Project Witness

RESEARCH BRIEF · APRIL 2026

Art Therapy with Holocaust Survivors

Neurobiological Foundations, Clinical Frameworks, and the Empirical Evidence Base — A Narrative Review

PROJECT WITNESS · NARRATIVE REVIEW · APRIL 2026

CLINICAL LITERATURE · NOT PEER-REVIEWED

DISCLOSURE AND SCOPE

Publisher. This review is published by Project Witness, a Holocaust-education nonprofit that operates the *Remember & Rebuild* program — a clinical and educational initiative connecting Holocaust-survivor art therapy with classroom-based Holocaust education. The publisher has a direct operational interest in the literature reviewed here; the conclusions art therapy with this population is clinically defensible directly informs the publisher's programming. Readers should read the review's evaluative judgments in that light.

Author independence. The review was prepared as an editorial synthesis of the primary clinical and empirical literature. No external funding was received for its preparation. The author is not a clinician and is not a peer-reviewed researcher in this field. The review is a narrative synthesis of published work by others, with citations provided for independent verification.

AI-tool contribution. This document was drafted with substantial assistance from large-language-model tools. Specifically, those tools supported literature-search scoping, structural outlining, initial drafting of framework-summary passages, and iterative editing. All cited references were independently verified against primary sources by the author. All substantive clinical, empirical, and historical claims were reviewed by the author for fidelity to the cited literature. Responsibility for any residual errors, characterizations, or interpretive commitments rests with the author alone. Citation-verification records are available on request from the Project Witness editorial address.

Document status. This is a narrative review, not a systematic review and not a peer-reviewed publication. It has not been formally submitted to or refereed by a scholarly journal. It is intended as educational and credentialing material for clinicians, educators, administrators, and funders evaluating work with Holocaust-survivor populations, and should be read and cited as such.

Citation integrity. All references cited below are traceable to their primary publications via their listed DOIs or journal/volume/page citations. Readers are encouraged to consult primary sources directly; any error in transcription or characterization is the responsibility of the author.

ABSTRACT

Background. Traumatic memory in Holocaust survivors is encoded in a form that sits in tension with the demands of verbal therapy. Positron emission tomography work dating to the mid-1990s documented reduced perfusion of Broca's area during symptom provocation in post-traumatic stress disorder, alongside hyper-activation of right-lateralized limbic and paralimbic structures and the visual cortex. This neurobiological asymmetry has been invoked to justify non-verbal, image-based interventions for trauma populations for more than two decades. Whether art therapy delivers the clinical benefit the mechanism predicts — and whether the specific cohort of Holocaust survivors benefits in particular — remains an empirical question with a thinner evidence base than the theoretical literature implies.

Aims. This narrative review (a) synthesizes the neurobiological and theoretical foundations most often invoked for art therapy with trauma survivors; (b) profiles the clinical presentation of Holocaust survivors in late life using meta-analytic and longitudinal data; (c) appraises the published empirical and case literature on art therapy with Holocaust-survivor populations specifically; and (d) identifies the principal methodological gaps that future research must close.

Findings. The neurobiological rationale for non-verbal, sensorimotor, image-based intervention is well-supported at the level of symptom-provocation neuroimaging but is frequently over-stated in clinical writing. The 1996 Rauch finding of left-hemispheric hypoactivation has been replicated and also substantively qualified by more than two decades of subsequent work, including the Lanius dissociative-subtype literature showing that a substantial minority of PTSD patients display the opposite neural signature. The meta-analytic profile of Holocaust survivors (Barel et al., 2010) documents elevated posttraumatic-stress symptoms and psychopathology alongside substantial functional resilience — a pattern Diamond and Shrira (2018) later reproduce in a community sample and extend to show a significant association between creative-art engagement and resilience. The population-specific empirical base for art therapy with Holocaust survivors is slim: one peer-reviewed quantitative study with this cohort (Diamond & Shrira, 2018), two peer-reviewed qualitative studies (Diamond & Shrira, 2022; Israeli, Regev, & Goldner, 2021), and a small number of clinical case reports and program descriptions. A related quantitative pilot (Hass-Cohen et al., 2018) and one randomized trial in an adjacent trauma population (Campbell et al., 2016) are informative by analogy. No randomized controlled trial of art therapy has been conducted with a Holocaust-survivor population.

Conclusion. Art therapy with Holocaust survivors rests on a defensible theoretical and neurobiological foundation and a coherent but underpowered empirical base. Clinical frameworks — material titration, the holding environment, fantastic reality, bilateral activation, the inner-witness function — are consistent across clinical accounts and draw on identifiable theoretical traditions. The population-specific evidence base is characterized by small samples, cross-sectional designs, and case-study dominance. Rigorous clinical adoption is warranted; claims of mechanistic or curative certainty are not.

EVIDENCE-TIER MATRIX

The following matrix summarizes the principal claims made in this review against the evidence type available and its strength. It is intended as a quick-reference for readers who want to calibrate how heavily any given claim can carry weight. Full source citations are given in the relevant sections.

CLAIM	EVIDENCE TYPE	STRENGTH	SECTION
Traumatic memory shows left inferior frontal hypoactivation during symptom provocation (the “Broca’s area” finding)	Meta-analysis of fMRI/PET symptom-provocation studies	Strong	§2.2
A dissociative subtype of PTSD exists with the opposite neural profile (over-modulation)	Latent-class analyses + replicated neuroimaging	Strong	§2.2
Porges’s polyvagal formulation	Contested theoretical framework	Limited / disputed	§2.3
Holocaust survivors show elevated PTSD symptomatology with preserved cognitive and physical functioning (“resilient vulnerability”)	Meta-analysis, 71 samples, N=12,746	Strong	§4.1
Creative-art engagement is positively associated with resilience in aging Holocaust survivors	One peer-reviewed cross-sectional study (N=154)	Moderate	§5.1.1
Art therapy added to verbal trauma treatment improves retention in combat-veteran PTSD	One small RCT (N=11 completers), adjacent population	Limited	§5.1.2
Four-drawing protocol produces decreases in negative affect and increases in resiliency resources	Mixed-methods pilot, no control group, non-clinical sample	Limited	§3.3 / §5.1.3
Survivor artwork in clinical settings avoids direct Holocaust imagery as	Two qualitative studies + case reports	Moderate (phenomenological)	§5.2 / §6.5

CLAIM	EVIDENCE TYPE	STRENGTH	SECTION
symbolic-mastery strategy			
The Expressive Therapies Continuum provides a non-arbitrary logic for material choice	Framework with clinical synthesis; limited direct outcome testing	Clinical-framework (framework-level), not outcome-validated	§3.1
Art objects function as mediators in intergenerational family communication	Case reports and qualitative accounts	Limited	§8.2
Intergenerational cortisol and epigenetic effects in Holocaust offspring	Mixed findings; epigenetic work contested	Moderate (cortisol); limited / contested (epigenetic)	§8.1
Art therapy is superior to verbal therapy for Holocaust-survivor populations	—	Absent (no RCT)	§5.5 / §9.1
A specific minimum effective dose of art therapy for this population	—	Absent	§6.3 / §11

Legend. **Strong** = meta-analysis or multiple converging studies. **Moderate** = single well-conducted study or consistent qualitative corpus. **Limited** = pilot, small case series, or contested methodology. **Absent** = the corresponding controlled evidence has not been published.

CONTENTS

1. Introduction

1.1 THE CLINICAL PROBLEM

Holocaust survivors constitute one of the most extensively documented trauma cohorts in the history of psychiatry and psychology. More than eight decades after liberation, the population that remains alive is small, elderly, and geographically concentrated in Israel, the United States, and a handful of other countries that received post-war refugee migration. Published work on this population is extensive. A PubMed search combining “Holocaust” with “trauma” or “PTSD” returns several thousand records. Coverage is uneven, however, across outcomes, methods, and historical periods. The bulk of rigorous quantitative work appeared between the mid-1990s and the present, concentrating on epidemiologic prevalence, intergenerational transmission, and aging-related sequelae.

Within this body of work, a recurring clinical observation is that talk-based interventions encounter specific limits with this population. Verbal reconstruction of traumatic content is, for some survivors, physiologically difficult (Rauch et al., 1996; van der Kolk, 2014). For others, it conflicts with decades of defensive organization around non-disclosure (Krystal, 1988; Kellermann, 2009). A third cohort consists of those who were children during the war, whose developmental stage of play was interrupted. For them, verbal reconstruction asks for a narrative competence that was never cultivated, because the early environment did not permit it (Kellermann, 2001; Diamond & Shrira, 2022). Non-verbal and sensorimotor interventions have been proposed as clinically indicated for exactly these reasons (Talwar,

2007; Hass-Cohen et al., 2014; Malchiodi, 2020). Art therapy, specifically, has been positioned as a modality whose mechanism aligns with the documented neurobiology of traumatic memory and with the developmental and defensive profile of this population.

1.2 WHY THIS REVIEW

Three problems motivate the present review.

The first is a problem of citation drift. Clinical writing on art therapy with Holocaust survivors repeatedly invokes a small set of foundational neuroimaging and theoretical references (most prominently Rauch and colleagues' 1996 PET study, van der Kolk's body of work, and Lusebrink's Expressive Therapies Continuum) in ways that sometimes outrun what those sources actually claim. The "Broca's area goes offline" formulation is now a staple of trauma-informed clinical discourse. It traces to a specific finding from a small, well-conducted study that has been replicated at the meta-analytic level (Etkin & Wager, 2007; Patel et al., 2012) and also qualified considerably by subsequent work. A review addressed to educators, funders, and clinicians benefits from seeing the original claim and its qualifications in proximity.

The second is a problem of evidence granularity. The empirical record on art therapy with Holocaust survivors is small enough to be read in a single sitting, yet the clinical and programmatic literature frequently cites it as if it were dense. Readers deserve an honest accounting of what has and has not been studied.

The third is a problem of framework diffusion. At least five distinguishable theoretical frameworks are routinely cited in art-therapy writing on trauma: the Expressive Therapies Continuum, bilateral activation, Hass-Cohen's relational-neurobiological protocols, Winnicottian holding and fantastic reality, and Herman's three-stage trauma-recovery model. These frameworks are not interchangeable. Practitioners operating under one may be doing something meaningfully different from practitioners operating under another. This review maps the frameworks against one another.

1.3 SCOPE AND METHOD

This is a narrative review, not a systematic review. The choice is deliberate. The population-specific empirical record on art therapy with Holocaust survivors is small enough that a full PRISMA-compliant systematic review would mostly document the absence of trials. A scoping-review treatment would duplicate the theoretical-framework and historical-context material in ways less useful to the review's stated audience. A narrative review was chosen on that pragmatic ground. Readers seeking a more formal synthesis of the broader trauma-and-creative-arts literature (not Holocaust-specific) are referred to Shukla et al. (2022) and to King (2016).

Searches were conducted in PubMed, PsycINFO, and Google Scholar between January and March 2026 for combinations of “art therapy,” “Holocaust survivor,” “trauma,” “PTSD,” “geriatric,” “aging,” and “creative arts.” Hand-review of issues of *The Arts in Psychotherapy*, *Art Therapy: Journal of the American Art Therapy Association*, *Psychology of Aesthetics, Creativity, and the Arts*, *Psychiatry Research*, and *Psychological Bulletin* was performed for the years 2000–2026. Forward and backward citation tracing from Barel et al. (2010) and Diamond and Shrira (2018) was used to surface further sources. Sources were retained when they either (i) reported primary empirical data (quantitative or qualitative) on art therapy with Holocaust-survivor populations, (ii) developed or tested a theoretical framework canonically cited in that literature, or (iii) provided meta-analytic or population-level data on Holocaust-survivor clinical presentation. No formal screening flow diagram or inter-rater reliability procedure was implemented. The review was conducted by a single author, and that limitation is flagged here as a standard caveat on narrative-review methodology (Baethge, Goldbeck-Wood, & Mertens, 2019).

No meta-analysis is attempted. Effect sizes, where reported by primary studies, are presented as published. Case-study and program-description material is included, as it must be for a population this size and this clinically specific, but is labeled as such throughout.

1.4 A NOTE ON WHAT THIS REVIEW IS NOT

This review is not a program description, an endorsement of any particular clinical protocol, or an argument for a specific funding model. It is not a substitute for AATA practice guidelines or for the trauma-treatment guidelines of the International Society for Traumatic Stress Studies (ISTSS, 2019). It does not address the aesthetic or art-historical dimensions of survivor artwork. That is a substantial literature in its own right (Apel, 2002; Costanza, 1982; Makarova, 1999), intersecting but not coinciding with the clinical question. It also does not treat adjacent creative-arts modalities (music therapy, dance/movement therapy, drama therapy, bibliotherapy) except where comparative framing is clinically relevant.

