

**A Trauma-Informed Art Therapy Model for Memory Integration: Combining Somatic,
Bilateral, and Parts-Based Approaches.**

Ashley M. Mahurin

Department of Psychology, Counseling and Art Therapy

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Dr. Penny Orr, LPC-S, ATR-BC, ATCS, RPT

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Abstract

This project examined trauma-related disruptions in memory integration, nervous system regulation, sensory experience, and internal organization to inform the development of a clinician-facing art therapy resource. Literature related to trauma neuroscience, trauma-informed art therapy, somatic approaches, Internal Family Systems (IFS), Eye Movement Desensitization and Reprocessing (EMDR), bilateral artmaking, and the Expressive Therapies Continuum (ETC) was reviewed and synthesized. Shared principles across these approaches included stabilization, client choice, attention to protective responses, body awareness, symbolic distance, material adaptation, bilateral engagement, and intentional closure. These findings informed the development of a five-phase IFS- and EMDR-informed art therapy handbook that progresses from safety and Self qualities to manager parts, firefighter responses, vulnerable exile-related experiences, and integration. The handbook includes client card decks, two ETC-informed material pathways for each phase, bilateral art-based processes, reflection prompts, clinical cautions, and containment procedures. The resource is intended to support ethically paced trauma-informed art therapy practice and does not function as formal IFS therapy or EMDR treatment. The project was developed through literature synthesis and project design rather than empirical testing; therefore, future expert review, clinical evaluation, and continued refinement are recommended.

Terms Related to the Study

Bilateral Art-Based Processing: Within this project, bilateral art-based processing refers to art therapy processes that involve alternating or coordinated engagement of the left and right sides of the body. These processes may include alternating hand use, two-handed artmaking, crossing the midline, visual scanning, sorting, sequencing, beading, clay manipulation, collage, body mapping, and repeated movement across an art surface. Bilateral art-based processing is used to support sensory engagement, affect regulation, organization, and meaning-making (McNamee, 2003, 2004, 2006; Talwar, 2007; Tripp, 2007). It is not presented as formal Eye Movement Desensitization and Reprocessing treatment.

Bottom-Up Processing: refers to therapeutic approaches that begin with sensory, physiological, motor, or implicit experience before emphasizing cognitive interpretation or verbal analysis. In trauma treatment, bottom-up approaches attend to body sensations, autonomic responses, movement, sensory experience, and other processes that may occur before conscious verbal understanding (Ogden & Minton, 2000; van der Kolk, 2002, 2014). Within this project, bottom-up processing informs the use of art materials, body awareness, movement, and sensory engagement as pathways toward regulation and integration.

Dissociation: refers to a disruption in the typical integration of consciousness, memory, identity, emotion, perception, or bodily experience and is commonly associated with traumatic stress (American Psychiatric Association, 2000; van der Kolk & Fisler, 1995). Within this project, dissociation is considered an important indicator of client readiness and regulation. Increased dissociation, disorientation, or inability to remain sufficiently connected to the present signals a need to pause, modify, or discontinue deeper experiential work and return to stabilization.

Dual Attention: refers to the capacity to maintain awareness of an internal experience while simultaneously remaining oriented to present-moment safety and the external environment.

Within this project, dual attention may involve noticing an emotion, body sensation, image, or internal part while also remaining aware of the artwork, therapist, room, sensory resources, or other present-moment anchors. Dual attention is included as an EMDR-informed principle that supports paced engagement with difficult internal material without requiring formal EMDR reprocessing (Shapiro, 2001).

EMDR-Informed Principles: refer to selected concepts derived from Eye Movement Desensitization and Reprocessing that inform the organization and pacing of the art therapy process. Within this project, these principles include preparation, resourcing, dual attention, attention to bodily experience, bilateral engagement, reevaluation, and intentional closure (Shapiro, 2001). These principles are incorporated into trauma-informed art therapy interventions and do not constitute formal EMDR assessment, desensitization, installation, reprocessing, or treatment. Use of the term EMDR-informed is intended to distinguish the handbook from formal EMDR practice.

Expressive Therapies Continuum: (ETC) is an art therapy framework describing information processing across kinesthetic/sensory, perceptual/affective, cognitive, and symbolic levels (Lusebrink, 2004). Within this project, the ETC informs material selection and adaptation rather than functioning as a strictly linear progression. The clinician considers whether a client may benefit from greater structure, predictability, and symbolic distance or from greater tactile, sensory, and kinesthetic engagement based on regulation, sensory preferences, developmental needs, and readiness.

Internal Family Systems-Informed Parts Language

Internal Family Systems (IFS) is a parts-based psychotherapy model that conceptualizes the mind as containing multiple parts with different roles, emotions, beliefs, experiences, and protective functions, alongside the capacity for Self-led awareness (Schwartz & Sweezy, 2020). Within this project, IFS-informed language is used as a conceptual and organizational framework for art therapy rather than as formal IFS treatment. The terms Self, managers, firefighters, and exiles support compassionate exploration and externalization of internal experiences without assigning or diagnosing parts for the client.

Somatic Awareness

Somatic awareness refers to attention to bodily sensations, movement, posture, tension, activation, numbness, temperature, pressure, breathing, and other physiological experiences that may accompany emotional or trauma-related responses. Somatic approaches recognize that trauma may be experienced through bodily and autonomic patterns that are not immediately available through verbal processing (Levine, 1997; Ogden & Minton, 2000). Within this project, somatic awareness supports regulation, recognition of activation and shutdown, and present-moment assessment throughout the artmaking process.

Somatic Memory

Somatic memory refers to trauma-related experience that is expressed or reactivated through bodily sensation, posture, movement, physiological responses, or autonomic activation rather than solely through explicit verbal recall (Levine, 1997; van der Kolk, 2014). Within this project, somatic memory supports the understanding that a client may experience the effects of trauma physically or emotionally even when an organized narrative memory is unavailable.

Trauma-Informed Art Therapy: refers to the use of art therapy within a framework that prioritizes emotional and physiological safety, client choice, consent, pacing, regulation, containment, relational attunement, and sensitivity to the effects of traumatic experience. Within this project, artmaking provides a means of externalizing and organizing internal experiences through image, color, movement, texture, symbolism, and material engagement while allowing the client control over the depth of disclosure and interpretation (Klorer, 2017; Malchiodi, 2003).

Trauma Integration: Within this project, trauma integration refers to increased connection, awareness, differentiation, organization, and relationship among sensory, emotional, physiological, cognitive, symbolic, and parts-related aspects of experience. Integration does not require complete memory retrieval, elimination of protective responses, resolution of all internal conflict, or disclosure of a complete trauma narrative. Instead, it may involve increased ability to recognize internal states, understand protective functions, remain present with difficult experiences, access resources, and relate to previously fragmented experiences with greater choice and compassion (Siegel, 2012; van der Kolk & Fisler, 1995).

Section I: Introduction

Trauma has increasingly been conceptualized as a disorder of memory integration and nervous system regulation rather than solely a response to distressing events. Earlier understandings of trauma primarily focused on exposure to overwhelming experiences; however, later research demonstrated that the lasting effects of trauma are frequently related to how the experience is encoded, stored, and reexperienced within the mind and body (van der Kolk & van der Hart, 1991, pp. 431–433). Traumatic experiences can disrupt the normal integration of sensory, emotional, and cognitive processing, resulting in fragmented memory, physiological dysregulation, and persistent symptoms that continue long after the event has ended (van der Kolk & Fisler, 1995, pp. 514–515). These findings have significant implications for treatment, particularly when traumatic material is not fully accessible through language alone.

Neurobiological research further expanded the understanding of trauma by demonstrating altered patterns of brain activation during trauma recall. Studies reported increased activation in limbic regions associated with fear and emotion, alongside decreased activation in cortical language areas responsible for verbal processing and executive functioning (Rauch et al., 1996, pp. 376–378). These findings support the role of sensory-based and nonverbal processing in trauma recall, as neurobiological research indicates heightened limbic activation and reduced prefrontal regulation during recall (Lanius et al., 2010, pp. 641–644). Similarly, Siegel (2012) emphasized that integration involves linking implicit sensory experience with explicit awareness, a process not fully achieved through verbal approaches alone (pp. 62–65). As a result, individuals commonly reexperience trauma through flashbacks, bodily sensations, emotional states, or intrusive imagery rather than organized verbal memory. This distinction is particularly important when considering treatment approaches that rely primarily on cognition, insight, or

verbal retelling. Research also demonstrated that trauma significantly affects autonomic nervous system regulation. When survival responses such as fight, flight, or freeze are overwhelmed or incomplete, physiological activation can persist in the body long after the threat has passed (Levine, 1997, pp. 19–22). Survivors may experience chronic hyperarousal, emotional reactivity, dissociation, muscular tension, sensory sensitivity, or difficulty returning to a regulated baseline. These symptoms support the view that trauma is not only psychological in nature, but also physiological. The body can continue to respond as if danger persists, even after the traumatic event has ended.

