Trauma-Informed Expressive Arts Therapy for Adults at a Short-Term Inpatient Psychiatric Hospital

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Trauma-Informed Expressive Arts Therapy for Adults at a Short-Term Inpatient Psychiatric Hospital

Capstone Thesis

Lesley University

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Expressive Arts Therapy

Kellogg
Abstract

Research has shown that trauma has serious effects on a person throughout their lifespan and can often be linked with mental illness. This is significant because individuals with mental illness who have experienced trauma may be hospitalized at an inpatient psychiatric facility at some point in their lifetime. Because patients in an inpatient level of care are in crisis, it would be inappropriate to provide trauma treatment. Instead, the focus of an inpatient stay is on safety and stabilization. However, providing trauma-informed care at an inpatient facility is vital for all levels of acuity. This means providing care that is appropriate for all, including those with a trauma history. This literature review discusses trauma, the inpatient hospital experience, and the implications for providing trauma-informed expressive art therapy to adults at an inpatient facility.
According to 2014 data, on any given night there were over 170,000 residents in inpatient psychiatric hospitals and other 24-hour residential treatment beds throughout the year (NRI, 2017). This is significant because hospitalization most often requires that a person be a serious imminent threat to themselves or others. Such cases including people with the intention to commit self-injury or suicide (Craw and Compton, 2006, p. 981). The Centers for Disease Control and Prevention in their Leading Cause of Death Reports for 2016 cited suicide as the 10th leading cause of death in the US. Furthermore, “There were more than twice as many suicides (44,965) in the United States as there were homicides (19,362).” (CDC, 2017). This being so, individuals who are hospitalized are most often in an extremely vulnerable state.

This is significant because many people who have a mental illness, have also experienced some form of trauma. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 61 percent of men and 51 percent of women in the US report have been exposed to at least one traumatic event in their lifetime (“Trauma,” para. 2). In public behavioral health care settings, 90 percent of clients have experienced a form of trauma (SAMHSA, “Trauma,” para. 2).

Trauma and severe mental illness can often be linked. For example, Filippo et al. (2012) produced evidence indicating a connection between childhood trauma and adult psychosis (p. 8). Additionally, Devries et al. (2013) findings indicated a connection between intimate partner violence and depression (p. 8). The link between severe mental illness and trauma, combined with the idea that individuals who have experienced trauma and/or have severe mental illness will most likely receive mental health services and possibly be hospitalized in their lifetime,
indicate the need for mental health services appropriate for those who have experienced trauma. Inpatient psychiatric hospitals as organizations need to provide informed care for individuals who have experienced trauma. All staff, including expressive art therapists should be responsible for understanding the implications trauma can have on individuals throughout their lifetime and provide care to all consumers that is sufficient for all, including those who have experienced trauma.

**Method**

The inspiration for this thesis came from my experiences this year as an intern at a short-term acute care psychiatric hospital for adults with mood and personality disorders. At this internship, I recognized the prevalence of patients with severe trauma histories and became interested in the implications of having a trauma history while being in a high stress environment like an inpatient hospital. In order to understand what it means to be a trauma-informed expressive art therapist working in an inpatient hospital it was necessary to conduct a comprehensive review of the literature.

To gather this literature, various data bases and search engines were used. These include Lesley University’s research database, Google scholar, qualitative research journals and quantitative research journals. To identify these articles the search terms used include “trauma-informed expressive art therapy,” “expressive therapies and trauma,” “creative art therapies and trauma,” “art therapy and trauma-informed,” “music therapy and trauma-informed,” “trauma-informed and mental health,” “inpatient psychiatric hospital and trauma,” “trauma-informed and inpatient psychiatric hospital,” “trauma-informed approaches,” “seclusion and
restraint,” “staff perceptions and inpatient hospital,” “patient perceptions and inpatient hospital.”

From within these search terms, peer-reviewed articles and distinguished books were generated. From this research it was concluded that there is a wealth of research on expressive art therapy and trauma treatment, however there is no singular trauma-informed expressive art therapy approach. As such, research was cross-referenced for expressive art therapy and trauma with trauma-informed inpatient hospital approaches so that one model of trauma-informed expressive art therapy could be obtained. In an effort to organize the expressed research so that it may be effectively understood, categories were generated. These categories include defining trauma, inpatient hospital practices, trauma-informed care, defining expressive art therapy, and trauma-informed expressive art therapy. The scope of this paper was limited and by no means comprehensive to all terms. Instead, the aim of presenting this information is to provide a general understanding and awareness of trauma-informed care and its implications for expressive art therapy.