2. The Neurobiology of Traumatic Memory

2.1 ENCODING UNDER EXTREME THREAT

The psychobiology of traumatic memory diverges, by most contemporary accounts, from the psychobiology of ordinary autobiographical memory in ways that have direct implications for intervention design. Under ordinary encoding conditions, declarative memory for an event is consolidated through hippocampal-dependent processes that permit later retrieval as a narratively organized, temporally situated representation (Squire, 1992; Nadel & Moscovitch, 1997). Under conditions of extreme threat (prolonged, inescapable, accompanied by high levels of circulating glucocorticoids and catecholamines), this process is disrupted. Sensory and affective elements of the event are encoded and stored. Narrative and temporal integration are attenuated (van der Kolk & Fisler, 1995; Brewin, Dalgleish, & Joseph, 1996).

Brewin's dual-representation theory (Brewin et al., 1996; Brewin, 2014) formalizes this asymmetry by positing two parallel memory systems. A verbally accessible memory system (VAM) supports deliberate retrieval and narrative construction. A situationally accessible memory system (SAM) stores sensory, affective, and physiological fragments and is triggered by environmental cues instead of willed recall. Traumatic memory, on this account, is disproportionately represented in SAM. The clinical phenomenology of post-traumatic stress (intrusive sensory fragments, body-based re-experiencing, the frequent absence of a coherent verbal narrative) is the predicted surface expression of that asymmetry.

2.2 THE RAUCH FINDING AND ITS REPLICATIONS

The most-cited neurobiological anchor for non-verbal trauma intervention is Rauch, van der Kolk, Fisler, and colleagues' 1996 positron-emission-tomography (PET) study, published in *Archives of General Psychiatry*. Eight adults with PTSD were exposed sequentially to audiotaped traumatic and neutral scripts while PET imaging measured regional cerebral blood flow. The traumatic condition relative to the neutral condition produced increases in right-hemispheric limbic, paralimbic, and visual cortex activation, and decreases in left inferior frontal cortex, an area that includes Broca's area, implicated in speech production and, more broadly, in the verbal labeling of internal states (Rauch et al., 1996).

The clinical gloss on this finding, "Broca's area goes offline," is a defensible shorthand, but it remains a shorthand. What Rauch and colleagues reported was reduced activation, not absence, in a small sample, during symptom provocation (not during ordinary recall), in participants meeting criteria for PTSD (not in trauma survivors generally). Subsequent replications and meta-analyses have both confirmed the broad pattern and qualified it.

Hull's (2002) review of neuroimaging in PTSD confirmed the right–left asymmetry across multiple studies. Etkin and Wager (2007), in a meta-analysis of functional neuroimaging studies of anxiety disorders, reported hyper-activation of the amygdala and insula that was *shared* across PTSD, social anxiety disorder, and specific phobia, and was not specific to PTSD. This finding is occasionally mis-cited in clinical writing as corroboration of a PTSD-specific signature. Patel and colleagues (2012), in a larger meta-analysis focused on PTSD symptom provocation, confirmed activation of right-lateralized limbic and paralimbic structures and of visual association cortex. The left inferior frontal finding was present but more variable across studies than the Rauch-era literature sometimes implies.

The most consequential qualification since Rauch is the *dissociative subtype* of PTSD described by Lanius and colleagues (2010, 2012). Latent-class analyses in veteran samples (Wolf et al., 2012) classified approximately 15% of a male cohort and 30% of a female cohort into a dissociative-subtype class presenting a neural pattern substantially opposite to the one described above. During symptom provocation, these patients show *hyper*-activation of medial prefrontal regions and *hypo*-activation of limbic structures. That overmodulation profile is associated with depersonalization, derealization, and emotional numbing, rather than with reexperiencing and hyperarousal. The clinical consequence is that the "trauma-neurobiology picture" is not singular. A trauma-informed art-therapy protocol calibrated only to the undermodulating profile (the "Broca-offline" picture) will misfit the subset of patients whose presentation is overmodulating. The Holocaust-survivor population, in which dissociative defense is well-documented clinically, includes both profiles, and published art-therapy frameworks have not yet specified how to distinguish them at intake.

The phrase "speechless terror," used by van der Kolk (2014) and repeated widely in clinical training materials, captures an experiential reality that patients report. It should not be read as a claim that language systems are anatomically disconnected in all trauma survivors at all times.

2.3 IMPLICATIONS FOR INTERVENTION

Three implications follow for the design of non-verbal intervention.

First, if traumatic material is disproportionately represented in sensory, visual, and affective systems instead of in verbal-declarative ones, interventions that engage those systems are approaching the material through the channel in which it is actually stored. This is the core claim of the art-therapy trauma literature (Talwar, 2007; Malchiodi, 2020; reviewed critically in Shukla, Choudhari, Gaidhane, & Quazi Syed, 2022) and of somatic and sensorimotor-oriented psychotherapies more broadly (Ogden, Minton, & Pain, 2006; Levine, 2010).

Second, because the visual cortex is activated during trauma recall, image-based interventions have, in effect, a pre-existing neural substrate on which to operate. Producing and examining an image, one's own or another's, engages systems that are already online. This is distinct from the claim that verbal systems are offline. It is the parallel, affirmative claim that visual systems are engaged.

Third, the autonomic regulation literature suggests that rhythmic, controlled motor output (stroke, pressure, repetition in a contained physical task) down-regulates sympathetic arousal through mechanisms involving the vagal complex and interoceptive-regulation pathways (Porges, 2011; Craig, 2009). Porges's polyvagal formulation has been substantively contested in the cardiac-physiology literature (Grossman & Taylor, 2007). Clinical writing should treat it as a working theoretical framework and not as settled neurophysiology. The clinical observation that rhythmic motor engagement tends to down-regulate arousal does not depend on the specific evolutionary and vagal-branch claims of polyvagal theory to hold empirically. Contemporary art-therapy neurobiology (Lusebrink, 2004; King, 2016; Hass-Cohen & Findlay, 2015) treats the motor engagement of art-making as an active therapeutic ingredient in its own right, not simply as a delivery mechanism for symbolic content.

2.4 WHAT THE NEUROBIOLOGY DOES NOT ESTABLISH

It is worth stating explicitly what this neurobiological evidence does not establish. It does not establish that art therapy works better than verbal therapy for any given patient. It establishes that a mechanism is available through which art-based intervention could work. It does not establish that any particular art-therapy protocol is empirically validated. The protocols are reviewed in §3 and their evidence base in §5. And it does not establish that findings from combat-veteran PTSD samples, which dominate the neuroimaging literature, generalize straightforwardly to Holocaust-survivor populations, whose trauma profile is in important respects distinct (Yehuda, Kahana, Binder-Brynes, Southwick, Mason, & Giller, 1995; Shrira, 2019).

Neurobiology provides a permission here, not a prescription. The prescriptions, where they exist, come from the clinical-framework and empirical literatures reviewed in the sections that follow.

3. Theoretical Frameworks for Art Therapy with Trauma

The art-therapy literature addressed to trauma populations is theoretically plural. At least five distinguishable frameworks recur across the clinical and empirical record, each making a different claim about how art-making is therapeutic and each suggesting different specifications of clinical practice. This section describes each framework, identifies its sources, and notes where its claims have been empirically tested.

3.1 THE EXPRESSIVE THERAPIES CONTINUUM

Vija Lusebrink's Expressive Therapies Continuum (ETC), first proposed with Kagin (Kagin & Lusebrink, 1978) and substantially developed in Lusebrink (2004; 2010), is the most widely cited organizing framework in contemporary art therapy for trauma and for mental-health populations generally. The ETC posits three hierarchical levels of information processing engaged by art-making, paralleled to the occipital, temporal, and parietal sensory-processing hierarchy:

- A *kinesthetic/sensory* level, engaging motor action and somatosensory experience with materials;
- A *perceptual/affective* level, engaging form perception and emotional expression; and
- A *cognitive/symbolic* level, engaging representational thought and symbolic meaning-making.

A fourth, *creative* level sits transverse to the hierarchy and represents integration across levels (Lusebrink, 2010; Hinz, 2020).

The clinical utility of the ETC lies in the claim that particular materials and tasks preferentially engage particular levels, and that clinicians can titrate the level of engagement by titrating the material. Fluid media (wet paint, wet clay) engage kinesthetic/sensory processing. Resistive media (pencil, marker, pre-cut collage) engage perceptual/affective and cognitive processing. A patient in acute sympathetic arousal is poorly served by materials that will deepen sensory engagement. A patient over-intellectualizing trauma content is poorly served by materials that permit only cognitive processing. The ETC thus provides a non-arbitrary clinical logic for material choice.

Empirical tests of the ETC are sparse. Hinz (2020) synthesizes the clinical record. Lusebrink and Hinz (2016) apply the ETC to trauma specifically. The framework's influence is in its diagnostic and planning vocabulary, and not in a body of outcome research. For Holocaust-survivor populations, the ETC is frequently invoked in clinical writing (Israeli, Regev, & Goldner, 2021; Keselman, 2020) but has not been the subject of a dedicated empirical study with this cohort.

3.2 BILATERAL ART AND THE MCNAMEE–TALWAR TRADITION

A second framework derives from the eye-movement-desensitization-and-reprocessing (EMDR) literature (Shapiro, 1995, 2017) and from McNamee's adaptation of bilateral stimulation to art-making (McNamee, 2003, 2004). McNamee's "bilateral art" procedure asks the patient to draw first with one hand and then with the other in an alternating, structured sequence. The clinical rationale is that alternating motor activation engages both cerebral hemispheres and facilitates the integration of affectively charged right-hemispheric material with left-hemispheric narrative processing.

Talwar (2007) extended this logic into the Art Therapy Trauma Protocol (ATTP), published in *The Arts in Psychotherapy*. The ATTP uses alternating tactile and auditory bilateral stimulation in combination with a sequence of directed drawings, with the patient's associations to each drawing brought into verbal processing as the drawings progress. Talwar positioned the ATTP explicitly as a right-and-left-brain methodology responsive to the Rauch-era neurobiology. She drew on EMDR's bilateral-stimulation component and on Cassou's painting method (Cassou & Cubley, 1995) for its material dimension. The protocol was introduced as a clinical proposal with supporting case examples, not as a randomized trial. Talwar described client-reported benefit but did not attempt a controlled outcome study.

The bilateral-art tradition has generated further protocol development but remains empirically thin. A systematic review of art-based bilateral stimulation for PTSD has not, to the present author's knowledge, been conducted. What the tradition provides clinically is a structured procedure and a neurobiological rationale. What it does not yet provide is outcome evidence at the level of a randomized trial.

3.3 ART THERAPY RELATIONAL NEUROSCIENCE: THE HASS-COHEN PROTOCOLS

A third, more recent framework is the Art Therapy Relational Neuroscience (ATR-N) program developed by Hass-Cohen and colleagues (Hass-Cohen & Carr, 2008; Hass-Cohen, 2008). ATR-N integrates attachment theory, interpersonal neurobiology (Siegel, 1999), memory-reconsolidation research (Nader, Schafe, & LeDoux, 2000; Schiller et al., 2010; Ecker, Ticic, & Hulley, 2012), and an explicit stance on the therapeutic relationship as a neurobiological event. The reconsolidation evidence base is itself a moving target. Nader, Schafe, and LeDoux's (2000) *Nature* demonstration that consolidated fear memories re-enter a protein-synthesis-dependent labile state upon retrieval established the phenomenon in rodents. Schiller and colleagues' (2010) extension to a behavioural reconsolidation-update paradigm in humans propagated it into clinical psychology. That human-behavioural extension has since had substantial replication difficulty (Chalkia, Van Oudenhove, & Beckers, 2020). Clinical protocols grounded in the human-behavioural version should be read as theoretically motivated, and not as implementations of a settled mechanism.

Two protocols have been articulated within the ATR-N framework. The CHECK protocol ("Check, Change What You Need To Change and/or Keep What You Want") specifies a sequence of art-therapy directives for trauma-narrative processing and autobiographical reconsolidation (Hass-Cohen, Findlay, Carr, & Vanderlan, 2014). The four-drawing protocol builds on the CHECK structure with a fixed sequence of four drawings targeting specific trauma and resiliency constructs (Hass-Cohen, Bokoch, Findlay, & Witting, 2018).