Because trauma affects both mind and body, many clinicians and researchers have questioned the adequacy of treatment approaches that rely solely on verbal processing. While cognitive and narrative therapies can be effective for some individuals, language-based interventions may not fully access implicit sensory memory systems or dysregulated physiological states associated with trauma (van der Kolk, 2002, pp. 59–61). This has led to increasing interest in bottom-up treatment approaches that engage sensation, movement, emotional regulation, and nonverbal expression. Somatic therapies, bilateral stimulation, and art therapies have emerged as important modalities for addressing dimensions of trauma that remain outside conscious verbal awareness.

Art therapy is uniquely positioned within this area of trauma treatment by engaging sensory, emotional, cognitive, and symbolic systems simultaneously. Through image making, movement, tactile stimulation, and creative expression, traumatic experiences can be externalized and processed in ways that do not depend solely on words. Art making also provides structure, containment, pacing, and emotional distance, allowing clients to engage in difficult material while maintaining regulation (Malchiodi, 2003, pp. 15–18). For trauma survivors who

struggle to verbalize their experiences, art therapy offers an alternative pathway for communication and integration.

Neurodevelopmental and brain-based models of art therapy further support its relevance in trauma treatment. Lusebrink (2004) proposed the Expressive Therapies Continuum (ETC), which organized art processes across levels of functioning, including kinesthetic/sensory, perceptual/affective, and cognitive/symbolic domains (pp. 127–130). This model suggested that sensory regulation and embodied engagement serve as foundations for later cognitive integration. Such sequencing closely aligns with trauma treatment models emphasizing physiological and emotional stabilization before deeper processing. Art therapy offers not only expression, but also a structured method for engaging different levels of information processing based on client readiness and need.

Empirical and clinical studies have further supported the integration of somatic approaches within art therapy. Sherwood (2004) demonstrated that body-based art interventions can support trauma processing by increasing awareness of internal sensations and promoting regulation. Zielona-Jenek et al. (2019) found that combining arts-based methods with somatic focus improved body awareness and emotional regulation (p. 325). Tripp et al. (2019) also demonstrated that structured art-making resources can support grounding and stabilization when paired with somatic resourcing techniques.

Another significant development in trauma treatment involves bilateral stimulation, particularly through Eye Movement Desensitization and Reprocessing (EMDR). Research has shown that alternating bilateral input can support the integration of traumatic memory networks while reducing emotional intensity during recall (Shapiro, 2001, pp. 50–52). However, some individuals may experience increased distress if traumatic material is activated too quickly or

without adequate regulation. These concerns highlight the need for approaches that retain the benefits of bilateral stimulation while allowing greater pacing, flexibility, and sensory containment. Bilateral art making offers one such alternative by combining alternating movement with image creation and creative control.

Internal Family Systems (IFS) provides an organizational framework for identifying, pacing, and integrating trauma-related internal states. IFS conceptualizes the mind as composed of internal parts that play different roles, express emotions, and carry experiences (Schwartz & Sweezy, 2020, pp. 25–28). In trauma survivors, certain parts may hold fear, shame, protective responses, or unresolved sensory memory. When paired with art therapy, these parts can be externalized visually, observed safely, and engaged through symbolic dialogue. IFS-informed parts language offers a compassionate way to organize and understand trauma-related internal experiences while supporting pacing, symbolic distance, and reduced emotional overwhelm. In this way, parts-based approaches extend neurobiological models of trauma by offering a structured method for organizing and engaging fragmented experience in treatment.

Problem to Be Investigated

There remains a need for structured art therapy resources that clearly distinguish between formal trauma treatment models and art therapy interventions informed by those models. While IFS and EMDR offer important clinical frameworks, this project does not attempt to replicate either model. Instead, it translates selected IFS-informed and bilateral principles into an art therapy handbook that emphasizes safety, pacing, symbolic externalization, clinical judgment, and ethical scope of practice. Existing treatments frequently emphasize one dimension of trauma recovery, such as cognition, exposure, or emotional processing, without fully addressing the interaction between memory fragmentation, nervous system dysregulation,

sensory experience, and internal protective systems. Art therapy has been widely used in trauma treatment, yet fewer models clearly describe how bilateral methods and parts-based conceptualizations can be intentionally incorporated into art therapy practice. This gap limits access to integrated interventions that may better meet the complex needs of trauma survivors.

Purpose Statement

The purpose of this research was to develop a trauma-informed art therapy resource integrating somatic, bilateral, and parts-based approaches for the treatment of trauma-related dysregulation and fragmented memory. Drawing from trauma neuroscience, art therapy theory, bilateral processing principles, and IFS-informed parts concepts, this project sought to create a structured model that supports regulation, symbolic access to internal experience, and gradual integration. This project is intended to function as a clinician-facing art therapy handbook rather than a formal treatment manual for Internal Family Systems therapy or Eye Movement Desensitization and Reprocessing. IFS-informed language is used as a conceptual and organizational framework for helping clients notice Self qualities, protective parts, reactive parts, and vulnerable parts through art-making. Bilateral processes are used as art-based methods that may support regulation, organization, and meaning-making. The project does not train clinicians to provide IFS therapy or EMDR treatment and should be used only by qualified art therapists practicing within their scope of competence.

Justification

This project is important because trauma remains highly prevalent and produces lasting psychological, physiological, relational, and occupational impairment. Survivors frequently experience anxiety, depression, dissociation, emotional dysregulation, chronic stress activation,

and disruptions in identity and interpersonal functioning. These effects often persist long after the traumatic event and can interfere with daily functioning, treatment engagement, and quality of life. Effective trauma treatment must address not only conscious memory and cognition, but also bodily regulation, implicit sensory memory, and internal protective responses.

This project is also significant because many trauma treatments emphasize a single dimension of recovery, such as cognition, verbal processing, or exposure, without fully integrating the sensory, physiological, emotional, and relational effects of trauma. Survivors who become overwhelmed in direct processing or who struggle to verbalize traumatic experiences may require alternative pathways to healing. By integrating multiple evidence-informed perspectives into a coherent model, this project responds to the growing need for flexible, regulating, and trauma-informed multimodal interventions.

This project holds particular significance for the field of art therapy, because it is designed as a practical resource for ATR-BCs rather than a generalized trauma treatment protocol. The handbook provides structured interventions, readiness considerations, material adaptations, clinical cautions, and scope notes to support ethical decision-making. This focus is important because clinicians need clear guidance when integrating trauma-informed, parts-informed, and bilateral art-based approaches with clients who may present with complex trauma, dissociation, emotional dysregulation, or safety concerns. Although art therapists have long recognized the value of nonverbal expression in trauma treatment, the field continues to need clearly articulated resources grounded in contemporary neuroscience and trauma theory. This model positions art therapy as more than expression by highlighting its role in regulation, bilateral engagement, parts-informed reflection, symbolic organization, and integration.. In doing so, the project strengthens the theoretical and clinical foundation of trauma-informed art therapy

practice.

Finally, this project offers practical value for clinicians working with trauma survivors who require greater pacing, containment, and client control during treatment. A creative model that emphasizes safety and regulation can increase treatment accessibility, reduce the risk of emotional flooding, and improve readiness for deeper trauma work. By bridging trauma neuroscience, expressive therapies, and parts-based treatment, this project expands clinically relevant options for trauma recovery.

Conclusion

Trauma research has demonstrated that traumatic experience affects memory integration, physiological regulation, and internal organization in ways that may not be fully addressed through verbal treatment approaches alone. These findings support the need for interventions that integrate sensory, emotional, cognitive, and relational processes within a structured and regulated model. This chapter introduced the problem, purpose, significance, and key concepts for developing a trauma-informed art therapy resource. Chapter II will review the literature related to trauma neuroscience, somatic regulation, bilateral processing, Internal Family Systems, and art therapy foundations that informed the development of the proposed intervention. The resulting project is a five-phase, IFS-informed and bilateral art-based handbook that moves from safety and Self qualities to manager parts, firefighter parts, exile-related wounds, and integration.

