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Connecting ETC and ARC: The Beginnings of an Integrative Framework for Working with
Children with Relational Trauma, a Literature Review

Capstone Thesis

Lesley University

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Expressive Arts Therapy

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Abstract

Relational trauma is an impactful experience, affecting a person's physical, mental, and emotional well-being. Children with relational trauma experiences are particularly vulnerable due to being in a stage of active development. Relational trauma can have a lasting impact on a child's psychosocial, cognitive, and neurological development. This literature review explores the current research concerning children who have experienced relational trauma, the developmental impact of relational trauma, the treatment needs of this population, and a current, evidence-based treatment option for this population—the Attachment, Self-Regulation, Competency (ARC) framework. On the basis of this research, this literature review will outline how expressive arts therapy and the Expressive Therapies Continuum (ETC) can be used as effective treatment options for this population. Additionally, this literature review will highlight treatment correlations between the ETC and ARC, demonstrating the beginnings of an ETC/ARC integrative framework for working with children with relational trauma.

Connecting ETC and ARC: The Beginnings of an Integrative Framework for Working with
Children with Relational Trauma, a Literature Review

*I found that I could say things with colors and shapes that I
couldn't say any other way – things I had no words for.
– Georgia O'Keeffe, 1925*

Trauma. It is an experience that most of us will have in our lifetimes. It comes in many forms: the loss of a loved one, a car accident, an illness. For some, trauma occurs in childhood and is relational in nature: witnessing domestic violence, being neglected and/or abused by caretakers, or being removed from the family home. Research has shown that traumatic experiences are sensory in nature and can have a lasting impact on the cognitive, psychological, relational, and neurological development of children (Richardson, 2016). Being that trauma is a somatic experience, the memory of it is not stored in a verbal, narrative form. Rather, trauma is remembered in a non-verbal, sensory, and image-based form of “physical sensations, emotional vulnerabilities, flashbacks and nightmares, dissociative inclinations, and behavioral reenactments (Allen, 1993; van der Kolk, van der Kolk & van der Hart, 1991)” (Estrella, 2007, p. 187). Since the experience of trauma is remembered somatically, it seems fitting that the approach to accessing and processing trauma would incorporate the senses and the body, in conjunction with psychological processing. Arts-based methods, including expressive arts therapy, can be used to facilitate embodied psychological processing.

Expressive arts therapy is a therapeutic approach that uses various arts modalities to access, express, transform, and process psychological content (Estrella, 2007). Expressive arts therapy, and arts-based methods, have been found to be beneficial in the treatment of children with relational trauma. Several authors demonstrate that arts-based methods are effective in processing trauma, as well as, create a positive impact on children's behaviors and symptoms of

relational trauma (Coholic, Loughheed, & Lebreton, 2009; Hass-Cohen, Bokoch, Findlay, & Witting, 2018; Mohr, 2014). The benefits of using art-based methods with children who have experienced relational trauma are improved self-esteem, decreased symptoms of trauma, and decreased negative affect.

Within expressive arts therapy, there are several approaches that can inform its implementation in therapy. For the purposes of this literature review, I have chosen to focus on the Expressive Therapies Continuum (ETC). The ETC is a foundational framework for implementing expressive arts therapy, which is based in cognitive and brain development (Richardson, 2016). In researching the ETC and its implementation in treatment for children who have experienced relational trauma, I found no peer-reviewed research articles on the topic. This is a major gap in research for the population of children with relational trauma, as well as, for the expressive arts field.

In this project, I will demonstrate how the expressive arts and the ETC are effective treatment options for children with relational trauma experiences. Additionally, I will highlight correlations between the ETC and ARC which demonstrate the beginnings of an integrative framework for this population. With this project, it is my hope that further research will be performed on how the ETC can be shown to be a credible and effective modality of treating children who have experienced relational trauma.

Literature Review

In proposing the creation of an ETC/ARC integrative framework to use in the treatment of children with relational trauma, this literature review will define the population of children with relational trauma. It will examine the history, development, and theory of the evidence-based trauma treatment, ARC. Additionally, this literature review will summarize the history and development of expressive arts therapy and the ETC, explore theoretical orientations, and examine connections between the ETC and ARC. These connections are the foundation for demonstrating how the ETC can be applied in the treatment of trauma. This literature review was performed by researching published texts on expressive arts therapy, ETC, relational trauma, complex trauma, developmental trauma, and developmental trauma disorder, ARC, using the search terms: *expressive arts therapy, expressive therapies continuum, trauma, relational trauma, interpersonal trauma, complex trauma, developmental trauma, developmental trauma disorder, attachment, regulation, competency, ARC, children*.

Trauma

Richardson (2016) states that “trauma is experienced in the body, mind, and spirit of a child through direct or indirect exposure to events such as natural disasters, accidents, maltreatment, or illness” (p. 35). In addition to trauma occurring from a variety of events, trauma can also vary in its length of experience, either being a single event or a chronic occurrence (Blaustein & Kinniburgh, 2010). The impact of trauma on a child is variable due to the complexity of the individual experience, including the individual’s resources and challenges (Blaustein & Kinniburgh, 2010). As one can see, the term *trauma* is expansive and can encompass a variety of experiences.

Due to the broad nature of the term *trauma*, the mental health field has developed several terms used to describe specific trauma experiences and their effects on children. These terms include *complex trauma*, *developmental trauma*, and *relational trauma*.

According to van der Kolk (2005), the term *complex trauma* is used “to describe the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence and early-life onset” (p. 402). In addition, Blaustein & Kinniburgh (2010) describe *complex trauma* as chronic stress experiences that occur within the child-caregiver relationship, which can include neglect, abuse, psychological maltreatment, caregiver disruptions, and impaired caregiving systems.

Developmental trauma, or developmental trauma disorder, is a proposed diagnosis by Bessel van der Kolk (2005). *Developmental trauma* is similar to what is defined as *complex trauma*, in that, it refers to multiple and on-going incidents of interpersonal trauma that cause neurodevelopmentally adverse effects on the child.

The term, *relational trauma*, includes “physical, emotional, and sexual abuse; neglect; witnessing domestic violence; and a loss of or abandonment by primary caregivers” (Richardson, 2016, p. 36). *Relational trauma* is a term that specifies the source of the trauma experience as within the context of interpersonal relationship, most often within the relationship with a primary caregiver (Schoore, 2001).

The terms discussed are interrelated and similar in the trauma experiences and effects of trauma they attempt to describe. For the purposes of this project, I have chosen to use the term *relational trauma*. This term clearly identifies where the impact of trauma occurs for the child—within the caregiver-child relationship.