Hass-Cohen and colleagues (2018) report a mixed-methods pilot study of the four-drawing protocol with non-clinical adults reporting recent adverse life events. Of nine preregistered hypotheses, five were supported: significant decreases in the rating of the traumatic-event effect, in endorsement and ratings of negative affect, trending decreases in pain ratings, significant increases in endorsed resiliency resources, and positive ratings of the drawing activity's impact. Four hypotheses were not supported, including no significant changes in pain endorsement, posttraumatic-growth cognitions, or relational security. Decreased negative-affect endorsement was maintained at follow-up. The study is a pilot and does not include a control group. It is, however, one of the more rigorous outcome studies in the contemporary art-therapy trauma literature.

3.4 HOLDING ENVIRONMENT AND FANTASTIC REALITY

A fourth framework draws on the object-relations tradition and on the Israeli art-therapy literature that extends Winnicott's (1971) concepts of the holding environment and transitional phenomena to trauma work. A holding environment, in Winnicott's original formulation, is the affective and physical matrix within which the infant's emerging sense of self can consolidate. In adult trauma work, the concept is generalized to describe the therapeutic frame as a space that tolerates what the patient cannot yet tolerate alone (Bollas, 1987; Ogden, 1994).

"Fantastic reality" is a more specific concept, originating in the Israeli drama-therapy and psychotrauma literature with Lahad (2000, 2005) and subsequently applied in Israeli art therapy with Holocaust survivors (Israeli, Regev, & Goldner, 2021; Diamond & Shrira, 2022). The term describes the permissive frame of the creative-arts-therapy space as one in which dissociative defense is not only tolerated but strategically employed. The patient is invited to produce work that is "fantastic" (imaginary, symbolic, indirect) instead of directly representational, on the clinical understanding that indirect symbolic expression permits processing of material that direct representation would overwhelm. Survivor artists in the Israeli work (Diamond & Shrira, 2022; see §5 below) often explicitly avoid black, or paint nature and light in preference to Holocaust imagery. Within this framework, that pattern is read as a form of symbolic mastery conducted at the safety of aesthetic remove, and not as avoidance.

The holding/fantastic-reality framework is phenomenological and psychoanalytic in orientation. It is not a neurobiological theory. It is testable, but the tests that would bear on it are qualitative. Do patients report the frame as safe? Is symbolic indirection observed clinically? Does the framework predict clinical response? These are not quantitative outcome tests.

3.5 HERMAN'S STAGE MODEL AND ART THERAPY

Finally, Judith Herman's three-stage trauma-recovery model (Herman, 1992) — safety and stabilization, remembrance and mourning, reconnection and integration — is invoked across art-therapy writing as a staging logic for intervention sequence. The model is not originally an art-therapy framework but has been adopted by art therapists (Malchiodi, 2020) because it provides a principled structure for deciding when to offer stabilizing versus processing versus reconnection-oriented tasks.

The adoption is loose. Art-therapy writing cites Herman's stages as organizing labels more often than as clinical-decision rules. Where the stages are applied rigorously, they suggest a sequence. Processing-stage art tasks (direct symbolic engagement with traumatic material) should be preceded by stabilization-stage work (containment, grounding, material familiarization) and followed by reconnection-stage work (integration of the reworked material into relational and occupational life). A two-session structure, one session of surfacing and one of reconstruction, is a Herman-stage logic operating at a compressed timescale. Whether that compression is clinically sound is an empirical question that has not, to the present author's knowledge, been tested.

3.6 HOW THE FRAMEWORKS RELATE

The five frameworks are not alternatives in the sense that a clinician must choose among them. The ETC specifies *what level* of processing a material or task is engaging. The bilateral-art/ATTP tradition specifies *a procedural structure* for organizing bilateral activation within a session. The ATR-N protocols specify *sequences* of directives for specific trauma and resiliency targets. The holding/fantastic-reality framework specifies *a stance toward indirection and symbolic distance*. Herman's model specifies *a staging logic* across a course of treatment.

A clinically competent practitioner working with a Holocaust-survivor patient may, in any given session, be employing the ETC to select materials, fantastic-reality framing to invite indirect symbolic production, Herman's stabilization-stage logic to decide that now is not the moment for direct confrontation with traumatic content, and a holding-environment stance at the relational level. The frameworks are layered, not competing. What the published record does not yet provide is empirical evidence about which framework is doing most of the work for which patient under which conditions.

4. The Clinical Profile of Holocaust Survivors in Late Life

4.1 THE BAREL META-ANALYSIS

The most comprehensive quantitative characterization of the Holocaust-survivor population is Barel, van IJzendoorn, Sagi-Schwartz, and Bakermans-Kranenburg's (2010) meta-analysis, published in *Psychological Bulletin*. The authors synthesized 71 samples with 12,746 participants comparing Holocaust survivors with non-Holocaust-background counterparts on physical health, psychological well-being, posttraumatic-stress symptomatology, psychopathology, cognitive functioning, and stress-related physiology.

Their central findings were three. First, Holocaust survivors were, on aggregate, less well adjusted than comparison participants. The trimmed combined effect size on general adjustment was d = 0.22 for nonselected samples (95% CI [0.13, 0.31], N = 9,803) and d = 0.45 for selected samples (95% CI [0.32, 0.59], N = 2,943). Second, the effect was substantially larger on posttraumatic-stress symptomatology specifically: d = 0.72 in nonselected samples (95% CI [0.46, 0.98], N = 1,763). Third, and this is the finding that grounds the "resilient vulnerability" construct used throughout the clinical literature, Holocaust survivors did not differ significantly from comparison participants on cognitive functioning or on physical health at the meta-analytic level.

The pattern is not "survivors are symptomatic and impaired." Survivors carry an elevated, statistically detectable burden of posttraumatic-stress symptomatology and general psychological distress, alongside functional and cognitive resilience that is not meaningfully distinguishable from same-age non-survivor peers.

4.2 RESILIENT VULNERABILITY AS A CLINICAL CONSTRUCT

Several authors (Shmotkin, Shrira, Goldberg, & Palgi, 2011; Diamond & Shrira, 2018) have refined the "resilient vulnerability" construct since Barel et al. (2010). The refinement is that the resilience is real but load-bearing. It is supported by defensive compartmentalization, by selective attention, by role-based identity stabilization (the survivor as parent, worker, community member), and by social and familial structures that have held for decades. As those supports erode with age (through widowhood, retirement, relocation from home to congregate care, onset of cognitive impairment), the compartmentalization weakens, and previously contained traumatic material can resurge (Kellermann, 2009; Palgi, Shrira, Ben-Ezra, Shmotkin, Kavé, & Halevi, 2015).

This late-life resurgence is not a return of suppressed content in a crude sense. It is the loss of the cognitive and social architecture that kept the content at manageable distance. Kellermann (2009) describes comparable clinical presentations in survivor-care settings, and Shmotkin and colleagues (2011) document the intergenerational pattern.

The clinical implication, which the art-therapy record consistently draws, is that proactive intervention before symptom resurgence reaches crisis is preferable to reactive intervention after. Whether art therapy specifically meets this need in a way other interventions do not is a question §5 addresses. That the need exists is well-documented.

4.3 THE CHILD-SURVIVOR COHORT

As of the Claims Conference's 2026 demographic report, approximately 196,600 Jewish Holocaust survivors remain alive globally, with a median age of 87. Approximately 97% were born between 1928 and 1946. Nearly all remaining survivors are therefore "child survivors" in the demographic-cohort sense, having been under 17 at the end of the war (Claims Conference, 2026). The child-survivor cohort differs from the adult-survivor cohort in at least three clinically relevant ways.

First, encoding. Traumatic material experienced before full language acquisition, or before the consolidation of narrative-autobiographical memory, is stored in forms that are constitutively non-verbal. Such material is not merely dissociated from language; it was encoded prior to the developmental availability of language (Kellermann, 2001; Terr, 1991). The Rauch-era neurobiology applies with particular force to this subset.

Second, developmental interruption. Survival in occupied and post-occupied Europe required, for children, a precocious adultification (food-seeking, hiding, silence, dissimulation) at developmental stages that, under peacetime conditions, would have been occupied by play, schooling, and the structured social learning that accompanies them (Keilson, 1992). Clinicians working with this cohort routinely observe a "developmental gap." Survivors in their eighties and nineties who have never held a brush, never made art, may require explicit pedagogical instruction in how to use basic materials (Diamond & Shrira, 2022). Art therapy with this cohort is therefore not only trauma-processing. It is, in part, the restoration of a developmental stage that war prevented.

Third, identity. Child survivors frequently report having had their childhood *taken*. The late-life return to creative play, when supported, is reported in qualitative studies (Israeli, Regev, & Goldner, 2021; Diamond & Shrira, 2022) as experienced by patients as a reclamation, not as a regression. A patient in the Diamond and Shrira (2022) corpus reports that her art "makes me laugh. I feel like a little girl but a happy girl." This is a clinical observation that has diagnostic and prognostic implications for how the intervention is framed to the patient.

4.4 HETEROGENEITY WITHIN THE COHORT

The clinical presentation of Holocaust survivors is heterogeneous along dimensions that matter for intervention. Barel et al. (2010) report that concentration-camp survivors show larger effect sizes on psychopathology than survivors of other Holocaust experiences (hiding, ghetto, forced labor, escape). The reason is over-determined. Duration of exposure, severity of threat, age at exposure, pre-war and post-war protective factors all vary. The clinical consequence is that interventions calibrated to one subgroup may not be calibrated to another.

A commonly drawn clinical distinction is between survivors who required high levels of containment throughout life (often associated with camp experience) and survivors whose defenses were less stringent (often associated with hiding or child-refugee experiences). Published clinical accounts translate this distinction into material recommendations. Camp-experience survivors are frequently described as poorly tolerating fluid, regressive media early in treatment. These patients are said to require the structure of controlled, cognitively engaging tasks (pencils, pre-cut collage) before a shift to fluid media (watercolor, diluted acrylic) becomes clinically indicated (Israeli, Regev, & Goldner, 2021; Keselman, 2020). This is a clinical heuristic, not a tested empirical claim. Its evidence base is the aggregated observation of experienced clinicians, not a randomized design.

4.5 CULTURAL AND LINGUISTIC VARIATION

A final dimension of heterogeneity is cultural and linguistic. The Holocaust-survivor populations in Israel, the United States, Canada, Western Europe, and the states of the former Soviet Union differ in language of origin, in the cultural frame within which they have processed their experience, in post-war resettlement trajectories, and in access to mental-health services. Keselman (2020), describing community-based art-therapy programs with Holocaust survivors from the former Soviet Union in the United States, emphasizes that the stigma around mental-health services in this subgroup is substantial enough to require indirect framings. A “wellness” or “arts” program, instead of a “therapy” program, is often the only framing that permits clinical access. Potash (2022), reflecting on Jewish art-therapy practice, frames cultural and religious literacy as a clinical competence in its own right, not as a contextual ornament.

The implication for intervention design is that a protocol developed and tested in an Israeli context may not transport directly to a FSU-origin community in Philadelphia or to a German-Jewish survivor cohort in New York. Cultural competence at the level of language, religious practice, migration history, and community norms is part of what the clinical work requires.

5. The Empirical Evidence Base

Empirical work on art therapy with Holocaust survivors specifically, as distinct from the broader trauma-and-arts record, is small. This section organizes what exists by study design, reports sample sizes and key findings, and identifies what each design can and cannot support as a claim.

5.1 QUANTITATIVE STUDIES

5.1.1 Diamond and Shrira (2018)

The only peer-reviewed quantitative study in which art engagement is examined as a variable in a Holocaust-survivor sample is Diamond and Shrira (2018), published in *Psychiatry Research*. This cross-sectional study enrolled 154 community-dwelling older adults of European Jewish origin in Israel (mean age 81.67, SD 5.33), distributed across four groups: (1) Holocaust survivors engaged in creative art (n = 26); (2) non-survivor comparison participants engaged in art (n = 27); (3) Holocaust survivors not engaged in art (n = 61); and (4) non-survivor comparisons not engaged in art (n = 40). Art engagement was defined as self-reported current participation in plastic art, music, writing, dance, drama, or "other" creative activity.

Outcomes were PTSD symptomatology (PTSD Checklist for DSM-5, PCL-5), psychological distress (Brief Symptom Inventory-18, BSI-18), resilience (Connor-Davidson Resilience Scale, CD-RISC), subjective successful aging (Attitudes to Ageing Questionnaire), and subjective age.

The pattern of findings runs as follows. On PTSD symptomatology, the main effect of Holocaust background was significant ($F[1,150] = 19.55$, $p < .0001$, $\eta^2 = .115$). Survivors reported higher symptomatology than non-survivors regardless of art engagement, and art engagement was not a significant moderator of this effect. On resilience, the interaction between Holocaust background and art engagement was significant ($F[1,150] = 5.48$, $p = .021$, $\eta^2 = .035$). Holocaust survivors engaged in art reported the highest resilience scores of any group ($M = 2.95$, $SD = 0.92$), significantly higher than Holocaust survivors not engaged in art ($M = 2.18$, $SD = 0.90$), and also significantly higher than both comparison groups. On subjective successful aging, the main effect of art engagement was significant ($F[1,150] = 7.45$, $p = .007$, $\eta^2 = .047$), persisting after adjustment for background covariates.

