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Merryl Emily Raubeson
Learning from Art Therapists:
Strategies for Treating Children with
PTSD

ABSTRACT

This study was undertaken to develop and pilot a methodology for looking at theoretical underpinnings and techniques employed by art therapists, with the goal of adding to our knowledge about the use of art therapy to treat children and adolescents with trauma histories and PTSD. **Methods:** Five practicing art therapists with advanced degrees and certification in art therapy who have been practicing with the target population for more than two years were interviewed about their theoretical orientations, diagnostic strategies, and clinical practices, including their understanding of the relationships, if any, between the presenting symptoms of their trauma-exposed clients and their artistic actions, chosen mediums, and colors. The study also asked about common themes depicted in the children's artwork. **Findings:** Study participants had various theoretical backgrounds that were mostly influenced by mentors. Most participants were not determining client's diagnosis but were using clinical observation to contribute to the evaluation of clients. All clients thought that there was a relationship between their client's symptomatology and their artistic actions, and some participants found choice of color and medium to be relevant as well. Participants listed several similar themes they have observed in the artwork created by this population. **Conclusions:** Clinical social workers who work with trauma-exposed youth have a great deal to learn from the work of parallel specialists who are exploring practical applications of our emerging understanding of the neurobiology of emotions.

**LEARNING FROM ART THERAPISTS:
STRATEGIES FOR TREATING CHILDREN WITH PTSD**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2012

ACKNOWLEDGEMENTS

This thesis could not have been completed without the assistance of many individuals whose contributions are greatly acknowledged and appreciated.

I wish to give special thanks to my thesis advisor, Dr. “Liz, Irvin,” for her patience, encouragement, and dedication throughout this process; my family, friends, and colleagues for their love, support, and humor; to the art therapists who participated in the study for sharing their time and experiences with me.

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CHAPTER I

Introduction

Art therapy appears to be an emerging modality for the treatment of PTSD in children. The aim of this project is to examine the theoretical underpinnings of this approach through a comprehensive review of the literature and to explore, through interviews with experienced art therapists, some of the assumptions that underpin their decisions about the choice of modalities selected for the treatment of children with PTSD.

Rationale for the Study

The purpose of this study is to explore the theoretical underpinnings and techniques in use by art therapists when working with children and adolescents who have histories of trauma and who may be diagnosed with PTSD. The use of art therapy to treat trauma is a body of research that has not been fully developed; most of the literature is made up of anecdotal case studies (Avrahami, 2005; Bowers, 1992; Harnden, Rosales & Greenfield, 2004; Lantz & Raiz, 2003). There are a handful of studies that examine the effectiveness of specific art therapy interventions with small groups of trauma exposed children (Isaksson, Norlen, Englund & Lindqvist 2009; Kozłowska & Hanney, 2001; Pfeifer, 2010; Pifalo, 2002). Little research was found that focus exclusively on an exploration of the theoretical underpinnings of art therapy with trauma exposed children and adolescents; there is a rich parallel literature on the neurobiology of emotions and expression that clearly informs the work of modern art therapists.

There is an emerging literature on the relationships between child-patient symptoms and the art they create (Avrahami, 2005; Malchiodi, 2005; Rubin, 2005; Tinnin, 1990; Wilson, 2001). Art therapy is believed to be an effective technique for treating trauma exposed children because it does not rely on language processing, but rather on non-verbal pathways for processing emotionally important material. Given the developmental stages of children, art therapy may be an especially appropriate form of treatment trauma exposed youth (Klorer, 2005). Clearly, with all of the emerging interest in the efficacy of art therapy interventions for treatment of PTSD, research in this important area will expand to include treatment outcome studies. To date, such studies are not available.

Art therapy has been described as a process for treating clients with PTSD that enables dissociated materials stored as visual memories to reach consciousness and be expressed (Avrahami, 2005; Kozłowska & Hanney, 2001; Talwar, 2007). Neurobiologists have hypothesized that traumatic memories are stored in the right hemisphere of the brain, specifically in the areas that are most involved in emotional arousal, including parts of the limbic system most intimately associated with the amygdala (Talwar, 2007). In addition, Broca's area, located in the left hemisphere, thought to be responsible for translating personal experiences into communicable language, has been noted to be "turned off" in patients with PTSD (Van der Kolk, McFarlane & Weisaeth, 1996). Art therapy is believed to be an effective technique in treating trauma because it does not rely on the client's use of left brain, language processing, but rather allows the client to express themselves non-verbally (Klorer, 2005). Through art, fragmented traumatic memory can assume a concrete form in which the complete experience is visualized (Avrahami, 2005).

Importance of the Study

This study is designed to address an existing gap in our knowledge about the theoretical underpinnings that inform art therapy as it is used in the treatment of trauma-exposed children and adolescents. Because of the developmental capabilities of their clients, it is likely that social workers who treat trauma-exposed children are using drawing and other forms of art and play therapy during treatment sessions. In 2008, there were 642,000 social workers in the United States (Bureau of Labor Statistics, 2009). Of these, 292,600 were employed as child, family, and school social workers. Studies of the general population have found that 15-43 % of girls and 14-43 % of boys have experienced at least one traumatic event. “Of those children and adolescents who have experienced a trauma, 3% to 15% of girls and 1% to 6% of boys could be diagnosed with PTSD,” (Hamblen & Barnett, 2011). Clearly, clinical social workers who work with trauma-exposed youth have a great deal to learn from the work of parallel specialists who are exploring practical applications of our emerging understanding of the neurobiology of emotions. This narrowly focused study is designed to explore one such field, art therapy.

Summary

This is an exploratory pilot study designed to expand our understanding of the theoretical underpinnings that guide the work of experienced art therapists in their work with trauma-exposed children. Art therapists are one of a group of specialists who have begun to translate the important findings of neurobiology into practical applications in the treatment of trauma-exposed children. As such, social workers and other mental health specialists can benefit from a gaining a richer understanding of the theoretical underpinnings of this applied field of treatment.

This qualitative study draws on discussions with five art therapists who had been practicing for two or more years and whose work has focused primarily on helping children and

adolescents reduce their symptoms of trauma. Interview questions developed for the study explore participant's theoretical orientations, diagnostic strategies, and clinical practices, including their understanding of the relationships, if any, between the presenting symptoms of their trauma-exposed clients and their artistic actions, chosen mediums, and colors. The study also asked about common themes depicted in the children's artwork. In addition, participants were asked to discuss the theoretical underpinnings for their work, how they approach formulating assessments, and how they determine which interventions to use. By exploring these dimensions, the study hopes to learn more about the theoretical underpinnings that inform the applied aspects of this important treatment modality for children. As pioneers in the translation of neurobiology into practical therapeutic practice, other fields of practice have much to learn from practicing art therapists.

CHAPTER 2

Literature Review

Art therapy appears to be an emerging modality for the treatment of PTSD in children. The aim of this project is to examine the theoretical underpinnings of this approach through a comprehensive review of the literature, and to explore through interviews with experienced art therapists some of the assumptions that underpin their decisions about the choice of modalities in the treatment of children with PTSD. Art therapy, as a field, is in the forefront of translating emerging findings about the neurobiology of emotion into practical applications in the treatment of trauma-exposed children and adults. As such, clinical social workers and others in child mental health and psychology have a great deal to learn from our specialist colleagues, particularly with regard to the applied aspects of treating trauma-exposed youth. The emerging theoretical literature in this important field is explored in this literature review.

Overview: The Field of Art Therapy

Definition: Art therapy is, essentially, the combination of two disciplines; art and psychology. Malchiodi (2007) states that there are two general definitions of art therapy: the process of art as therapy, and the symbolic communication in art psychotherapy. The process of making art can provide inherent benefits of relaxation, be self soothing, and fun for the artist therefore; the action itself is therapeutic (Malchiodi, 2007).

The second definition proposed by Malchiodi (2007) is:

Art therapy is based on the idea that art is a means of symbolic communication. This approach, often referred to as art psychotherapy emphasizes the products – drawings, paintings, and other art expressions- as helpful in communicating issues, emotions, and conflicts. Psychotherapy is essential to this approach, and the art image becomes significant in enhancing verbal exchange between the person and the therapist and in achieving insight. (p. 6)

A great portion of the literature states that an important part of the art therapy process is having the client comment on their work and their interpretation of what they produced.

Mental health professionals are beginning to study how traumatic memories are stored in the brain. Avrahami (2005) reports that when a victim experiences a traumatic event it becomes difficult to think intellectually, and create an internal narrative to explain it instead the event is remembered by sensations, emotions and images. Neurobiologists have hypothesized that traumatic memories are stored in parts of the right hemisphere of the brain that are responsible for emotional arousal (Talwar, 2007). It is also believed that traumatic memories are stored pictorially and nonverbally as implicit memories (Kozłowska & Hanney, 2001).

History of the field: While art therapy is a relatively new field of practice, art has been used as a form of treatment and has played a role in health since ancient times. The use of art for healing and mastery is at least as old as the drawing on the walls of caves; yet the profession itself is a youngster in the family of mental health disciplines (Rubin, 2005).

People have been using art as a way to express themselves as far back as 20,000 BC. Early writing can be viewed as early form of art such as the Egyptians writing hieroglyphics, the

Mayan's logograms, and both ancient and contemporary Chinese characters. "Humans have consistently created art for purposes of magic, to protect themselves from evil and harm, to express and control powerful emotions such as fear and anxiety, and to prepare themselves for coming events such as hunting" (Malchiodi, 2007, p. 24).

Early influences: While many artists, historians, psychologists and psychiatrists have had a great impact on the creation of art therapy as a field, the influence of a several pioneers stands out. In the early twentieth century, psychiatry became increasingly interested in the connections between imagery, human emotion, and the unconscious (Malchiodi, 2007). Many psychiatrists became fascinated by the art that was being created by their patients with mental illness. Several researchers collected and studied such spontaneous expressions, hoping to better understand the creators and their ailments (Rubin, 2005). Malchiodi (2007) describes the work of Marcel Reja, a French psychiatrist, who in 1901 noted similarities between the art of people who were mentally ill, children and primitive artists. In 1912 two psychiatrists, Emil Kraepelin and Karl Jaspers, "observed that drawings by patients could be used as aids in understanding psychopathology." (Malchiodi, 2007 p. 26) Freud's theories of the unconscious and writing regarding the images presented in dreams helped support Kraepelin and Jaspers observation.

This observation inspired and eventually confirmed the belief that art expression could be a route to understanding the inner world of the human psyche. Freud also included artistic concepts in his clinical work and derived many of his theories from his study of literature and visual art. (Malchiodi, 2007, p.26)

Malchiodi (2007) reports that Jung formulated the concept of a collective unconscious. He was an artist himself and participated in drawings, paintings and carvings throughout his life. Jung used his visual artwork to record and explore his own dreams.