Section II: Literature Review

Early psychoanalytic theory described trauma as a failure of memory integration. Freud (1914, 1958, 1939) and Janet (1925, 1973) argued that traumatic experiences became pathological when they remained unintegrated, dissociated, and unsymbolized (Janet, 1925, 1973, pp. 589–592; van der Kolk & van der Hart, 1991, pp. 431–433). Van der Kolk and Ducey

(1989) summarized this position, stating that “a sudden and passively endured trauma is relived repeatedly...” (p. 271).

Later research extended this model by examining the biological mechanisms underlying traumatic memory. Van der Kolk and Fisler (1995) reported that traumatic memories emerged as sensory fragments, images, and bodily sensations rather than coherent narratives (pp. 514–515, 519). Dissociation during trauma interfered with integration into explicit memory systems. More recent neuroscience research demonstrated that traumatic stress disrupts large-scale brain networks involved in emotional regulation and self-referential processing (Menon, 2011; Lanius et al., 2010; Siegel, 2012).

Nervous System Dysregulation and Somatic Memory

Expanding on trauma as a disruption of memory integration, research further demonstrated that trauma affects the regulation of the autonomic nervous system. Trauma disrupts autonomic regulation when defensive responses such as fight, flight, or freeze remain incomplete, resulting in persistent physiological activation and patterns of bodily tension and arousal (Levine, 1997, pp. 19–22; Scaer, 2001, pp. 8–12). This dysregulation also affects integration across emotional, cognitive, and sensorimotor systems, contributing to ongoing difficulties in regulation and processing (Ogden & Minton, 2000; Levine, 1997; van der Kolk, 2014). The literature suggested that trauma is not only stored as fragmented memory within the brain but also within the body, where it manifests as ongoing physiological dysregulation and somatic symptoms.

Research on traumatic memory further demonstrated that dissociation contributes to fragmented recall. Traumatic stress alters hippocampal functioning and impairs explicit memory

formation, leading to incomplete encoding of experience (Bremner, 2001, pp. 170–173). As a result, traumatic memories often emerge as sensory fragments rather than coherent narratives, contributing to intrusive symptoms and difficulty integrating experience (van der Kolk et al., 2001, pp. 14–16). These findings reinforced the need for approaches that address both memory fragmentation and physiological dysregulation (van der Kolk, 2002; Levine, 1997; Ogden & Minton, 2000).

Internal Family Systems and Parts-Based Models

Extending this understanding of fragmentation, parts-based models provided a conceptual approach for understanding how traumatic experiences are organized within the individual. Trauma disrupts integration of memory and experience, resulting in compartmentalized internal states associated with specific emotional, sensory, and cognitive patterns. Internal Family Systems (IFS) conceptualized these disruptions as distinct parts that hold different roles, emotions, and memories within the system (Schwartz, 1995, pp. 25–28). In this model, the mind is composed of multiple parts, often organized around protective and vulnerable functions. In trauma, these parts may carry fragmented sensory and emotional experiences that are not fully integrated into conscious awareness. This conceptualization aligns with trauma research demonstrating that traumatic memory may be compartmentalized and not fully integrated (van der Kolk & Fisler, 1995; Siegel, 2012; van der Kolk, 2002). Together, these models provide a structured way of understanding fragmentation as an organized internal system rather than a random disruption, supporting approaches that engage and integrate these parts in treatment. This approach also offers a method for identifying, externalizing, and integrating fragmented aspects of traumatic experience, particularly when combined with interventions that engage sensory and somatic systems (Schwartz, 1995; Malchiodi, 2003; van der Kolk, 2014). Emerging integrative

approaches have begun to combine Internal Family Systems with expressive and trauma-focused modalities. Within this project, IFS-informed parts language functions as a conceptual and organizational framework rather than formal IFS therapy. The language of Self qualities, managers, firefighters, and exiles is used to help clients externalize, differentiate, and relate to internal experiences through art-making. This framing supports compassionate observation and symbolic organization without requiring the clinician to diagnose parts, conduct formal IFS interventions, or push clients toward direct trauma processing. This positions IFS-informed language as a useful framework for organizing and pacing trauma-informed art therapy when combined with somatic and art-based interventions.

Somatic and Body-Based Approaches to Trauma Treatment

Extending models of fragmentation and dysregulation, somatic approaches emphasized that trauma is stored not only in memory but also within the body. Trauma disrupts physiological regulation systems, leading to persistent autonomic activation and somatic symptoms when defensive responses remain unresolved (Levine, 1997, pp. 19–22; Ogden & Minton, 2000, pp. 152–154). These approaches used bottom-up processing, focusing on sensation, movement, and autonomic regulation, allowing traumatic responses to be accessed and reorganized at the level where they are encoded. Somatic models also emphasized the importance of regulation as a prerequisite for trauma processing.

Early stages of treatment focused on sensory, relational, and repetitive interventions that support stabilization and engagement of preverbal systems (Klorer, 2017, pp. 142–145). This sequencing reflected a neurodevelopmental approach in which regulation precedes integration. Collectively, the literature indicates the use of body-based interventions as a foundational component of trauma treatment and directly informed later models incorporating bilateral and

expressive processes.

EMDR and Bilateral Stimulation

In response to somatic and bottom-up approaches, Eye Movement Desensitization and Reprocessing (EMDR) was developed to facilitate processing of traumatic memory through bilateral stimulation. EMDR activated maladaptive memory networks while engaging bilateral sensory input to support integration across emotional, cognitive, and physiological systems (Shapiro, 2001, pp. 30–34, 50–52). This process aligned with research demonstrating that bottom-up engagement supports integration of implicit memory systems (Ogden & Minton, 2000; van der Kolk, 2002; Siegel, 2012).

Narrative approaches, such as Cognitive Processing Therapy, addressed cognitive and belief-based aspects of trauma, while somatic and EMDR approaches targeted physiological dysregulation and implicit memory systems. Together, these models demonstrated that trauma affects multiple levels of processing and requires integrative treatment approaches. However, EMDR may involve direct activation of traumatic material, which can increase emotional intensity and reduce a client's sense of control if regulation is not maintained (Shapiro, 2001, pp. 211–214). These limitations highlighted the need for approaches that retain the benefits of bilateral stimulation while offering greater flexibility and stronger regulatory support (Shapiro, 2001; Levine, 1997; van der Kolk, 2014). For the purpose of this project, bilateral processing is not used as EMDR treatment. Instead, bilateral principles inform art-based processes such as alternating hand use, two-handed movement, visual scanning, sequencing, crossing the midline, clay manipulation, beading, collage, and body mapping. These methods are intended to support regulation, sensory engagement, and organization while remaining within the scope of art therapy practice.

Foundations of Art Therapy in Trauma Treatment

In response to these limitations, research examined nonverbal approaches that engage traumatic memory while maintaining regulation. Because traumatic memory is not fully accessible through language alone, expressive approaches provided alternative pathways for processing (van der Kolk, 2002; Malchiodi, 2003; Siegel, 2012). Art therapy facilitated expression of traumatic material through imagery and sensory engagement, allowing individuals to externalize internal experience in a structured manner (Malchiodi, 2003, pp. 15–18). Art making also supported regulation during trauma processing by engaging sensory and motor systems while maintaining distance from traumatic material. Visual representation allowed individuals to explore traumatic experience without becoming overwhelmed, supporting both expression and emotional stability (Klorer, 2017, pp. 142–145). These findings positioned art therapy as a modality that integrates sensory, emotional, and cognitive systems while maintaining regulation, addressing limitations of purely verbal or exposure-based approaches (Malchiodi, 2003; Klorer, 2017; Hass-Cohen & Carr, 2008).

Neurodevelopmental and Brain-Based Art Therapy

Following the development of art-based approaches, neurodevelopmental models further explained how art therapy engages brain systems involved in trauma processing. Lusebrink (2004) proposed the Expressive Therapies Continuum (ETC), which organized art processes from sensorimotor and perceptual engagement to affective and cognitive processing (pp. 127–130). This model emphasized that lower-level sensory engagement supports regulation before higher-order symbolic processing can occur. Neuroscience research supported this model by demonstrating that art-making activates multiple neural systems simultaneously. Hass-Cohen and Carr (2008) reported that art making engages visual, motor, limbic, and prefrontal systems,

facilitating integration across brain regions. Klorer (2005) similarly reported that structured art interventions supported affect regulation and cognitive organization in traumatized individuals (pp. 139–153).