The study's central contribution is the demonstration that art engagement is associated with the highest resilience in precisely the subgroup (Holocaust survivors) that also reports the highest PTSD symptomatology. In the authors' own framing, this is consistent with a model in which art does not

reduce trauma symptomatology but builds the resilience with which trauma symptomatology is borne. The correlational structure ($r = –0.51$ between PTSD symptoms and resilience, $r = 0.63$ between resilience and subjective successful aging) is consistent with that interpretation without confirming it.

The study's limitations are explicit in the original paper. It is cross-sectional, so causal direction cannot be determined from the data. The art-engagement measure is coarse: duration, frequency, and role of art in the participant's life are not captured. The sample is convenience-based and higher-functioning than the general survivor population. The findings cannot, therefore, be read as evidence that introducing art therapy to a survivor who has not previously engaged with art will raise that survivor's resilience to the level of survivors who have a lifetime of creative engagement. What the study establishes is an association. What it does not establish is a causal or interventional effect.

5.1.2 Campbell et al. (2016)

A directly interventional randomized controlled trial of art therapy in a trauma population exists, though not in a Holocaust-survivor sample. Campbell, Decker, Kruk, and Deaver (2016), published in *Art Therapy: Journal of the American Art Therapy Association*, randomized 15 male combat veterans with PTSD at a U.S. Veterans Affairs facility to either (a) eight individual cognitive processing therapy (CPT) sessions alone, or (b) eight CPT sessions plus eight individual art-therapy sessions. Both groups received concurrent group therapy.

Of the 15 randomized, 11 completed treatment (73%). All five in the CPT-plus-art-therapy group completed (0% dropout) and six of ten in the CPT-alone group completed (40% dropout). Both groups showed significant reductions in PTSD symptomatology (PCL-M) and depression (BDI-II) over time ($p < .001$, $\eta^2 = .80$ for both). The between-group difference on PTSD symptomatology was not significant ($p = .54$, $\eta^2 = .14$). The between-group difference on depression trended toward greater improvement in the art-therapy group ($p = .06$, $\eta^2 = .30$) but did not reach significance.

Two results bear comment. The first is the dropout asymmetry. All participants in the art-therapy group completed treatment. Four of ten CPT-alone participants did not. A 0% versus 40% dropout differential in a trauma trial is a clinically meaningful signal about retention and engagement, even if it does not speak to within-treatment symptom change. The second is the qualitative finding that "all participants who received art therapy stated that they either recovered previously blocked memories or gained insights" relevant to their healing. The trial is small, unblinded, and conducted in a population (male combat veterans) that differs from Holocaust survivors in demographics, trauma type, and age. What it offers is the only randomized evidence available that art therapy added to an evidence-based verbal trauma treatment may support retention and may yield clinically meaningful process benefits. It does not offer evidence of superior symptom reduction.

5.1.3 Hass-Cohen et al. (2018) four-drawing protocol

As described in §3.3, Hass-Cohen and colleagues (2018) report a mixed-methods pilot of a structured four-drawing protocol for trauma and resiliency. The pilot is conducted with non-clinical adults reporting recent adverse events, not with a Holocaust-survivor sample. It does not include a control group. It does report statistically significant decreases in trauma-effect ratings and negative-affect endorsement, maintained at follow-up, and increases in endorsed resiliency resources.

The pilot is methodologically more rigorous than most in the art-therapy trauma record, and the protocol is manualized, making it a candidate for future controlled testing. For the present review, it is relevant as (a) the most carefully specified protocol in the ATR-N tradition, and (b) evidence that art-therapy protocols can produce statistically detectable affective and resiliency changes under pre-post design even in non-clinical populations.

5.2 QUALITATIVE AND PHENOMENOLOGICAL STUDIES

5.2.1 Diamond and Shrira (2022)

Diamond and Shrira (2022), published in *Psychology of Aesthetics, Creativity, and the Arts*, report a phenomenological interview study of 30 self-identified Holocaust-survivor artists. The study is qualitative, using semi-structured interviews analyzed under a phenomenological paradigm. Three themes are reported:

1. *Art as a holding space where subjective inner states are seen and valued.* Participants describe the creative process as affording a form of witnessing that their post-war social environment did not provide. For many survivors, the decades following 1945 involved being positioned through the "sheep to the slaughter" trope (*ke-tson la-tevaḥ*). The phrase originates in Abba Kovner's Vilna-ghetto manifesto of late December 1941, first read publicly on January 1, 1942. It was a call *against* passivity. In the decades after the war it was redeployed in Yishuv and early-Israeli discourse as an accusation against survivors (Segev, 1993; Solomon, 1995; Yablonka, 1999), and was not read as the resistance call it originally was. The survivor-as-subject-with-complex-inner-life that Diamond and Shrira's interviews recover is therefore a reclamation against a specific historical mis-hearing, not against inattention alone.
2. *Art as a safe space where traumatic memories may be exposed.* Participants describe art-making as a setting in which traumatic material can be approached, often indirectly through symbol, without the protective failure that direct verbal confrontation would risk.
3. *Art as a holding space enabling creative exploration and enjoyment.* The creative space is not reducible to trauma-processing. It is also reported as a site of aesthetic pleasure, mastery, and identity independent of survivor status.

The study is qualitative and phenomenological. It makes no claims to generalizable causal inference and is appropriately cautious about doing so. Its contribution is in specifying the subjective experience through which the interventional mechanisms of art therapy (as theorized in §3) are reported, phenomenologically, to operate.

5.2.2 Israeli, Regev, and Goldner (2021)

Israeli, Regev, and Goldner (2021), published in *The Arts in Psychotherapy*, report a qualitative study of art therapy with older Holocaust survivors conducted at the University of Haifa's School of Creative Arts Therapies. Five survivors (four women aged 80–88; one man aged 95) and their three art therapists completed semi-structured interviews addressing the meaning, challenges, and characteristics of art therapy for this population. Thematic analysis identified the functions of art in the therapeutic work, the notable absence (and selective presence) of Holocaust imagery in the artwork produced, and the distinctive intergenerational dynamics that arise when — as is common in Israeli practice — the therapist is herself a second- or third-generation Holocaust descendant.

The "absence of the Holocaust" finding is clinically consequential. Participants routinely produced artwork that avoided direct Holocaust representation, choosing flowers, landscapes, nature, and family scenes. They explicitly declined, in interviews, to use colors (black, in particular) that they associated with wartime experience. The therapists and researchers interpret this as a deliberate strategy of symbolic mastery rather than avoidance: patients exerting control, within the therapeutic frame, over the imagery produced, and thereby over the psychic material that imagery activates.

The study is small (n = 5 patients, 3 therapists) and qualitative. Its clinical utility is in specifying what practicing art therapists and their Holocaust-survivor patients report about the intervention's mechanism and in raising questions that future research can test quantitatively.

5.3 CASE STUDIES AND PROGRAM DESCRIPTIONS

5.3.1 Kastner (2018)

Kastner's (2018) case study, published by the Claims Conference's *Kavod* journal, describes art-therapy work with "Mrs. A," an aging Holocaust survivor with stroke-related dementia and right-hand paralysis whose pre-stroke identity included substantial engagement with painting. The intervention was a home-based "Friday painting club" using watercolor, Mrs. A's pre-illness preferred medium.

Kastner reports clinical observations consistent with the theoretical accounts in §3: restoration of identity as "artist" instead of "patient"; verbal disclosure of family-conflict and migration content during painting that did not occur in ordinary conversation; softening of affect during engagement with art objects the patient had collected with her late husband; and use of the painting session as a space under the patient's control, distinct from the care environment otherwise organized around her. Kastner is explicit that the approach was process-oriented, not product-oriented.

As a single-case report, Kastner (2018) cannot support causal inference. It is cited here because it is one of a small set of published accounts that documents in clinical detail what art therapy with a Holocaust survivor with significant geriatric comorbidity actually looks like, and what a skilled clinician's observations of response look like.

5.3.2 Keselman (2020)

Keselman's (2020) program description, also published in *Kavod*, describes a community-based art-therapy program with Holocaust survivors from the former Soviet Union at a wellness center in Philadelphia. Program participants were not individually enrolled patients in a clinical trial. They were members of a community-wellness program who elected to participate in arts-based groups.

The "Family Album Project" combined photograph-based life review with digital album construction. Keselman reports multiple case examples of participants using the album process to address previously unspoken family-history content (Holocaust losses, post-migration occupational demotion, transgenerational silence) through a medium that community participants experienced as less stigmatizing than mental-health framing would have permitted. Keselman is explicit about the program-level limitations. The non-clinical framing is a necessary accommodation to a population in which the stigma of psychiatric or psychotherapeutic framing would have prevented engagement at all.

The program description is not an outcome study. It is a demonstration of how clinical principles (holding environment, indirect symbolic engagement, material titration, intergenerational framing) translate into community-program structure when the clinical frame itself is not available to the participants.

5.4 THE DICKER-BRANDEIS HISTORICAL PRECEDENT

A review of art therapy with Holocaust survivors is incomplete without serious acknowledgment of the Terezín-ghetto work of Friedl Dicker-Brandeis (1898–1944). Trained at the Bauhaus in Weimar under Johannes Itten, Paul Klee, and Lyonel Feininger, and formed by the child-centered art pedagogy of Franz Cižek in Vienna, Dicker-Brandeis was deported to the Terezín (Theresienstadt) ghetto in December 1942 and to Auschwitz-Birkenau in October 1944, where she was murdered (Makarova, 1999; Wix, 2009).

During her nearly two years in Terezín, Dicker-Brandeis organized art classes for the imprisoned children of the ghetto. Volavková's (1959/1993) collection and Makarova's (1999) biographical study document a pedagogy that was neither ad hoc nor merely consolatory. Dicker-Brandeis adapted Cižek's emphasis on children's creative autonomy (the child as originator of visible form, not as recipient of adult instruction) to the specific psychic conditions of ghetto life. Still-life drawing from ordinary objects (a bowl, a flower) served as counter-practice against the hyper-stimulation of deportation and hunger. Systematic attention to color and composition built interior attention where external conditions were overwhelming. Memory and imagination were cultivated explicitly in children whose present environment

was designed to erase both. Wix (2009) characterizes the practice as “aesthetic empathy”: pedagogy directed at the restoration of the child’s capacity for perception and intention, and not at the production of art objects as such.

Before her deportation to Auschwitz, Dicker-Brandeis packed approximately 4,500 of the children’s drawings into two suitcases, which she entrusted to Raja Engländerová, a fellow prisoner, before leaving Terezín. Engländerová kept the suitcases through the remainder of the war. After liberation they were transferred to Willy Groag, director of the Girls’ Home L 410 in Terezín and a pedagogical colleague who had also survived. Groag conveyed them to the Jewish Community in Prague. The collection is now held at the Jewish Museum in Prague, where the bulk of the drawings remain. Selected works have been reproduced in Volavková (1959/1993) and exhibited internationally.

Dicker-Brandeis is not an originator of art therapy in the professional-discipline sense, since the profession postdates her death by decades. Her Terezín practice is the discipline’s most direct historical antecedent. The pedagogical specificity of that practice (Cižek-derived, memory-attentive, psychically purposive) informs the clinical intuition, formalized much later, that art-making under extremity can serve psychological functions the circumstance itself would otherwise deny.

5.5 WHAT THE EVIDENCE BASE SUPPORTS

Taken together, the published record supports a cautious, specific set of claims:

1. Creative-art engagement is positively associated with resilience in aging Holocaust survivors at the cross-sectional level, with an observed effect size in the modest-to-moderate range, in a single peer-reviewed study (Diamond & Shrira, 2018).
2. A directly interventional randomized trial of art therapy in a Holocaust-survivor population has not been published.
3. The one RCT of art therapy in an adjacent trauma population (Campbell et al., 2016) shows no superior symptom reduction over an evidence-based verbal treatment, but a substantial retention advantage and qualitatively consistent process benefit.
4. Qualitative and phenomenological work (Diamond & Shrira, 2022; Israeli, Regev, & Goldner, 2021) supports the theoretical accounts in §3 as phenomenologically recognizable to patients and therapists.
5. Case-study and program accounts support the clinical translatability of the theoretical frameworks across settings (home-based, community-based, eldercare-based), across survivor subgroups (camp, hiding, post-war refugee; FSU-origin, Israeli-origin, US-origin), and across comorbidities (dementia, stroke, depression).