Due to the chronic nature of relational trauma, there are substantial effects on a child's development. Relational trauma effects a child's "neurobiological development and the capacity to integrate sensory, emotional, and cognitive information into a cohesive whole" (van der Kolk, 2005, p. 402). Children who have experienced relational trauma can have difficulties with social-emotional functioning due to the interpersonal nature of the trauma. These difficulties include chronic and severe problems with emotion regulation, impulse control, attention and cognition, dissociation, somatization, interpersonal relationships, and self and relational schemas (van der Kolk, 2014; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). While these symptoms and behaviors are important to name for the treatment of children with relational trauma, it is also important to recognize the resilience of children with these experiences. In my clinical experience as an intern in a community based acute treatment program for children, each child I have worked with has demonstrated their resilience in developing behaviors that are adaptive to their environments and experiences, behaviors that kept them safe enough to survive.

Relational Trauma and Psychosocial Development. A child's developmental skills are first cultivated within the relationship with primary caregiver(s) and the environment in which they live (Blaustein & Kinniburgh, 2010). In attachment theory,

"Attachment" describes the interactions between children and their caregivers that have a longstanding impact on the development of identity and personal agency, early working models [internal schemas] of self and other, and the capacity to regulate emotions.

Nurturing and consistent caregiving promotes skill development and a safety net for coping with difficult experiences. (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005, p. 426)

While it is important for the child to have an attachment to their caregivers, the quality of this attachment is another factor affecting the child's development. The quality of attachment, or attachment style, is determined by the caregiver's capacity to mentalize the child's experience and respond with empathic attunement to the child's needs (Berzoff, Flanagan, & Hertz, 2011). When this occurs, the caregiver can be seen as a secure base and the foundation of a secure attachment style is created. Conversely, when a child's needs are not met, are met inconsistently, or when there is abuse and/or neglect, the attachment style created is one that is insecure or disorganized.

While attachment theory focuses on the importance and quality of primary attachment and how this affects psychosocial development, object relations theory maintains that primary attachment is a basic need and examines how early relational experiences become internalized in order to create concepts of self and other, the process of distinguishing self and other, and the integration of both negative and positive aspects of self and other (Berzoff, Flanagan, & Hertz, 2011). Relational trauma occurs within the caregiver-child relationship, which is the basis of a child's early psychological representations of self, other, and relationship. The internal working models created by a child are the foundation of their developmental competencies (Cook, et al., 2005). When relational trauma occurs, a child and their "capacity for negotiation around boundaries, intimacy, and selfhood...is deeply harmed, creating difficulties even in the most basic of relationships" (Pitre, 2014, p. 243). This difficulty in relationships occurs as a result of a child's internal working models of their caregiver as being unresponsive, their environment as being dangerous, and themselves as being unworthy of love (Ainsworth, Bowlby, & Knox, as cited in Anderson & Gedo, 2013).

The object relations theorist Winnicott stated, “there is no such thing as a baby” (as cited in Berzoff, Flanagan, & Hertz, 2011, p. 134), meaning there is no such thing as a baby without their relation and experience of caregivers, community, culture, gender, race, ethnicity, and other external variables that significantly affect the development of the child. Included in these variables can be relational trauma and adversity. When relational trauma occurs, a child becomes at risk of developmental deficits in

- intrapersonal competencies (e.g., sense of self and self-development);
- interpersonal competencies (e.g., capacity to form and engage in relationships with others);
- regulatory competencies (e.g., capacity to recognize and modulate emotional and physiological experience); and
- neurocognitive competencies (e.g., capacity to engage in executive functions and other cognitive abilities to act meaningfully in the world). (Blaustein & Kinniburgh, 2010, pp. 10-11)

These potential developmental deficits are as a result of the lack of opportunity and experience with these competencies. Treatment for children with relational trauma experiences can be centered on creating opportunity for the growth and experience of these competencies within the therapeutic relationship.

Relational Trauma and the Brain. Not only are a child’s psychosocial skills developed in response to their environment, but so is a child’s neurodevelopment. In this way, neurodevelopment occurs in connection with developmental skills. This can be explained by the neural plasticity of the brain: “the ability of the brain to adapt and change in response to experience (Abitz, et al., 2007)” (Blaustein & Kinniburgh, 2010, p. 10). Repeated experiences

cause the brain to respond by forming synaptic connections to strengthen its response to this input. A lack of input from the environment causes the brain to respond by pruning away synapses that are not being used in repeated experiences (Blaustein & Kinniburgh, 2010).

The concept of neurodevelopment being use or experience-dependent can be demonstrated in the neurodevelopment of children in relation to attachment. According to Schore (2001), when a child develops in an environment with a secure attachment figure, this figure cares for and balances arousal of the child, or co-regulates, which helps a child develop coping capacities. Through these repeated experiences of co-regulation, a further development of coping capacities occurs and a child's right-brain functions efficiently; being able to access coping skills and manage stress (Carey, 2006). When a child experiences relational trauma, an insecure or disorganized attachment pattern can occur as a result of missed opportunities for co-regulation. This results in inefficient functioning of the right-brain. In this way, the right-brain's coping systems can cause a child to over-respond (hyperarousal) or under-respond (hypoarousal) to stress (Carey, 2006). With this in mind, it is important then to offer interventions that can facilitate co-regulation with the child; interventions that can increase and/or decrease arousal depending on the child's needs. Supporting the child in co-regulation not only helps the child learn new strategies to manage overwhelming feelings but can also positively affect a child's neurodevelopment and right brain functioning.

The right brain, the emotional brain, and the body are connected to how a child remembers their relational trauma experiences. In *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*, van der Kolk (2015) describes this connection between memory, the body, and the brain:

When memory traces original sounds, images, and sensations are reactivated, the frontal lobe shuts down, including, as we've seen, the region necessary to put feelings into words, the region that creates our sense of location in time, and the thalamus, which integrates the raw data of incoming sensations. At this point, the emotional brain, which is not under conscious control and cannot communicate in words, takes over. The emotional brain (the limbic area and the brain stem) expresses its altered activation through changes in emotional arousal, body physiology, and muscular action. Under ordinary conditions, these two memory systems – rational and emotional – collaborate to produce an integrate response. But high arousal not only changes the balance between them but disconnects other brain areas necessary for the proper storage and integration of incoming information, such as the hippocampus and the thalamus. As a result, the imprints of traumatic experiences are organized not as coherent logical narratives but in fragmented sensory and emotional traces: images, sounds, and physical sensations. (p. 178)

Van der Kolk (2015) highlights how physiologic experiences, activated by emotions, sounds, sensations, smells, and so forth, can then be connected to memories of traumatic experiences within the body, causing high arousal. This high arousal reaction activates the emotional brain (the right brain, specifically the limbic system), which then takes over information processing. With the emotional brain being highly activated, it disconnects from other sections of the brain normally used to process and integrate information in a linear, verbal, and narrative form. The emotional brain then remembers and contains the implicit memory, the nonverbal memory, the emotional-body memory, of trauma. In this context, the treatment for children with relational trauma could include interventions to engage the emotional/right brain.

