Spring 5-19-2018

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Eroo Kim

Lesley University, ekim13@lesley.edu

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Art therapy with Homeless Children: Role of Art Therapy on Complex Trauma Event

Capstone Thesis

Lesley University

3/9/2018

E Roo Kim

Art Therapy

Kawano, Tomoyo
Abstract
This research focused on the role of art therapy on complex traumatic events of children and explored how art therapy interventions can benefit children with trauma. Complex trauma is defined as a traumatic, chronic, and interpersonal event that begins in childhood, which later may foster a child to develop and maintain a system of strict maladaptive defenses and display symptoms such as excessive temper, regression, aggression, and overly demanding attention. Since a trivial, insignificant event on an adult’s eyes may not necessarily be the same insignificant event on children, there is a difficulty in defining trauma for children. This capstone project explored the role of art therapy with children who had complex traumatic events in the past. The participants of this project were four homeless children from ages 11 to 13, who reside in the housing program in an urban area with a single parent or parents. The results of using art therapy to treat children who had complex trauma events will be also discussed.
ROLE OF ART THERAPY ON COMPLEX TRAUMA

Introduction

This capstone project is a qualitative study of the role of art therapy with children who had complex trauma. This research focused on the role of art therapy on complex traumatic events of children and explored how art therapy interventions can benefit children with trauma. Approximately 25% of children in the United States are believed to experience at least one potentially traumatic event in their lifetime, including natural disasters, life-threatening accidents, maltreatment, assault, and family and community violence (Sitzer & Stockwell, 2015). Prior research has shown the power of art therapy in working with traumatized children when focusing on the development of self-awareness and self-esteem (Coholic, Lougheed, & Cadell, 2009). Throughout the process of researching the literature, the understanding of art therapy in relationship to trauma, methods of art therapy, and demonstrated clinical benefits came to light. The method that was implemented for this capstone project was originally intended for one child with complex trauma who was not homeless, but this was changed due to unforeseeable circumstances and implemented with a group of homeless children.

Literature Review

Definition of Trauma for Children

Trauma is defined as an experience that threatens the life or physical integrity of oneself or others and overwheels an individual’s capacity to cope (Enlow, Blood & Egeland, 2013). Since a trivial, insignificant event to an adult’s eyes may not necessarily be the same insignificant event for children, there is a difficulty in defining trauma for children. Child trauma is currently defined in the Diagnostic and Statistical Manual Fifth edition (DSM-5) under posttraumatic stress disorder (PTSD), which relates to adults as well as children who are six years and older (American Psychiatric Association, 2013). Trauma is also defined as an
experience that creates a lasting, substantial, psychosocial, and somatic impact on a child (Malchiodi, 2008). Child sexual or physical abuse, domestic violence, school or community violence, unexpected death of family, and car accident can all be examples of traumatic events. According to research, children tend to incorporate their own experiences of trauma into their worldview and personality structure (Center for Substance Abuse Treatment, 2014). They may also establish relationships and life decisions by taking into account the possibility of trauma’s recurrence. As a result of both protective measure and a response to stress, children may develop and maintain a system of strict maladaptive defenses (Wamser-Nanney & Vandenberg, 2013).

**Homelessness as trauma.** Homelessness has been described as a ‘psychological trauma’ characterized by issues such as loss of home, possessions and connections to one’s familiar environment (Davies & Allen, 2017). It also represents a type of social exclusion, as individuals who are homeless often experience poverty and disconnection from social networks. Homelessness has:

- multiple, overlapping problems often including poor physical and mental health, frequent street victimization, and histories of physical and sexual abuse. Further, current street victimization interacts with childhood abuse to produce complex, unique presentations of traumatic symptoms and related disorders in runaway and homeless youth. (Davies & Allen, 2017, p. 17)