The evidence does not support any confident statement of superiority over verbal modalities, any specific dose–response claim, or any generalizable effect-size estimate for Holocaust-survivor populations. The record supports adoption. It does not support complacency.

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6. Clinical Practice Frameworks in Application

Translating the theoretical and empirical work reviewed above into clinical practice requires specification at several levels: material choice, session structure, modality (group vs. individual), time-framing, and the management of therapist-patient dynamics. This section describes the dimensions along which art therapy with Holocaust survivors is clinically specified. It identifies where clinical writing is consistent, where it varies, and where it is empirically underdetermined.

6.1 MATERIAL SELECTION AS CLINICAL DECISION

The Expressive Therapies Continuum (§3.1) grounds a broadly consistent logic about material choice. Four material classes and their clinical roles are identified in the published accounts (Hinz, 2020; Israeli, Regev, & Goldner, 2021; Keselman, 2020):

Controlled media (pencils, fine-tip markers, pre-cut collage imagery) engage primarily perceptual and cognitive processing. They provide gradual entry to art-making for patients who require high structure, whose defensive organization depends on control, or who (in the child-survivor cohort) have no prior experience with art materials at all. For survivors of camp experiences, controlled media are frequently recommended as the initial default (Israeli, Regev, & Goldner, 2021).

Fluid media (watercolor, diluted acrylic, wet inks) engage perceptual/affective processing and permit a softer, more emotionally mobile expression. They are typically introduced later in the treatment arc and often not introduced at all for patients whose tolerance for affective mobilization is low.

Regressive or sensorimotor media (clay, modeling compounds, fingerpaint) engage kinesthetic/sensory processing and provide the most direct route to body-based experience. They are also the media with the highest potential for inducing sympathetic arousal. Clinical writing is explicit that these media are introduced only when the patient is ready, and that readiness cannot be assumed from interest or curiosity alone (Hinz, 2020; Lusebrink & Hinz, 2016).

Reconstructive media (photographic and printed-image collage) reduce the barrier to participation for patients who feel untalented, are perfectionistic, or cannot engage with blank material. They also support life-review and narrative-assembly tasks with particular cohort relevance, as in the Family Album Project (Keselman, 2020).

Material choice in this framework is a clinical titration variable, not a preference accommodation. Its rationale is that the level of processing engaged by the material must be matched to the level of processing the patient can presently tolerate and integrate.

6.2 GROUP VERSUS INDIVIDUAL MODALITIES

Most published clinical art-therapy work with Holocaust survivors is group-based (Israeli, Regev, & Goldner, 2021; Keselman, 2020; Abraham, Snir, & Regev, 2026). The group format offers several clinical advantages with this population. It permits social witnessing, a survivor's work seen by peers whose experience resembles her own, of a kind that is specifically valuable given the historical experience of social silence around survivor testimony in the post-war decades (Solomon, 1995). It reduces the sense of individual exposure that a one-to-one setting can intensify. And it permits economies of clinical coverage for populations in which individualized care may not be accessible.

The disadvantages are also real. Group settings reduce the depth of any individual engagement with the clinician. They place constraints on the kind of content that can be surfaced. They require group-dynamic competence that not all trauma-informed art therapists possess. For some patients (those with severe personality-structure difficulties, those whose trauma is bound up with group experience such as camp settings, or those in acute crisis) individual work is clinically indicated.

The choice between group and individual work is not, in the available guidance, fully routinized. It is a clinical judgment, made on the basis of the individual patient's capacity for group tolerance, the nature of the material to be engaged, and the resources of the setting.

6.3 TIME-LIMITED STRUCTURES

A growing subliterature addresses time-limited art therapy specifically (Abraham, Snir, & Regev, 2026). Time-limited work is often the only structure available in community and eldercare settings, where open-ended individual psychotherapy is resource-infeasible. Group supervisors and practicing art therapists interviewed in this subliterature describe time-limited work as requiring: (a) greater early-session investment in frame-setting and safety, (b) more directive clinical decision-making about what to introduce when, (c) explicit termination planning from session one, and (d) close attention to what can realistically be achieved in a compressed arc.

The clinical question whether a two-session, six-session, or twelve-session art-therapy engagement is sufficient for the kind of processing the frameworks in §3 describe is empirically unresolved. There is no dose-response evidence for art therapy with Holocaust survivors. The pragmatic answer is that time-limited work produces discernible benefit on qualitative measures, as documented in the TLAT subliterature, and that finding is empirically supported. The stronger claim that time-limited work is sufficient for the deeper processing goals associated with Herman-stage trauma treatment is not.

6.4 THE INNER-WITNESS FUNCTION AND COUNTER-TRANSFERENCE

Across clinical writing in this area, the therapist's role with Holocaust-survivor patients is characterized not only as technical administration of an intervention, but as the *witnessing* of testimony that may never have been witnessed before. The "inner-witness" framing (Israeli, Regev, & Goldner, 2021; Diamond &

Shrira, 2022) is a specific instance of the holding-environment idea. The therapist holds the organizing function for material the patient cannot yet integrate into self-narrative, and the integration process depends on the holding as much as it does on the drawing.

Counter-transference in this setting is unusually specific. The therapist's own relation to Jewish history, to family Holocaust exposure (if any), to the patient's country of origin, and to the political questions surrounding Holocaust memory is clinically present whether or not it is explicit. §8.3 treats the specific counter-transference dynamics of second- and third-generation-descendant clinicians working with first-generation survivor patients in more detail. For the purposes of the present section, the point is that clinical supervision in this work is not a discretionary professional courtesy. It is an operational requirement.

6.5 "ABSENCE OF THE HOLOCAUST" AS CLINICAL ACHIEVEMENT

One of the more theoretically charged findings of the qualitative record is the consistent observation that survivor artwork, produced under clinical conditions, frequently avoids direct Holocaust imagery. Flowers, nature, landscapes, domestic scenes, and in some work religious imagery (the Western Wall in Israeli samples, synagogue interiors in others) dominate. Black is avoided. Chaos is structured.

The interpretive question is whether this pattern represents clinical failure (avoidance of therapeutically indicated processing), clinical success (symbolic mastery of traumatic content at a safe remove), or an empirical middle ground. The Israeli-Jewish clinical writing (Israeli, Regev, & Goldner, 2021; Diamond & Shrira, 2022) is consistent in reading the pattern as success, as a form of transformation of traumatic content rather than flight from it. Langer's (1991) distinction between "deep memory" and "common memory" in Holocaust testimony is relevant here. The imagery a survivor declines to produce in a clinical studio is not absent from deep memory. It is being held in the defensive organization that common-memory speech-and-image has constructed around it. The phenomenological evidence supports that reading. Patients describe the choice of bright colors and non-Holocaust imagery as victory, not avoidance, and as a refusal to be defined by darkness rather than flight from it.

This reading is defensible, but it is an interpretive commitment and should be labeled as such. An alternative reading is also defensible. Clinical conditions may themselves favor the production of non-Holocaust imagery, and deeper work on directly Holocaust-related material may require more intensive, longer-form, individually calibrated treatment not currently available in most settings. The existing data do not, to this author's knowledge, adjudicate between the two readings.

7. Session Administration: Best Practices from the Clinical Literature

7.1 SCOPE AND FRAMING

The preceding sections have described the theoretical frameworks under which art therapy with Holocaust survivors is conducted, the clinical population it serves, the empirical base that supports it, and the interpretive debates that remain open. The practical question a clinician, supervisor, program director, or funder asks has not yet been addressed: *what does competent administration of an art-therapy session with a Holocaust-survivor patient actually look like?* This section synthesizes that guidance from the published practice literature.

Three framing commitments inform what follows. The first is the American Art Therapy Association's *Ethical Principles for Art Therapists* (AATA, 2013), the current version posted by AATA as of this writing and the document to which the Association binds its members. It establishes the discipline's baseline requirements for responsibility to clients, confidentiality and records, dual-relationship management, and cultural responsiveness. The second is the Art Therapy Credentials Board's *Code of Ethics, Conduct, and Disciplinary Procedures* (ATCB, current edition), which governs conduct for ATR-BC and ATCS credential holders and specifies supervision obligations in more granular form than AATA's principles do. The third is the Substance Abuse and Mental Health Services Administration's trauma-informed-care framework (SAMHSA, 2014). Its six principles (safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender considerations) specify the interpersonal and institutional register within which session administration with any trauma-exposed population must operate.

The six SAMHSA principles are not merely invoked as a slogan below. The session-administration subsections that follow operationalize each. *Safety* is addressed in §7.2 (physical environment) and §7.3 (process consent, arrival ritual). *Trustworthiness and transparency* is addressed in §7.3 (explicit session-structure disclosure) and §7.5 (artifact-disposition agreement made at intake, not at closure). *Peer support* is addressed in §7.4 (group-modality considerations) and the broader group-versus-individual discussion in §6.2. *Collaboration and mutuality* is addressed in §7.3 (task negotiation by offer, not prescription) and §7.6 (care-team coordination). *Empowerment, voice, and choice* is addressed throughout §7.3 and in §10.4 (the right to decline). *Cultural, historical, and gender considerations* is addressed most directly in §10.2.

The guidance that follows is a synthesis, not a protocol. It is organized around the temporal phases of a session cycle and, separately, around institutional-regulatory context and common comorbidity adaptations. It is explicitly not a substitute for credentialed clinical judgment, ongoing supervision, or population-specific training. It is also not a directive about which clinical framework (ETC, ATR-N, bilateral-art, holding-environment) a practitioner should operate under. The section assumes the practitioner has made that choice and is working from some coherent framework.

7.2 PRE-SESSION: ENVIRONMENT, MATERIALS, LOGISTICS

Space. The physical environment of an art-therapy session is a clinical variable, not an administrative afterthought. Privacy matters particularly with this population. Patients will not disclose wartime content within earshot of strangers, and the default eldercare facility "activity room" is often inadequate. Lighting affects arousal. Natural light where possible is preferable, and some survivors report fluorescent lighting as dysregulating in ways they cannot always articulate. Seating should be comfortable for sustained work by an aging body and should permit orientation to exits. A survivor who cannot see the door may feel physiologically trapped regardless of the therapist's assurance.

Session length. The 45–50-minute session common in insurance-reimbursed psychotherapy is, in this work, an awkward fit. Sixty- to ninety-minute sessions are more typical in the clinical-practice writing (Hinz, 2020; Malchiodi, 2020), allowing adequate time for opening, sustained art engagement, and proper closure. However, 90 minutes may exceed the attentional and physical capacity of frail survivors, particularly those with fatigue disorders or cognitive impairment. Session-length calibration is therefore patient-specific, conservative by default, and responsive to observed stamina rather than to scheduling convenience.

Materials. Kit selection follows the ETC logic described in §6.1: controlled media for high-containment entry, fluid media when affective mobility is appropriate, regressive media with care. The kit also carries operational considerations: allergen screening (solvent-based paints, certain pastels), adaptive grips for motor impairment, high-contrast surfaces for visual impairment, and substitutions for the specific color avoidances that some patients exhibit (black most commonly, certain reds in camp-survivor populations). Materials should be laid out before the patient enters, with an excess available so that selection itself becomes part of the clinical offer.

Facility and infection considerations. Many eldercare settings restrict materials on infection-control grounds (shared water containers, clay, fingerpaint) or on facility-maintenance grounds (charcoal, certain inks). These restrictions are real and require session planning that works within them rather than around them. A practitioner entering a new facility should meet with facility management before the first session to clarify permissible materials and cleanup expectations.

Documentation. Pre-session preparation includes readying documentation appropriate to the practice setting. The AATA Ethical Principles (AATA, 2013, Principle 2.7, within the Confidentiality section) specify that art therapists maintain treatment records for a reasonable period consistent with federal, state, and institutional laws, stored or disposed of in ways that maintain confidentiality. For art therapy specifically, documentation has an additional dimension: the artwork itself. A decision about whether and how the artwork will be recorded (photograph, retained original, returned to patient) should be made before the first session and confirmed with the patient at intake. It should not be addressed reactively at closure.

7.3 OPENING: GROUNDING, PROCESS CONSENT, TASK NEGOTIATION

Arrival and ritual. Ritual is not decorative in trauma-informed work; it is regulating. The same greeting, the same seat, the same presentation of materials at each session provides a predictable environment that reduces the autonomic load of entering the clinical space. For patients with cognitive impairment, ritual carries additional weight: the sequence itself may be what is remembered even when session content is not.

Process consent. The consent obtained at intake is not the only consent that matters. Dewing's (2007) process-consent framework holds that consent must be renewed across the course of participation, with observable assent and dissent treated as meaningful. That framing applies with particular force to this population. In practice, this means a brief, explicit check at the start of each session ("Is today a good day to continue our work?"), and a responsiveness to non-verbal signals throughout (body turning away from materials, verbal deflection, flat affect) that reads assent or dissent from behavior in addition to the prior written document.