The ETC also provided a structure for understanding how art therapy aligns with bottom-up processing. Sensorimotor engagement activated subcortical systems associated with arousal and sensation, while perceptual and affective processes supported emotional processing. Cognitive and symbolic levels reflected higher-order integration. This progression mirrored neurobiological models of trauma treatment (Lusebrink, 2004; Hass-Cohen & Carr, 2008; van der Kolk, 2014). Learning research further supported these mechanisms. Kandel and Hawkins (1992) demonstrated that learning involves activity-dependent synaptic change, in which repeated activation strengthens neural connections (pp. 283–285). Repeated engagement in art-making provided a mechanism for neural reorganization through multisensory activation. Evidence suggests that art therapy is a neurobiologically informed intervention that supports integration across sensory, emotional, and cognitive systems.

Bilateral Processing and Art Therapy Integration

Integrating neuroscience, somatic, and expressive models, bilateral approaches examined how sensory and motor engagement support trauma integration. Traumatic memory was encoded in implicit systems and not fully accessible through verbal processing (van der Kolk, 1994, pp. 258–260; 2002, pp. 59–61). Bottom-up processing engaged somatic memory systems involved in trauma integration (Ogden & Minton, 2000, pp. 152–154). The Expressive Therapies Continuum provided a framework for understanding how sensory engagement supports progression toward higher-order processing (Lusebrink, 2004, pp. 127–130). Bilateral stimulation, as used in EMDR, supported the integration of traumatic memory networks by simultaneously engaging

multiple neural systems (Shapiro, 2001, pp. 50–52).

These processes suggested that bilateral engagement may enhance communication across neural systems involved in memory processing (Shapiro, 2001; van der Kolk, 2002; Siegel, 2012). Art Therapy models applied similar principles through structured bilateral engagement. Tripp (2007) reported that bilateral art making supported affect regulation while activating implicit memory systems (pp. 178–180). Talwar (2007) demonstrated that alternating movement between the left and right hands during art-making engaged sensory and motor systems and supported emotional processing (pp. 25–28). Additional studies have explored the integration of EMDR principles with art therapy. Breed (2013) found that combining EMDR with art therapy supported access to nonverbal traumatic material while allowing for greater emotional containment. Tripp (2022) further described how art-making can be incorporated into EMDR phases to support dual attention and symbolic processing. McNamee (2003, 2004, 2006) reported that bilateral art interventions increased internal coherence and supported integration of conflicting internal states. Bilateral art therapy combines sensory engagement, movement, and image making within a structured process. This approach allowed for simultaneous activation of multiple systems involved in trauma processing, including sensory, emotional, and cognitive domains. Research demonstrated that bilateral art therapy integrates bottom-up processing with structured trauma reprocessing (Tripp, 2007; Talwar, 2007; McNamee, 2003, 2004, 2006). This integration provided a direct link between neuroscience, EMDR, and expressive therapies and supported the development of more comprehensive trauma-informed interventions.

Additional research has examined the clinical impact of bilateral art-making interventions. O'Malley (2019) found that bilateral art therapy was associated with reductions in dissociation and improvements in emotional regulation among trauma survivors. These findings

support the use of bilateral art-making as a flexible and regulating alternative to more direct exposure-based methods.

Integration and Rationale for Resource Development

The literature reviewed supported the development of a trauma-informed art therapy resource that integrates somatic and bilateral processes within a parts-based framework. Trauma research consistently demonstrated that traumatic memory is encoded in sensory, emotional, and physiological systems and is not fully accessible through verbal processing alone (van der Kolk, 1994, 2002; Lanius et al., 2010; Siegel, 2012). Research in this area established the need for treatment approaches that engage implicit memory systems through bottom-up processing. Neurobiological and somatic research further demonstrated that trauma disrupts nervous system regulation and requires interventions that directly engage bodily systems (Levine, 1997, pp. 19–22; Ogden & Minton, 2000, pp. 152–154).

Somatic models also emphasized the importance of regulation as a prerequisite for trauma processing (Levine, 1997; Ogden & Minton, 2000; van der Kolk, 2014). These models supported the use of sensory and motor engagement as foundational components of trauma treatment. Parts-based models provided an additional method for understanding the organization of traumatic experience. Internal Family Systems conceptualized trauma as distributed across distinct internal parts associated with specific emotional and sensory states (Schwartz, 1995, pp. 25–28). This model aligned with research on fragmentation and dissociation, which described traumatic memory as compartmentalized and not fully integrated (van der Kolk & Fisler, 1995, pp. 514–515). Parts-based approaches, therefore, provided a structure for accessing and organizing fragmented experience during treatment. EMDR research demonstrated that bilateral stimulation supports the integration of traumatic memory networks by simultaneously engaging

multiple neural systems (Shapiro, 2001, pp. 50–52). This process aligned with bottom-up models of trauma treatment and provided a mechanism for integrating implicit and explicit memory systems.

The use of bilateral art-based processes within a structured resource may support regulation while allowing paced, symbolic access to internal material. Art therapy research extended these findings by demonstrating that image making engages sensory, emotional, and cognitive systems simultaneously. Art therapy provided a method for accessing implicit memory through visual and motor processes while maintaining regulation (Malchiodi, 2003, pp. 15–18; Klorer, 2017, pp. 142–145). The Expressive Therapies Continuum further explained how art making progresses from sensorimotor engagement to higher-order symbolic processing (Lusebrink, 2004, pp. 127–130).

These findings positioned art therapy as a modality that aligns with both neurobiological and somatic models of trauma treatment. Bilateral art therapy integrated these approaches by combining sensory engagement, movement, and image making within a structured process. Research demonstrated that bilateral art interventions supported affect regulation and integration of fragmented experience (Tripp, 2007, pp. 178–180; Talwar, 2007, pp. 25–28; McNamee, 2003, 2004, 2006). These approaches paralleled EMDR in their use of bilateral stimulation while extending processing into visual and symbolic domains. The proposed resource incorporates somatic and bilateral art therapy interventions within an Internal Family Systems framework. Within this model, bilateral art making provides a method for engaging and externalizing internal parts through sensory and visual processes, allowing for observation and interaction with these parts while maintaining regulation. Traumatic experience is conceptualized as both somatically encoded and organized into distinct internal parts. Art making provides a way to externalize

these parts through visual and sensory processes, allowing for observation and engagement without overwhelming the individual.

This approach draws from bilateral and dual-attention principles associated with trauma treatment while translating them into art-based processes that emphasize regulation, symbolic distance, flexibility, and client control. Bilateral engagement supports integration across neural systems while maintaining regulation. This integrated approach combines bottom-up processing, bilateral stimulation, and parts-based work within a structured art therapy intervention. By engaging sensory, motor, emotional, and cognitive systems simultaneously, the resource is designed to support both regulation and integration of fragmented traumatic experience. This model extends existing trauma treatments by providing a multimodal approach that is grounded in neuroscience, somatic theory, and expressive therapy practice. Although research has examined art therapy, EMDR, somatic approaches, and parts-based models independently, fewer studies have provided structured guidance for integrating these modalities within a single clinical framework (Breed, 2013). This gap highlights the need for a clearly defined, integrative model that combines these approaches to support regulation, access, and integration of traumatic experience. The literature reviewed supports the development of a five-phase handbook structure rather than a single linear trauma-processing protocol. The first phase introduces safety, Self qualities, and the card deck. The second phase focuses on manager parts and protective roles. The third phase addresses firefighter parts and reactive protective responses through body-based art-making. The fourth phase supports gentle symbolic contact with exile-related wounds. The fifth phase focuses on integration through visual organization and Self-to-part connection. This sequence reflects the need for stabilization, pacing, symbolic distance, and flexible movement between phases based on client readiness.

Section III: Methodology

The methodology used for this project focused on program development and the creation of a structured clinical handbook rather than empirical data collection. Existing literature was reviewed and synthesized to translate evidence-informed concepts from trauma research, art therapy, the Expressive Therapies Continuum (ETC), Internal Family Systems-informed theory, somatic psychology, and bilateral processing into a practical resource for art therapists (Lusebrink, 2004; Malchiodi, 2003; McNamee, 2003; Schwartz & Sweezy, 2020; Tripp, 2007).