Interventions that engage the emotional/right brain include “somatosensory interventions including music, play, art therapy . . . to both promote modulation of regulatory processes and access [the emotional/right] brain (Gaskill & Perry; van Westerhenen & Fritz)” (Dauber, Lotsos, & Pulido, 2015, p. 530).

Attachment, Self-Regulation, and Competency (ARC)

The ARC treatment framework is a developmentally-based, evidenced-based practice for treating complex trauma with children, adolescents and families. The ARC treatment framework offers “flexibility within fidelity (as defined by Kendall and Beidas, 2007)” (Blaustein & Kinniburgh, 2010). This framework, shown in Figure 1, focuses on three domains: attachment, self-regulation, and competency (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). Within these domains are nine components of intervention with specific skills and areas of treatment focus. The tenth component, trauma experience integration, is the culmination of the previous nine components (Blaustein & Kinniburgh, 2010).

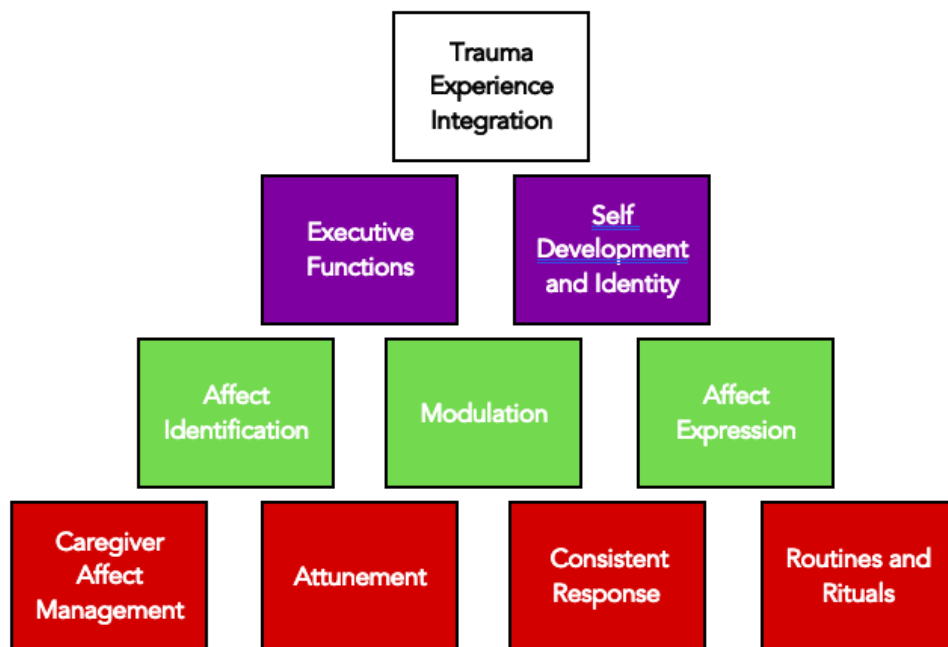


Figure 1. Core building blocks of the Attachment, Self-Regulation, and Competency framework. Adapted from “Treating traumatic stress in children and adolescents: How to foster

resilience through attachment, self-regulation, and competency,” M. Blaustein and K. M. Kinniburgh, 2010, p. 36.

Development of ARC. The ARC treatment framework was co-developed by Margaret Blaustein and Kristine Kinniburgh (2010), clinicians with extensive experience working with children with complex trauma in a variety of settings. The ARC treatment framework was developed in order to provide a flexible framework that could be implemented across systems that serve this population (Blaustein & Kinniburgh, 2010). In addition, Blaustein and Kinniburgh (2010) formulated and constructed ARC in response to seeking to contribute to scientific literature and evidence base of treatment for children, adolescents, and families with complex trauma experiences; naming key components of treatment intervention that can be addressed within a variety of service systems; and, maintaining flexibility and creativity of treatment, within a larger structure.

Attachment. The attachment domain of ARC, and the four components it's comprised of, target a child's caregiving system to build a “‘safe enough,’ ‘healthy-enough’ relationship with a child and their caregiving system” (Blaustein & Kinniburgh, 2010, p. 36), thereby establishing safety for the child. Children with complex and/or relational trauma experiences likely have experienced a variety of caregiving systems; therefore, Blaustein and Kinniburgh define “caregiving systems...[as] biological parents or relatives, foster or adoptive parents, school systems, residential programs, caseworkers, and...[other] professionals” (p. 36). The attachment domain also focuses on creating skills related to a child's attachment needs to provide further support for positive development. Within the attachment domain of ARC, are four building blocks: caregiver affect management, attunement, consistent response, and routines and rituals.

The component of caregiver affect management discusses the importance of the caregiver effectively managing their emotions and responses, in order to provide optimal support for the child (Blaustein & Kinniburgh, 2010). This component also examines the impact of caregiver affect management in correlation to outcomes for the child, influences on a caregiver's bandwidth to manage affect, and the essential role of support for the caregiver.

As defined by Blaustein and Kinniburgh (2010), "attunement is the capacity of caregivers to accurately read children's cues and respond appropriately" (p. 37). The attunement component supports caregivers in paying attention to a child's cues and learning how to accurately read and respond to the "emotional message" (p. 37) hiding beneath the behavior. Children with trauma experiences need the attunement of a caregiver to aid them in communicating their feelings, wants, and needs.

Traditional parenting strategies (limit setting, positive reinforcement, etc.) might be triggering for a child with a previous trauma history due to the child's fear of losing control, and therefore, losing safety (Blaustein & Kinniburgh, 2010). The component of consistent response outlines and assists caregivers in building parenting skills that can provide the child with consistent, predictable expectations and responses from both the caregiver and the environment.

Children with complex trauma often have experienced life as chaotic and unpredictable (Blaustein & Kinniburgh, 2010). This can cause a child to exhibit vigilant behavior as a means of keeping themselves safe. By maintaining routines and rituals, a child gains a sense of safety through structure and predictability. This component supports the caregiving systems in building routines and rituals within a child's daily living activities (Blaustein & Kinniburgh, 2010).