He came to believe that it was important to bring to consciousness emotionally laden images because, if left unconscious, they could have a negative effect on the person's behavior. He felt that dreams, memories, stories, and art could bring forth images hidden in the unconscious (Malchiodi, 2007, p26).

Jung developed a foundation for understanding symbolic meanings in imagery through his studies of archetypes and universalities inherent in visual art. The psychiatric community was interested in the explanations of Freud and Jung with regard to images in art and dreams and their work generated an interest artistic expression within the psychoanalytic profession (Malchiodi, 2007). Psychotherapists started to develop a greater appreciation for the use of art because visuals created by clients often provided information beyond what their words could express. As psychoanalysis developed, therapists tried to explore client's unconscious, illogical thoughts and tried to learn about the meanings behind images in dreams and those depicted in art created by people who were mentally ill. (Rubin, 2005) "The growth of projective testing in the young field of clinical psychology stimulated further systematic work with visual stimuli such as the Rorschach inkblots or drawings, like those of the human figure, primarily for diagnostic purposes" (Rubin, 2005, p. 7).

Art therapy and mental illness: Professionals in the field started to collect and study pieces of art created by people who were diagnosed with a mental illness in order to further explore their meaning. Some mental health professionals thought that it was possible to use art work to assess someone who was mentally ill (Malchiodi, 2007; Rubin, 2005). French psychiatrist, Paul-Max Simon, gathered an extensive collection of art pieces created by people with mental illness from 1876 to 1888. "Simon has been credited with influencing the diagnostic

use of drawings, based on his belief that symptoms could be related to the content of artwork” (Malchiodi, 2007, p.27). He earned the nicknamed “father of art and psychiatry” for this work.

Hans Prinzhorn, was an art historian and a psychiatrist who also collected paintings created by adults diagnosed as mentally ill. He collected five thousand pieces from more than five hundred patients who were located in hospitals in Germany, Switzerland, Italy, Austria, and the Netherlands. This collection influenced his publication *Artistry of the Mentally Ill* (Prinzhorn, 1922). Unlike others before him who studied the psychopathology of their patients, Prinzhorn was interested in the creative process and visual forms created by people who had mental illness. Prinzhorn believed that expression through art was something that could be beneficial to anyone, not just people with mental illness. He thought that, “art was a natural way to achieve psychological integration and wellness” (Malchiodi, 2007, p.27). His ideas were similar to Jung’s about archetypes and the collective unconscious (Jung, 1959). He saw art as a method of self-discovery for individuals with mental illness and perhaps even an avenue to mental wellness.

Art therapy in the United States: Art therapy as a field of practice grew out of the initiation of moral therapy during the nineteenth century in the United States and Europe (Malchiodi, 2007). Prior to moral therapy, people who were mentally ill were treated inhumanely. Moral therapists advocated for people who had mental illness to be treated more humanely. As a result some people being treated for mental illness were sent to country retreats where they received occupational training in the arts. The movement lasted only a few years but it resurfaced in the twentieth century in what were eventually known as milieu therapies (Malchiodi, 2007).

In 1925 the Menninger Clinic was founded in Topeka, Kansas by Charles Menninger and his two sons, Karl and William. It was a world famous psychiatric facility which had an influence on the development of art therapy as a distinct field. Charles Menninger hired Mary Huntoon to work at his facility to facilitate art classes for the psychiatric patients who attended the program. Huntoon used art to help the patient's process and let loose emotional troubles and trauma. Huntoon is responsible for the term *art-synthesis* which she used to describe the process of self-discovery that numerous patients she worked with experienced after completing an artwork (Malchiodi, 2007). She felt that the process of making art held the most therapeutic value, rather than analyzing it for diagnostic or symbolic meaning.

Use with children: Simultaneously, teachers from the schools systems were exploring the value of a "freer" form of artistic expression. Professionals in this progressive movement believed that an important part of a child's education and development was to explore their creativity. Rubin (2005) describes how art educators from this movement learned that allowing children to express themselves also improved their ability to tolerate feelings of frustration and self definition. Around this time, Viktor Lowenfield developed "art education therapy" for children with disabilities. During this period art was also beginning to be offered as therapy to patients in general hospitals and psychiatric settings (Malchiodi, 2007).

Melanie Klein in the mid 1930's was the first psychoanalyst to use artwork with children as an adjunct to analysis (Rubin, 2005). Melanie Klein is known for the role in describing play therapy [primary reference here]. However, like most therapists who work with children through play. Melanie Klein also incorporated art in her play therapy.

Naumburg and Kramer are two of the highest regarded women in the field of art therapy. They were influential in defining and founding the field of art therapy. They began their work

with children. Naumburg started her work with children in a hospital setting around 1947 and Kramer worked with children in a special school around 1958. Both worked from their experience as educators, and both were Freudian in their orientation, though each used different aspects of psychoanalytic theory to develop her own ideas about the best therapeutic use of art (Rubin, 2005). “The introduction of art as a therapeutic modality is attributed to Margaret Naumburg in the 1940’s. Naumburg is considered to be one of the first to delineate art therapy as a distinctive form of psychotherapy” (Malchiodi, 2007, p.36). She had similar beliefs to Freud and Jung and used art expression as a way to manifest unconscious imagery. However she took Freud’s modalities a step further and had her patients draw their dreams rather than just talk about them. “For Margaret Naumburg art was a form of symbolic speech coming from the unconscious, like dreams to be evoked in a spontaneous way and to be understood through free association always respecting the artist’s own interpretations” (Rubin, 2005, p. 7). Naumburg believed art was used as a method to explore unconscious symbolic contents, a means of diagnosis and therapy, requiring verbalization and insight as well as art expression (Rubin, 2005).

Edith Kramer differed from Naumburg and focused on using art therapy to explore sublimation, “a way of integrating conflicting feelings and impulses in an aesthetically satisfying form, helping the ego to control, manage, and synthesize via the creative process itself” (Rubin, 2005, p. 7). Kramer proposed that the healing potential of art making stemmed from the ability of creative work to activate certain psychological processes [primary reference her from the 1950’s). “Kramer stressed creativity, not merely communication of visually symbolic speech, as key to the art therapy process” (Malchiodi, 2007, p.36) She believed that through creating a

piece of art the client would have to channel, reduce, and transform inner experiences that could be an act of sublimation, integration and synthesis.

Another well known art therapist from the 1960's, Janie Rhyne, who utilized the person-centered approach to therapy which was popular at the time (Rhyne, 1995). Rhyne encouraged her clients to give their own interpretation of the art works they created during therapy sessions.

Many of the founders of the art therapy movement started their careers as art teachers and were influenced by their own art education which, in the period from 1930 to 1950, tended towards the 'child centered' approach. Both Naumburg and Kramer's approaches are still visible in the field of art therapy today, although the field has grown rapidly over the last 50 years.

Art therapy in the 1970's was a technique in search of a theory and had already found many useful different psychological frames of reference, including: "psychoanalytic (Naumburg, 1947, 1950), Gestalt (Rhyne, 1973), humanistic (Garai, 1971), and phenomenological (Betensky, 1973). Art therapy during the 1970's and 1980's grew into a separate profession. Art therapists built primary partnerships with medicine and psychiatry which resulted in jobs being created in mental health centers, medical centers, day treatment programs, and substance abuse programs. "Today, art therapy is a profession in its own right, and guidelines for practice and training have been established" (Malchiodi, 2007, p.44). An Art Therapy Credentials Board provides a route to certification for practicing art therapists. There is also an American Art Therapy Association which is generally responsible for the promotion and education of art therapy among the public, in addition to the progressive development of research and standards of which to base training, grants, and normative implementation within institutional and private settings.

Summary: Art therapy has its roots in the psychoanalytic movement with its beliefs about the symbolic content of images that could be derived from patients' art expressions and dreams. By midcentury there was a growing belief that the creative process of art making could encourage rehabilitation, change, and growth. "Both a growing interest in images as representation of the unconscious and the therapeutic potential of the creative process helped open the door for the emergence of the field of art therapy" (Malchiodi, 2007, p.35).

Professional Training, Licensing

The American Art Therapy Association (AATA) is responsible for many developments in the field. AATA lead the way to professionalizing the field and the development of credentialing standards. The first licensure test to become a registered art therapist was offered in 1996. AATA has encouraged its members to seek licensure, and many states now have licensing standards for art therapists. Many art therapists are now practicing at a doctoral level (Retrieved from <http://www.americanarttherapyassociation.org>).

Credentialing: There are many different levels of credentialing for art therapists. An entry-level credential to art therapy is a Registered Art Therapist (ATR). Qualifications for the ATR include specific graduate-level education in art therapy and documentation of supervised post-graduate clinical experience. An ATR may then apply to become Board Certified (ATR-BC). To receive board certification an ATR must complete the national examination, which demonstrates a comprehensive knowledge of the theories and clinical skills used in art therapy. The highest art therapy certification is an Art Therapist Certified Supervisor (ATCS) which is an advanced supervisory credential. It is designed both for professional art therapists who have acquired specific training skills in supervision and to ensure that supervisees receive the best training available. All credential holders must adhere to the *ATCB Code of Professional*

Practice (AATA, 2012), similar to the National Association of Social Work (NASW) Code of Ethics, describes ethical standards for the profession.

“The Art Therapy Credential Board had recently been asked to assist with the process of debuting Art therapy as a stand-alone occupational classification for the U.S. Department of Labor’s (USDOL’s) O*NET program” (Good, 2011, p. 5). This development is an important step for the profession, especially since Art Therapy has been considered part of Recreation Therapy in earlier USDOL classifications. “O*NET is seeking to better understand the criteria that should be used to identify someone as an Art Therapist occupation expert. Education as an art therapist and art therapy practitioner experience are two of the already established defining criteria” (Good, 2011 p. 5).

In addition to making progress toward better establishing the identity of Art Therapy as a profession, this process may lead to a future professional occupational listing with the Bureau of labor and Statistics (BLS). Should this occur, it will help with licensure efforts, advocacy, and could assist with work toward third party reimbursement for Art Therapists (Good, 2011, p.5).

Statistics: The Art Therapy Credential Board (ATCB) reports that in the summer of 2011 there were nearly 3,000 licensed clinical professional art therapists (Good, 2011). As of July 9th, 2001 there were 2,462 registered, board certified (ATR-BC) art therapists, 31 of which hold the Art Therapist Certified Supervisor credential (Good, 2011). In addition, there was 2,282 Registered Art Therapists (ATR).