**Literature Review**

To understand trauma-informed expressive art therapy in an inpatient psychiatric hospital, it is first necessary to define trauma. To provide trauma-informed care, clinicians must be aware of trauma’s prevalence, impact across the lifespan, signs and symptoms. It is also necessary to understand trauma within the context of an individual’s life, acknowledging the role of race, ethnicity, socioeconomic status, ability, gender, sexual orientation, and their intersectionality. Additionally, it is necessary to understand the impact of retraumatization.
Both historical and current day psychiatric hospital practices are explored to discern the hospital environment and the role of trauma-informed care.

**Trauma**

In order for clinicians to understand trauma, it is necessary to agree on a definition. Trauma can be defined as experiencing exposure to actual or threatened death, serious injury, or sexual violence and can include being exposed firsthand or being a witness to the event (American Psychiatric Association, 2013, p. 271). However, the definition of what constitutes a traumatic experience is highly contested and various organizations and professionals have different ways of conceptualizing trauma. For instance, the US Federal organization Substance Abuse and Mental Health Services Administration (SAMHSA) described trauma as including three factors – the traumatic event, the way in which the event is experienced intra- and interpersonally, and its effects (SAMHSA, 2014b, p. 8). Additionally, SAMHSA made the distinction that the traumatic event does not necessarily have to be life threatening.

From a multicultural standpoint it is necessary to acknowledge that certain groups of people are more likely to experience trauma. For instance, “Black people are simultaneously more likely to experience trauma, are overrepresented in the mental health system, and receive the most negative and adversarial responses (such as compulsory treatment) which are known to cause iatrogenic harm” (Sweeney, Filson, Kennedy, Collinson, and Gillard. 2018, p. 321). Williams, Metzger, Leins, and DeLapp (2018) explain how differences have been observed in race/ethnicity and rates of trauma. Williams et al. (2018) assert that “Hispanic Americans and African Americans are more likely to report experiencing traumatic events, and they are more likely to report polyvictimization than are their White American counterparts” (p. 243).
Polyvictimization meaning that they are more likely to report multiple incidents of traumatic experiences. One possible reason for the disparities in racial groups and traumatic experiences is racial discrimination. This being so, there is a push for racial trauma to be considered a contributing factor with regards to differences in rates of trauma (Williams et al. 2018, p. 245).

Furthermore, intergenerational trauma, or trauma passed on to subsequent generations, is also critical to consider. This can occur when environmental stress related to ethnic identity causes a traumatic response in one individual which is then passed down to the next generation. In the case of intergenerational trauma, research indicates that experiencing a traumatic event can cause enzymatic alterations or epigenetic changes which are then inheritable through DNA (Williams et al. 2018, p. 245). In order to be considered a trauma-informed expressive art therapist, it is necessary to acknowledge how trauma affects certain groups of people disproportionately, an effect that can cause epigenetic changes which can be passed on to subsequent generations.

According to alternative conceptualizations of trauma, socioeconomic status also plays a role. Specifically, poverty has been recognized to have traumatic effects. Santiago, Wadsworth, and Stump (2011) asserted that individuals living in poverty experience more stressful events than other socioeconomic groups. Adverse stressors include “conflict among family members, exposure to violence, frequent moves and transitions, and exposure to discrimination and other traumatic experiences” (Santiago et al. 2011, p. 219). Additionally, low socioeconomic status may contribute to an individual being more likely to have psychological conditions such as anxiety or depression, as well as make them more likely to commit suicide or perform self-harm behaviors (Santiago et al. 2011, p. 219, Congdon, 2011, p. 1205).
With these alternative conceptualizations and more generalized definitions “However, there is concern among some survivors that, in adopting a broad conceptualization of trauma, the term could lose its meaning, with anything and everything subsumed under its label” (Sweeney et al. 2018, p. 321). Additionally, some believe that individuals should be able to develop their own narratives as to the experience and effect of trauma (Sweeney et al. 2018, 321).

Regardless of how broad a definition of trauma a clinician ascribes to, it is irrefutable that trauma has serious implications for children and adults across their lifespan (Sweeney, 2018, p. 319). Experiencing trauma can have detrimental effects on a person’s physical, mental, and emotional health. Common symptoms can include dissociation, numbing, emotional dysregulation, hopelessness, flashbacks, hypervigilance, and somatization (SAMHSA, 2014b, p. 61-72). There is also emerging evidence to support that trauma impacts neurobiological development. Not only that, but it can shorten life expectancy (Sweeney et al. 2018, p. 319).

The effects of trauma are also cumulative. The implications being that the more traumatic experiences a person has, the more detrimental the impact on a person’s overall health. Complex psychological trauma involves repetitive or prolonged exposure to severe stressors that may involve harm or abandonment from caregivers and occur during childhood/adolescence when individuals are developmentally vulnerable (Courtois and Ford, 2009, p. 13).