Self-regulation. The self-regulation component of ARC contains three building blocks which each focus on supporting the child in creating awareness of their internal experience,

building skills to modulate that experience, and growing the capacity to share their internal experience with others (Blaustein & Kinniburgh, 2010). Children with complex trauma experiences have faced failures of their attachment systems, which are the systems that provide and teach a child regulation skills. Due to the chronic stress related to complex trauma, a child's regulatory system can be significantly impacted, causing on-going dysregulation and creating limitations in a child's ability to understand, name, and communicate their internal experience.

The building block of affect identification supports a child in identifying emotions within themselves and others, identifying physical states, and connecting their emotional and physical experiences, to their thoughts and behaviors. In this way, a child can gain an understanding of the links between their feelings and internal and external factors (Blaustein & Kinniburgh, 2010).

The modulation building block focuses on interventions to help the child develop necessary skills to maintain an optimal level of arousal and to expand their tolerance of a varying emotional experiences (Blaustein & Kinniburgh, 2010). This is done through developing specific skills of expanding awareness of degrees of feelings, building ability to move through different arousal states, and using strategies to increase and decrease arousal.

The affect expression building block has the primary goal of implementing interventions that target skill-building to support safely sharing their emotions with others (Blaustein & Kinniburgh, 2010). This includes identifying safe resources, how to effectively use resources, and how to communicate nonverbally through vocal tone, physical proximity, and eye contact, verbal communication skills (using "I" statements), and developing various strategies for self-expression.

Competency. The competency domain targets the goal of developing internal and external resources for a child and their family that support positive functioning including in

social and community connections, and academic success. The interventions within this domain support the child in gaining a sense of achievement, developing the skills to function as a positive constructor of their lives, and “developing...a positive and coherent sense of self” (Blaustein & Kinniburgh, 2010, p. 40).

Within this domain are two building blocks: executive functions and self-development and identity. The executive function building block emphasizes the building and practicing of executive functioning—problem-solving skills like, evaluating situations, delaying response, and making mindful decisions (Blaustein & Kinniburgh, 2010). A framework of problem-solving skills is taught with steps added that recognize a child’s trauma response. Within this framework, the distinction between “acting” and “reacting” (p. 40) is made, and the child’s understanding of “choice” is developed. These problem-solving skills are important to teach all children, but especially those with trauma experience. When a child is exposed to chronic trauma, their bodies and brains are often in prolonged states of stress. This can lead to inadequate development of the prefrontal cortex, the cognitive center of one’s executive functions.

The second building block of the competency domain is self-development and identity. Children who have experienced relational trauma, can often internalize negative values and self-image due to the negative experience of trauma (Blaustein & Kinniburgh, 2010). This building block targets various aspects of creating a sense of self and identity, which include: “the unique self” exploring and celebrating the personal self, values, opinions, culture, etc., “the positive self” developing and identifying personal strengths and successes, “the coherent self” examining the self within various experiences, for example, the self before and after trauma, and “the future self” creating an image of the self in the future (Blaustein & Kinniburgh, 2010, p. 41).

Trauma experience integration. The trauma experience integration building block is the final building block of the ARC framework. This building block supports the child in accessing the skills and resources developed through the other nine building blocks (Blaustein & Kinniburgh, 2010). In addition, this building block targets the integration and use of these resources and skills in response to a child's past trauma impacting their present life.

Expressive Arts Therapy

Since the ETC is a framework created for implementing expressive arts therapy, I will first discuss expressive arts therapy. In this section, the history and development, concepts, theories, and applications of expressive arts therapy will be examined. In addition, current research findings of the effectiveness of expressive arts therapy in the treatment of children with relational trauma experiences will be discussed.

History. In the early 1970's, the Expressive Therapy program was founded at Lesley College Graduate School in Cambridge, Massachusetts (Levine & Levine, 1999). The principle of this program was contradictory to the specialized, siloed art programs at the time, as it offered an interdisciplinary approach to the arts therapies. In addition, the program was a "creative therapeutic community of students and faculty" (p. 9). This community helped to develop expressive arts therapy by finding connections of expressive arts to ancient healing systems and philosophical concepts. The expressive therapies community continued to expand beyond Cambridge and Lesley College to other parts of North America and the world, including countries such as, Switzerland, Denmark, Germany, and Israel. In 1994, expressive arts therapists united to create the International Expressive Arts Therapy Association (IEATA), a professional organization created to establish expressive arts therapy as a field apart from other

specialized arts therapy organizations, and to continue the development and progression of the expressive arts therapies field.

Concepts, theories, and approaches. Expressive arts therapy is a multi-modal therapy that uses all art forms to explore, express, and transform psychological content. There are several foundational concepts that inform the practice of expressive arts therapy. Expressive arts therapy is first and foremost interdisciplinary in nature and, as such, it weaves together an array of “perspectives and practices without privileging any of them...Expressive arts therapy is grounded not in particular techniques or media but in the capacity of the arts to respond to human suffering” (Levine & Levine, 1999, p. 11). By having an array of art disciplines to choose from, expressive arts therapy can meet the needs of the client in the here and now.

Expressive arts therapy also takes a phenomenological approach to therapy. This means that the therapist and the client follow the phenomenon created in the therapy—the art, the content that presents itself, the play, whatever arises (Knill, Barba, & Fuchs-Knill, 2004). This phenomenological approach underlies the theories of expressive arts therapy that will be discussed. It is also linked to the fundamental concepts of play, imagination, and creativity because from these, the phenomenon created springs forth.

The arts, play, imagination, and creativity are complementary elements and interactions that unite to provide a means to express and celebrate our humanness (Knill, Barba, & Fuchs-Knill, 2004). The process of creativity is a unique human experience. Creativity brings imagination, which is the depth of our psyche, to life. In its newly living form, our psychic material can be handled, examined, molded, and transformed—it can be played with. Play is intimately connected to the creative process because, play provides the space for us to explore

our imagination, our psyche. Play allows us to do this without a goal, it allows us to simply be with the content of our imaginations.

The above concepts are the foundation of expressive arts therapy and are interwoven into the many theories of this field. The theories of expressive arts therapy include:

- Intermodal theory investigates the use of modalities (sound, rhythm, movement, words, image, etc.) and art disciplines (visual arts, theatre, dance, music, etc.) within the therapeutic process (Knill, Barba, & Fuchs-Knill, 2004).
- Interpersonal theory explains group dynamics in relation to aspects of play in various art forms, as well as, in interventions (Knill et al., 1995).
- Intrapersonal theory explores the personal response to engaging in various art disciplines, as well as, incorporates the concept of *low skill/high sensitivity* into creating with the arts (Knill, 1999, p. 46). Low skill/high sensitivity is a concept that emphasizes sensory-perception and expression, rather than skill (Knill, 1999).
- Transpersonal theory explores how the arts and their meaning are deeply rooted in our daily lives, in rituals, and in spirituality that connects the individual human experience with the larger community (Knill, 1999).
- Synesthetic explores how the experience or participation in art has sensory qualities, as well as, creates intermodal sensory perceptions (Knill, Barba, & Fuchs-Knill, 2004).
- Crystallization theory relates to our need as humans to gain insight and clarity of our psyches and how the arts exclusively support this therapeutic process through intermodal transfer, amplification, and substitution (Knill, Barba, & Fuchs-Knill, 2004; Knill, 1999).