Practice arena: Art therapy has gained a foothold in the mental health community and its practices are growing to a wide variety of clinical settings, including: mental health clinics, schools, medical hospitals, hospices, detention centers, shelters and specialized settings for those

with eating disorders and substance abuse (Rubin, 2005). In some settings, art therapists can conduct forensic evaluations and may offer immediate help to youngsters who have suffered traumas (Rubin, 2005). Art therapy is practiced with diverse client populations, including people of all ages with many different mental and medical illnesses. It is also practiced in many different formats such as art therapy with individuals, couples, families, and group therapy formats.

Overview of PTSD in Children

DSM-IV: According to the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000), post-traumatic stress disorder (PTSD) is characterized by three distinct symptom clusters:

1) persistent re-experiencing of the trauma, 2) avoidance of traumatic reminders with a general numbing of emotional responsiveness; and, 3) chronic physiological hyper arousal. “In children, re-experiencing may occur through repetitive play involving trauma related themes, rather than through memories, and nightmares” (Kaminer, Seedat & Stein, 2005, p. 121). For children, themes may be generalized rather than having trauma-specific content.

Symptoms: The *DSM-IV-TR* also states that, in order to meet criteria for a diagnosis of PTSD, there must be the following: 1) at least one re-experiencing symptom (e.g., intrusive memories and flashback experiences, often triggered by exposure to traumatic reminders, and recurring trauma related nightmares); 2) three avoidance/numbing symptoms (including places, people, and conversations), and 3) two hyperarousal symptoms (could include sleep disturbances, poor concentration, and hypervigilance to threat).

Duration: Symptoms must be present for at least one month, and must cause significant distress or functional impairment. One would be diagnosed with acute stress disorder (ASD) instead of PTSD if the duration of symptoms is less than one month.

Definition of traumatic event: A traumatic event is defined as having experienced or witnessed actual or threatened death or serious injury, or a threat to the physical integrity of others (DSM-IV-TR, 2000). Traumatic events can include many experiences such as physical abuse, sexual abuse, witnessing domestic violence, community violence, and natural disasters all of which are common amongst children living in the United States.

According to a nationally representative sample of children aged 2 to 17 years surveyed in late 2002 and early 2003, one in eight children experienced a form of child maltreatment (including abuse, neglect, bullying, or abduction by a caretaker); one in 12 experienced sexual victimization; and more than one in three witnessed violence or experienced another form of indirect victimization (Wethington et al., 2008, p 288).

Limitations of PTSD diagnostic criteria for children. Kaminer, Seedat and Stein (2005) state two major limitations of the DSM's PTSD diagnostic criteria for young children. The first is that "eight of the eighteen PTSD criteria require a verbal description of internal states and experiences, a task beyond the cognitive and expressive language skills of young children" (Kaminer, Seedat & Stein, 2005, p. 122). I would hypothesize that this is one reason why art therapy may be beneficial when working with trauma-exposed children because it provides an alternative means for expressing content that is not available verbally to children because of their developmental age, or because of the nature of the traumatic memory.

The second limitation proposed by Kaminer, Seedat and Stein (2005) is that, while traumatized children frequently may present with similar symptoms to those seen in adults with

PTSD, children often display symptoms that are not usually assessed using typical structured interviews and scales. For example, children may present with more symptoms of regression, fearfulness, be more likely to have accidents and/or display reckless behavior and separation anxiety, and may present with anxious clinging behavior and/or psychosomatic complaints. Children may also present with hyperactivity, distractibility and impulsivity. Because of the unique way PTSD may present in children, Kaminer, Seedat and Stein (2005) suggest that it may be more accurate to assess childhood PTSD by the intensity of symptoms and their relationship to functional impairment, rather than basing it on the number of symptoms.

Age and symptom development: Nader (2011) has suggested that symptoms of trauma or complex trauma tend to cluster in children related to their age. For the purpose of this paper, I have focused on middle childhood (starting around age 6 or 7 and ending around age 11 or 12). Nader (2011) states that trauma or complex symptoms for this age group may include the following: 1) irrational guilt, where the child may feel as though they had caused the problem and or the emotional reactions of others; 2) feeling frightened and/or depressed, with the presence possibly of suicidal ideation; 3) identification with their parents or primary caregivers distress or pain; 4) internalized symptoms such as crying, poor concentration, intrusive thoughts, low school achievement and/or withdrawal. Trauma-exposed children in this age group may also have more conflict with others and may display emotional and behavioral problems. Nader argues that this age group may become hyperactive and may develop anxiety. A middle aged child may also display deficits in self-regulation of affect, behavior, consciousness, self-concept integration, and cognition, as well as difficulties soothing in the absence of responsive care.

Kaminer, Seedat and Stein (2005) have discussed that trauma-exposed children may develop problems in the ability to label and discriminate among affective states, have difficulties

modulating or regulating internal experience and expressing emotions safely, and possible may display symptoms of chronic numbing, dissociation, dysphoria, avoidance of affectively laden situations, and or maladaptive coping strategies. They may also have over-controlled behavior such as inflexibility or compulsive behaviors, or may present with an opposite picture of under-controlled behaviors such as aggression and oppositional defiance (Kaminer, Seedat & Stein, 2005). Children in this age group who have experienced trauma may also have impaired functioning affecting IQ, flexibility, creativity, problem solving, attention, and abstract reasoning. Finally, self-representations include viewing themselves as defective, unlovable, helpless and deficient (Kaminer, Seedat & Stein, 2005).

Incidence of PTSD in children: PTSD has become a common threat for children in the United States. Children and adolescents may be exposed to multiple environmental stressors, including: domestic or community violence, physical, sexual and emotional abuse, terrorism, and natural disasters. Stressors such as these put children and adolescents at risk for developing PTSD (Ardino, 2011). More research is needed given the high rates of exposure to traumatic events children and adolescents experience and the potential for long-term consequences of such exposures if they go untreated.

Treatment Approaches

The two treatment approaches with the most empirical evidence-based practice are cognitive behavioral therapy (CBT), and eye movement desensitization reprocessing (EMDR).

CBT: Cognitive Behavioral Therapy is the most researched and best evidence-based intervention for PTSD. CBT is a generalized term that can be used to describe a group of interventions that are based on the paradigm that our thoughts cause our feelings and behaviors, not external things such as; people, situations, and events. Therefore, people can learn to change

the way they think to effect how they feel and act, even if the situation does not change (National Association of Cognitive-Behavioral Therapists, 2010).

EMDR: Eye Movement Desensitization Reprocessing is an approved treatment for children and adults with PTSD.

EMDR therapy uses bilateral stimulation, right/left eye movement, or tactile stimulation, which repeatedly activates the opposite sides of the brain, releasing emotional experiences that are "trapped" in the nervous system. This assists the neurophysiological system, the basis of the mind/body connection, to free itself of blockages and reconnect itself (Boulware, 2006, p 1).

TST: Trauma Systems Therapy is a treatment approach used as an intervention for children who have experienced trauma. It is used to help children gain control over emotions and behavior by diminishing the ongoing stresses and threats in their social environment. The strategy relies on teaching others in the child's environment to support him or her in developing appropriate emotional and behavioral regulations skills.

Theoretical Underpinnings for Use of Art therapy in Treatment of PTSD

Art therapy is a relatively new field with a growing literature on the theoretical rational for art therapy and it's mechanism of action. Much of the literature supports the use of art therapy in treating PTSD because of the non-verbal strength of the approach (Avrahami, 2005; Gnatt & Tinnin, 2009; Klorer, 2005; Kozlowska & Hanney, 2001; Rubin, 2005; Talwar, 2006; Wilson, 2001). There is also support for the notion that art therapy may be an effective technique to locate traumatic implicit memories because it allows the client to express themselves non-verbally (Avrahami, 2005; Gnatt & Tinnin, 2009; Kozlowska & Hanney, 2001; Rubin, 2005; Talwar, 2006; Wilson, 2001). Art therapy is also believed to help the client feel as

though they can distance themselves from the traumatic experience while also growing a sense of control (Avrahami, 2005; Talwar, 2006). Avrahami (2005) describes that “when trauma occurs, adult, cognitive, verbal and linear coping tools are bypassed, and the victims return to the primary chaotic place of sensations, feelings and pictures” (p.34).

Implicit memory: Many art therapists believe that art therapy can help to bring forward implicit memory from its wordless form. Traumatic memories are often recorded in ‘photographic form’ as imaged memories also known as implicit memory (Kozłowska & Hanney, 2001).

Non-verbal expression: Nonverbal, expressive therapy approaches are highly effective interventions for trauma-exposed youth because they do not rely on the child’s use of the left brain and language for processing (Klorer, 2005). Art therapists believe that art therapy can help to bring forward implicit memories from their wordless form (Avrahami, 2005; Gnatt & Tinnin, 2009; Kozłowska & Hanney, 2001; Rubin, 2005; Talwar, 2006).

The treatment “involves ‘doing,’ provides a non-verbal medium, the creation of an ‘image,’ a concrete visual expression depicting memories and experiences stored at both conscious (declarative) and unconscious (implicit) levels, for exposure to conscious reflection and cortical processing (Kozłowska & Hanney, 2001, p. 52).

Art can be a non-threatening way to visually communicate that which is too painful to put into words.

Narrative: Some view art therapy as an alternative to talk therapy; however art therapists use the process of creating art to facilitate conversation. The literature suggests that even when an idea is beginning to approach consciousness; it will frequently be expressed in art long before it is talked about (Rubin, 2005). Talwar (2006) and Avrahami (2005) both discuss

using the meaning in the symbolism of their client's art work to help them develop a narrative to process their trauma. Avrahami (2005) describes the use of art therapy to assist the change of traumatic encoding from an isolated event to an integrated event that is interlaced with the rest of a person's experience, including thought, emotions, and other events in a personal biographical narrative.

Control: Art allows for the clients to experience a process that can help them shift their feelings of hopelessness and helplessness to feelings of hope. Creating art in therapy encourages clients to be active and to externalize their feelings into concrete images. Clients can feel a sense of control by deciding if they want to share their art with others or keep it private. Clients can also explore being in control of the materials, what they produce and take comfort in knowing that their art is modifiable (Kolzlowska & Hanney, 2001; Rubin, 2005). Rubin (2005) adds that through art therapy children can learn to remain in control of impulses that might not be as destructive or disorganizing as they may have anticipated.

In addition, the process can create a space for the client to test loss of control. Waller (2006) writes about the importance of having a space where a child is allowed to be messy in handling art materials. Some children who have been sexually or physically abused may explore a loosening of control by being messy while creating art by smearing, spilling and wasting materials. Having a place where it is ok to have a loosening of control is important so that a child can work through this phase and have the ability to safely create images that can also be destroyed in private if the child feels too disturbed to keep them (Waller, 2006).

Transitional Object: Waller (2006) describes the importance of D.W. Winnicott's paper, 'Transitional Objects and Transitional Phenomena' (1951), which influenced art therapists thinking. He introduced the idea that artwork created in art therapy could be thought of as a

transitional object because it provides the client with something physical that they can hold on to for themselves between sessions to remind them of their therapist (Waller, 2006).