Additionally, research has shown that the effects of trauma are not limited to the individual in the present. Trauma can have generational effects socially, psychologically, and epigenetically (Sweeney et al., 2018, p. 320). Sweeney et al. (2018) reported that “having a
trauma history is associated with poorer outcomes for survivors, including a greater likelihood of attempting suicide, of self-harming, longer and more frequent hospital admissions and higher levels of prescribed medication” (p. 319). This is significant because it means individuals with trauma histories are likely to be hospitalized, making the need for trauma-informed psychiatric hospitals immense. As an expressive art therapist, this involves understanding what constitutes trauma, its prevalence, and its impact and factoring that into all interactions with patients.

Retraumatization.

Trauma may not end after the singular event. This can occur when someone with a trauma history is traumatized again. According to Sweeney et al. (2018) retraumatization “occurs when something in a present experience is redolent of past trauma, such as the inability to stop or escape a perceived or actual personal threat” (p. 322). The stimulus that incites traumatic memories is sometimes called a trigger (SAMHSA, 2014b, p. 68). Retraumatization is particularly important to consider when providing care in an inpatient hospital because “evident forms of retraumatisation include seclusion, restraint, forced medication, body searches and round-the-clock observation,” all standard practices at most psychiatric hospitals (Sweeney et al., 2018, p. 322). Additionally, retraumatization can occur related to experiencing historical or cultural trauma “such as pathologising an individual’s response to racism” (Sweeney et al. 2018, p. 322). It is imperative to recognize trauma does not end for the individual after the defining event and that a person can experience retraumatization, even through common practices of an inpatient psychiatric hospital.
Historical Hospital Practices

To understand current inpatient hospital practices, it is necessary to acknowledge historical practices of institutionalization. Institutions of the past include jails, concentration camps, and mental institutions (Slemon, Jenkins, and Bungay, 2017, p. 1). These institutions were “characterized by surveillance and control, and with admission to total institution, inmates undergo a mortification in which autonomy and self-expression are replaced with institutionally mediated behaviors” (Slemon et al. 2017, p. 2). Within these environments, staff members may exercise power over any inmate. Individuals who performed “disruptive or indicative of disorder” could face punitive punishments such as loss of privileges including off grounds access or access to personal belongings (Slemon et al. 2017, p. 2).

Other forms of punishment commonly used were seclusion, restraint, and bodily harm (Slemon et al. 2017, p. 2). Within these institutions, these practices were rationalized as necessary to preserve safety. Not only that, but they were also recognized as a form of treatment, further rationalizing them. In the worst cases, these practices promoted inhumane treatment, such as involuntary hysterectomies and lobotomies. Overall, “freedom of action, including movement in the outside world, is reframed as a privilege which must be earned through acceptable and safe behavior” (Slemon et al. 2017, p. 2). Patients were held in strict control with little potential for autonomy and high possibility of severe punishments in the form of seclusion, restraint and harm.

The driving forces behind institutionalization practices were stigma and fear. Slemon et al. (2017) explained how stereotypes and historical values around illness were still prevalent.
For example that people with mental illness are “mad,” “evil,” or “animalistic” (p. 3). This fear of difference led to people being confined to jails and mental institutions. Slemón et al. (2017) also discussed the duality of the fear of “the mad” and staff as “providers of benevolent therapeutic care” justifying the practices of institutionalization (p. 3). The societal ideas of those with mental illness as people to be feared and staff as benign caretakers promoted institutionalization as an appropriate practice of the time.

**Current Day Practices**

However, the practice of institutionalization did not last forever. Deinstitutionalization began in the 1950’s in the US, and although asylums were deemed unethical and closed, many practices from institutionalization were carried into current day (Slemón et al., 2017, p. 3). These “risk management” strategies include locked wards, seclusion, restraints, surveillance, denial of leave, and removal of personal belongings (Slemón et al., 2017, p. 3). Loukidou et al. (2010) argued how even with the practice of deinstitutionalization, present day practices still warrant the use of risk management strategies from the era of institutionalization. Therefore the profession of mental health nursing is still institutionalized. Similarly, Slemón et al. (2017) asserted that although attitudes were changed to favoring more safe and ethical healthcare, these attitudes had also been used to justify harmful risk management strategies.

