transitional object that clients can take with them beyond the therapy space, offering not only a reminder of where they've been, but a visual affirmation of where they are going.

Concluding Comments on the Program

While the interventions outlined above represent a proposed structure, it is essential that the program remain flexible in its implementation. If tested clinically in a pilot study, the pacing of the intervention should be guided by the client's needs rather than rigid adherence to the program timeline. In particular, additional time may be required to fully establish the initial phase of safety and stabilization, or to engage with the second phase focused on emotional suffering, remembrance, and mourning. Clients should not be rushed through the stages of the intervention for the sake of completing the full program. Their readiness must take priority, and if they wish to spend more time within a particular phase or intervention, the art therapist should support and follow their unique therapeutic process toward healing.

Chapter 5. Discussion

Revisiting the Research Question

This theoretical intervention research project set out to explore how a DBT-informed art therapy model could be structured as a trauma-responsive treatment for adolescents living with complex post-traumatic stress disorder (CPTSD). Rooted in Fraser and Galinsky's (2010) first two steps of intervention research, this analysis culminated in the design of the Trauma-Responsive Integrative Art and DBT (TRIAD) Intervention Model. The TRIAD model responds to a pressing clinical need for developmentally appropriate, multimodal interventions that

integrate emotional regulation, narrative reconstruction, and creative expression for adolescents with complex trauma histories marked by neglect, attachment rupture, and prolonged emotional distress.

Creative Synthesis and New Insights

The trauma-informed integration of Dialectical Behaviour Therapy (DBT) with art therapy revealed powerful synergies between structured, skills-based approaches and the embodied, symbolic processes of creative expression. While DBT provides a framework for emotional regulation, distress tolerance, and interpersonal effectiveness, art therapy offers a parallel pathway to healing that engages implicit memory, sensory integration, and non-verbal processing, which are key components to healing from complex trauma (Malchiodi, 2020). This combination was especially well-suited to adolescents with complex trauma, who often experience disruptions in verbal processing, emotional literacy, and trust in relational contexts (Ford & Courtois, 2020; Lofthouse et al., 2024). Each session was thoughtfully crafted to attend to emotional safety, creative agency, and skill-building, while also encouraging identity development and future orientation.

Potential Implications and Clinical Contributions

As a structured yet creative intervention model, TRIAD holds promise for bridging gaps between traditional talk psychotherapy, expressive therapies, and skills-based modalities in therapeutic work with vulnerable youth. Future directions in this research would be to follow through with the following remaining steps of Fraser and Galinsky's (2010) intervention research model: "(3) confirm and refine program components in efficacy tests; (4) test effectiveness in a variety of practice settings; and (5) disseminate program findings and materials" (p. 459). Clinicians could also adapt elements of the model into group settings such as family work or school-based interventions and test it with such adaptations. Given the relatively recent inclusion of CPTSD in international diagnostic systems and the evolving understanding of its etiology and expression in youth, there is growing recognition of the need for novel, integrative treatment models. As Maercker (2021) observes, "it is obvious that research into the bio-psycho-social-cultural conditions of the disorder should be intensified, and this will certainly happen more intensively in the coming years" (p. 3). The TRIAD model is one contribution to that emerging body of work, offering both a clinical structure and a theoretical basis for such future innovation.

Limitations and Possible Challenges

Despite its potential strengths, the proposed TRIAD model is not without limitations. As a theoretical framework, it has not yet been tested in clinical practice or subjected to empirical evaluation. Its effectiveness, feasibility, and cultural relevance would need to be tested through clinical implementation and outcome-based research before any strengths can be attested to the intervention. Additionally, while the model draws from general principles of DBT and art therapy, its design may reflect more on Western assumptions and individualistic notions of healing that may not translate across all cultural or community contexts. Furthermore, while the use of theoretical integration is a valued part of intervention development, it is essential to move toward greater empirical validation. As Clark (2016) cautions, "We creative arts therapists emphatically believe in the healing powers of our respective disciplines; however, clinical observation will not suffice over the long term" (p. 293). This quote underscores the importance of balancing passionate advocacy with evidence-informed practice and calls for more rigorous research to substantiate the therapeutic benefits of creative arts therapies interventions.

Ethical Considerations

Given that this is theoretical research and that no participants are partaking in the composition of this intervention model, the ethical concerns are few. Nonetheless, it is imperative to follow principles of cultural humility, to be mindful of the systemic factors which impact the context of therapeutic work, and to avoid perpetuating harmful stereotypes regarding pathology. Additionally, as in any ethical trauma-informed intervention, the implementation of the TRIAD model requires careful attention to safety, consent, pacing, and cultural responsiveness, to minimize the risk of potentially triggering or re-traumatizing the client. Working with adolescents demands supplementary sensitivity to developmental stages, identity exploration, and to the power dynamics inherent in adult-teen therapeutic relationships (Sitzer & Stockwell, 2015). The model also emphasizes relational safety and attunement as ethical imperatives, particularly when inviting clients into symbolic or narrative trauma work, which is incredibly vulnerable. Lastly, given the emerging nature of CPTSD research, therapists must remain aware of diagnostic uncertainty and avoid over-pathologizing clients.