- Polyaesthetic theory supports the concept that the arts are innately intermodal and part of “one harmonic body” (Knill, Barba, & Fuchs-Knill, 2004, p. 27). In addition, polyaesthetic theory, “gives the understanding of the sensory connections between perception and expression with respect to the arts disciplines” (Knill, 1999, p. 46).
- Aesthetic theory explores the role that the art product, the manifestation of imagination, plays in the therapeutic process (Knill, 1999).

In addition to these theories of expressive arts therapy, there are several approaches to implementing expressive arts. Art as medicine is an approach of expressive arts therapy that was created by Shaun McNiff and is rooted in the belief that creative expressions, in all forms, are interwoven and inseparable in both art and life (Estrella, 2007). This approach emphasizes the idea that the creative arts and their expression are able to access and reveal an individual’s or a community’s, spirit and imagination. Within the spirit and the imagination are “messengers of healing” (McNiff, as cited in Estrella, 2007, p. 197) which are discovered in the form of images and expressions through the creative arts process. These creative images and expressions are considered “co-participants” (McNiff, as cited in Estrella, 2007, p. 197) in the therapeutic process and are present to be dialogued and interacted with through image, the body, and physical enactment. By engaging with images and creative expressions in this way, self-awareness and therapeutic transformations are possible.

The Creative Connection is a person-centered approach to implementing expressive arts therapy (Rogers, 1993). This approach was developed by Natalie Rogers and is grounded in the principles of person-centered/humanistic therapy, created by her father Carl Rogers. These principles include empathy, congruence, and unconditional positive regard. In addition, the therapist trusts the client to flourish in their own individual process towards growth. The

Creative Connection is founded on the belief that people “need to fulfill their creative capacities. An inherent impulse or drive within each of us longs for creative expression” (Rogers, 1993, p. 96). Rogers emphasizes the importance of the therapist facilitating a space free of judgement, fear, and criticism, which provides the client space to engage in the process of creative expression and psychological exploration. (Estrella, 2007). The creative expression, achieved through the expressive arts, connects a person to their unconscious, thereby bringing the unconscious into awareness (Rogers, 1993). The Creative Connection incorporates concepts from intermodal theory, in that, this approach promotes the concept of the arts as interrelated; and, in transitioning from art form to art form, the journey into the unconscious deepens, which reveals the soul, the essence of a person. Rogers’ approach believes that in discovering and connecting to one’s essence, relatedness and integration of the inner world with the outer world can occur.

Expressive arts therapy as treatment for children with relational trauma. Expressive arts therapy is a unique form of treatment because it engages the whole person—mind, body, and spirit—in multisensory, creative experiences with varying art modalities (Malchiodi & Crenshaw, 2014). In drama therapy, a person uses their voice and their body to create and express. Music therapy offers a person the opportunity to engage with sound, vibration, and rhythm. In art therapy, a person creates visual images and interacts with art materials in a kinesthetic and tactile way. Dance therapy connects a person with their body, but also to rhythm and movement.

In early childhood, a child relates and develops in the world through sensory based experiences (Perry, as cited in Malchiodi & Crenshaw, 2014). These experiences are important in cultivating secure attachments with caregivers, developing empathy, learning and practicing self-regulation, and forming relationships with others. For children who have experienced

relational trauma, attachment to caregivers may be insecure, disrupted, or disorganized.

Research has shown that sensory based experiences are important for this population because they are effective in changing the neural pathways connected to stress response and creating secure attachment.

Children with relational trauma histories have not had consistent support with regulation provided by their caregivers. Due to this, children can have inefficient functioning of the emotional/right brain (Perry, as cited in Malchiodi & Crenshaw, 2014). Sensory based experiences, such as expressive arts, have the ability to engage the emotional/right brain functioning of a child. “Research on the impact of trauma proposes that highly charged emotional experiences are encoded by the limbic system and right brain as sensory memories” (van der Kolk, as cited in Malchiodi & Crenshaw, 2014, p. 7). With the memory of trauma being psycho-sensory in nature, it is logical to use interventions that are grounded in sensory experience to engage the emotional/right brain. Expressive arts therapy can provide this avenue (Malchiodi & Crenshaw, 2014).

Expressive arts therapy not only engages the emotional/right brain but facilitates the integration of both brain hemispheres (Hinz, 2009). This supports the child in accessing, expressing, processing, and integrating their relational trauma experiences.

Repetitive and patterned kinesthetic activities like yoga, massage, movement, and music support are also effective in treatment for children with relational trauma. According to Perry (2009), these activities provide organization and regulation of neurological input which help to diminish trauma related symptoms, like anxiety and impulsivity, associated with dysregulation.

Nonverbal communication is a child’s first form of communication with their caregivers and it is our most basic form of communication (Schoore, 2003). As previously stated, traumatic

memories are encoded by the limbic system as sensory memories in the emotional/right brain (van der Kolk, 2015). Due to this, children with relational trauma experiences can have difficulty accessing and processing traumatic memories verbally. Expressive arts therapy can access these nonverbal memories through activations of the emotional/right brain. Additionally, expressive arts therapy facilitates the integration of the emotional/right brain and the rational/left brain, which can aid in the verbalization of trauma experiences (Klorer, 2005). Due to thoughts and feelings being “not strictly verbal and are not limited to storage as verbal language in the brain, expressive modalities are particularly useful in helping individuals communicate aspects of memories and stories that may not be readily available through conversation” (Malchiodi & Crenshaw, 2014, p. 6). Expressive arts therapy facilitates nonverbal expression through the arts and play, in order to, access, process, and express psychological content.

Expressive Therapy Continuum (ETC)

The Expressive Therapies Continuum (ETC) is a foundational theoretical framework of expressive arts therapy. The ETC is developmentally-based and is used to assess, plan, and create expressive arts therapies interventions (Hinz, 2009). The ETC can be used to assess and describe a client’s internal process through identifying and describing how they interact with the arts/art materials and the level used to process and express information (Estrella, 2007; Hinz, 2009).