Materials: The literature illustrates that one can learn about a client through their choice of medium. For example, someone who feels threatened or out of control may prefer easily controlled mediums such as pencil or pen and rulers. On the other hand, someone who feels as though they are overly controlled and structured may want to rebel by using more fluid materials such as water colors, oil paints, large brushes, or pastels (Avrahami, 2005). Moving away from the use of controllable materials may also represent a growth in development, or allow for a breakthrough in therapy. Avrahami (2005) states that “the transition from working with controllable materials (e.g., pencils collage, photographs) to less manageable, fluid materials (e.g., clay, liquid paint) enables a gradual shedding of defenses, reflecting an increasing ability to cope with the feelings that arise” (p. 9). Unstructured mediums seem to stimulate children to symbolic expression of feelings which they can’t articulate or are not ready to express, (Rubin, 2005).

Interpretation: The use of interpretation in art therapy, and its role in assessing clients, is a controversial one. Tobin (2001) discusses how when one creates a piece of art they engage in an act of projection and thus they express their “experience, emotions and moods, personality and psychic structure, energy, and degree of health and integration” (p. 5). Therefore the art they create can be viewed as an extension of the artist and can be used for observation just like nonverbal communication, body language and facial expressions (Tobin, 2001).

Tobin (2001) describes the “non-verbal communication” that occurs when one views a clients artwork. Tobin (2001) states that the “object or art informs the ‘subject’ or art therapist, and the art therapist projects an interpretation onto the art (it is important to avoid allowing one’s

own projections to obscure what the child is trying to communicate”. Yet the client knows best the meaning behind the art that they create. The client’s interpretation and narrative about their artwork is most important in the development of insight that makes for forward progress in therapy (Tobin, 2001).

Most art therapists believe that their role is to encourage clients to interpret their own art work by asking appropriate questions, and to facilitate a discussion about its meaning. Although the clients know more about the meaning of their art; the art therapist might pick up on things in the art that the client is unaware of. Tobin (2001) stresses the importance of the art therapist asking effective questions, which encourages the client to reflect on their art as a model of their life experience. This facilitates focusing on their life situation. For example, Avrahami (2005) states that the symbolism depicted in the art created by clients with PTSD enables them to cope in a way more suited to the trauma’s nature that is neither linear nor verbal. Symbolism in a client’s artwork contains the complexities of fragments of memories, sensations, colors, and shapes that line the various events and periods of the client’s life.

Malchiodi (2007) reports that a “great deal of research is being conducted to determine if there are recurring symbols, artistic content, and styles of drawing that may be connected to emotional disorders, trauma, physical illness, or neurological problems (p. 7).” To date, art therapists have studied reoccurring content depicted in art created by adults diagnosed with dissociative disorders and severe childhood trauma. Another aspect that has been researched is the connections between images and colors and certain psychological or physical conditions. Simple human figure drawings are also being explored to see if they can reveal anything about the creator’s personality, development, trauma, and neurological symptoms, among other maladies.

Themes: Rubin, (2005) states that two common themes can be found in children's art work: aggression and love (or need for affection). She practices from a psychoanalytic background and believes that themes of aggression can be demonstrated from oral, anal, or phallic phases. An example of oral aggression may be a child's drawing of a monster who the child says is going to eat up other family members. Rubin discusses another example of a client of hers who demonstrated anal aggression in a model of a volcano that was described as being explosive with lava spilling over. Rubin gives a third example of a boy she treated who she thought was displaying phallic aggression by thrusting his knife into a pile of clay cutting up what he reported to be "enemies."

Sexuality: Sexuality was the second greatest theme Rubin found demonstrated in the art created by her child clients (2005). She thought sexuality was revealed in themes of nurturance or physical comfort. For example, one child Rubin treated talked about how her art work reminded her of her mother who was "big, round, warm and happy." Rubin states that "themes relating to lack of protective care, rejection, or abandonment sometimes appear" (2005, p. 130). For example, one of her young clients drew a picture of a dog kicked out of the house who the child reported had been left to die. Rubin states that another example of a theme of love or sexuality can be pre-genital wishes for a kind of merger as when a child's two wood scrap houses came together to hug and kiss. Also displayed in the windows were family members hugging and kissing to further emphasize the point.

Competition: Themes of competition often with older and stronger adversaries are also common, which may suggest an oedipal quality. It can be demonstrated by major concerns or receiving some kind of injury to the self. It could also be suggesting anxiety about bodily injury as punishment for "bad" aggressive or sexual impulses and or confusion about sexual identity.

Monsters: Malchiodi, (1990) mentions that many of her young clients would use the metaphor of *monsters* to represent traumatic experiences such as having an abusive parent, being neglected, being a victim of incest, or having severe emotional trauma.

If a particular theme is repeated several times in a child's products then one can assume its special importance in their inner life (Rubin, 2005). Symbols can often contain more than one idea. For example, a child may describe wanting to be away from a snake that he drew because he is frightened by it, at the same time the child may wish to be the snake in order to scare away others. It is always important to ask the client what the art work means to them or their interpretation of it. Self-representation may reflect the way things realistically are, or may be projections of children fantasies. They may convey how they wish or fear themselves to be, or they may represent different facets of their personality (Rubin, 2005).

Containment: Much of the reviewed literature explores the theme of containment. Avrahami, (2005) has a case example where one of her clients often put borders around his artwork when he started art therapy. As he became more comfortable with art therapy and started to process some of his unconscious traumatic memories, his technique become more fluid and he stopped using rulers, pens and creating borders. Instead, he started working with paints and other more messy materials. Morgan and White, (2003) give case examples where some of their participants added symbolic forms of containment in their art pieces such as cubes, boxes, and a frame around the picture similar to Avrahami's case study.

Empirical evidence for treatment efficacy using art therapy. Five of the nine reviewed research studies depicted cases where therapists used art therapy as an intervention to help their client's process their traumatic experiences. All of the studies reported that the clients had positive experiences of the art therapy and had a decrease in traumatic symptoms.

Anecdotal studies: Avrahami (2005) and Bowers (1992) both reported that the patients in their case studies were able to retrieve memories from their unconscious. Avrahami (2005) stated that art therapy facilitated bringing traumatic, dissociative and repressed material stored as unconscious sensory and photographic memories to consciousness. Bowers (1992) also reports that it helped her client to be able to retrieve childhood memories that were repressed. Harnden, Rosales and Greenfield state that “Mary’s drawings led to the surfacing of new material, contributed to the consolidation of an alliance with the therapist and gave further insight into her conflicts” (2004, p. 178).

Effect on symptoms: Most of the studies reviewed found that the participants had a decrease in trauma symptoms once the intervention was completed. Harnden, Rosales and Greenfield (2004) report that the child from their case study had an “increased self-esteem, decreased sense of hopelessness and depression, and resolution of her desire to commit suicide and of her symptoms of post-traumatic stress disorder” (p. 178). Avrahami (2005) reports two case studies in which she helped clients process their dissociative memories. She states that the clients experienced a unique integrative process that assisted change of the traumatic encoding from an isolated event to an integrated event that was interlaced with the rest of the client’s experience; an event that is associatively linked to thought, emotions, and other events in a personal biographical narrative. The concreteness of work with art media allowed her clients to observe the symbolism of their works and create a narrative about what they produced and experienced.

Structuring: In six of the nine research articles reviewed therapists gave the subjects themes or ideas of what they should create. Many of the themes were part of a suggested treatment modality to be used as an intervention to help the participant process their traumatic

experience. Many of the authors felt that the art created in therapy should be somewhat structured. Others disagreed and indicated that the client should be able to create whatever comes to mind. Most art therapists who advocated unstructured sessions also believed that the client will introduce themes of traumatic experiences spontaneously or unconsciously. No empirical evidence for the strength of one approach over the other was found in the literature review.

Inferences about the effectiveness of art therapy for treatment of PTSD in trauma-exposed youth were indirectly assessed by the therapist's clinical observation and sometimes by the client's self report. No standardized measures were reported across numerous studies (Avrahami, 2005; Bowers, 1992; Harnden, Rosales, & Greenfield, 2004; Klorer, 2005; Lantz & Raiz, 2003).

Most of the literature documented case studies. Lantz and Raiz (2003); Klorer (2005); Harnden, Rosales and Greenfield (2004) all reported case studies of children ages four years old to fourteen years old. These interesting studies provide the basis for arguing for the value of art therapy in the treatment of childhood PTSD. However, they are limited by their anecdotal nature, and point to the need for more formalized treatment outcome studies conducted across larger populations. Such studies are daunting to fund and create, and would take considerable institutional support to conduct.

Group studies: A number of studies were conducted on the use of art therapy with groups (Isaksson, Norlen, Englund, & Lindqvist, 2009; Kozlowska & Hanney, 2001; Pfeifer, 2010; Pifalo, 2002). Three of the four group studies included children as participants. One was with adult women ages 40 to 60 years old.

Length of sessions: There was a great difference in the range of time therapists worked with their clients in groups or individually. The shortest reported was a group that lasted for only seven sessions (Kozłowska & Hanney, 2001). The longest was a case study of a young girl who received art therapy for three years. Although it was for a long period of time, the author did not mention how often they met for sessions or how long the sessions were.

Summary: Art therapy has been influenced by psychiatry, psychology, counseling, education and the arts. It became a distinct profession in the 1940's. There are now about 3,000 licensed clinical art therapists. Therapeutic art-making can aid in connecting one's internal and external experiences, and allow for this increased self-understanding to be shared with others. Art therapy may be a beneficial form of treatment for children and adolescents with PTSD because it allows for clients to express themselves non-verbally. This format may be useful because much literature states that traumatic memories are stored pictorially without words. Common themes in the literature about art therapy include; interpretation, use of materials to help clients feel in control vs. loose expression and themes depicted in clients artwork such as competition, sexuality, monsters and containment.

Little research exists that provides a description of theories and techniques for using art media in the treatment of traumatized children and adolescents. Therefore, a general examination of the phenomena is an appropriate place to begin in order to take the broadest view possible and capture the nuances of this work in the narratives of experienced art therapists (Rubin & Babbie, 2010). The study will employ an exploratory design, collecting qualitative data through semi-structured interviews with practicing art therapists, to allow for breadth of discussion on this little researched topic.

CHAPTER 3

Methodology

Introduction

The goal of this study is to explore art therapist's theoretical underpinnings and techniques when working with children and adolescents who have histories of trauma and who may be diagnosed with PTSD. A qualitative, exploratory study was conducted using flexible methods through semi-structured interviews with art therapists to explore art therapist's theoretical backgrounds, preferred interventions for trauma recovery work with children and adolescents, and their thoughts on relationships between clients art and their symptomatology. A combination of closed ended questions and open ended questions were developed and deployed to elicit a conversation about the clinical experiences of participating art therapists.