The resulting project was developed as an IFS-informed and bilateral art-based art therapy handbook intended to support ethically paced, trauma-informed clinical practice. The handbook provides a structured sequence of interventions while maintaining flexibility based on client readiness, regulation, developmental level, sensory preferences, and clinical presentation. The development process involved identifying key principles from the literature, organizing those principles into a phased clinical structure, selecting art materials that supported different

levels of processing, and developing safety, pacing, readiness, and containment guidelines for each stage of the work.

The handbook was not developed as a formal Internal Family Systems treatment manual or an Eye Movement Desensitization and Reprocessing resource. Instead, IFS-informed language and bilateral art-based processes were incorporated within the established scope of art therapy practice. Internal Family Systems concepts were used to support compassionate, non-pathologizing exploration of protective and vulnerable internal experiences, while bilateral art-making processes were used to support sensory engagement, regulation, organization, and meaning-making (McNamee, 2003, 2004, 2006; Schwartz & Sweezy, 2020; Talwar, 2007; Tripp, 2007).

The project emphasized regulation, symbolic externalization, internal organization, compassionate observation, and gradual integration rather than direct trauma exposure or forced memory processing. This approach was informed by trauma literature indicating that traumatic experience may be encoded through sensory, physiological, emotional, and implicit memory systems that are not always fully accessible through verbal processing alone (Lanius et al., 2010; van der Kolk, 2002; van der Kolk & Fisler, 1995).

Intended Clinician Audience

The primary audience for the handbook is board-certified art therapists practicing within their established scope of competence. The handbook is intended for clinicians with training and clinical experience in trauma-informed art therapy and sufficient understanding of dissociation, emotional dysregulation, crisis assessment, stabilization, and client readiness.

Clinicians using the handbook should understand the distinction between IFS-informed parts language and formal Internal Family Systems therapy. They should also understand the distinction between bilateral art-based processing and EMDR treatment. The interventions are not intended to qualify clinicians to practice either modality independently and should not be represented as formal IFS therapy or EMDR unless the clinician possesses the appropriate training and credentials.

The handbook is intended to supplement, rather than replace, individualized treatment planning, clinical judgment, supervision, consultation, crisis assessment, and referral to a higher level of care when necessary. The clinician remains responsible for determining whether each intervention is appropriate based on the client's diagnosis, developmental level, trauma history, cultural context, sensory needs, risk level, and current capacity for regulation.

Intended Client Population

The handbook was developed for use with adolescents and adults who may benefit from structured, sensory-based, symbolic, and experiential art therapy interventions. The interventions may be especially appropriate for individuals experiencing trauma-related dysregulation, fragmented internal experience, emotional reactivity, somatic distress, dissociation, difficulty identifying internal states, or limited access to verbal processing (Lanius et al., 2010; van der Kolk & Fisler, 1995).

The handbook may also support clients who become overwhelmed by direct trauma narration or who benefit from symbolic distance, visual organization, tactile engagement, and choice in how they approach internal experiences. Art-making can provide a nonverbal pathway

for externalizing difficult experiences while supporting pacing, containment, sensory engagement, and emotional distance (Klorer, 2017; Malchiodi, 2003).

Appropriateness should be determined through clinical assessment. Clients should demonstrate sufficient stability to participate in basic art-making, identify or access at least one grounding strategy, communicate distress or the need to pause, and remain present enough to engage in reflection. Clients should also understand that they are not required to disclose more than they choose.

The interventions should be modified, paused, or discontinued when clients demonstrate significant flooding, panic, dissociation, disorientation, escalating shame, active suicidal or homicidal intent, or an inability to regain enough regulation to close the session safely. Trauma-informed and somatic models emphasize stabilization and physiological regulation before deeper engagement with distressing material (Levine, 1997; Ogden et al., 2006).

Theoretical Foundations

The handbook was developed from four primary theoretical foundations: trauma-informed art therapy, IFS-informed parts language, bilateral art-based processing, and ETC-informed material adaptation.

Trauma-Informed Art Therapy

Trauma-informed art therapy provided the overarching clinical frame for the handbook. The interventions were developed to prioritize emotional and physiological safety, client choice, pacing, consent, containment, and regulation. Art-making was used as a means of externalizing internal experience through image, color, line, texture, symbol, movement, and material engagement.

Art therapy can engage visual, motor, sensory, affective, and cognitive processes simultaneously, providing an alternative pathway for clients who struggle to communicate traumatic experiences through language alone (Hass-Cohen & Carr, 2008; Malchiodi, 2003). Structured art interventions may also support emotional regulation and symbolic organization by allowing clients to approach difficult material with greater distance and control (Klorer, 2017).

IFS-Informed Parts Language

Internal Family Systems-informed concepts provided a nonpathologizing framework for organizing internal experience. IFS conceptualizes the mind as containing multiple parts that may hold distinct roles, emotions, beliefs, protective functions, or vulnerable experiences (Schwartz & Sweezy, 2020). Within the handbook, the language of Self qualities, managers, firefighters, and exiles was used to support curiosity toward protective, reactive, and vulnerable internal states.

These categories were used as flexible clinical concepts rather than diagnostic labels. Clients were invited to notice and represent parts of their experience without being told which parts they had or what those parts meant. The goal was not to diagnose internal parts or conduct formal IFS therapy, but to provide a compassionate structure for externalizing and organizing experiences that may feel fragmented, overwhelming, or difficult to name.

Bilateral Art-Based Processing

Bilateral art-based processing was incorporated through two-handed movement, alternating hand use, visual scanning, sorting, sequencing, crossing the midline, clay manipulation, beading, cutting, gluing, body mapping, and repeated movement across the page.

Research on bilateral art-making has suggested that alternating or coordinated use of both sides of the body may support affect regulation, sensory organization, and integration of internal experience (McNamee, 2003, 2004, 2006; Talwar, 2007; Tripp, 2007). These processes were included to support sensory engagement, emotional regulation, organization, and meaning-making. Although influenced by principles associated with bilateral stimulation, the interventions were not presented as EMDR treatment.

Expressive Therapies Continuum

The Expressive Therapies Continuum informed material selection and adaptation. The ETC describes art-making processes across kinesthetic/sensory, perceptual/affective, cognitive, and symbolic levels of information processing (Lusebrink, 2004).

Rather than using the ETC only as a linear progression, the handbook used it as a guide for choosing between more structured and contained materials and more sensory, tactile, or kinesthetic materials. Collage, tissue paper, cards, written prompts, and preselected images may provide predictability, organization, and emotional distance. Clay, large-scale body mapping, texture, movement, and mixed media may support embodied awareness, sensory-affective expression, and kinesthetic engagement.

Material selection was based on client readiness, sensory preferences, affect tolerance, developmental needs, and current level of regulation. If a material increased overwhelm, avoidance, shame, dissociation, or dysregulation, the clinician was directed to modify the intervention, shift to a more contained material, or return to grounding.

Handbook Development Process

The handbook was developed through a process of literature synthesis, clinical organization, and intervention design. Literature from trauma neuroscience, somatic psychology, Internal Family Systems, EMDR, art therapy, bilateral art-making, and the Expressive Therapies Continuum was reviewed to identify principles relevant to regulation, internal organization, symbolic processing, and trauma-informed care (Lusebrink, 2004; Malchiodi, 2003; McNamee, 2003; Schwartz & Sweezy, 2020; Shapiro, 2001; Tripp, 2007).

These principles were translated into a five-phase clinical structure. Each phase was assigned a distinct focus, clinical goal, therapist stance, and primary art therapy intervention. The sequence was designed to move from safety and orientation toward increasingly complex parts-based exploration and eventual integration.

The phases were not intended to function as a rigid or strictly linear treatment sequence. Movement between phases should remain responsive to client readiness. Clinicians may return to earlier phases, repeat interventions, reduce the depth of processing, or remain focused on stabilization for as long as clinically necessary. This flexible structure reflects trauma-treatment literature emphasizing regulation and stabilization before deeper engagement with vulnerable or activating material (Levine, 1997; Ogden et al., 2006).

A client card deck was also developed as part of the handbook. The cards provide concrete, visual language for Self qualities, manager parts, firefighter responses, and exile-related childhood wounds. The cards are intended to support identification, choice, reflection, and symbolic distance. They are not diagnostic tools and should not be used to assign parts, meanings, or clinical interpretations to clients.