The developmental basis for the ETC is in its organization of media experiences. These experiences are sequenced as a hierarchy of levels from simple information processing and image formation, like kinesthetic experiences, to more complex information processing and image formation, like creating symbolic images (Hinz, 2009). Each level is comprised of two complementary components. As engagement with one component begins, activation of the

complementary component occurs. As processing within the first component continues, engagement with its complementary component decreases and can even be blocked.

The ETC, as shown in Figure 2, contains four levels. The first level of the ETC is the kinesthetic/sensory level, the second level is the perceptual/affective level, and the third level is the cognitive/symbolic level (Hinz, 2009). The fourth level, the creative level, can occur at any level, as well as, encompass functioning from all levels. Each level has a “healing dimension,” which demonstrates “optimum intrapersonal functioning” (Lusebrink, as cited in Estrella, 2007, p. 200). In addition, each level has an “emergent function” (Lusebrink, as cited in Estrella, 2007, p. 200), which are aspects of the level that lead to higher level functions.



Figure 2. The Expressive Therapies Continuum. Adapted from “The Expressive Therapies Continuum: A Framework for Using Art in Therapy,” L. D. Hinz, 2009, p. 5.

History and development of the ETC. The ETC was developed by Kagin and Lusebrink (1978), and later expanded by Lusebrink (1990, 1991, 2004). The ETC is a blending of theoretical concepts, practices, and approaches to art therapy from a breadth of art therapists, such as, Viktor Lowenfeld, Florence Cane, Margaret Naumberg, and Mala Betensky. Viktor Lowenfeld worked as an art educator and helped to define the stages of graphic development based on Jean Piaget’s stages of cognitive development (Lusebrink, Mārtinsone, & Dzilna-Šilova, 2013). Lowenfeld’s work described that optimal, creative learning occurred when

information was received and processed through different modes, such as, kinesthetic, sensory, perceptual, emotional, and intellectual modes (Hinz, 2009). Lowenfeld's stages of graphic development are the foundation of the ETC (Kagin & Lusebrink as cited in Hinz, 2009). Kagin and Lusebrink (as cited in Hinz, 2009) expanded the framework created by Lowenfeld by organizing the modes of information processing in a sequence according to complexity. According to Lowenfeld (as cited in Lusebrink, Mārtinsone, & Džilna-Šilova, 2013), when a child personally identifies with the content they are learning about, through sensory, perceptual, and/or emotional information, the child can have a comprehensive and creative learning experience.

Florence Cane, and her approach to art, centered on the belief that people perceive and process information through the functions of movement, emotion, and thought (Lusebrink, Mārtinsone, & Džilna-Šilova, 2013). Cane's approach is founded on the belief that it is our life's goal to integrate these functions and find balance within them (p. 78). She hypothesized that behavioral dysfunctions came from an imbalance within these functions, and that by creating art, one can experience all of these functions and experience a fourth function, a "spiritual awakening" (p. 78). These postulations concerning the functions of movement, emotion, and thought are comparable to the kinesthetic, affective, and cognitive components of the ETC.

Margaret Naumburg, an educator and psychotherapist, used art therapy in her psychodynamic work and believed that the most essential psychological content was found in the unconscious (Lusebrink, Mārtinsone, & Džilna-Šilova, 2013). She posited that the unconscious was most fully expressed through images and symbols, as opposed to words. According to Cane's work, integration and healing are achieved thorough and exploring these images and symbols cognitively and verbally and making meaning of these symbols.

Mala Betensky and her phenomenological approach to art therapy, is closely aligned with the ETC through the process by which she facilitated art therapy (Lusebrink, Mārtinsone, & Džilna-Šilova, 2013). Mala Betensky began art therapy sessions with a time of free play, in which individuals were encouraged to touch and explore various art materials, correlating to the kinesthetic/sensory level of the ETC (Hinz, 2009). The therapeutic process would continue with creating an image and then processing the image with formal artistic properties, correlating to the perceptual/affective level of the ETC. Next, the process would continue with individuals exploring their art for meaning and connections to their life, correlating to the cognitive/symbolic level of the ETC. Mala Betensky's work demonstrates one approach to the movement between each level of the ETC.

Kinesthetic/sensory level. The kinesthetic/sensory level is the first level of the ETC. The kinesthetic component of this level “encompasses the sensations that inform people of and accompany bodily movement, rhythms, and actions” (Hinz, 2009, p. 39). Kinesthetic activity is also connected to nonverbal communication, spatial awareness of the body, and increasing or decreasing arousal and tension. The healing dimension of the kinesthetic component is the activation of arousal or energy through kinesthetic activity, or the release of energy that reduces the individual's level of tension (Kagin & Lusebrink, as cited in Estrella, 2007). In addition, the kinesthetic component is associated with finding one's inner rhythm (Hinz, 2009). Keywords of the kinesthetic component are rhythm, action, movement, and energy release. The emergent function of the kinesthetic component is an image or feeling that leads the client to the perceptual/affective level. An example of this is a scribble drawing, which is primarily a kinesthetic activity; however, this shifts to the perceptual component when the client perceives an image within their drawing. Kinesthetic activity can also lead to the expression of emotion,

where vigorous movement can likely increase arousal and relaxed movement will likely create calmness. The emergent function can also be facilitated by the therapist through first asking questions about the action, then asking questions about the feeling of the action.

The sensory component is the pure experience of internal and external sensations through the interaction with the sensory qualities of art materials (Lusebrink, 1990 as cited in Hinz, 2009). Sensory activities are closely associated with the ability to elicit emotional responses and can be used therapeutically to aid people who struggle to retrieve, identify, and communicate feelings (Lacroix, Peterson, & Verrier, 2001; Meijer-Degen & Lanssen, 2006 as cited in Hinz, 2009). The healing dimension of the sensory component is “slow sensual experience” (Lusebrink, as cited in Hinz, 2009, p. 62). Through this experience, awareness is brought to the internal sensations being experienced, rather than on thoughts or emotions occurring in the mind (Hinz, 2009). The focus becomes the internal, rather than the external, which leads to an increase of “internal calm” (p. 62). The emergent function of the sensory component can be attributed to this internal focus on sensations, that can lead to internal awareness of emotions, thereby being an affective experience and moving the person in to the perceptual/affective level.

Perceptual/affective level. The perceptual/affective level is the second level of the ETC. The perceptual component is connected to the “figurative aspects of mental imagery and the formal elements of visual expression” (Hinz, 2009, p. 79). Working in the perceptual component, invites clients to create visual images, using formal elements of art like line, color, form, and size, to represent their inner worlds. The perceptual component also focuses on the structures and form of images, as well as, how structured images and art materials can create perceptual experiences of structure that can be internalized by the client. The healing dimension of the perceptual component comes from the structuring and organization of external elements

(art media, art images), that can then be translated into an organized internal state. The healing dimension of the perceptual component is also related to focusing on boundaries, concrete properties (art media), and the elements of the image. By focusing on these limits, the art is able to safely contain the emotions of an experience (Kagin & Lusebrink; Lusebrink, as cited in Hinz, 2009). The emergent function of the perceptual component relates to the client's perception and ability to perceive situations with more clarity, identifying experiences for what they are, as well as, challenge their views of the situation (Hinz, 2009). In challenging and expanding the client's perceptions, cognitive functioning and understanding of the self and others, are increased.