Check-in. The opening of the session should include brief inquiry into recent sleep, pain, medication changes, and mood; awareness of calendrical context (Yom HaShoah and the surrounding week, anniversaries of deportations or family deaths, religious calendar events); and inquiry into any recent family events — loss, contact with estranged relatives, news from the country of origin. These factors condition what the session can hold and whether the originally planned task remains appropriate.

Task negotiation. Instead of prescribing a task, the clinician typically offers options (materials, subject prompts, or open invitation) and the patient selects or declines. The material-titration logic from §6.1 is operationalized here. A patient visibly dysregulated at opening is offered controlled materials and structured prompts. A patient arriving settled may be offered more fluid options. The offer is accepted or declined without the clinician's attachment to either outcome.

7.4 DURING THE SESSION: PACING, DISSOCIATION, SYMBOLIC DISTANCE

Pacing. The clinician's task during the session is to titrate between cognitive engagement (talking about the work, naming choices, making meaning) and affective-sensorimotor flow (allowing the patient to stay in the material without interruption). Pacing signals include breathing rate, shoulder and facial tension, eye movement and tracking, and the rhythm of the patient's own hand on the surface. Competent practitioners read these signals continuously and shift their verbal-vs-quiet balance accordingly.

Dissociation. Dissociation in this population is common, familiar, and not in itself a clinical emergency. For some patients, it is the established defensive organization that has kept them functional for decades. The Lanius et al. (2010) dissociative-subtype framework should inform how dissociation is read at the table. Glazed gaze, loss of response to verbal prompts, motor freezing, or sudden withdrawal may be the patient's characteristic way of managing overload, and not decompensation requiring urgent response. The clinician's task is not to pull the patient out immediately, but to provide safe holding (verbal grounding, continued presence, offer of water or a change of posture) until the patient returns, which most do.

Symbolic distance. §6.5 described the clinical debate about whether indirect, non-Holocaust imagery represents avoidance or mastery. At the session-administration level, the practical heuristic is that indirect symbolic expression should be honored as the patient's chosen distance. It should be named only when the symbolic distance appears to be collapsing into overwhelm, when the image itself is producing dysregulation that the patient cannot metabolize within the frame. In that moment the clinician may name what the image is holding and support containment. Short of that, staying with the symbol is the default.

Somatic regulation. Non-verbal regulation tools (grounding through contact with the chair, slower breathing, a sip of water, brief standing and return) should be available to offer without disrupting the frame. Porges's polyvagal work (Porges, 2011) and Craig's interoceptive-regulation research (Craig, 2009), described in §2, are the theoretical base for these practices. Bilateral rhythmic movement (alternating-hand strokes, pendulum drawing) can be offered when appropriate (McNamee, 2003; Talwar, 2007).

Disclosure of traumatic content. A patient may disclose traumatic material directly in the session, verbally, in the image, or in an association that suddenly surfaces. The appropriate response is the appropriate response to any trauma disclosure. The clinician receives, does not probe, helps stabilize, and does not treat the disclosure as a breakthrough that demands further excavation. The disclosure itself is clinical material. What the patient does next is the patient's to decide.

Group settings. In group work (§6.2), one member's disclosure can destabilize others through cascade effect. Competent group-leadership practice in this population includes monitoring the rest of the group during any one member's engagement with difficult content, providing grounding for other members as needed, and holding the frame that permits members to leave the work temporarily without leaving the group.

7.5 CLOSURE: TRANSITION, ARTIFACT, AFFECT CHECK

The closure phase is the most-often-neglected part of session administration and the most clinically consequential for patients who will be returning to an institutional environment (nursing home, eldercare facility) that does not know what they have just done.

Transition. Five to ten minutes before the scheduled end, the clinician shifts register: verbal pacing slows, sensory intensity is reduced, the patient is helped to return to present-moment awareness. This is not rushing the patient toward an exit; it is the active work of rebuilding the interface between session space and outside space.

Put-away ritual. The physical act of putting materials away has regulatory function. For patients with cognitive impairment (Chancellor, Duncan, & Chatterjee, 2014), the sequence of put-away also serves as orientation — the body knowing the session is ending even when the verbal-declarative memory does not yet register.

Artifact disposition. At session end, the artwork is addressed — stored in the session folder, photographed for the record, returned to the patient, or taken for display (per pre-agreed protocol). The decision should have been made at intake and confirmed at the start of the session; it is not a spontaneous closing negotiation.

Affect check. A brief explicit inquiry at end — "Where are you now? Is there anything you need before you leave?" — allows the clinician to identify a patient who has not returned to a pre-session baseline and to respond accordingly (extended closure, hand-off to a staff member, scheduled check-in, or, in rare cases, referral).

7.6 BETWEEN SESSIONS: DOCUMENTATION, SUPERVISION, SELF-CARE

Documentation. Session notes, per AATA (2013) standards, include date, attendance, materials used, summary of session content, the patient's affective trajectory, and any clinically significant observations. For art therapy, the artwork itself is part of the record — whether retained, photographed, or described. HIPAA governs image-based records; programs handling such records should have explicit policies addressing storage, access, and destruction.

Supervision. Supervision is not optional for work with this population. AATA (2013, Principle 1.7) and the ATCB *Code of Ethics, Conduct, and Disciplinary Procedures* jointly specify the practitioner's obligation to seek consultation in the presence of personal or clinical difficulty. The vicarious-traumatization literature (§7.6 below) further supports the claim that ongoing supervision is structurally protective, not discretionary. Supervision is the context in which counter-transference is processed, in which emerging clinical judgments are tested, and in which the clinician's own reactions to material of historical significance are contained. The second- and third-generation-clinician considerations raised in §6.4 and §10.5 apply with particular force. Supervision should be conducted with a supervisor who is either experienced with this population or explicitly engaged with the generational dimensions of the work.

Self-care and vicarious traumatization. Figley (1995) and Pearlman and Saakvitne (1995) describe vicarious traumatization and compassion fatigue as cumulative effects of sustained engagement with traumatized clients. These are not optional occupational risks but predicted outcomes absent structural prevention. For art therapists working with Holocaust survivors, the protective structures are the same as for any trauma-oriented practice: caseload limits, peer consultation, personal therapy, attention to somatic and cognitive markers of cumulative stress, and, perhaps especially, the practitioner's own creative practice as a site of restoration in its own right, not only as a clinical tool.

Care-team coordination. Survivors in eldercare or community-wellness programming are typically under the care of multiple providers (primary care, psychiatry, social work, family). Coordination is a clinical-ethics obligation, not a courtesy. Care-team communication should be organized around the patient's interest, conducted with explicit consent, and documented.

7.7 TERMINATION: PLANNED, UNPLANNED, ARTIFACT TRANSITION

Planned termination. Time-limited work (§6.3) defines its end at session 1 and walks toward it structurally. Even in open-ended work, termination is named, prepared for, and held as a distinct phase, typically the final three to five sessions, during which the work shifts explicitly toward integration, artifact review, and transition.

Unplanned termination. With this population, unplanned termination is not rare. Death, hospitalization, rapid cognitive decline, and facility transfer are regular occurrences. The clinician should have a protocol for each before the first session. The elements include notification of the patient's family (where consent permits), disposition of the artwork (per the patient's wishes if documented, or to the family if not and if not otherwise constrained), closure for the therapist's own experience (in supervision, not alone), and, where a group modality is involved, explicit work with remaining group members.

Artifact disposition at termination. The disposition question introduced at intake is revisited at termination. The patient who can still participate in the decision does so. The patient who cannot has the decision made on her behalf by the protocol established at intake. Posthumous disposition (including any question of archival use or classroom display) is governed by the consent framework described in §10.3.

The clinician's grief. The death of a patient, in this work, is expected and frequent. Grief is a clinical reality for the practitioner, and protected time for it — in supervision, in peer consultation, in the practitioner's own personal practice — is part of sustainable engagement with this population.

7.8 INSTITUTIONAL AND REGULATORY CONSIDERATIONS

Ethics and licensure. The AATA Ethical Principles (AATA, 2013) and the ATCB *Code of Ethics, Conduct, and Disciplinary Procedures* (current edition) together govern credentialed practice. ATR-BC and ATCS credential holders are bound by the ATCB *Code* as a condition of credentialing and must report ethical violations within the timeframe specified in the *Code*. State licensure for art therapy has shifted materially since the early 2010s. As of 2025–2026, direct art-therapy licensure or title-protection is in place in approximately fifteen U.S. states (with AATA's state-advocacy initiative tracking further legislative activity), and art therapists in non-licensing states typically practice under related credentials (licensed professional counselor, licensed creative-arts therapist, licensed mental-health counselor, licensed social worker). Practitioners are responsible for knowing which regulatory frame governs their jurisdiction and for documenting their practice to that frame's standards. Liability-insurance coverage and scope-of-practice clarity both turn on this question.

Reimbursement. Medicare, Medicaid, and commercial insurance reimbursement for art therapy is variable and often constrained. Where reimbursement drives session length, the constraints must be accommodated without compromising clinical integrity. Where they cannot be reconciled, the practitioner's ethical obligation under AATA (2013, Principle 1.0, Responsibility to Clients) is to the welfare of the client, not to billing convenience.

Institutional settings. Eldercare and long-term-care facilities have their own regulatory frameworks (CMS regulations in the United States; equivalent bodies elsewhere), infection-control requirements, and documentation integration requirements. A practitioner working in these settings should establish working relationships with nursing leadership, social work, and activity staff — not around the clinical frame (which remains confidential) but around logistical coordination.

HIPAA and image-based records. The image-based record is a category that standard HIPAA guidance does not fully anticipate. Several predictable compliance failure modes merit explicit attention. Photographs of artwork containing the patient's face, an identifying tattoo, or recognizable autobiographical content are Protected Health Information under 45 CFR § 164.514, and are not reliably de-identified by removing the name caption alone. Digital photographs taken on a clinician's personal

device commonly auto-back-up to consumer cloud services (iCloud, Google Photos, Dropbox), which typically do not satisfy HIPAA business-associate requirements. Programs should require that photographic documentation use program-owned devices with cloud-sync disabled and with encrypted transfer to a compliant record system. Retention periods for treatment records are governed by state law and typically run six to seven years post-termination for adult records (longer for minors). Retention of the artwork *itself* is not automatically bounded by the treatment-record clock. Programs retaining original artwork must set and document their own retention rules, reviewed against the consent obtained at intake.

Mandated reporting. Art therapists working with elderly populations in the United States are mandated reporters under state adult-protective-services statutes. Suspected elder abuse, neglect, or financial exploitation (including concerns that arise through observation of the patient, through the content of the artwork, or through disclosure in session) triggers a statutory reporting obligation in most jurisdictions, not a discretionary clinical judgment. Practitioners should know their state's specific mandated-reporting thresholds and contact procedures before the first session with a patient in an eldercare or community-wellness setting.

Crisis protocol. §7.4 addresses within-session dissociation and §7.5 addresses the patient who has not returned to baseline at closure. A written crisis protocol belongs in program-level documentation, not in individual clinical memory. Such a protocol should specify escalation thresholds, on-call contacts, the specific pathway into psychiatric emergency services in the setting where the practitioner works, and coordination with facility nursing or family in the event of acute distress. For community-based programs, the protocol additionally specifies what happens when the patient is in her own home and distressed after the clinician has left.

Telehealth and remote sessions. A non-trivial fraction of art-therapy work with geographically distributed survivor populations has shifted to video-mediated session formats since 2020. Telehealth art therapy has specific considerations that in-person practice does not. Materials must be supplied to the patient in advance, which raises the operational question of who assembles and ships the kit, and with what consent procedures. The therapist's capacity to observe somatic and environmental signals is reduced and therefore requires explicit in-session check-ins that compensate. Privacy at the patient's end is not always within the clinician's control, particularly in congregate settings. The consent, documentation, and HIPAA considerations described above apply *a fortiori* when video recording, screen sharing, or image transfer are involved. The manuscript's other §7 subsections assume in-person session administration. The remote-session adaptations of each belong in a program-specific telehealth protocol, not in this general guidance.

7.9 COMORBIDITY-SPECIFIC ADAPTATIONS

Dementia. The dementia evidence on art therapy (Chancellor et al., 2014) documents preserved art-making capacity well into moderate impairment and suggests that engaged art-making can support attention, reduce neuropsychiatric symptoms, and improve social behavior in this population. Clinically, adaptations include familiar materials as the default (the patient's pre-illness preferred medium if identifiable), shorter sessions, greater reliance on ritual and structure, acceptance of day-to-day cognitive variability, and particular attention to put-away ritual as an orientation cue.