Standardized Intervention Structure

Each intervention in the handbook follows a repeated clinical format to promote consistency, usability, and ethical pacing. The structure includes the phase focus, purpose of the phase, clinical goal, therapist stance, helpful therapist language, IFS-informed category, primary prompt, two material options, guidance for when to use each material option, step-by-step directives, bilateral art-based components, optional card use, IFS-informed integration questions, closing and containment, clinical cautions, and scope notes.

Each phase includes two material pathways so the clinician can select the option that best matches the client's current needs. One option typically offers more structure, predictability, or symbolic distance, while the second option offers greater tactile, sensory, or kinesthetic engagement. This structure was informed by the ETC and by trauma-informed principles emphasizing adaptation, choice, and regulation (Lusebrink, 2004; Malchiodi, 2003).

Five-Phase Curricular Structure

Phase 1: Safety, Self, and the Card Deck

The first phase focuses on regulation, trust, choice, and introduction to Self qualities. The goal is not deep parts work or trauma processing. Instead, the client is invited to explore the 8 C's of Self through color, movement, sensation, and art-making.

The primary intervention is Color and Felt-Sense Mapping the 8 C's. Option 1 uses tissue paper color mapping. The client assigns colors to the 8 C's and arranges them visually. This option offers structure, predictability, and containment.

Option 2 uses moon clay felt-sense movement. The client selects colors and moves the clay in ways that represent how each Self quality feels. This option provides tactile, kinesthetic, and sensory engagement.

The 8 C's were adapted from the IFS concept of Self-energy and include calm, curiosity, compassion, clarity, courage, confidence, creativity, and connection (Schwartz & Sweezy, 2020). These qualities are presented as possible experiences rather than assumed traits that every client can easily access or identify.

Some clients may experience certain qualities as available, unfamiliar, distant, blocked, or inaccessible. The purpose is exploration rather than mastery. When a client is unable to relate meaningfully to the 8 C's, the clinician should simplify the language, shift toward grounding or sensory-based regulation, and consult with the larger care team when clinically appropriate.

Phase 2: Meeting the Managers

The second phase focuses on manager parts, or protective internal states that attempt to prevent distress through control, perfectionism, pleasing, criticism, avoidance, productivity, caretaking, or other organizing behaviors.

The primary intervention is the Protector Mask. Option 1 uses collage to create an inside-and-outside mask. The outside represents what the manager allows others to see, while the inside represents what the manager may be protecting, hiding, or afraid would happen if it stopped doing its job.

Collage can offer symbolic distance and perceptual structure because clients may select and arrange existing images rather than create vulnerable content from a blank page (Lusebrink, 2004; Malchiodi, 2003).

Option 2 uses clay or dimensional materials to create a protector symbol, object, wall, gate, shield, container, tool, or creature. Clay may support tactile, sensory, and kinesthetic

engagement through pressing, rolling, shaping, and manipulating material with both hands (Sherwood, 2004).

The manager is approached with curiosity and respect. The goal is not to challenge, remove, confront, or bypass the part. Instead, the art process supports separation from global identity statements such as “I am controlling” and encourages language such as “A part of me tries to stay in control.”

Phase 3: Meeting the Firefighters

The third phase focuses on firefighter parts, or reactive protective responses that emerge quickly when distress, shame, fear, grief, or overwhelm becomes difficult to manage.

The primary intervention is the Body Map of Activation and Protection. Option 1 uses color, line, shape, and symbol to map where the firefighter response is experienced in or around the body. This option offers greater structure and visual containment.

Option 2 uses texture, collage, yarn, fabric, tissue paper, oil pastels, or other mixed media to represent activation, shutdown, numbness, urgency, or protection in the body. This option allows greater sensory-affective and kinesthetic engagement. Body-based and arts-based interventions may support increased awareness of internal sensation and emotional regulation when used with appropriate pacing and containment (Sherwood, 2004; Zielona-Jenek et al., 2019).

Firefighter responses may include numbing, shutdown, rage, isolation, denial, compulsion, overworking, overeating, undereating, oversleeping, undersleeping, substance use, self-harm, suicidality, violence, or other urgent coping responses.

High-risk firefighter responses, including self-harm, suicidality, violence, and homicidality, require immediate clinical assessment, safety planning, consultation, supervision, and appropriate level-of-care decision-making. The cards and art-making process should never replace risk assessment, crisis intervention, or collaboration with other members of the treatment team.

Phase 4: Listening for the Exile

The fourth phase focuses on vulnerable parts associated with unmet needs, childhood wounds, shame, loneliness, fear, rejection, grief, betrayal, disconnection, or lack of safety.

The primary intervention is the Wounded Child SoulCollage-Inspired Card. Option 1 uses collage imagery to create a card for a younger, wounded, hidden, or vulnerable part. The card may represent what the part feels, carries, remembers, needs, fears, or hopes for. The client is not required to explain the full meaning of the image.

Option 2 uses beads to create an exile needs strand. The client identifies a vulnerable part and selects beads representing what the part carries, what it needed then, what it needs now, and which Self qualities may offer support. Sorting, sequencing, and stringing beads provide structured tactile engagement while supporting symbolic meaning-making.

The exile is approached symbolically and from a safe enough distance. The clinician should not push for trauma details, memory narration, or emotional intensity. The purpose is witnessing and beginning relationship rather than uncovering or processing the full traumatic story. This reflects trauma-informed principles of pacing, client control, and containment (Klorer, 2017; Malchiodi, 2003).

Phase 5: Integration

The fifth phase focuses on connection, organization, and Self-to-part relationship. The goal is not to force resolution or agreement among all parts. Instead, the client is invited to create a visual representation of the internal system as connected rather than fragmented.

The primary intervention is the Tree of Me. Option 1 uses drawing on paper or cardstock. The sun represents Self. The roots may represent vulnerable parts, wounds, hidden experiences, or unmet needs. The trunk may represent manager parts or protectors that helped the client remain functional. The branches may represent firefighter parts, roles, reactions, relationships, or energy moving outward. Leaves, flowers, and fruit may represent Self qualities, support, growth, repair, and new possibilities.

Option 2 continues the large body map developed in Phase 3. The client adds the Tree of Me as a new integration layer within, around, beside, or through the body image.

The intervention supports visual organization of the internal system while allowing some parts to remain distant, protected, unresolved, or not yet represented. Integration is defined as increased relationship, awareness, and internal organization rather than complete resolution. Art-making may support integration by linking sensory, emotional, cognitive, and symbolic processes within one visual form (Hass-Cohen & Carr, 2008; Lusebrink, 2004).

Readiness, Safety, and Clinical Adaptation

Safety and pacing were incorporated throughout the development of the handbook. Each intervention includes guidance for assessment, modification, containment, and closure.

The clinician should pause, modify, or return to stabilization when the client becomes flooded, panicked, disoriented, highly ashamed, numb, dissociated, or unable to remain present. The intervention should also be paused when the client feels pressured to disclose trauma,

becomes overly blended with a vulnerable or reactive part, or cannot regain enough regulation to end the session safely.

Clinical adaptation may include simplifying prompts, decreasing verbal processing, using a smaller surface, shifting from fluid to structured materials, reducing the number of cards, focusing on one color or sensation, adding a container or border, returning to grounding, or postponing parts-based exploration.

Clients should be offered choice in materials, pacing, level of disclosure, and verbal reflection. They should be reminded that the artwork can hold experiences that do not need to be spoken aloud.

Consultation or collaboration with a larger care team may be necessary when clients present with complex trauma, significant dissociation, psychosis, neurodevelopmental differences, severe personality-related concerns, self-harm, suicidality, homicidality, substance-related risk, or other conditions that affect readiness and capacity for parts-based exploration.

Methodological Limitations

This project was developed through literature synthesis and clinical program design and was not empirically tested. The handbook does not establish the efficacy of the interventions, demonstrate causal treatment outcomes, or provide evidence that the sequence is appropriate for every client or clinical setting.

The intervention structure reflects an integration of theory, published literature, art therapy principles, and developing clinical experience. Future research may include expert review, clinician feedback, pilot implementation, client acceptability measures, outcome evaluation, and revision based on clinical use.

The handbook is also limited by its integration of concepts from formal treatment models without functioning as a substitute for training in those models. Clinicians must remain within their own scope of competence and should use supervision, consultation, and referral when client needs exceed the intended use of the resource.