One study indicated that 48% of homeless children come from families that had some kind of intra-familial abuse (Davies & Allen, 2017). The average abused youth had > 1 abuser and was first abused at younger than four years old. Homeless children are exposed to abuse at higher rate than the general population (Davies & Allen, 2017). Children who grow up within an
abusive family are far more likely to endorse abusive parenting styles than those who grow up in non-abusive homes. According to (Sitzer & Stockwell, 2015) disorganized attachment is particularly common in children experiencing domestic violence and constitutes approximately 80% of traumatized children’s attachment patterns. Symptoms include loneliness and sadness, loss of desire for amusement, excessive daydreaming, inattention, disturbed sleep, nightmares, easy perturbation, intrusive and disturbing imagery, separation anxiety, and fear of death.

**Impact of Childhood Trauma**

An extensive number of children and adolescents experience traumatic events, and a study found that 22% of surveyed children had experienced four or more different kinds of victimization within a single year, suggesting that the experience of repeated trauma is not uncommon. However, there is yet little attention regarding their unique needs. Symptoms of trauma may depend on how early a child had exposure to their trauma (Wamser-Nanney & Vandenberg, 2013). Children below the age two have symptoms that include memory problems and poor verbal skills. These children may also display symptoms such as excessive temper, regression, aggression, and overly demanding attention (Enlow et al., 2013). However, children between the age of three and six would display symptoms including poor development of skills, focusing difficulties, and learning disabilities (Enlow et al., 2013). Furthermore, exposure to even one form of trauma can have a damaging impact, with symptoms beyond posttraumatic stress disorder. Complex trauma, as a result, was a concept developed to describe the symptoms following severe and repeated trauma.

Complex trauma is defined as a traumatic event that is chronic, interpersonal, and begins in childhood (Cook et al., 2003). In response to these traumatic events, children may later develop and maintain a system of strict maladaptive defenses and display symptoms such as
excessive temper, regression, aggression, and overly demanding attention (Sitzer & Stockwell, 2015).

Marx, Young, Harvey, Rosenstein, and Seedat’s (2017) study compared resilience in individuals with posttraumatic stress disorder (PTSD) and social anxiety disorder (SAD) relative to age-, gender- and education- matched individuals with no psychiatric disorder. The results were that patients who have PTSD and SAD with moderate/severe childhood trauma appear to be significantly less resilient than those with no disorder. Assessing and addressing resilience in these disorders, particularly when childhood trauma is present, may facilitate long-term recovery and warrants further investigation.

The current DSM-5 criteria for PTSD can be summarized in the following general reactions and responses: Alterations in arousal that cause difficulty with concentration, sleep problems, hypervigilance, and irritability or outbursts of anger (APA, 2015, pp. 272-273). Specifically, children under the age of six years old may experience negative cognitions and mood, self-blame, or have decreased interest in activities they previously enjoyed. There may be developmental problems that include emotional and cognitive problems or attachment issues that disrupt relationships with parents or caregivers (APA, 2015, pp. 273-274). Children may also feel as if a traumatic event was recurring in the present, have intrusive thoughts about the event, and experience nightmares. They may try to avoid thoughts or feelings associated with the traumatic event or be unable to recall aspects of the event (APA, 2015, pp. 272-273). Anger, meditation, avoidance, self-blame, and emotional problems may all be addressed through art therapy interventions.
The Neurobiology of Trauma

Trauma can impact neurobiology because of its involvement in an extreme activation of the body’s stress response. Severe trauma in childhood also interferes with brain development and causes serious neurobiological damages in the hippocampus and prefrontal cortex, which inhibits cortisol, whereas the amygdala stimulates it (Sperry, 2016).