Conclusion

In conclusion, this intervention research paper has proposed the Trauma-Responsive Integrative Art and DBT (TRIAD) Intervention Model as a novel, theoretically grounded response to the particular needs of adolescents living with complex posttraumatic stress disorder (CPTSD). By integrating the structured, skills-based focus of DBT with the expressive, relational, and somatic dimensions of art therapy, the TRIAD model offers a multidimensional approach to healing which honors both the vulnerability and the resilience of youth with complex trauma. Although further research is needed, this model contributes to the growing discourse on trauma-informed care, adolescent mental health, and the transformative potential of art in clinical practice. In designing TRIAD, this project affirms that healing is possible when expression is safe and relationships are trusted, with the core belief that "creativity is life-affirming" (Clark, 2016, p. 290).

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Appendix A: Tables for Trauma-Responsive Integrative Art and DBT (TRIAD)

Table A1.

Alignment of proposed phase-based Trauma-Responsive Integrative Art and DBT (TRIAD) intervention program

Phase	Theme / Focus	Goals	Objectives	Core DBT Skills	Core Trauma-Informed Practices
Phase 1: Building Basic Stability / Safety and Overcoming Dysregulation	Building emotional and physical safety; reducing crises; establishing trust	**1a.** Stabilize emotional and behavioural dysregulation	Teach emotion identification and tracking	• Mindfulness	• Grounding techniques
			Build daily regulation routines	• Distress Tolerance	• Psychoeducation about trauma
		1b. Develop foundational coping and relational trust	Establish safety in therapeutic space	• Behavior Chain Analysis	• Body-based stabilization
			Promote reliable interpersonal boundaries		• Co-regulation in therapeutic alliance
Phase 2: Addressing Emotional Suffering / Remembrance and Mourning	Exploring the trauma narrative; processing shame, loss, and grief	**2a.** Facilitate safe exploration of trauma memories and emotional pain	Use creative expression to externalize trauma	• Radical Acceptance	• Trauma narrative / storytelling
			Identify and label difficult emotions (guilt, shame, rage)	• Validation strategies	• Containment through metaphor
		2b. Cultivate emotional resilience and meaning-making	Promote non-judgmental acceptance of feelings	• Opposite Action	• Grief rituals and symbolic processing
			Support mourning through symbolic work	• Cognitive Restructuring	• Window of Tolerance work
Phase 3: Building a Life Worth Living / Reconnection and Integration	Identity formation, agency, and building a meaningful life	**3a.** Strengthen identity and future orientation	Define values and long-term goals	• Interpersonal Effectiveness	• Empowerment frameworks
			Visualize life beyond survival	• Building Mastery	• Meaning reconstruction
		3b. Support autonomy, community integration, and post-traumatic growth	Deepen relational skills and self-compassion	• Self-Soothing	• Reclaiming personal narrative
			Engage in symbolic transformation (legacy, healing)	• Wise Mind Integration	• Future-oriented symbolic art

Table A2.

Table of Art Therapy Interventions for TRIAD

Phase	Goal	Session	Art Therapy Intervention	Description / Focus
Phase 1: Building Basic Stability / Safety and Overcoming Dysregulation	**Goal 1a:** Stabilize emotional and behavioural dysregulation	1	*Depict a Safe Space*	Establish internal/external safety through visual containment
		2	*"I Feel, I Need, I Have, I Hope…"*	Express and organize affective states, unmet needs, and hopes
	Goal 1b: Develop foundational coping and relational trust	3	*Mindful Portrayal of a Positive Memory*	Build trust and positive affect using sensory-based art recall
		4	*Inside-Out Masks*	Contrast internal experience with outward presentation; increase self-awareness and therapist trust
Phase 2: Addressing Emotional Suffering / Remembrance and Mourning	**Goal 2a:** Facilitate safe exploration of trauma memories and emotional pain	5	*Autobiographical Timeline*	Sequence events symbolically; support narrative coherence and distance
		6	*Abstract Trauma Landscape*	Externalize trauma through color/form without verbal exposure
	Goal 2b: Cultivate emotional resilience and meaning making	7	*What I Lost / What I Keep*	Modify previous landscape to represent grief, resilience, and retained strengths
		8	*"Weathering the Storm"*	Represent overwhelm and survival through layered, metaphor-based art
Phase 3: Building a Life Worth Living / Reconnection and Integration	**Goal 3a:** Strengthen identity and future orientation	9	*Symbolic Future Self-Portrait*	Visualize identity development, goals, and self-worth beyond trauma
		10	*Interpersonal Effectiveness Power Symbols / Coat of Arms*	Reflect personal values, strengths, and boundary-setting through symbolic art
	Goal 3b: Support autonomy, community integration, and post-traumatic growth	11	*Bridge Drawing*	Visual metaphor for past–present–future; supports transition and growth
		12	*Vision Board of Hope*	Synthesize healing journey; imagine future meaning and fulfillment