Conclusion

This methodology used literature synthesis, theory integration, and program development to create a five-phase IFS-informed and bilateral art-based art therapy handbook. The handbook was designed for ATR-BCs and emphasizes safety, regulation, symbolic externalization, material choice, parts-informed reflection, and gradual integration.

The final structure includes clinician and client readiness guidance, ETC-informed material adaptation, card-based supports, two material options for each phase, and repeated attention to pacing, containment, and scope of practice. By moving from Self qualities to managers, firefighters, exiles, and integration, the handbook provides a flexible clinical structure for helping clients approach internal experiences with greater curiosity, compassion, organization, and choice.

Section IV: Outcomes

The outcome of this project is a clinician-facing resource titled *An IFS and EMDR-Informed Art Therapy Handbook for Trauma Integration*. The handbook translates the research and theoretical foundations reviewed in this paper into a practical art therapy resource for clinicians working with trauma-related dysregulation, fragmented internal experience, somatic activation, and protective internal responses.

The handbook integrates trauma-informed art therapy, IFS-informed parts language, EMDR-informed principles, bilateral art-based processes, somatic awareness, and Expressive Therapies Continuum-informed material selection. These approaches are organized within a five-phase structure that moves from safety and Self qualities to manager parts, firefighter parts, vulnerable exile-related experiences, and integration. The phases are intended to provide clinical organization rather than function as a rigid or linear treatment protocol.

Each phase includes a clinical focus, therapist stance, primary art therapy intervention, two material pathways, optional client card use, bilateral art-based components, reflection questions, closing and containment procedures, clinical cautions, and scope-of-practice considerations. One material pathway generally provides greater structure, predictability, or symbolic distance, while the second offers greater tactile, sensory, or kinesthetic engagement. This allows material selection to remain responsive to client regulation, sensory needs, developmental level, and readiness.

The handbook also includes visual card decks representing the eight qualities of Self, manager parts, firefighter responses, and exile-related wounds. The cards are designed to provide

concrete language for internal experience while preserving client choice. They are not diagnostic tools and should not be used to assign parts or meanings to clients.

Although the handbook incorporates concepts associated with Internal Family Systems and Eye Movement Desensitization and Reprocessing, it is not intended to function as formal IFS therapy or EMDR treatment. IFS-informed language is used to support compassionate exploration of internal parts, while EMDR-informed principles such as preparation, resourcing, dual attention, body awareness, bilateral engagement, reevaluation, and intentional closure inform the pacing and organization of the art therapy process. Clinicians remain responsible for practicing within their established training and scope of competence.

The completed handbook can be viewed at:

<https://canva.link/pakth9o47a5dx4i>

Conclusion

The final outcome of this project is a structured but flexible art therapy handbook that translates the literature reviewed in this paper into clinical application. The resource provides art therapists with a five-phase framework for integrating parts-informed, somatic, bilateral, and EMDR-informed principles while maintaining attention to regulation, material choice, client autonomy, safety, and ethical scope. The following section summarizes the research supporting the project, discusses the decisions that shaped the final handbook, identifies limitations, and considers future directions for development and research.

Section V: Discussion

The purpose of this project was to develop a trauma-informed art therapy resource that integrates somatic, bilateral, and parts-based approaches for trauma-related dysregulation and fragmented internal experience. The project began with an examination of trauma as a disruption of memory integration and nervous system regulation and considered how traumatic experience may remain organized through sensory, emotional, physiological, and implicit systems that are not always fully accessible through verbal processing alone. The literature was then used to explore how trauma-informed art therapy, Internal Family Systems-informed concepts, somatic approaches, EMDR-informed principles, bilateral artmaking, and the Expressive Therapies Continuum could be brought together within a structured clinical resource.

The resulting handbook represents the final synthesis of that research. Rather than developing a new psychotherapy model or attempting to reproduce existing trauma treatments, the project sought to identify principles across several bodies of literature that could meaningfully inform art therapy practice. The final resource therefore remains centered in art therapy while using IFS-informed language to organize internal experience, EMDR-informed principles to support preparation and pacing, bilateral processes to engage sensory and motor systems, somatic awareness to attend to physiological regulation, and the ETC to guide material selection.

Summary of the Research

The literature reviewed throughout this project consistently demonstrated that trauma affects more than conscious memory or cognitive understanding. Traumatic experience may disrupt the integration of sensory, emotional, physiological, and cognitive information, resulting

in experiences that are remembered or reactivated through bodily sensations, emotional states, intrusive imagery, dissociation, behavioral responses, and fragmented memory rather than through a coherent narrative (Lanius et al., 2010; van der Kolk, 2002; van der Kolk & Fisler, 1995).

Research related to nervous system regulation further emphasized that trauma may produce persistent patterns of physiological activation or shutdown. Somatic approaches therefore contributed an important principle to the project: deeper exploration should occur within sufficient regulation rather than being pursued independently of the client's current physiological state (Levine, 1997; Ogden & Minton, 2000). Body awareness, sensory engagement, grounding, movement, and attention to activation became important considerations in determining how the final handbook would approach trauma-related material.

Art therapy literature provided the central clinical foundation for translating these concepts into practice. Artmaking can engage visual, sensory, motor, emotional, cognitive, and symbolic processes while allowing internal experiences to be externalized and observed with greater distance and choice (Hass-Cohen & Carr, 2008; Klorer, 2017; Malchiodi, 2003). The literature also reinforced that art material selection affects the therapeutic process. The Expressive Therapies Continuum provided a framework for considering when a client might benefit from greater structure and containment or from greater tactile, kinesthetic, and sensory engagement (Lusebrink, 2004).

Internal Family Systems contributed a framework for understanding internal experiences through the language of Self, managers, firefighters, and exiles (Schwartz & Sweezy, 2020). One of the most meaningful implications of this perspective for the project was its nonpathologizing understanding of protective responses. Behaviors such as control, perfectionism, avoidance,

shutdown, anger, overworking, or other reactive responses may serve protective functions even when those behaviors create difficulties for the individual. IFS-informed language offered a way to approach these responses with curiosity while creating greater distinction between the individual and the protective response.

Research on EMDR and bilateral processing contributed another important dimension. EMDR literature emphasized preparation, resourcing, attention to bodily experience, dual attention, bilateral engagement, and closure within trauma treatment (Shapiro, 2001). Research on bilateral artmaking also suggested that alternating or coordinated movement may support affect regulation, sensory organization, and integration of internal experience (McNamee, 2003, 2004, 2006; Talwar, 2007; Tripp, 2007). Within this project, these principles were translated into art-based processes rather than formal EMDR procedures.

Across these areas of literature, several themes repeatedly emerged: safety and regulation should accompany access to difficult material; protective responses should be understood rather than immediately challenged; sensory and bodily experience contain clinically relevant information; clients require choice and control over the depth of exploration; symbolic distance may allow vulnerable material to be approached without requiring direct disclosure; material selection influences regulation; and closure is an important component of experiential trauma work. Together, these themes provided the foundation for the final project.

The most significant conclusion drawn from this project is that access to traumatic material is not, by itself, the goal of trauma-informed art therapy. Artmaking may create access to experiences that have been difficult to verbalize, but the emergence of an image, sensation, memory fragment, or emotional response does not necessarily indicate that the client is ready for deeper processing. Access must be considered alongside regulation, protection, symbolic distance, client autonomy, and the ability to return to present-moment safety.

This understanding became central to the final handbook. The intervention is not only the art directive. The therapist's pacing, language, material selection, attunement, observation, respect for protective responses, and willingness to modify or stop an intervention are also part of the therapeutic process. A directive that is supportive for one client may be overwhelming for another. Likewise, a material that provides sensory regulation for one person may increase activation or discomfort for someone else. Trauma-informed art therapy therefore requires responsiveness rather than assuming that a particular directive or material is inherently regulating.

The project also supported an understanding of integration as relationship rather than complete resolution. Within the handbook, integration does not require a client to recover every memory, eliminate every protective response, or create a unified internal experience. Integration may instead involve increased awareness of bodily activation, recognition of the function of a protective response, greater differentiation between Self and parts, increased compassion toward vulnerable experiences, or an improved ability to remain present while noticing difficult internal material.

This understanding influenced how the final phase of the handbook was conceptualized. Integration is represented as increased connection and organization while allowing some

experiences to remain distant, protected, unresolved, or outside the artwork. This reflects the broader trauma-informed principle that the client determines the pace and depth of the work.