Trauma reactions are both psychological (mind) and physiological (body) experiences. Neuroscience confirms that trauma is experienced in the mid brain and lower brain, also referred to as the emotional brain and survival brain. Thus, reason and logic, the ability to make sense of what has happened, are often simply not accessible through the usual talk therapy or cognitive interventions (Van der Kolk, 2014). As Malchiodi (2015) mentioned, “trauma reactions are believed to occur when responses of the limbic system, activated to mobilize oneself in the face of personal threat, are not utilized in a productive way” (p.7). Children who experienced trauma may go into ‘survival mode’ as the emotional activation is held in the nervous system and not dissipated or released. Then children may experience a disruption or impairment in normal functioning and develop habitual responses such as explosive emotions, noncompliant behavior, psychological numbness, cognitive problems, or other reactions depending on personality factors and the type and extent of distress.

In the case of traumatic events, sensory experiences related to the crises like images, touch, sound, and smell may become learned associations that resurface when one encounters a different, yet similar, set of stimuli (Malchiodi, 2008). Such post-traumatic stress reactions may result when implicit memory of trauma is excluded from explicit storage. In particular, Broca’s area, a section of the brain that controls language, is affected, making it difficult to communicate
the story of their trauma, leading to difficulties in identifying and verbalizing experiences (Malchiodi, 2015).

When the exposure to stress occurs early in life, it can have a long-lasting effect on the developing neurobiological systems. Research shows that adult women with childhood trauma histories exhibit sensitization of both neuroendocrine and autonomic stress responses (Sperry, 2016).

**Trauma Informed Art Therapy**

Art is widely used in both assessment and therapy with traumatized children. This includes free or spontaneous art, structured art evaluations, and standardized instruments using art (Kuban, 2015). More than words, art therapy allows children to access and externalize the sensations, memories, and visual images shaped by trauma. Youth benefit from drawing when used to safely communicate and provide symbolic representation of their experiences. In a sense, a picture is worth a thousand words and helps adolescents describe memories (Kuban, 2015).

Terr (1990) mentioned that “trauma does not ordinarily get better by itself. It burrows down further and further under the child’s defenses and coping strategies” (p. 293). Children who are traumatized may feel afraid to trust others and their environment. Therapists who encounter traumatized children must form a productive relationship with them to enable them not only to revisit painful experiences, but also to overcome intrusive memories, make meaning, and find hope. In order to reach these children effectively, both developmentally appropriate methods and interventions need to be used that address traumatic memories and provide emotional relief (Malchiodi, 2008). Because trauma is stored as somatic sensations and images, communication may not happen through language but may be available through sensory means such as creative arts, play, and other experiential activities and approaches (Malchiodi, 2008).
Malchiodi (2008) has worked extensively with children and adolescents within a trauma focused practice framework. She described the art therapy as suitable to support children in their resolution of trauma because the arts are sensory-based, and action-oriented. Most children naturally use art and play to act out what they are reliving and what they may find unspeakable (Molitor, 2009). Art therapy provides a means to deal with language barriers and encourage the use of historical cultural practice of arts.

Enabling a person to regain a sense of safety in their bodies and to come to a sense of closure with their unfinished past leads to successful therapy of PTSD (Carr & Hancock, 2017). For most people, regaining a sense of safety in their bodies requires engaging in activities that help them deal with issues of passivity and helplessness. This can include “play and exploration, artistic and creative pursuits, and some involvement with others” (Carr & Hancock, 2017, p. 10).

When working with Children who experienced trauma, new encounters with prospective caregivers can be potentially uncomfortable and anxiety provoking. If a new relationship survives the child’s guarded deployment of repetitious defenses, it opens an opportunity to restore the capacity to feel and to connect genuinely to others and to the self (Meshcheryakova, 2012).

Characteristics of trauma informed art therapy approaches include externalization of trauma memories and experiences through the creative process of making an image and self-expression through art making, sensory processing involving tangible experiences to encourage children to become active and empowered, right-hemisphere dominance in terms of engaging spatial, sensory and other nonverbal aspects of experience and communication, arousal reduction and affect regulation through drawing and having a pleasant time or focusing on a soothing mandala creation. The therapist attends to the relational aspects “through providing materials
(nurturer), assistant in the creative process and active participant in facilitating visual self-expression” (Malchiodi, 2008, p. 20).