The complementary component of the perceptual component is the affective component. The affective component of the ETC describes the process of emotional expression through the engagement with the arts (Hinz, 2009). Work on with the affective component encourages the amplification, identification, and expression of emotions. The healing dimension of the affective component is an increased awareness of how to regulate one's emotions, as well as, support for safe and constructive of emotional expression. The arts can be taught to be used to support clients in communicating their emotions without the fear of emotional flooding. The emergent function of the affective component is the ability to identify, reflect, and integrate emotional experience. From this, the integration of personal symbols may occur and moving to the cognitive/symbolic level is likely.

Cognitive/symbolic level. The cognitive/symbolic level is the third, and final level of hierarchy in the ETC. The cognitive component is focused on complex thought processes like abstract concept formation, analytical and logical thought, reality-directed information processing, cognitive maps, and the use of self-instructions when completing complex tasks

(Kagin & Lusebrink; Lusebrink, as cited in Hinz, 2009). In addition, problem solving with art media is a therapeutic aspect of this component (Hinz, 2009).

The cognitive component includes deliberate, intentional, thought processes that require conscious planning, organization, and problem solving (Lusebrink, as cited in Hinz, 2009). Information regarding the qualities of art materials are internalized for future reference, in order to understand and plan the use of art materials (Hinz, 2009). In this way, the cognitive component differs from the other components within the ETC because it includes referencing past experience to create mental images to use for future planning and action. The healing dimension of the cognitive component is the ability to recall and reference previous concrete experiences to generalize and problem-solve in current situations. This problem-solving aspect of the cognitive component is also its emergent function. Through using the arts to create images that relate to a client's thoughts and feelings regarding a situation or problem, new solutions can emerge.

The symbolic component is the complement to the cognitive component. Where the cognitive component focuses on concrete experiences and thought processes, the symbolic component concentrates on exploring an individual's intuition and inner world, including their symbolic thoughts, concepts, and personal and universal symbols (Hinz, 2009). Symbols themselves, can hold more meaning than verbal description can alone; they can hold duality, the inner world and the outer world of the individual. Through exploring personal symbolic content, individuals have the potential to gain deeper self-knowledge. The healing dimension of the symbolic component is the creation and understanding of personal symbols and metaphors and their significance to universal symbols. The emergent function of the symbolic component

occurs through discovering new aspects of one's self and integrating these into one's self concept.

Creative level. The creative level of the ETC runs through each of the levels previously discussed. The creative level is unique in that, creative experience can occur within the processing at each level and each component of the ETC or encompass the processing and functioning of all components (Hinz, 2009). The creative level, and its healing dimension, relates to the processes of synthesizing and integrating personal knowledge leading to the experience of self-actualization through the creative process. During the artistic experience, an individual can undergo several types of synthesis: "synthesis of inner experience and outer reality..., synthesis between the individual and the media utilized, and...synthesis between the different experiential and expressive components of the ETC" (Kagin & Lusebrink, as cited in Hinz, 2009, p. 170). Through these synthesizing experiences, an individual can feel self-actualized; meaning, they can feel united and whole, by using and fulfilling their talents and potential (Hinz, 2009). Through creative self-actualization experiences, an individual can find healing, self-acceptance, openness, and courage. The creative level holds the concept of viewing individuals as whole people that are unique and integrated, with each component of the ETC working in conjunction with the other to provide the individual with an optimal experience. The emergent function of the creative level is, through creative experience and expression, an individual can find a new way of viewing themselves, their inner world, and outer reality.

In my work at a residential treatment program, the majority of the children I've worked with developmentally present within the kinesthetic/sensory level or the perceptual/affective level in session. Factors that can contribute to what level a child presents at within the ETC are the child's age, the age when relational trauma occurred, the child's current needs, and the

current stage of treatment. An example of this is how the majority of clients I meet with want to make slime during almost every session. These clients range from ages 8 to 12. Slime is what it sounds like, a slippery, slimy concoction of glitter glue, shaving cream, contact solution, and baking soda. Making slime is a sensory experience; the child uses their hands to mix and knead the ingredients together, adding varying amounts of ingredients to achieve the right consistency, the right “feel,” of slime they are seeking. In assessing where the child/children are developmentally, in session, with me, it is clear they are presenting on the kinesthetic/sensory level. I can use this information to structure further sessions and implement varying expressive arts interventions within the kinesthetic/sensory level.

A Child-Centered Approach

Prior to discussing the connections between the ETC and ARC frameworks, it is important to discuss the therapeutic approach from which these frameworks are to be implemented. A child-centered approach is centered on the basic premise that children have an innate capacity to strive toward growth and maturity (Rogers, 1993). A child-centered approach is founded in the principles of empathy, congruence, and unconditional positive regard. In my clinical experience working with children with relational trauma, I have approached the work with a child-centered foundation. In doing so, I have provided a space for children to show up as they are, to follow the lead of the child, and offer them experiences of agency and control. In providing a child-directed space during sessions, I have also gained valuable information about my client's; information pertaining to their functional and developmental level. This information has guided me in how to assess the client, and how to approach and plan interventions for the client.

Discussion

The development of this project began as a result of several factors: my passion for expressive arts therapy, my clinical experience as an intern in a residential treatment program, and my desire to study the most effective methods of implementing the expressive arts in treatment with children with relational trauma experiences. I began my research with searching for studies that focused on the use of the ETC, a foundational framework of expressive arts therapy, in treatment with this population. I was disappointed to find no peer-reviewed research studies on the topic.

While I found no research demonstrating the use of the ETC in the treatment of children with relational trauma, I found a plethora of research supporting the use of art-based methods and expressive arts therapies with this population. Several articles I reviewed demonstrated that arts-based methods are effective in processing trauma, as well as, creating a positive impact on children's behavior and symptoms. The benefits of using art-based methods with children who have experienced trauma are improved self-esteem, decreased symptoms of trauma, and decreased negative affect (Coholic, Loughheed, & Lebreton, 2009; Hass-Cohen, Bokoch, Findlay, & Witting, 2018; Mohr, 2014). These findings prompted me to ask the question: If arts-based methods can be effective in treatment with this population, then can the ETC, a framework for implementing the expressive arts in therapy, also be shown to be an effective treatment option?