Research Design

This qualitative study employed an exploratory design with a non-probability purposive sample. Qualitative data allows for depth and breadth of information collection in order to gain better understanding of the questions being explored. This choice of design reflects the fact that little research exists on the experiences of art therapist's in regards to their theoretical underpinnings, techniques used and interpretations of the relationship between children and adolescents with PTSD and trauma histories symptomatology and their art process.

Sample

Inclusion Criteria: Participants had academic preparation at the master's level as an art therapist, and had at least 2 years of post-graduate experience as an art therapist, as well as experience working with children between the ages of 5 and 17. All participants self-identified as doing art therapy with 50% or more of their clients. Participants had experience treating children between the ages of 5 and 17 who have been diagnosed with PTSD. Additionally, participants were at least nineteen years of age, English speaking and practicing in the continental US.

Exclusion Criteria: Respondents who did not meet the educational and practice requirements were not able to participate in the study.

Sample Size: The study had a sample size of five art therapists. All participants met the inclusionary criteria and identified as being white/Caucasian, females and ranged in age from 31 to 61 years.

Recruitment Procedures

The American Art Therapy Association, (AATA) public member data base, located on the web, was used to find possible study candidates. The *Art Therapy Locator* icon can be found on the right hand column of the home page <http://arttherapy.org/>. The *Art Therapy Locator* is a database of art therapists who are part of the American Art Therapy Association. It includes a description of art therapist's specialty of practice and their contact information.

Sample selection: The AATA database was reviewed to find practice characteristics and certification of each potential participant and a list was refined to exclude those who did not meet enrollment criteria as described above.

Recruitment email: All potential candidates who appeared to meet enrollment criteria were emailed information about the study and instruction about how to enroll (Appendix A).

Recipients of the email were also asked to forward the recruitment email to any art therapists they knew who they thought might meet inclusionary criteria and who may be interested in participating in the study.

Response rates: Approximately twenty art therapists responded to the recruitment email. Out of the twenty, seven stated that they did not meet the inclusionary criteria and ten respondents expressed interest in participating in the study. The study received three emails from art therapists expressing a concern that a social worker was researching a specialized field without appropriate training.

Five art therapists who met inclusionary criteria were able to schedule time for an interview and participated in the study. They indicated their interest by a return email, at which point a PDF of the informed consent (Appendix B) was sent in return through email. Interested participants reviewed the informed consent, agreed to participate and mailed or emailed a scanned copy of the signed consent form. At this point participants were emailed again in order to arrange times for a phone conference in order to conduct the interview (Appendix C).

Ethics and Safeguards

Risks of participation: Participants were informed that they might face risks associated with discussing past cases of working with children and adolescents with trauma histories or diagnosis of PTSD due to the possibility of vicarious trauma. For example, participants were informed that they would be asked questions about aspects of their professional work. Although the study did not ask questions per se about negative experiences as an art therapist, it is possible that the process could have brought up distressing memories of work with particular clients. While the study was not designed to elicit distressing information, it is well documented that clinicians who work with traumatized clients may themselves be at risk of developing signs or

symptoms of secondary trauma (Bride, 2007). While unlikely, it is possible that a general discussion about their practice with traumatized children may reveal that the person struggles with issues related to vicarious trauma.

Resources: Study participants were provided with a list of online informational resources about compassion fatigue and vicarious traumatic stress. These web resources contain information about self care for professionals working with trauma survivors, and list specific resources for exploring personal and professional growth in this area. These online resources were listed in the Informed Consent document.

Benefits of participation: Participants were told that they may benefit by having the opportunity to reflect on their experiences or by gaining new perspective through reflecting upon their experiences using art therapy for recovery work with children and adolescents. They were told that they could benefit indirectly to the extent that this research may contribute to improved clinical practice for this vulnerable population.

Voluntary nature of participation: Participants were told that their participation in the study was voluntary in the informed consent and were reminded at the beginning of their interview. They were also told that they could refuse to answer any question and could end the interview at any time. Participants were notified that they could request to withdraw from the study up to and including March 1, 2012 by sending the investigator an email requesting same, and that the investigator would immediately destroy all materials related to subjects who withdrew, and that their data would not be included.

Informed consent procedures: Participants who expressed an interest in exploring participation were emailed a printable copy of the informed consent form. They were asked to read the informed consent and if they agreed to participate to then print and sign the form.

Participants were asked to keep one copy for their own records and to email a scanned copy or mail a copy of the signed informed consent to the researcher. At the beginning of each phone interview the informed consent was reviewed with each participant and participants were provided an opportunity to discuss any questions about the study or the informed consent.

Precautions taken to safeguard confidential and identifiable information:

Human Subjects Review Board: The Human Subject Review Board (HSRB) at Smith College School for Social Work approved this study after assuring that all materials met Federal and college standards for protection of human subjects. A copy of the HSRB's approval letter is provided in Appendix D.

Informed consent forms: The Informed Consent (IC) form is the only document that identifies the name of the participant (Appendix B). IC forms were assigned a case number as they arrived. Printed forms were kept in a locked drawer to which only the investigator had the key. IC's that were forwarded in an electronic format were stored on the investigator's personal computer in a password protected file.

Study ID numbers: The case number assigned to the signed informed consent form was also written on the researchers scoring sheets, digital recording, and transcripts of the interview. Only the researcher had access to the locked drawer or electronic file. No master code sheet was kept.

Audio tapes: Audio tapes were coded with the case number, as were the transcripts and score sheets. No other identifying information was written on them. The audio tapes were kept in a locked cabinet, the key for which is in the control of the researcher.

Transcriptions: The researcher personally transcribed the audio tapes into an electronic, printable format. These transcripts were password protected. Only the researcher had the

password. The transcriptions were reviewed by the researcher and any possibly identifying information was be redacted in the final transcription which was later be viewed by the research advisor.

Email exchanges: Email exchanges were stored on the investigators personal computer in a password protected file. Once the study closed, all email correspondence was deleted from the computer. No email addresses were archived. No email exchanges were stored on external intermediary servers once they are retrieved by the study investigator.

Clinical material: Participants were asked to take care when describing a case so as not to include any identifying information about the child or their family. As a double protection, the investigator did not transcribe any case names into the data base.

Thesis: The thesis document includes vignettes or quoted comments. These were be prepared carefully and reviewed by the research advisor. Any possible identifying information was disguised prior to submission.

Document retention: All notes and audio tapes will be stored in a locked or password protected environment for three years after study enrollment ends as required by Federal regulations and, after that time, they will be destroyed.

Data Collection

Overview: The data collection instrument was an interview guide created to elicit narratives from art therapists regarding their theoretical influences, techniques used, and thoughts on relationships between client's production of art work and their symptomatology. A registered art therapist was asked to review the interview guide and provide feedback. Her suggestions were incorporated into the final draft of the interview guide. A copy of the data collection guide can be found in Appendix E.

Screening process:

Informed consent procedures: Ensuring that individuals were fully informed about the research study and their participation in it was a critical component of the research design. Potential participants meeting inclusion criteria were mailed an informed consent (Appendix B) and asked to sign one copy to return to the researcher and to print a copy for their own records. At the beginning of each interview the informed consent was reviewed and participants were given an opportunity to ask questions about the informed consent. Participants were also encouraged to contact the researcher at any point if a question about the informed consent arose.

Survey Instrument: The final survey included open-ended and closed-ended questions in four areas: demographics, theoretical orientation, diagnostic procedures and/or tools, and current clinical practice. Questions about participants were asked to get a better understanding of the sample and how their similarities or differences may influence responses. The study asked about participant's theoretical orientation to see if there was a relationship between participant's theoretical underpinnings and clinical practice. Questions about participant's use of diagnostic procedures or tools were asked to explore art therapist's role in their settings and to determine what trauma assessments were most frequently being used, if any. The evaluation of participants clinical practice was used to explore commonly used interventions and therapeutic techniques. It also included several questions about the relationship art therapists noticed between their client's symptomatology and their artistic processes.

Data Analysis

Qualitative data from open-ended questions were analyzed using inductive logic. Throughout this process, the researcher kept careful, detailed notes of the process. A qualitative content analysis was performed to identify phenomena in the data (e.g., participants reporting

techniques used and the relationship between children and adolescents with PTSD and their process of making art) and describe the frequency of such phenomena in the sample.

Strengths and Limitations of the Methods

Strengths: A primary aim of the study was to develop and pilot a methodology for looking at this complex topic. The study was designed to explore, in depth, the perspectives of a small number of art therapy professionals. A possible strength of the research design was the fact that it was anonymous and could be completed privately without interaction with the researcher.

Limitations:

General: The study's methodology had a certain amount of subjectivity. For instance, qualitative, narrative data is inherently subjective. Likewise, interpreting and analyzing these narratives also involved subjectivity.

Methodological bias: The study's methodology had bias. First, selection bias was generated by the fact that the sample for this study was relatively small in size and nonrandomized. Second, the study has little transferability and generalizability because of its small sample size, 5 art therapists, and homogeneity of participant's demographics.

Measurement bias: Measurement bias, in the form of social desirability bias could have been expected on the part of the participants who may have been influenced to convey a favorable impression of themselves and their ability to effectively use art therapy to reduce trauma symptoms in their clients. The research design attempted to mediate this form of bias by clarifying in the informed consent and survey instructions that the survey was anonymous, so neither the names, e-mail addresses, nor the IP addresses of participants were known.

Personal bias of researcher: The study may be affected by personal bias of the researcher. The interview guide was created by the researcher therefore; it may be subject to researcher bias and assumptions. In effort to avoid this occurrence the guide was reviewed by an art therapist and suggested changes were made nevertheless the instrument was self made and as a result subject to researcher bias. Lastly, in analyzing the data it is possible for the narratives to be misconstrued or influenced by the researchers own preconceptions. To prevent this bias from skewing the data the researcher used the participants own dialogue whenever possible and remained focused on the participants own perspectives when analyzing the data.

CHAPTER IV

Findings

This was a qualitative study using an exploratory design with a non-probability sample. The purpose of the research was twofold: to develop and pilot a methodology for looking at theoretical underpinnings and techniques employed by art therapists with the goal of adding to our knowledge about the use of art therapy to treat children and adolescents with trauma histories and PTSD. The study surveyed practicing art therapists who have advanced degrees and certifications in art therapy and who have been practicing for at least two years with the stated population.

This chapter contains a summary of the major findings of the study, a demographic description of the sample, and summaries of the qualitative data. To illustrate the major findings, tables have been used to supplement descriptive summaries of the data. The data listed in the tables was taken from narrative responses that the five participants provided to open-ended questions. The notations used in the tables are reproduced by extracting key words participants expressed.