Coholic et al.’s (2009) research shows the powerfulness of art therapy in working with traumatized children. This research focused on development of self-awareness and self-esteem in children in care through art therapy. The writer developed the art therapy group program (17 six-week groups with 38 children over a period of 3 years) that is experiential and uses arts-based methods that create novel experiences and an environment within which group participants are encouraged to explore their viewpoints, feelings, and behaviors to develop their self-awareness and improve their self-esteem. The group’s focus was on using art therapy that teach the children how to pay attention; use their imagination; understand and practice mindfulness-based techniques; explore their feelings, thoughts, and behaviors; and develop their strength. When latter participant was asked what self-esteem meant to her, she replied, “Not being shy . . . like when you’re at school . . . being able to express your feelings, talk to people . . . not scared to do something” (Coholic et al., 2009, p.68).

It is important to understand the complexity of the different types of trauma. The therapist should then encourage the client to tell their story, and to listen, witness, and validate what the client communicates (Carr & Hancock, 2017).

According to Sitzer and Stockwell (2015), expressing and releasing anger appropriately was an important objective. Sitzer and Stockwell did an art directive of creating anger mandalas where students were instructed to paint or draw what anger is like for them within a contained circle. His goal was for his group to express and release anger appropriately, look at underlying feelings that fuel anger and identify situations that trigger anger (Sitzer & Stockwell, 2015).
A specific example of the use of an art therapy intervention that focused on trauma was written up by Lyshak-Stelzer, Singer, Patricia, and Chemtob (2017). Lyshak-Stelzer et al. used trauma-focused art therapy to create and strengthen an internal sense of safety. Each participant completed at least 13 collages or drawings compiled in a hand-made book format to express a narrative of their life story. The 16 session protocol of art and discussion topics were to compare the difference between feeling safe and unsafe with the participants’: (a) peers in the hospital; (b) peers on the street; (c) a staff member; (d) adults in their community; (e) peers at home; and (f) adults at home. Other questions that were asked were: When are feelings of fear and anger helpful and how can they lead to increasing safety? What makes a place safe or dangerous? Can you contrast dangerous activities that you have engaged in during the past with safe activities? What made you feel safe or dangerous? (Lyshak-Stelzer et al., 2017, p.166).

Methods

The following method was originally intended for an individual with complex trauma. Due to this client terminating unexpectedly, the method was adapted to address the needs of homeless children in a group therapy context. To reduce anxiety and provide safety in the presence of a new adult (this group leader), participants in peer groups met weekly. The group leader was under supervision working with this group to respond as effectively as possible to the group’s needs. This group leader focused on developing healthy therapeutic relationships with the group.

Participants

Five, 11-13-year-old girls were participants for this capstone project. They have been exposed to early childhood trauma and attend a counseling program for homeless children in an urban area. The participants had attended the program for 3-10 years and all were exhibiting
trauma symptoms. The demographics of the participants included: a 12-year-old female who immigrated from Africa, an 11-year-old Caucasian female, a 13-year-old African American female, and an 11-year-old Latino-American.

**Procedure**

The art therapy interventions were carried out during regularly scheduled group therapy sessions at the program where this writer was serving as an art therapy intern. The children had attended counseling groups and individual therapy in the past, but they were new to art therapy. The art therapy groups were conducted for 50 minutes on Tuesday afternoons over a five-week period. Progress was tracked by observation, making notes and writing in journals about the participants’ behaviors, as well as movement and verbal expression during the art therapy process. The outcome of the art was also analyzed. Art-based responses to the experience were also rendered by this writer. The protocols of each session are described below.