Motor impairment. Stroke-related hemiparesis, arthritis, Parkinsonian tremor, and generalized frailty all affect the mechanical capacity for art-making. Adaptations include built-up grips, larger and heavier tools that provide proprioceptive feedback, seated work with surface height adjustment, and, for patients with unilateral motor loss, explicit bilateral alternatives that permit the impaired limb to participate (even passively) in place of being excluded.

Sensory impairment. Low vision, hearing impairment, and peripheral neuropathy each require modality-specific adaptations. Low vision calls for high-contrast materials and tactile cueing. Hearing impairment calls for written check-ins and visual-field organization. Neuropathy calls for tools that provide sensory feedback at reduced intensity.

Psychiatric comorbidity. Depression, prolonged grief, and late-onset anxiety are common in this population and interact with trauma symptomatology in ways that affect session administration. The clinician's response is not to abandon the trauma-informed frame for a depression-focused one. It is to integrate the two, recognizing that art therapy with a depressed survivor may need to attend to motivation and engagement in ways that a non-depressed survivor does not require.

Three comorbidities merit specific attention beyond the general integration point. First, *suicide risk* in Holocaust-survivor populations is elevated relative to age-matched peers, with Barak and Shrira's work and the broader Holocaust-psychiatry record documenting increased rates of suicidal ideation and completion in aging survivor cohorts. Competent session administration includes routine suicide-risk screening at intake and re-assessment at clinically indicated intervals. Content that surfaces in art (pervasive themes of hopelessness, completed action, finality) should be treated as potential risk signal, not as purely symbolic. Escalation pathways are specified in the crisis protocol described in §7.8.

Second, *substance-use comorbidity* is under-diagnosed in older adults generally and in this population in particular. Practitioners should not assume absence on the basis of chronological age. Alcohol use, sedative-hypnotic dependence (particularly long-standing benzodiazepine prescriptions in trauma-exposed older adults), and recent initiation of sedative medication during grief are all clinically relevant to session engagement. Screening through the care team, not through direct in-session inquiry, is usually the appropriate pathway.

Third, *psychotropic-medication interactions with art-making capacity* are clinically underappreciated. Regular benzodiazepine use (lorazepam, clonazepam) can flatten affective engagement with material. Low-dose antipsychotics (quetiapine, prescribed for sleep or agitation in many eldercare facilities) can produce motor slowing that patients interpret as personal failure. Anticholinergic burden from commonly co-prescribed medications can produce the same cognitive-dulling patients may attribute to dementia. The clinician cannot prescribe or alter medication, but can recognize medication-related presentations, document them, and coordinate with the prescribing provider.

7.10 WHAT THIS GUIDANCE DOES NOT SUBSTITUTE FOR

The preceding subsections synthesize what the practice literature specifies about competent session administration. They are not a protocol that can be followed in place of credentialed clinical training, licensure, ongoing supervision, and direct experience with the population. Every item of guidance above is subject to clinical judgment in the individual case, and the clinician's judgment is the proper authority over the protocol rather than the other way around.

A further limitation is that this guidance is population-adjacent, not fully population-specific. The Holocaust-survivor-specific practice record is thin (§5). Much of what is compiled here derives from the broader trauma-informed art-therapy literature (Hinz, 2020; Malchiodi, 2020; Hass-Cohen & Findlay, 2015) with the population-specific considerations of §§4, 6, and 10 layered on top. A fully population-specific practice manual has not been written. Developing one is among the research-and-practice priorities identified in §11.

8. Intergenerational Dimensions

8.1 THE EMPIRICAL LITERATURE ON TRANSMISSION

The question of intergenerational transmission of Holocaust trauma is among the most-studied in the literature and among the most methodologically contested. The initial clinical observations of post-war clinicians working with survivor families (Barocas & Barocas, 1973; Danieli, 1998) documented what were then called "children of survivors" effects: elevated clinical help-seeking, identity-formation difficulties, parental-trauma absorption. The subsequent quantitative record has been more complicated. Sagi-Schwartz and colleagues' meta-analytic work (Sagi-Schwartz, van IJzendoorn, & Bakermans-Kranenburg, 2008) found no substantial second-generation psychopathology effect in nonclinical samples, though elevated effects appeared in clinical help-seeking subsamples.

A separate stream of research has examined biological mechanisms of intergenerational effects, including cortisol-system alterations in second-generation offspring of Holocaust survivors (Yehuda et al., 2000, 2007) and, more recently and more controversially, epigenetic findings on methylation patterns in offspring of Holocaust survivors (Yehuda et al., 2016). The epigenetic findings have been contested methodologically (Yehuda & Lehrner, 2018) and should not be cited as settled science. What is clearer is that whatever the biological pathway, intergenerational transmission effects exist at the behavioral and relational levels in subsets of survivor families, and do not exist uniformly across them.

8.2 ART AS FAMILY MEDIATOR

Against this empirical background, published art-therapy accounts describe a specific clinical phenomenon: the use of survivor artwork as a *mediator* in intergenerational family communication. Kellermann (2009), Israeli, Regev, and Goldner (2021), and Keselman (2020) describe survivor families in which direct verbal communication about Holocaust experience has been partially or entirely foreclosed across decades. A physical artwork (a painting the survivor has made in therapy, a family album constructed through an art-therapy program) can provide a non-threatening object around which conversation that was impossible in abstract form becomes possible in concrete form.

The proposed mechanism is that the art object externalizes the otherwise internal and internal-to-the-family material, making it an object of joint regard instead of a demand for verbal self-revelation. The clinical evidence for this function is qualitative and case-based. Its mechanism claim is consistent with the general literature on symbolic mediation in family therapy (Rober, 1999) and with the specific phenomenology reported by participants.

This function is particularly relevant to the present review because it identifies an extension of art-therapy clinical benefit *beyond* the identified patient. Art made by a survivor in therapy does not stop working when the session ends; it can continue to work, at longer timescales, in the family system.

8.3 THE SECOND- AND THIRD-GENERATION CLINICIAN

A structural feature of the Holocaust-survivor mental-health workforce, in Israel in particular but also in the United States and Europe, is the substantial representation of 2G and 3G therapists working with survivor patients. This is partly demographic accident and partly vocational signal. Therapists whose own family history includes Holocaust experience report that their work with survivor patients is both clinically informed and counter-transferentially complex in ways that non-2G/3G therapists may not fully anticipate (Israeli, Regev, & Goldner, 2021; Potash, 2022).

Two dynamics are clinically described. The first is “testing.” Patients, explicitly or implicitly, assess whether the therapist can bear the material being presented, often by probing historical literacy or generational-specific knowledge. Survivors whose post-war experience included being asked to perform “appropriate” testimony for non-survivor interlocutors often retain a calibrated skepticism about whether a given listener can actually hold what is being said. The second is “muted perception.” 2G/3G therapists who grew up in survivor households may have adapted to their own family environment by selectively not noticing certain affects (aggression in particular). That adaptation can carry into clinical work in ways that, without supervision, interfere with full engagement with the patient’s material (Israeli, Regev, & Goldner, 2021).

The clinical implication is not that 2G/3G therapists are contraindicated. The implication is that supervision, self-reflective practice, and attention to the generational positioning of the therapist-patient pair are structural features of sound clinical work with this population, not optional embellishments.

9. Limitations of the Current Evidence Base

The present review is, in significant part, an accounting of what is *not* known. This section states those limitations explicitly.

9.1 PAUCITY OF CONTROLLED TRIALS

No randomized controlled trial of art therapy has been conducted with a Holocaust-survivor population. The one directly relevant RCT in an adjacent population (Campbell et al., 2016) is small, unblinded, and in a demographically distinct cohort (male combat veterans, mean age substantially younger). This is not a flaw of the field in a moral sense. The demographic window for conducting such a trial has been narrow for a long time and is now closing rapidly. It remains, nonetheless, a structural limit on what can be claimed.

9.2 CROSS-SECTIONAL DESIGNS

The single peer-reviewed quantitative study in this area (Diamond & Shrira, 2018) is cross-sectional. Associations identified cross-sectionally cannot be read interventionally. The association between art engagement and resilience observed in that sample is consistent with (a) art engagement causally elevating resilience; (b) pre-existing resilience causally elevating the likelihood of art engagement; (c) a third factor (socioeconomic status, educational attainment, pre-war protective factors, personality) causally elevating both; or (d) some combination of the above. Longitudinal designs, which can in principle adjudicate among these, have not been conducted in this population with art engagement as the focal variable.

9.3 CASE-STUDY DOMINANCE

The case-study and program material reviewed in §5.3 is valuable and should not be dismissed as "anecdotal." Case reports are the appropriate reporting form for certain kinds of clinical material, and clinical disciplines regularly derive framework-level insight from skilled case reporting. That said, the predominance of case reports and program descriptions over outcome studies in this area reflects the resource-constrained reality of clinical work with an aging, geographically distributed, trauma-exposed population. It places real limits on what can be claimed at the population level.

9.4 SELECTION AND RECRUITMENT BIAS

The participants in the quantitative and qualitative studies reviewed here are systematically non-representative of the full Holocaust-survivor population. By convenience-sampling artifact, they are generally higher in education, better resourced, more geographically accessible to research sites, and, critically, more cognitively intact than the population of survivors who are not in clinical care, who have cognitive impairment that precludes research participation, or who have died of Holocaust-related comorbidity in the years preceding the study. Findings from these samples may overestimate the engageable, treatable subpopulation and underrepresent the subpopulation whose clinical need is greatest but whose participation is least practical.

9.5 POPULATION HETEROGENEITY NOT ALWAYS MODELED

As §4.4 noted, the Holocaust-survivor population is heterogeneous across experience type, age at exposure, country of origin, post-war trajectory, and cultural-linguistic context. The small-sample studies available in this literature are generally not powered to model that heterogeneity, and findings are often reported at a level of aggregation that elides clinically meaningful variation. Whether, for example, camp-experience survivors and hidden-child survivors respond similarly to a given art-therapy protocol is an open question that the existing data cannot answer.

9.6 BLINDING AND EXPECTANCY

Randomized control in psychotherapy trials is constitutively difficult. Blinding of therapist and patient is effectively impossible for active behavioral interventions. The Campbell et al. (2016) trial is unblinded. For qualitative and case-study work, the researcher-clinician is typically the same person as the reporter, which introduces expectancy and confirmation dynamics that the best work in this area is explicit about but that none of it can eliminate. This is a general limitation of psychotherapy research. It is flagged here because the tendency in clinical writing to read favorable findings as confirmation is particularly strong, and particularly in need of discipline, in literatures addressed to populations of moral significance.

9.7 PUBLICATION BIAS

Publication bias (the over-representation of positive findings in the published record) is likely in this area as in most clinical literatures. Negative or null findings, and treatment attempts that did not work, are underrepresented both because of standard publication dynamics and because clinical writing about a morally weighted population can inhibit the reporting of disappointment. The present review cannot correct this. It can only note it.

10. Ethical and Methodological Considerations

This section treats the ethical questions that bear specifically on art-therapy work with Holocaust-survivor populations. It does not exhaust the general research-ethics literature; readers operating research programs with this population should additionally consult population-specific clinical-ethics guidance (e.g., the Claims Conference and Yad Vashem testimony-archive protocols) and the IRB frameworks governing their local context.

10.1 INFORMED CONSENT WITH COGNITIVELY DECLINING POPULATIONS

A substantial portion of the remaining Holocaust-survivor population is in advanced age and at elevated risk of cognitive decline. Informed-consent frameworks must accommodate three facts simultaneously. Capacity is not binary but graded. It fluctuates. And it declines, often asymmetrically across domains, in the same individual over time.

The governing clinical-research guidance specifies four capacity components (understanding, appreciation, reasoning, and choice) assessed through structured instruments such as the MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR) developed by Appelbaum and Grisso (1988) and its derivatives. Karlawish and colleagues (2005) demonstrate that the capacity to consent to research can be empirically assessed and documented even in populations with mild and moderate cognitive impairment. The capacity does not automatically disappear on diagnosis. For research and clinical protocols with this population, the appropriate posture is not wholesale exclusion on diagnosis grounds, and not uncritical inclusion. It is structured assessment at enrollment with re-assessment at appropriate intervals.

A complementary tradition, articulated most clearly by Dewing (2007), frames consent as a *process* and not a one-time event. “Process consent” holds that consent must be actively renewed across the course of participation, that observable assent and dissent during sessions are meaningful even when formal consent rests with a surrogate, and that a participant’s current-moment capacity to express preference (often preserved well into cognitive decline) is dispositive for continued participation. For art therapy specifically, process consent has a natural translation. The patient who picks up the brush and continues is consenting. The patient who sets it down or who withdraws is not, and that withdrawal requires response regardless of surrogate status.