Due to the small sample size in this pilot study, the validity of the findings are not reliable and should not be read as such. However, some observations and inferences can be made for further exploration. Participant responses to the study revealed major findings across three areas of focus: theoretical orientation, diagnostic procedures and clinical practice.

Table 1

Sample demographics (N=5)

Subj	Age	Years in practice	Degree(s)	Certifications	# Hours a week working as AT?
1	48	20	Bachelors in art, masters in art therapy	ATR, BC-ATR	24-30
2	61	15+	PhD	LCAT	10-20
3	41	15	Bachelors is psychology & art, masters in creative arts & therapy	ATR, in process of LMHC	20
4	31	5.5	Bachelors fine arts, masters in art & art therapy	LCPC	40
5	56	11	Masters in marriage & family therapy	BC-ATR	20-30

All respondents identified as Caucasian, females and ranged in age from 31 to 56. This was a very experienced group of practitioners with various advanced degrees and certifications. Art therapists were practicing in different states therefore, requirements to practice as an art therapist differed.

Table 2

Practice setting

Subj	Current practice setting	Other practice settings	State
1	Therapeutic day school	Outpatient children, dual diagnosis adults	IL
2	University professor, private practice	Day treatment emotionally disturbed children	NY
3	Educational inpatient psych	Inpatient psych and & partial hospitalization program	MA
4	Acute psychiatric hospital for children and adolescents	Outpatient mental health community center	IL
5	Private practice and an agency	NA	CA

Participants differed in the settings that they currently worked in however, many of their responsibilities and experiences were similar. For example, participants working in hospital settings often brought up the importance of considering safety when working with clients and used similar interventions.

Table 3

Theoretical orientation: Personal influences

Q. Next, I would like to hear more about your influences in becoming an Art Therapist (your journey).

Subj	Describe your background prior to becoming an art therapist	How did you come to be working with children with PTSD?
1	Artist - interest in psych- book	Insight oriented, symbolism help heal
2	Artist- sand play therapy	Through internships
3	Psych & art interest, brother introduced me to program at his school	Population of interest
4	Art interest all life - introduced to therapy working a sexual assault crisis line- AT	No data
5	2nd career- creative, nurturing, intellectually stimulating	Not being able to have a child/ nurturing children/ agency is protective services foster care and adoption

Subj	Were you exposed to any particular theoretical orientation?	What has influenced your particular philosophy of work?
1	Relational, reflecting	Seeing the effect, mentors
2	Natalie Rogers, humanistic, person-centered expressive art therapy	Natalie Rogers
3	CBT, Freudian, Eclectic	Theories, mentors, children
4	YWCA training	Many things, family, culture, professors, philosophy, humanistic perspective
5	All, family systems and attachment	Art reaches areas of brain and person other therapies can't- underlying trauma

Four out of five art therapists started their careers as artists. Some participants spoke to how they found the act of creating art to be therapeutic which lead them to want to seek a degree that would fuse their two interests, art and therapy. Malchiodi (2007) states that there are two forms of art therapy. One definition being art as therapy, which several participants who started out as artists seemed to believe as a theoretical underpinning. The second definition being art

psychotherapy which participants coming from a psychoanalytic background appeared to employ.

Table 4

Theoretical orientation: Referral patterns

Subj	How are clients referred to you?	Do clients come to you with a diagnosis already established?	Do you evaluate your clients to determine a diagnosis?
1	School districts	Yes - in IEP	No
2	Word of mouth, school district, Family therapy center, Psych Today, Self referrals	Yes, Some	Yes
3	Psychiatrists	Yes, some questionable	Yes, work with treatment team
4	From assessment service (if threat to self or others)	Yes, a preliminary diagnosis	Not usually
5	Social worker, parent, self referred, therapist or suggested for teenagers resistant to talk therapy	Not usually	Yes

Participants varied greatly in how clients were referred to them which is most likely related to what type of setting they were working in. Similarly participant's responsibilities and therapeutic styles seemed to be related to their place of work. For example if there was a psychiatrist at the facility they would likely be responsible for determining a diagnosis but if an art therapist was working at a private practice they may be more apt to make this determination.

Table 5

Practice: Evaluation

Q. Do you evaluate your clients for PTSD?

Subj	Response	(If yes), what is your approach to diagnosing PTSD?	(If yes), do you use any formal trauma assessment tools as part of your assessment?	Do you refer your clients out to have assessments conducted?
1	No	NA	NA	Psychosocial Hx already
2	Yes	Clinical observation, interpretation	No	No
3	Yes	Clinical observation	No	Yes, to Social Worker
4	Yes	Clinical observation	No	Psychiatrist determines diagnosis in first 24 hrs
5	Yes	Looking at psychosocial Hx & symptoms	No	Sometimes a Psychologist or Psychiatrist

The literature described several trauma assessment tools commonly used by art therapists such as: Diagnostic Drawing Series (DDS), the Silver Drawing Test (SDT), Draw a Story (DAS), the Levick Emotional and Cognitive Art Therapy Assessment (LECATA), and the Person Picking an Apple from a Tree (PPAT), and the House –Tree - Person (HTP) to name a few. On the other hand, out of the nine empirical studies reviewed, six of the studies used the therapist’s clinical observation as an assessment tool. I was surprised to learn that participants who were active in diagnosing clients did so through use of clinical observation alone. None of the participants in this study reported use of a trauma assessment tool for their practice.

Table 6

Practice: Choice of creation

Q. Do you allow your client to create anything they choose?

Subj	Create anything they choose	Ask them to create something in particular	How do you determine which intervention to use
1	Yes, mostly	Yes, structure and intervention	Relational component
2	Yes, mostly	If young ask for house, tree, person	Developmental ability and assessment
3	No	Safe containment	Talk for assessment try allow freedom
4	Yes with some restrictions- no gang symbols, no negativity/ violence if not therapeutic would redirect	Yes- masks, hope and dream jars, word collage about life	If need more structure
5	Mostly/ sometimes	Common activity middle school age- scrolls roll up or open for control	Often ask to create visual understanding of what feeling/thinking

Some participants (n=2) spoke about giving a directive to provide “structure” or “containment.” One participant said that she may give a directive depending on the stage of the relationship formation. She said that if she felt as though the client needed more structure or was struggling with issues regarding safety, she may ask the client to draw a picture of an island and ask them to draw what they would need to survive or feel safe on the island.

Another participant gave an example of an activity she often prescribes for middle school aged children with histories of trauma who are working on feelings of control. She said that she may ask them to create a scroll and then they have the option to roll up the scroll to keep their art private or open it up giving them control of who they share their art, feelings and experiences with.

Another participant indicated that, if their client was very young, she may ask them to draw a house, tree, and person which, is a commonly used assessment tool in art therapy.

Another participant said that she will sometimes have clients make collages with precut words to express themselves, or have them make a mask. Another art therapist talked about the use of making masks with children and adolescents with PTSD. She said that she used the activity so that clients could draw, paint or collage on the inside of the mask to show how they were feeling internally that others may not know. Then she would ask them to decorate the outside as well to express what they allow others to see.

Participants spoke to their theoretical backgrounds and clinical observation when asked how they determine what to ask their clients to create. One participant said that sometimes she will suggest that a client partake in joint art work with her for an activity to help build trust and as a way to connect. Others mentioned that they may decide to give a client a directive to create something structured if they feel as though the client needs containment.

Table 7

Practice: Choice of medium

Q. Do you allow your client to work with *any medium they want*?

Subj	Response?	(If yes), what mediums do you have available to your clients?	(If yes) do you think there is a relationship between which mediums clients' choose and their symptomatology?
1	Yes, mostly	Drawing utensils, skulpty, 3D modeling	Choose what they need
2	Yes and suggest photographs and journaling	Sand tray, paint, crayon, chalk, canvas, acrylic, clay, stone ware, terracotta, photography	Yes, rage=clay cheery=water color
3	Structured within reason/ limited	Drawing utensils, popsicle sticks, tape	Yes
4	Allow for some choice because they haven't had many	Anything that's not a safety risk, no heat, welding, stones or welding	Absolutely- control and feeling of materials
5	Sometimes	Everything	Yes, trauma Hx = more controlled & muddy colors

Most interviewees spoke about release vs. containment. Participants felt as though they could learn a lot about a client by observing the mediums they chose. Clients who have trauma histories seem to want materials that are easier to control. The type of medium a child uses may help them to express themselves but if the medium is too “loose” or “fluid” it may be difficult to control and the child may regress. Additionally, some felt as though clients would instinctively work with materials that would help them process what they were ready to work on. The two participants who worked on inpatient psychiatric settings spoke about considering safety when choosing mediums to bring to art therapy sessions.

Table 8

Practice: Guided use of medium

Q. Do you ever *suggest what medium* the child should use?

Subj	Response	(If yes), how do you decide which medium to recommend?	(If yes-2), how do you decide which mediums to recommend (2).	(If yes), what mediums do you have available to your clients?
1	Yes if anxious suggest watercolors	Intuitive	Release vs. containment	Drawing utensils, sculpty, 3D modeling
2	Yes	Observation of what they may need	David Ofeald, observation	Sand tray, paint, crayon, chalk, canvas, acrylic, clay, stone ware, terracotta, photography
3	Yes	Activity Level, goals, safety	Consider activity level, diagnosis, individual or group, contain vs. express.	Drawing utensils, popsicle sticks, tape
4	Yes	Depending on what they need, encourage try and master new things	Safety, makeup of unit, holidays, seasons, themes, requests from Pt's, mediums clients can control (be successful)	Anything that's not a safety risk, no heat, welding, stones or welding
5	Yes, depending on experience trying to replicate if afraid to make mistakes will create a project that allows for it.	Art as a language	Control vs. loose, what client needs, psychodynamic create nightmare and take control of it/change it.	Everything

All 5 participants indicated that at times they have suggested clients use particular mediums. One art therapist stated that if she observed that a client was afraid to make mistakes with their artwork she may create a project using a medium that allowed for mistakes. Another

art therapist stated that her choice depended on whether she wanted to help the client release their emotions or contain them. She stated that if they seem to be working out feelings of anger she may suggest that the client creates a large project with fluid mediums. Similarly, a few other participants mentioned the use of clay to express or work out anger. On the other hand, if she wanted to encourage the client to contain their emotions she may suggest that they use markers or create something smaller.

Table 9

Practice: Guided productions?