**Protocols**

Trauma-informed art therapy approaches included: the externalization of trauma memories and anger through the creative process of making an image and self-expression through art making; sensory processing involving tangible experiences to encourage children to become active and empowered; sensory and other nonverbal aspects of experience and communication; and arousal reduction and affect regulation through the incorporations of a mandala.

**Session#1: Silent Mandala**

The first session consisted of using a mandala, and the goal was to introduce art therapy and meditative experience. A mandala is a circle, without a beginning or an end, that is generally drawn on a piece of paper. It symbolizes the universe with an inner and outer world. It is often
used as an object to focus attention on while meditating, because of the symmetrical shape and the participants can direct their attention to the center. The rationale for this intervention was to access one’s right-hemisphere in terms of engaging spatial, sensory and other nonverbal aspects of experience and communication, arousal reduction and affect regulation (Malchiodi, 2008).

- Directive goals: Introduction to art therapy and meditative experience, Mindfulness and resilience development

- Directive: Mandala was utilized to introduce art therapy and its meditative experience. The participants had options to choose from various printed mandala designs, which they would tape it under clear vinyl folder and outline the top. String music was chosen to be played in the background for them to listen to and to introduce a non-verbal process.

- Materials: Printed mandalas, Clear vinyl folder, Colored Sharpies

**Session#2: Safe Place Mandala**

The second session consisted of creating safe place mandala, the goal was to create and strengthen an internal sense of safety. The rationale for this intervention was intended for arousal reduction and affect regulation through drawing a pleasant time (Lyshak-Stelzer et al., 2017).

- Directive Goals: To foster a sense of safety and trust in group, to create and strengthen an internal sense of safety.

- Directive: Set intention for arousal reduction and affect regulation through drawing a pleasant time, directive was to draw a safe place on a blank mandala paper.

- Materials: Blank mandala paper, colored pencils, markers, crayons, pencil

**Session#3 Personal Shield**

The third session consisted of drawing personal shield of strengths. The goal was to deepen self-awareness. The rationale for this intervention was sensory processing involving
tangible experiences to encourage children to become active and empowered (Sitzer & Stockwell, 2015).

- Directive goal: Introduce the concept of resilience, Deepen Self-awareness
- Directive: Intend for participant’s self-expression through art making, directive was to create personal shields of their strengths
- Materials: White paper, colored pencils, markers, oil pastels, pencil

**Session#4: Anger Mandala**

The fourth session consisted of painting what anger looks like within a contained circle. The goal was to express and release anger. The rationale for this intervention was intended for participant’s externalization of trauma memories and experiences through the creative process of making an image (Sitzer & Stockwell, 2015).

- Directive goal: express and release anger appropriately look at underlying feelings that fuel anger
- Directive: paint what anger is like within a contained circle
- Materials: Mandala outlined paper, paint, brush

**Session #5: Hope Quilting**

The last session consisted of a closure and what the participants can take to the world through the group project of drawing their hopes and dreams for the future. The rationale for this intervention was to encourage children to become active and empowered (Coholic et al., 2009).

- Directive goal: Visual self-expression, Deepen Self-esteem, Closure: Take to the world
- Directive: To encourage children to become active and empowered, I invited participants to draw the things that give them hope in troubled times and their hopes and dreams for the future. When they were finished I connected the pieces into a hope quilt.
Materials: Different colored construction paper, crayons, pencils, tape

Results

The following findings are based on this writer’s observations of the participants’ behaviors, movement, and verbal expression during the art therapy process. All of the artwork are responses of this writer to the experience from each session.

Session#1: Silent Mandala

Meditation and art therapy were introduced through the use of a mandala. When options to pick a mandala and a folder were given to the participants, the group became very excited saying, “We get to keep this?” “Can I take this home when I am done?” The room immediately filled with high energy, and the participants began to outline their mandalas on to the folder they had picked. They began to pick different colors of Sharpies and talked among each other saying “can I use that pink?” “I love this color.” This writer then put on a recording of string music to the participants. They slowly became silent, focusing on their mandala. The room became silent with only the quiet music and the sound of drawing.