Warner and colleagues (2008) document participation rates and capacity correlates in dementia-research populations and reinforce the empirical finding that exclusion defaults are too conservative. Ethics boards should be calibrated accordingly.

10.2 CULTURAL, RELIGIOUS, AND LINGUISTIC COMPETENCE

Cultural and religious literacy are clinical competencies in their own right, not contextual ornaments. A therapist who does not understand the significance of Yom HaShoah (its calendrical placement in the Hebrew month of Nisan, between Pesach and Yom Ha'Atzma'ut, and what that placement implies about Israeli Holocaust memory) will miss meaning at sessions scheduled in that period. A therapist who does not recognize the depth of the FSU-origin stigma around mental-health framing (shaped by Soviet-era psychiatric abuse and by the broader suppression of Jewish Holocaust memory in official Soviet historiography) will misread clinical resistance as pathology, when it is often reasoned self-protection. A therapist unprepared for patients whose English is their fourth language will miss what is being said in the other three.

Specific competencies documented as clinically relevant include: familiarity with Jewish religious practice sufficient to recognize when a patient is operating within halakhic constraints (e.g., around image-making, Shabbat scheduling, mourning rituals); awareness of the specific traumatic resonances certain materials, colors, or sounds may carry (German-language encounters for camp survivors, loud sounds, specific times of year); and, where the session is conducted through an interpreter, clinical-ethics awareness of the interpreter's own role in the relational frame (Keselman, 2020; Potash, 2022).

10.3 THE WEIGHT OF TESTIMONY: ARTIFACTS, ARCHIVES, AND POSTHUMOUS USE

Art therapy with Holocaust survivors is a practice that produces artifacts (drawings, paintings, albums, objects) that outlive the session in which they were produced and, very often, the patient who produced them. The disposition of those artifacts is an ethical question in its own right, and one that the clinical discipline has been slow to fully address.

Three distinct consent moments are implicated and are not interchangeable. The first is consent for therapeutic production: the patient agreeing to make the work within the therapeutic frame. The second is consent for internal use: the therapist and patient using the work as a reference within the ongoing treatment, or discussing it with family members invited into that frame. The third is consent for external use: archival deposit, exhibition, reproduction in educational materials, inclusion in publications. Standard therapeutic informed consent addresses the first. It often partially addresses the second. It rarely, in standard form, addresses the third.

The testimony-archive tradition at institutions including Yad Vashem, the USC Shoah Foundation, and the United States Holocaust Memorial Museum has developed over four decades a body of consent practice for testimonial material (recorded interviews, written memoirs, donated objects) that is explicit about the third question. Comparable specificity for therapeutically produced artwork does not yet exist in clinical-art-therapy practice. Individual practitioners and programs are making decisions (whether to photograph session work, whether to retain it, whether to permit its use after the patient's death) that

accumulate into de facto policy without explicit deliberation. This review will not resolve that absence. It notes that consent for therapeutic production is not the same as consent for posthumous exhibition. Programs that treat the two consent moments as equivalent without explicit patient involvement in the distinction (including the present publisher's Remember & Rebuild initiative, insofar as survivor-produced artwork from therapeutic sessions is used in subsequent classroom engagement) are making a consequential choice without the deliberative framing that distinction deserves.

10.4 THE THERAPEUTIC OFFER AND THE RIGHT TO DECLINE

A specific ethical issue, rarely named in the clinical literature, is the ethics of *offering* the therapeutic intervention at all. Outreach to Holocaust-survivor populations in eldercare settings, community centers, and congregate housing typically takes place through program infrastructures that are enthusiastic about participation. The offer is made, often warmly, often repeatedly, and often in a social context that makes declining socially costly. The survivor who has spent seven decades not processing traumatic material may have reasons for that choice that the discipline should respect rather than override. The right to continue not processing is a right the discipline is ethically obligated to protect.

The practical implication is that recruitment for art-therapy programs in eldercare settings should distinguish between offering and recruiting. A one-time invitation with clear information, honored if declined, is an offer. Repeated invitation, social pressure, or framing of non-participation as pathological is recruitment. The distinction matters ethically regardless of the practitioner's benign intent. Program-level evaluation should include non-participant cohorts (survivors who were offered the intervention and declined) and should ask whether their non-participation was informed and respected.

10.5 DUAL-RELATIONSHIP ETHICS AND THE SECOND- AND THIRD-GENERATION CLINICIAN

Sections 6.4 and 8.3 described the clinical complexity of second- and third-generation-descendant clinicians working with first-generation survivor patients. That clinical complexity has ethical corollaries that clinical writing in this area addresses only glancingly.

The dual-relationship framework that ordinarily governs therapist-patient boundaries assumes the therapist's life is biographically separate from the patient's in ways that permit professional framing. For 2G/3G therapists working with 1G patients, that assumption is partial at best. The therapist's parents and grandparents are, in the relevant historical sense, the patient's age-mates, and the therapist's family history overlaps with the patient's on a category dimension that cannot be set aside and should not be concealed.

The canonical intergenerational-transmission literature (Kestenberg, 1982; Jucovy, 1992; Auerhahn & Laub, 1998; Kestenberg & Brenner, 1996) anticipated this problem several decades before the clinical art-therapy literature engaged it directly. Kestenberg's account of "transposition" in children of survivors,

Jucovy's work on therapeutic work with survivors and their children, and Auerhahn and Laub's treatment of "knowing and not knowing" in the intergenerational transmission of Holocaust trauma together specify the psychic mechanisms through which the generational boundary can collapse in the consulting room, and the therapeutic work required to recover it without effacing it. These are foundational references for any 2G/3G clinician entering this work, and their absence from current art-therapy training curricula is itself a gap worth naming.

The ethical requirements that follow are structural: explicit supervision, formalized management of counter-transference (not individual goodwill alone), and disclosure frameworks that are neither the over-sharing that would distort the therapeutic frame nor the false neutrality that would deny what is evidently present. A practitioner operating outside these structures is not ipso facto unethical, but is operating without the scaffolding the generational positioning requires.

10.6 THE CLOSING RESEARCH WINDOW

The population within which art-therapy research with Holocaust survivors can be conducted is small and shrinking. As of 2026, most living survivors are in their late eighties or older, with child-survivor cohorts constituting the majority of those still alive. The demographic window for rigorous research with this population as study participants is a matter of years, not decades.

The ethical resolution is not to choose urgency over caution, or caution over urgency. It is to conduct only research whose burden on participants is proportionate to its expected clinical value and whose design is methodologically capable of producing that value. Pragmatic designs that embed data collection into routine clinical care, stepped-wedge implementations in place of no-treatment control arms, and within-subject instead of between-subject comparisons where possible are all ethically preferable to ambitious designs that impose large burdens for marginal methodological gains. The research that will not get done in the remaining window is the research pursued as an abstract academic exercise, not as a clinically useful instrument. That research should not be pursued now, if ever.

11. Directions for Future Research

The present review identifies several empirically addressable questions whose answers would materially advance clinical practice with this population.

Longitudinal characterization. A repeated-measures design tracking art-engaged and non-art-engaged Holocaust survivors over time, with standardized measures of PTSD symptomatology, resilience, depression, and subjective well-being, would adjudicate the causal-direction question that the cross-sectional Diamond and Shrira (2018) data cannot. Such a study is demanding but not impossible; the protocol would have to be explicitly engineered around a population whose participation time is finite.

Pragmatic intervention trials. A pragmatic randomized trial of a structured art-therapy protocol (the four-drawing protocol, an ETC-grounded material-titrated sequence, or a time-limited group protocol) against treatment-as-usual in a Holocaust-survivor sample would provide the population-specific interventional evidence that does not currently exist. The trial should use outcomes that the population values (resilience, subjective successful aging, perceived quality of life) alongside symptom measures, and should use a stepped-wedge or waitlist-control design, not a pure no-treatment arm.

Heterogeneity modeling. Existing and future quantitative data on Holocaust-survivor art-therapy engagement should be modeled with attention to the cohort divisions (camp, hiding, child-refugee, post-war-born-to-survivors, FSU-origin, Israeli-origin, US-origin) that experienced clinicians describe as meaningful. Aggregation across cohorts risks averaging away clinically important differences in response.

Dose-response. The question of minimum effective dose — how many sessions, over what span, with what intensity — has no published answer for this population. Even a well-conducted case-series dose-finding study would be more than exists.

Intergenerational outcome studies. The clinical claim that survivor artwork produced in therapy functions as family mediator is empirically unresolved at the quantitative level. A study linking survivor-patient art-therapy engagement to second- and third-generation family-communication and well-being outcomes, controlling for pre-existing family dynamics, would test a clinical claim that is currently supported by case reports alone.

Biomarker integration. As the field has matured, the feasibility of integrating non-invasive biomarkers (cortisol, heart-rate variability, even portable EEG) into art-therapy research has increased. A study linking in-session autonomic markers to reported subjective experience and to outcome measures would provide a level of mechanistic specificity that current work lacks.

Cultural replication. Most published clinical art-therapy research with Holocaust survivors is Israeli or US-based. Replication in other communities (Argentina, Canada, Western Europe, the FSU diaspora) would test the cultural specificity of findings and would generate data the current record lacks.

None of this research will be easy. The population is small. The remaining time is short. The clinical context is delicate. The research is nevertheless warranted by the clinical claims the discipline has repeatedly made (that art therapy is an indicated intervention for this population) and by the practical obligation to equip practitioners working in the remaining demographic window with evidence commensurate with those claims.

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12. Conclusion

Art therapy with Holocaust survivors rests on a theoretical and neurobiological foundation that is, in its broad strokes, well-supported by the trauma-memory literature. Verbal accessibility of traumatic material is compromised, at the symptom-provocation level, by the physiological state that trauma recall produces. Sensory and visual accessibility is available through the same physiological state. The available art-therapy frameworks (the Expressive Therapies Continuum, the bilateral-art tradition, the Hass-Cohen relational-neurobiological protocols, the holding-environment and fantastic-reality traditions, Herman's staging model) each specify clinically coherent accounts of how art-making operates as trauma-processing. Each is compatible with, not contradictory to, the others.

The population-specific evidence for art therapy's clinical benefit with Holocaust survivors consists of a single peer-reviewed cross-sectional quantitative study, two peer-reviewed qualitative studies, a small body of case reports and program descriptions, and no randomized trials. The quantitative study documents a significant association between art engagement and resilience in a community sample of aging Israeli survivors. The qualitative studies specify the phenomenology of the intervention as reported by patients and therapists and describe a consistent set of clinical observations (the strategic avoidance of direct Holocaust imagery, the use of symbolic transformation, the experience of the therapeutic frame as a holding space) that map recognizably onto the theoretical accounts. The case material documents skilled clinical practice with individual survivors under varied comorbidity and cultural conditions.

The evidence supports adoption. It does not support strong claims. Art therapy with Holocaust survivors is a defensible clinical practice. It is not a validated intervention in the sense that the word *validated* carries in randomized-trial-based evidence hierarchies. Practitioners who adopt it should do so with clear acknowledgment of what the evidence supports (clinically coherent framework, significant association between engagement and resilience, high patient engagement and retention, qualitative signal of meaningful subjective experience) and of what it does not (controlled effect-size estimates for the population, dose-response specifications, comparative superiority to verbal modalities, generalization certainty across cohort subtypes).

Three conclusions bear specific emphasis.

First, the neurobiology is a permission, not a prescription. The fact that a mechanism is available through which art-based intervention *could* operate does not establish that any particular protocol *does* operate through it, and clinical writing that conflates mechanism with efficacy misrepresents the evidence.

Second, the evidence base that does exist, while thin, is not empty. Clinicians and programs that treat art therapy with this population as inherently unsupported are dismissing a real, if small, body of work. Clinicians and programs that treat it as robustly validated are overstating what that body currently carries.

Third, the research window for closing the evidence gap is short. Longitudinal, pragmatic-interventional, heterogeneity-modeled, intergenerationally-extended research is possible with this population at the present historical moment and will not be for long. Research programs that want to make a durable contribution to the clinical practice this population deserves should move now.

The Holocaust-survivor population is, by any clinical measure, among the most burdened and most resilient groups in the trauma-psychology record. Over roughly three decades of clinical work with this population, the discipline of art therapy has developed an approach that patients engage with at high rates, that clinicians experienced with the population describe as producing observable clinical benefit, and that rests on theoretical and neurobiological scaffolding consistent with the broader trauma literature. The empirical base is less developed than the clinical base. That asymmetry is itself a finding of the present review.

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