Q. Do you ever ask your client to create something in particular?

Subj	Response	(If yes), how do you determine what to ask them to create?	Do your clients create anything they choose?
1	Yes, structure and intervention	Relational component	Yes, mostly
2	If young ask for house, tree, person	Developmental ability and assessment	Yes, mostly
3	Safe containment	Talk for assessment try to allow freedom	No
4	Yes- masks, hope & dream jars, word collage about life	If need more structure	Yes with some restrictions- no gang symbols, no negativity/ violence if not therapeutic would redirect
5	Common activity middle school age- scrolls roll up or open for control	often ask to create visual understanding of what feeling/thinking	Mostly/ sometimes

The participant whose work was described as more directed, and the participant who listed some restrictions both work in inpatient psychiatric settings. Their responses suggest that

considering clients safety is a great factor that influences their therapeutic style. Safety was a topic that came up frequently during both of their interviews.

Table 10

Symptomatology and clients's art

Q. Do you think there is a relationship between client's symptomatology and the color(s) they use; between their artistic actions i.e.: brush strokes, how hard they press down with drawing?

Do you think there is a relationship between . . .

Subj	<i>Medium and symptomatology?</i>	<i>Age and medium?</i>	<i>Color and symptomatology?</i>	<i>Actions and symptomatology?</i>
1	Choose what they need	No pattern	Red and black = angst bold contrast, duality of color.	Yes, ex: anger and ADD erratic
2	Yes, rage=clay cheery=water color	Older = fussy Young = paint	NA	Yes, definitely
3	Yes	More gender, boys 3D	Red & black = borderline yellow = ambivalence	Behaviors sign of escalation/agitation
4	Absolutely- control and feeling of materials	Yes more developmental level regression and mastery, gender too	Yes their own assignment of meaning to colors	Yes
5	Yes, trauma Hx more controlled, muddy colors	Yes	Yes but different colors mean different things to each individual	Yes, absolutely

The colors red and black were the two most commonly discussed colors during participant's interviews and they were highly represented in the literature. The colors red and black may represent signs of psychopathology or distress for some art therapists. On the other hand, several participants were reporting that colors are meaningful however; the meaning is derived from the client's definition of it. Interestingly, one participant who felt as though the

client's assignment of meaning to color was most telling later discussed the use of colors red and black as a theme depicted in art created by children with PTSD and trauma histories.

Table 11

Interpretation of children's artwork

Q. Do you analyze your client's are work?

Subj	Analyze/interpret art work	(If yes), do you include in your assessment how your client interprets or narrates their art work?
1	Formulate ideas and thoughts	Yes
2	Keep in back of mind for a formulation	Yes
3	Yes	Yes
4	Yes for developmental level	Yes
5	Keep in back of mind, look for patterns	Definitely, projection of some sort of free association

The interpretation of a client's artwork was mentioned in much of the literature.

Participant's responses were complimentary of the literature. As expected most reported that they would use client's art to help formulate an assessment however they were not reading direct meaning from what the client produced. Participants appeared to practice a more "modern" form of art therapy because they were not psychoanalyzing the art their clients produced to help formulate a diagnosis. Instead, participants derived more meaning from their client's description or narrative regarding their artwork. One participant stated that she didn't feel the need to know the clients narrative of the art they created. She seems to practice the belief (art as therapy) that creating art alone is therapeutic.

Table 12

Themes in the artwork of children with PTSD

Q. Have you noticed any common themes in the art produced by children with PTSD?

Subj	Response	Themes
1	Yes	Lost, imagery of house and family, orifices scaring
2	Yes	Pounding clay when angry, loose with colors, loss of control, placement of people in sand tray
3	Yes	Anxiety and acting out, naked figures
4	Yes	Red & black = anger & pain, images of anger & pain, locked/closed things, dichotomy of inside & outside, self harming & wounds
5	Yes	Muddy colors, control, fear of mistakes, covering things over, not being able to differentiate feelings

Interestingly, participant's answers differed some regarding specific themes that can be found in art created by children and adolescents with PTSD however, examples given are similar and related. Knowing common themes depicted in art work created by children and adolescents with PTSD can be useful for several reasons. Art therapists could benefit from knowing common themes so that they can be aware of them if they show up in their client's artwork. This way they can be used for clinical observation towards creating a working assessment, determining a diagnosis and then considering interventions and treatment plans.

CHAPTER V

Discussion

The aim of this exploratory study was to add to the knowledge about art therapist's theoretical underpinnings and techniques when working with children and adolescents who have trauma histories and who may be diagnosed with PTSD. A qualitative study was conducted using flexible methods through semi-structured interviews with art therapists. Qualitative data from open-ended questions was analyzed using inductive logic. A qualitative content analysis was performed to identify phenomena in the data (e.g., participants reporting techniques used and the relationship between children and adolescents with PTSD and their process of making art) and describe the frequency of such phenomena in the sample.

The questionnaire used in the study was developed after an extensive review of the relevant literature and made use of open ended questions designed to explore participant's theoretical orientations, diagnostic strategies, and clinical practices, including their understanding of the relationships, if any, between the presenting symptoms of their trauma-exposed clients and their artistic actions, chosen mediums and colors. The study asked about common themes depicted in the children's artwork. In addition participants were asked to discuss how they approach formulating assessments and how they determine which intervention to use.

There is a substantial and growing literature documenting the use of art therapy to treat trauma-exposed youth. This study contributes to that literature by exploring practicing art therapist's responses to open ended questions that were created using common themes depicted

in the literature and prior studies. In summary, the study's sample was comprised of art therapists with academic preparation at the master's level, with at least two years of experience, who mostly work with children and adolescents with trauma histories and PTSD. The study addressed the following question: What theoretical underpinnings and techniques are in use by art therapists when working with children and adolescents with trauma histories and/or PTSD.

This study was undertaken with the hope that greater awareness of the use of art therapy for trauma recovery work with children and adolescents would inform and direct practice with this population, specifically in terms of using art to express implicit memories, and educate mental health clinicians about this important, emerging field of practice.

The results of this study suggest that, for this sample, participants had various theoretical backgrounds but were mostly influenced by mentors. Most participants were not determining client's diagnosis but were using clinical observation to contribute evaluating clients. Several participants' considered clients choice or suggested medium in terms of release vs. containment. All clients thought that there was a relationship between their client's symptomatology and their artistic actions, some participants found color to be relevant as well. Participants provided several different themes they have observed in the artwork created by this population.

This chapter will consider these findings relative to the body of literature reviewed earlier in this report, examine the implications of the findings for clinical practice and policy, and provide recommendations for future work.

Continuity of this Study and Past Research

The interview protocol questions were derived after an extensive review of the literature and past studies. The literature and past studies highlighted themes of interpretation, use of mediums, colors, and common themes depicted in art created by clients with PTSD. The

literature made an argument for art therapists to not psychoanalyze client's artwork by developing meaning from symbolism (Tobin, 2001). Instead Tobin suggested that art therapists use observation of client's artwork to guide them in the types of questions they may ask a client to help them build a narrative. The literature suggested that art therapists pay more attention to client's interpretation and given meaning of the art that they produce to formulate an assessment (Tobin, 2001). Study participants were asked about their use of interpretation and their client's narrative in forming an assessment after taking these factors into consideration.

Client's choice of medium was also a common topic in the literature of art therapy. Previous studies also explored mediums young people with PTSD used. Therefore, the study asked participant's how they determined which mediums to use with clients, and if they felt as though there was a relationship between the mediums clients use and their symptomatology. Avrahami (2005), reports that clients use various mediums to express themselves in an attempt to recreate memories and feelings. Avrahami (2005) also discussed that clients with trauma histories typically use controllable materials and once they are able to use more fluid materials they are able to explore and process implicit emotions and memoires. Similarly the literature and reviewed studies explored the use of color and themes that were commonly depicted in art produced by children and adolescents with PTSD. All of these topics were used to formulate questions for the interview guide in order to stimulate conversation with art therapists regarding their opinions upon the matters.

Consistency of Findings with Previous Work and Future Research

This studies small sample size of five participants limited its generalizability. All participants were white, Caucasian females. It could be beneficial for a study to include art therapists who practice in a wide range of settings with diverse educational and work experiences

for a more generalizable data. It would be helpful to recruit male participants as well as participants from different racial and ethnic backgrounds for a more comprehensive study. Future studies may also gain from recruiting participants from various states and degrees of licensure. A larger and more diverse sample size is recommended for future research.

It may be beneficial to learn how many social workers are currently using art as an intervention for working with children and adolescents with PTSD, and explore where their clinical knowledge originates. It is plausible that many social workers working with this population use art as an activity or means for initiating discussion due to the population's developmental capabilities. If there are many social workers using art as a clinical intervention then an argument may be made for social workers to have further training in the theoretical underpinnings that inform this important work.

Further research to explore the use of art therapy interventions to lessen PTSD symptoms in children and adolescents may be valuable. The literature states that the use of art therapy is an effective form of treatment for children and adolescents because it allows them to express themselves non-verbally. After much exploration it appears that there has been little empirical research done on this topic. The field can benefit from examining the use of different interventions to learn which techniques are most effective for this vulnerable population.

It could also be helpful to further examine common themes shown in the art work of children and adolescents who have PTSD. If professionals have a better understanding of what to look for it could help in formulating assessments and diagnosis.

Implications for Social Work Practice

Art therapy is an emerging field of practice that has found a practical way to implement knowledge about the neurobiology of trauma for treating children and adolescents with PTSD.

Art therapy proposes a practical way of thinking about trauma and a nuanced application of techniques and interventions. Art therapy is unique in how it encourages clients to produce art in order to express implicit memories that are stored non-verbally in the mind. Social work and art therapy are divergent fields that have come from a similar place. Art therapy and social work shares common ground consequently we may have a lot that we can learn from one another.

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APPENDIX A

Recruitment Email

Dear (*Participants name here*)

Hello. My name is Merryl Raubeson. I am a graduate student at Smith College School for Social Work. I am writing to invite your participation in a research project that is exploring the use of art therapy with children and adolescents. You have been selected as a possible candidate for this study after reviewing your profile on the AATA's "art therapy locator."

The study aims to assess and understand the theoretical underpinnings and techniques used by experienced art therapists in trauma recovery work with children and adolescents. Participants will be asked to participate in a semi-structured telephone interview. The interview is expected to take from thirty minutes to an hour to complete. You will also be asked about your age, gender, race, and how many years you have been practicing as an art therapist.

In order to participate, art therapists would need to meet the following criteria:

- 1) Academic preparation at the master's level as an art therapist.
- 2) Have at least 2 years of post-graduate experience as an art therapist.
- 3) Work with children ages 5 – 17 and self identify as doing art therapy with 50% or more of their clients
- 4) Have some experience treating children who have been diagnosed with PTSD.
- 5) You must be at least nineteen years old to participate, speak English, and practice in the continental US.

If you know anyone who might be interested in participating in this study and you think they meet the criteria listed above please forward them this email.

Could you please forward this email to any art therapists who you think might meet inclusionary criteria and who may be interested in participating in this study. If you or someone you know is interested in taking part in this research project, please contact me at the following email address:.... I am very appreciative of your time and possible interest in this study.