When the group shared the experience, their voice was calmer than their high energetic voice before starting the directive. Their body seemed relaxed and grounded. One participant mentioned, “This is so relaxing,” followed by another participant, “This makes me calm.” The facilitator felt successful with this intervention, as the responses from participants were clear, and felt that the participants’ first experience of art therapy was positive. Figure 1 reflects how the mandala introduced relaxation and meditation to the participants. It represents the energy and silence during the session.
Figure 1. Reflection on silent mandala.

Session#2: Safe Place Mandala

On the second week, to give participants continuity and comfort, a blank mandala was handed to them and was explained that it is the mandala used from last week, but without the designs inside. When the directive was explained to draw a safe place, the participants seemed to be hesitant to start. Each participant slowly began to start the drawing process, but the group seemed uncomfortable with their movement with hands and arms. They have drawn phones, YouTube, and TVs in the mandala. This directive was intended for arousal reduction and affect regulation through drawing a pleasant place. However, for the participants, better
contextualization of a safe place was needed as a safe place cannot be a location. Instead, a safe place can be a place in their bodies, or to focus on the resiliency. It was a learning experience from participants that this particular directive can use more metaphor or imagery of “if you can be anywhere.” When they finished the drawing, the facilitator asked group, “What builds trust?” “What takes away trust?” “What do you need to feel safe?” The participants responded with “Backstabbing takes away trust,” “I trust when someone trusts me first,” “I feel safe when someone takes me as who I am,” “I give trust when they like things I like.” We then discussed how we can make the group a safe place. Figure 2 and Figure 3 are visual representations of the process of making safe place mandala during the session. Figure 2 shows the writer’s reflection on the directives and what homelessness and safe place meant to the participants, while Figure 3 reflects on witnessing how participants felt uncomfortable through this particular directive.

Figure 2. Reflection on safe place mandala:
Session#3: Personal Shield

The personal shield directive was given to participants with a discussion about what their strengths are and what attributes help them recover from difficult times. The participants were very focused and used their full energy during the art making process. Three participants had drawn big shield-like shaped outline and drew symbols of their strengths inside, including a smiley face, superhero symbol, the word “Shameless,” “100” and a phone. One participant drew a rainy scenery with a brick black house. During the group sharing after the drawing process, the
words they shared were, “my social skills,” “Art,” “I’m nice,” “happy,” and “positive.” Figure 4 represents the participant’s art making process. Symbols and words were used in this process.

Figure 4. Reflection on personal shield.

Session#4: Anger Mandala

The blank mandala was revisited with the participants. When the anger mandala directive was explained to the participants and paint and brush were introduced, they immediately grabbed
paint brushes and painted on the paper. One participant used red paint on the brush and flicked it on to the paper from the beginning till end of the session. After a while, she looked around the room and commented, “I don’t know what I am doing.” During the process, one participant while using red paint commented, “Color red triggers me” and mixed red, black, yellow paint inside of the circle and drew mad eyes, a nose, and sharp teeth on top of the painted colors. She later shared that when she gets angry, “it reminds her of the devil.” One participant was new to paint and was excited to try many lines and darker combinations of colors including red, blue and black inside of the circle. During the process, she mentioned, “I like this, it kind of looks like ink.” Another participant put words like “School, art, drawing, good guys, math” inside the circle and “Ex-friends, boys, crying” outside of the circle and shared that “good guys make me angry.” For the closing, the group identified situations that trigger anger and then expressed through negative sounds like “ugh!!” “ahhh!!” “sigh” and body movements including punching, kicking and stumbling with two feet together in circle. One participant yelled, “ugh Math!!” The participants were active and were able to express their anger through this directive. Figure 5 is a visual reflection on one participant’s art making process where the participant used red paint on the brush and flicked it on to the paper from the beginning till end of the session.
Session #5: Hope Quilting