As I delved deeper into exploring the ETC, its developmentally-based framework seemed vaguely connected to the ARC treatment framework I was becoming more familiar with at my internship site. I felt it was necessary to explore this connection further. Not only for my own understanding of how to potentially use expressive arts and the ETC in treatment with this

population, but also to call attention to this gap in research of treatment options for children with relational trauma and in the expressive arts therapy field.

ETC and ARC: The Beginnings of an Integrative, Trauma Treatment Framework

In studying and researching both ETC and ARC separately, I have found correlations between the two. The ETC and ARC frameworks are both developmentally-based and flexible, and as such, largely focus on similar treatment goals. In a general sense, there is a correlation between each level of the ETC and each domain of ARC. The divergence between the ETC and ARC occurs at the entry point of intervention. The ETC intervenes using the arts, primarily sensory-nonverbal means (Hinz, 2009), while ARC uses worksheets, psychoeducation, and some creative interventions, its primary mode is through verbal means (Blaustein & Kinniburgh, 2010). The following will discuss points of connection between each level of the ETC and each domain/component of ARC. These connections demonstrate how the ETC targets similar aspects of intervention that ARC targets and identifies as important in the treatment of children with relational trauma. Within these connections, an expressive arts therapist can then plan and develop expressive arts-based interventions to support this population.

Kinesthetic-sensory level/Attachment domain. The building blocks of ARC in the attachment domain are held within the kinesthetic-sensory level of the ETC. The kinesthetic-sensory level of the ETC focuses on rhythm, movement, action, internal and external sensations (Hinz, 2009).

Routines and rituals are the actions that hold the rhythms of daily living. The consistent response of a caregiver is both an action performed by the caregiver, and a sensory experience of co-regulation felt by the child (Hinz, 2009). The sensory experience of predictable and consistent co-regulation leads the child to feel safe and to create a secure attachment (Blaustein

& Kinniburgh, 2010). Attunement is both an action and an internal sensation; it is recognizing one's internal feelings and sensations, recognizing another's feelings through their actions, and responding accordingly. Caregiver affect management is also rooted in the kinesthetic-sensory; a caregiver must be attuned to their internal feelings and take action to care for themselves.

Examples of expressive therapy interventions within the kinesthetic-sensory level/attachment domain, could be creating opening and closing rituals in session, which provide consistency and containment, and therefore a sense of safety for the child. Mirroring and follow-the-leader activities, which could include movement, playing drums, painting, support opportunities for attunement through kinesthetic-sensory experiences.

Perceptual-affective level/Self-regulation domain. The building blocks of ARC within the self-regulation domain relate to the perceptual-affective level of the ETC. The perceptual-affective level of the ETC focuses on organization, containment, perception of internal and external images, affective identification, affective expression, and affective regulation (Hinz, 2009).

The ARC building block of affect identification correlates to the perceptual-affective level and the sensory component of the ETC. Affect identification first begins with an awareness of internal states, which relates to the sensory component of the ETC. The identification of emotions within the self, relates to affective experience, while the identification of affective states in others, relates to the perceptual experience. An example of an expressive therapy intervention that could be used to support these areas of treatment is feelings forehead. This intervention has the child place a card with an emotion on their forehead. The therapist then enacts the feeling displayed on the card and the child must guess the feeling the therapist is

enacting (i.e. the feeling on the card). This intervention targets affect identification through perceptual and affective means.

The modulation building block of ARC relates to the both the kinesthetic and affective components of the ETC. This building block targets the child learning regulation skills to manage emotions and maintain optimal levels of arousal (Blaustein & Kinniburgh, 2010). The affective component of the ETC is important to include in connection to the modulation building block within ARC because, modulation begins with affect identification. Additionally, the ETC uses the kinesthetic component (movement, rhythm, physical activity) to support regulation, or the increase of arousal and the decrease of tension (Hinz, 2009). Expressive arts therapy movement interventions can be used to both increase and decrease arousal, depending on the needs of the client. An expressive arts intervention that can be used to decrease arousal is simply using art materials to draw their breath.

The affect expression building block of ARC connects to the affective component of the ETC. The affective component of the ETC supports the goals of this building block by using the arts as a channel for affective expression. The affective expression, manifested in the art created by the client, can be shared safely with the therapist. Any expressive art therapy interventions that focus on emotional expression support this goal.

Cognitive-symbolic level/Competency domain. The building blocks of ARC within the competency domain relate to the cognitive-symbolic level of the ETC. The cognitive-symbolic level of the ETC focuses on problem-solving, thought processes, intuition, the inner world, and identifying personal symbols (Hinz, 2009).

The building block of executive functions of ARC strongly connects to the cognitive component of the ETC. Both emphasize the development and practice of problem-solving.

Within the ETC context, problem-solving is developed and practiced through the creation of art (Hinz, 2009). This is achieved through the client organizing, planning, and evaluating their artistic product through-out the creative process. Through the evaluation of the artistic product, the client can implement problem-solving skills to alter the product to match their vision.

The self-development and identity building block of ARC relates to the symbolic component of the ETC. Both the ARC building block and ETC component, focus on the development of a coherent sense of self and identity (Hinz, 2009; Blaustein & Kinniburgh, 2010). This is achieved within the ETC context through the creation of personal symbols. Expressive arts therapy interventions within the symbolic component, that support the development of self and identity, could be creating personal symbols related to positive, strengths-based personal qualities, and creating self-portraits relating to the self-image before trauma, during the trauma, and after the trauma.

Creative level/Trauma experience integration domain. The ARC building block of trauma experience integration relates to the creative level of the ETC. In the context of the ETC, a creative experience integrates the functioning and developed skills of each ETC component, of each ETC level (Hinz, 2009). This is similar to the trauma experience integration building block of ARC, in that, this building block also emphasizes the integration of developed skills to support the continued growth of the client (Blaustein & Kinniburgh, 2010).

Conclusion

In connecting the components and targets of intervention identified in ARC, within the framework of the ETC, I have provided an expressive arts therapy context for working with children with relational trauma. Additionally, I have highlighted the connections between the ETC and ARC. Figure 3 is an artistic representation of the beginnings of an integrative

ETC/ARC framework. It is my hope that further research will be performed to develop this preliminary ETC/ARC framework for working with children with relational trauma.



Figure 3. An artistic representation of the preliminary ETC/ARC framework.

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THESIS APPROVAL FORM

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Title: Connecting ETC and ARC: The Beginnings of an Integrative Framework for Working with Children with Relational Trauma, a Literature Review

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Donna C. Owens, PhD