Sincerely yours,

Merryl Raubeson
Graduate Student in Social Work
Smith College School for Social Work

APPENDIX B

Informed Consent

Dear Participant,

My name is Merryl Raubeson and I am a graduate student at Smith College School for Social Work. I am conducting a research study on the use of art therapy for treatment of children and adolescents who have been diagnosed with PTSD. The aim of this exploratory study is to clarify the theories and techniques that experienced art therapy practitioners have found useful in their work with traumatized children and to discuss aspects of this practice that may be transferable to the field of clinical social work. The study will employ an exploratory design collecting qualitative data to allow for breadth of discussion on this little researched topic. This research will be presented in my master of social work (MSW) thesis and may be used in possible future presentations to mental health clinicians, art therapists, researchers, or in publications in professional journals.

Your participation involves one telephone interview which is expected to take from thirty minutes to an hour to complete. You do not need to disclose your telephone number to participate; you will be provided with a number to call at an agreed upon time and will speak only with me.

At the beginning of the phone interview you will be asked if you have any questioning about the study or about this informed consent, and any questions you may have will be answered. You will be asked a few questions to confirm that you meet all the inclusion criteria for the study. If you agree, the interview will be tape recorded. Your will be asked for permission to

turn on the recording device. If you prefer not to have the interview recorded, the interview will not be recorded.

The interview will be guided by an interview tool developed for the project. The interview asks questions that are designed to explore the theoretical underpinnings that inform your trauma recovery work with children and adolescents as an art therapy specialist. You will also be asked to discuss the types of modalities you select for treatment sessions with child patients and asked about your interpretation of the relationship between client's symptomatology and art work they produce. You will also be asked for information about your age, gender, race, and how many years you have been practicing as an art therapist.

Your participation is entirely voluntary. You can end the interview at any time. You can withdraw from the study at any point during the interview. You can skip questions that you don't want to discuss.

If you would like to have a copy of the study results, you will be asked to provide an email address; once the thesis is published, you will be sent the URL pointing to an electronic copy of the study.

The risks of participating in this study are considered minimal. You will be asked to discuss aspects of your professional trauma recovery work with children. It is possible that you will find some of the questions more difficult to answer than others. Although the study does not ask questions about negative experiences as an art therapist, it is possible that the process could bring up distressing memories of work with particular clients. While the study is not designed to elicit information that is distressing, it is well documented that clinicians who work with traumatized clients may themselves be at risk of developing signs or symptoms of secondary trauma (Bride, 2007). You will be provided with a list of online informational resources about

compassion, fatigue and secondary traumatic stress. These web resources contain information about self care for professionals working with trauma survivors, and list specific resources for exploring personal and professional growth in this area. The list appears at the end of this informed consent document.

You may benefit by having the opportunity to reflect on your experiences or by gaining new perspective through reflecting upon your experiences using art therapy for recovery work with children and adolescents. You may benefit indirectly to the extent that this research may contribute to improved clinical practice for this vulnerable population. You will not receive any payment or other form of compensation for your participation.

Your name and professional contact information will only be known to me and will be treated with the utmost confidentiality.

Email exchanges: email exchanges will be stored on my personal computer in a password protected file. Once the study is closed, all email correspondence will be deleted from the computer. No email addresses will be archived. No email exchanges will be stored on external intermediary servers once they are retrieved by me.

Informed consent forms: The informed consent contains your signature. Informed consent (IC) forms will be assigned a file number as they are received. If returned by mail, printed forms will be kept in a locked drawer to which only I will have the key. IC's that have been forwarded in an electronic format will be stored on my personal computer in a password protected file.

Study ID numbers: The file number assigned to the informed consent form will also be written on my scoring sheets, digital recording (if any), and transcripts of the interview. Since the informed consent forms will be separated from other study data and be stored in a locked

cabined or password protected electronic folder, no identifying information will be coded on study documents. No master code sheet will be kept.

Audio tapes will be coded with the file number. No identifying information will be written on the tape or recorded on the tape. The audio tapes will be kept in a locked cabinet.

Transcriptions: I will personally transcribe the audio tapes into an electronic format. The transcripts will be password protected. The transcriptions will be reviewed by only me and any possible identifying information will be redacted in the final transcription which may later be viewed by my research advisor, Dr. Irvin.

Clinical material: Please take care if describing a case so as not to include any identifying information about the child/patient. As a double protection, I will not transcribe any case names into the data base.

Thesis: The thesis document may include vignettes or quoted comments. These will be prepared carefully and reviewed by my research advisor before submission of the thesis document. Any possible identifying information will be disguised prior to submission.

Document retention: All notes and audio tapes will be stored in a locked or password protected environment for three years after study enrollment ends as required by Federal regulations and, after that time, will be destroyed.

Your participation is entirely voluntary. You may decline to answer any particular question or questions, and can stop the interview at any time. You may request to withdraw from the study up to and including March 1, 2012 by sending me an email requesting same. I will immediately destroy all materials related to you if you withdraw, and your data will not be included in analyses. It will not be possible to withdraw from the study after March 1, 2012 because enrollment will have closed and data will already have been aggregated and dissociated

from file numbers. If you have any concerns about your rights or about any aspect of the study, you are encouraged to call me at_____.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant _____ Date: _____

Signature of Researcher: _____ Date: _____

Researcher's Contact:

Merryl Raubeson

RESOURCES

These web resources contain information about self care for professionals working with trauma survivors, and list specific resources for exploring personal and professional growth in this area. These online resources will also be listed in the Informed Consent document

The Compassion Fatigue Awareness Project© is dedicated to educating caregivers about authentic, sustainable self-care and aiding organizations in their goal of providing healthy, compassionate care to those whom they serve.

URL: <http://www.compassionfatigue.org>

Gift from Within is a non-profit organization dedicated to those who suffer post-traumatic stress disorder (PTSD), those at risk for PTSD, and those who care for traumatized individuals. Through its online resources the project disseminates educational material, including videotapes, articles, books, and other resources about PTDS and secondary trauma. .

URL: <http://www.giftfromwithin.org>

APPENDIX C
Response Email

Hello (*Participants Name Here*),

Thank you for your interest in participating in my study exploring the use of art therapy with children and adolescents. Attached to this email is an informed consent form. Could you please review it, keep a copy for yourself and sign a copy to mail to me at... or fax it to....

I am available to conduct interviews on:

Wednesdays from 8 am to 3 pm

Thursdays from 6 pm to 8 pm

Tuesdays from 6 pm to 8 pm

Saturdays from 7 am to 4 pm

Sundays from 7 am to 4 pm

Please let me know when you are available for me to call you to conduct the telephone interview. If you would like to participate in the study but none of the times listed above work for you please email me with suggestions. I can be flexible in my availability with notice.

Best,

Merryl Raubeson
Graduate Student in Social Work
Smith College School for Social Work

APPENDIX D

Human Subject Review Board's Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 12, 2012
Merryl Raubeson
Dear Merryl,

You have done a very nice job and great responses! Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Best of luck on a very interesting project!

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a horizontal line underneath.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Elizabeth Irvin, Research Advisor

APPENDIX E

Data Collection Guide

Hello. My name is Merryl Raubeson and I am a master's student at Smith College's School for Social Work. I am conducting a study to explore the theoretical underpinnings and techniques used by experienced art therapists for trauma recovery work with children and adolescents. I am calling because I received a response from you stating that you would be interested in participating in this study. Do you agree to participate in this study?
(if they agree to participate I will ask) Is it ok with you if I record this conversation?
(if the participant doesn't want to be recorded I will ask) Are you still willing to participate in the study if you are not audio recorded?

ID # _____

To start I would like to ask you a few questions to confirm that you meet criteria to be able to participate in the study. The next few questions I ask you will reflect the exclusionary criteria you received along with the recruitment letter.

*Do you work as an art therapist?

What degrees do you have?

Do you have a certification as an art therapist? Yes No

(If yes) What certifications do you have? ATR BC-ATR ATCS Other

Do you practice under a license?

*Do you work with children and or adolescents with a diagnosis of PTSD? Yes No

*Of your child and adolescent clients what percent are being treated for PTSD?

*Do you provide at least 5 hours a week of clinical practice using art therapy to treat children and adolescents with trauma histories?

* (For supervisors)

*How many years have you been practicing as an art therapist?

*Are you English speaking? Yes No

*Do you practice art therapy in the continental U.S.? Yes No

Demographics

Now I would like to ask you a few questions to learn a little bit about your demographic background.

How old are you?

What is your sexual orientation? M F Other _____

How do you define yourself racially? white Black/African American

American Indian/Alaska Native Asian Native Hawaiian/ Other Pacific Islander

Other: _____

What setting(s) do you currently work in?

Hospital School Residential Private Practice
other_____

Have you worked in other settings? Yes No
(If yes) What other settings have you worked in?
What state do you practice art therapy in?
MA CT RI NH VT ME NY Other_____

Theoretical Orientation

Next I would like to hear more about your influence in becoming an art therapist.
Can you tell me about your journey to becoming an art therapist?
How did you come to be working with children with PTSD? – learn about influences
Were you exposed to any particular theoretical orientation?
What has influenced your particular philosophy of work?
What guides your decisions for therapeutic interventions?

Diagnostics

How are clients referred to you?
Do clients come to you with a diagnosis?
Do you evaluate your clients to determine a diagnosis?
Do you evaluate your clients for PTSD?
 (Yes) What is your approach to diagnosing PTSD?
 What trauma assessments do you use in your practice?
 (No) Do you refer your clients out to have assessments conducted?

Clinical Practice

What mediums do you have available to your clients?
Do your clients use any medium they choose?
- (if client chooses) do you think there is a relationship between which mediums clients choose and their symptomatology?
Do you ever suggest clients use particular mediums?
 (If yes) How do you decide which medium to suggest your client to use?
Do your clients create anything they choose?
Do you ever ask clients to create something in particular?
 - (If yes) how do you determine what to ask them to create?

Do you think there is a relationship between client's symptomatology and the colors they use?
Do you think there is a relationship between client's symptomatology and their artistic actions i.e.: brush strokes, how hard they press down with drawing utensils, the way they manipulate clay etc.

Do you ask your clients to tell you about the pieces of art they create?
Do you analyze/interpret your client's art work?
 - (If yes) do you include in your assessment how your client interprets or narrates their art work?

Have you noticed any common themes in the art produced by children and adolescents diagnosed with PTSD?
(If yes) Can you tell me more about that?

I want to thank you for participating in the study. I really appreciate you taking the time to answer my questions. Before we end I would like to ask if there is anything more you would like to add?

Are there any questions I haven't asked that you think I should have included?

Thank you again for sharing your experiences with me.