When Hope Quilting directive was explained to the participants, they became excited with laughter, and was able to start right away. During the process of art making, there was sound of quiet humming. Participants made verbal comments during the process like, “I need all shades of green,” “Love makes me feel better” (while drawing red heart-like shape). One said, “This part is nice calming scene, and other one is going to be crazy.”
When they were finished, the facilitator connected four drawings into one square. The group gathered around the drawing in circle and shared some thoughts. They commented, “Nice calming scene, and calming colors,” “Art makes me happy,” “Colors make me happy,” “I’m going to be a fashion designer.”

This writer was able to witness how every participant included art-related words or drawings in to their paper. The first paper had the word “Art” and a heart shape. The second paper had the word “Drawing” and two people. The third paper had the word “hope” inside of the heart shape outline, and herself as a fashion designer. Figure 6 is a visual reflection on Hope quilting. The “calming colors” that were used by the participants were used to reflect on the collaborative group work.

Figure 6. Reflection on hope quilting.
Finally, Figure 7 represents how complex trauma affects children’s emotion and behavior, and how art therapy can provide safe place.

Figure 7. Reflection on the overall experience working with the participants.

Discussion

Over the course of the five weeks, this writer witnessed how homelessness impacted the children. It was clear through the outcomes of their art and discussion that participants experienced complex trauma which includes primary and secondary trauma, that is, the initial trauma of being made homeless and then dealing with parental trauma, worry about the future, fitting into schools and peer groups.

Initially, this writer was too focused on emotional and behavior issues that not enough attention was given to how homelessness was such a traumatic experience for them. The children’s drawings of shields, not being able to identify strengths or a safe place provided
insights that as the facilitator, there needed to be more awareness of the homelessness in the art therapy directives. Additionally, as witnessed through working with homeless children, it was noted that their dependency on environmental conditions provided by caretakers make them especially vulnerable to the effects of violence. The experience of domestic violence not only places caretakers at extreme personal risk, but also creates an unsafe environment for children, and provides ample opportunities for the transmission of maladaptive attachments and coping resources and sets the stage for abnormal development throughout the life span (Sitzer & Stockwell, 2015). Also, through supervision, some of the issues of transference and counter transference were highlighted when working with this group of children. This may have been related to the significant levels of both primary and secondary traumas experienced by the children, rendering them extremely vulnerable. In particular, the frequent experience of loss of parents by these children, both physically and psychologically, may evoke a parental dynamic between therapist and child, and counter transference feelings of sadness, loss and desire to rescue (Tischler, Edwards, & Vostanis, 2009).

Still, there were examples to show the power of art therapy – to allow space to express emotions appropriately and give hope. Art therapy allows right-hemisphere dominance in terms of engaging spatial, sensory and other nonverbal aspects of experience and communication, arousal reduction and affect regulation (Malchiodi & Crenshaw, 2015; Lyshak-Stelzer et al., 2017). Experiencing through tangible sensory processing encouraged children to become active and empowered (Sitzer & Stockwell, 2015). The participants could externalize traumatic memories and experiences through the creative process of making an image (Sitzer & Stockwell, 2015). Art therapy can encourage children to become active and empowered (Coholic et al., 2009).
Limitations and Recommendations for Future Studies

I have learned that the expressive therapy field currently lacks empirically validated trauma interventions in homeless children and youth. On the bright side, I believe that talking about feelings within the context of a supportive and safe relationship is the most important and effective in working with children with trauma. I also believe in the power of group sessions, where it reduces feeling of isolation and alienation, normalizes suffering, allows to give and receive support within sharing, provides a chance to relate to others, and encourages both talking about life outside of the group and the dynamics within the group. For homeless children, the goal may be to provide hope for the future by doing art with others in a safe group with a trusting facilitator. Longer-term communal and social psychotherapeutic involvement will be helpful in the future.
References