Another important conclusion was that the integration of several theoretical perspectives could provide a stronger clinical structure than relying on any one concept alone. Art therapy provides the central expressive and relational modality. IFS-informed concepts provide language for internal organization and protection. Somatic approaches support awareness of physiological states. EMDR-informed principles contribute preparation, resourcing, dual attention, bilateral engagement, reevaluation, and closure. The ETC supports decisions about material properties and levels of engagement.

The value of the project therefore lies less in any individual intervention and more in the way these perspectives are organized together around clinical decision-making.

Development of the Final Project

The final handbook was developed through literature synthesis, clinical organization, and intervention design. Several decisions emerged as the research progressed and shaped the final structure of the resource.

One of the first decisions was to develop a clinician-facing handbook rather than a formal treatment manual. The literature supported the integration of trauma-informed, somatic, bilateral, and parts-based concepts, but this project did not empirically establish a new treatment protocol. A handbook allowed the project to translate theoretical concepts into usable clinical guidance while preserving therapist judgment, flexibility, and individualized treatment planning.

The decision to use a five-phase structure developed from the repeated emphasis in the literature on regulation and stabilization before deeper engagement with vulnerable material. The

final sequence begins with safety, resources, and Self qualities before moving toward manager parts, firefighter responses, vulnerable exile-related material, and eventual integration. The order was selected to reflect increasing levels of vulnerability rather than to establish a rigid progression.

Managers were placed before firefighters and exiles because proactive protective strategies can often be observed and explored without immediately approaching the experiences they protect. Understanding these protective roles may help create a foundation of curiosity and compassion before working with more reactive or vulnerable states.

Firefighter work was then paired with body mapping because reactive protective responses are frequently experienced through physiological activation, shutdown, urgency, or sensation. This allowed somatic awareness to become central to the phase without requiring direct exploration of the trauma that may underlie the response.

Exile-related exploration was intentionally placed later in the handbook and designed with the greatest emphasis on symbolic distance, preparation, and containment. The purpose of this phase is witnessing and relationship rather than memory retrieval, emotional catharsis, or direct trauma reprocessing.

The decision to include two material pathways within each phase emerged from the ETC and from trauma-informed principles of flexibility and client choice. One material option generally provides greater structure, predictability, or symbolic distance, while the second offers greater sensory, tactile, or kinesthetic engagement. This allows the same clinical theme to be approached differently depending on the client's current needs.

The development of the card decks was another final design decision. The cards provide visual language for the eight qualities of Self, manager parts, firefighter responses, and exile-related wounds. They were developed to support clients who may have difficulty responding to open-ended verbal questions or identifying internal experiences. At the same time, the cards are intentionally framed as optional and non-diagnostic. The client remains the authority on whether a particular image, word, or category represents their experience.

The decision to describe the project as EMDR-informed also became clearer during the later development of the handbook. Bilateral artmaking was initially one of the primary concepts connecting the project to EMDR. However, the final structure incorporated broader principles associated with EMDR, including preparation, resourcing, dual attention, attention to bodily experience, bilateral engagement, reevaluation, and intentional closure. The term EMDR-informed therefore more accurately reflects how these principles influenced the organization and pacing of the handbook while maintaining the distinction between the resource and formal EMDR treatment.

Ultimately, the final design reflects the central conclusion reached through the literature: the goal is not to move clients toward traumatic material as quickly as possible. The goal is to create enough safety, regulation, choice, symbolic distance, and internal relationship for difficult experiences to be approached without making access more important than the client's capacity to remain present.

Limitations

This project has several important limitations. The handbook was developed through literature review, theoretical synthesis, and project design rather than through empirical research.

It was not tested with participants, evaluated using standardized outcome measures, or compared with an established treatment. Therefore, the project does not demonstrate the effectiveness of the handbook or establish that its interventions produce specific treatment outcomes.

The handbook has also not yet undergone formal expert review. Although the project draws from literature related to art therapy, trauma neuroscience, IFS, EMDR, somatic psychology, bilateral artmaking, and the ETC, clinicians with advanced training in these areas may identify concepts, terminology, cautions, or procedures that require clarification or revision.

An additional limitation involves the use of principles derived from formal psychotherapy models. The terms IFS-informed and EMDR-informed are intended to clearly distinguish this resource from the formal practice of either therapy. However, the possibility remains that clinicians could misunderstand or overextend these concepts beyond their training or scope of competence. The handbook therefore cannot substitute for appropriate education, supervision, consultation, or formal training.

The five-phase structure also may not be appropriate for every individual or treatment setting. Some clients may require extended stabilization and may not be appropriate for exile-related exploration. Others may not identify with parts terminology or may experience the framework as inconsistent with their cultural, developmental, or personal understanding of internal experience.

The resource was primarily developed with adolescents and adults in mind and has not been systematically adapted or evaluated for young children, older adults, neurodivergent clients, individuals with physical or sensory disabilities, or diverse cultural populations. The material pathways and interventions reflect the author's synthesis of the literature and developing clinical

experience. Other clinicians may make different decisions about materials, sequence, or intervention design. The current handbook should therefore be understood as a developing clinical resource rather than a finalized or empirically validated model.

Suggestions for Future Research and Development

The next stage of the project should begin with formal expert review. Feedback from board-certified art therapists, trauma-informed clinicians, EMDR-trained clinicians, IFS-trained clinicians, somatic practitioners, and clinicians with expertise in dissociation would help evaluate the theoretical accuracy, clinical safety, ethical scope, terminology, and usability of the handbook. Expert feedback could be used to revise the phase structure, card language, bilateral components, therapist prompts, clinical cautions, readiness criteria, and explanations of IFS-informed and EMDR-informed practice.

Following expert review and revision, a small feasibility or pilot project could examine how clinicians use the handbook in practice. Early evaluation should focus primarily on usability, clarity, feasibility, and acceptability rather than immediately attempting to establish treatment effectiveness. Clinician feedback could examine whether the handbook provides sufficient guidance for choosing materials, determining readiness, adapting interventions, using the cards, maintaining appropriate scope, and closing sessions safely.

Client feedback would also be important. Future evaluation could consider whether the language, materials, imagery, parts framework, and interventions are experienced as understandable, respectful, empowering, culturally appropriate, and emotionally safe. Later empirical research could examine outcomes related to emotional regulation, body awareness, dissociation, self-compassion, internal organization, therapeutic engagement, and the ability to

maintain dual attention. Individual phases or interventions could also be studied separately to better understand which components are most useful for different clinical populations.

Future development should also include adaptation for younger children, older adults, neurodivergent individuals, clients with disabilities, and culturally diverse populations. These adaptations should be informed by collaboration with the populations for whom they are intended rather than assuming that the existing language, imagery, or structure is universally applicable. Additional resources may eventually include clinician decision-making guides, case examples, expanded safety and readiness tools, low-cost material alternatives, digital versions of the card decks, and training materials that further clarify the ethical use and limitations of the handbook.

Conclusion

The purpose of this project was to develop a trauma-informed art therapy resource that integrates somatic, bilateral, EMDR-informed, and parts-based principles in response to trauma-related dysregulation and fragmented internal experience. The literature demonstrated that traumatic experience may involve disruptions across memory, physiological regulation, sensory experience, emotion, and internal organization, supporting the need for clinical approaches that extend beyond verbal processing alone.

The project resulted in a five-phase clinician-facing handbook organized around safety and Self qualities, manager parts, firefighter responses, vulnerable exile-related experiences, and integration. The final design incorporates two material pathways, visual card decks, bilateral art-based processes, IFS-informed reflection, EMDR-informed preparation and pacing, ETC-informed material adaptation, and repeated attention to safety, choice, containment, and closure.

The process of developing the handbook reinforced that trauma-informed art therapy is not defined only by the directive being used. Clinical pacing, therapist attunement, material properties, client readiness, protective responses, symbolic distance, and the ability to pause are equally important components of the intervention. The central conclusion of this project is that access to traumatic material should never become more important than the client's safety and capacity for regulation. The goal of the handbook is not to uncover traumatic experience as quickly as possible, but to provide a structured and flexible way for art therapists to help clients approach internal experiences with greater curiosity, compassion, choice, and connection.

The handbook remains a developing clinical resource requiring expert review, continued refinement, and future evaluation. However, it offers a practical bridge between the theoretical foundations reviewed in this paper and the complex clinical decisions involved in trauma-informed art therapy practice.

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