Stigmatizing views were also carried over from the era of institutionalization, such as those with mental illness being “dangerous” and people to be feared. Slemón et al. (2017) specifically addressed nurses in their article. This is important because nurses are direct care staff and work closely with patients on inpatient hospitals for the majority of their time on the job. Slemón et al. (2017) explained that “specifically, nurses fear unknown patients; those who
are not familiar to the nurses from previous hospitalizations are deemed unpredictable and therefore unsafe” (p. 3). Furthermore, “nurses’ fear of patient aggression increases the use of seclusion, reduces therapeutic engagement, and gives rise to unnecessary restrictions of patient autonomy such as cancelling off-ground privileges” (p. 3). The stigma of individuals with mental illness as people to be feared, led to nurses exercising more control and punishment over patients.

The range of acceptable behavior is notably constricted. Despite these rules and boundaries being strictly upheld by nurses, the nurses and patients experience them as “arbitrary.” Yet they continue to be upheld by “fear, stigma and the aim to ensure safety” (Slemon et al., 2017, p. 3). Slemon et al. (2017) asserted that “the safety discourse, grounded in fear of individuals with mental illness, continues to legitimize the use of these practices in the same manner in which inhumane interventions were justified in the era of institutionalization” (p. 3). The very discourse that was meant to create a more ethical and humane healthcare approach is still being used to rationalize practices from the era of institutionalization.

A vital aspect of many current day mental healthcare practices is the therapeutic relationship, valuing the clients’ needs and goals at the center of care. However, “the upholding of safety as the ‘highest aim’ of mental health care nursing may contradict the therapeutic relationship.” For example, Slemon at al. (2017) asserted that many nurses value seclusion as “essential” to treatment (p. 3). Additionally, many nurses hold risk management interventions to be “effective and beneficent treatment” (Slemon et al., 2017, p. 4). Therefore, these risk management strategies need to be reframed as contradictory to the therapeutic relationship and ineffective forms of treatment.
Slemon et al. (2017) noted other contradictions in nurse’s attitudes toward these practices. For instance, “Happell and Koehn (2010) report a concerning cognitive dissonance in which 87% of nurses regretted using seclusion yet almost half believed that patients felt safe and relieved after being secluded” (p. 4). Additionally, “nurses on unlocked units expressed anxiety about patients leaving the unit and harming themselves or others, while nurses on locked units were concerned that patient conflict and ‘disturbed behaviours’ would increase” (Slemon et al., 2017, p. 4). The contradictions in nurse’s views indicate a conflict in values as well as ignorance of patient’s experience of risk management strategies. The moral distress nurses feel is akin to “feeling powerless and beholden to a system which necessitates a certain type of mental health care, with few alternative options for care provisions” (Slemon et al., 2017, p. 4). This moral distress is noteworthy because it could negatively impact patient care, potentially contributing to burnout.

Notably, patient views towards these risk management strategies are often negative. Patients may experience these practices as “dehumanizing and traumatizing” (Slemon et al. 2017, p. 4). Slemon et al. (2017) recognized that “patients describe seclusion as humiliating and causing distress and fear.” Patients perceive hospital units as similar to jails due to their locked doors and patients inability to experience the outside world. Overall, based on patient and staff perspectives, the current focus on safety as the highest aim “is not contributing to increased perceptions of safety, but rather is causing moral distress for direct care nurses and traumatizing patients” (Slemon et al., 2017, p. 4). In taking into consideration perceptions of staff and patients, it is clear that the current focus on safety is having a negative impact indicating a need for change in the values of inpatient hospitals.
In particular, one risk management strategy used in inpatient hospitals is observation. This can include increased vigilance, direct observation/monitoring, and electronic surveillance of the unit (Slemon et al., 2017, p. 4). This observation of patients can be intermittent or constant. That is, patients may be intermittently observed at scheduled intervals, or patients may be constantly observed one-on-one by a staff member—not excluding private spaces such as bedrooms and bathrooms/showers (Slemon et al., 2017 p. 4-5). Despite arguments that observation is necessary to prevent inpatient suicide, Slemon et al. (2017) argued that “this intervention has not successfully demonstrated its efficacy” (p. 5). Furthermore, “Cutcliffe and Stevenson (2008) describe the use of constant observation as a “defensive and custodial practice” (p. 943). It is thought of as a form of care even when it limits the use of other forms of treatment. Overall, the use of constant observation can have the negative effects of making patients feel a loss of privacy, disempowerment, and loss of control.

Restraint and seclusion are other risk management strategies commonly used in inpatient hospitals. The use of these methods still prevails despite there being no evidence-based research to support the claim that they are therapeutic (SAMHSA, 2014a, p. 11). These strategies were born out of the stigmatizing view that individuals with mental illness are violent, unpredictable, and dangerous (Slemon et al., 2017, p. 5). Despite methods like restraint and seclusion being hailed as necessary to maintain safety, they most often cause physical, emotional, and mental harm (SAMHSA, 2014a, p. 11).

Efforts have been made to reduce the use of restraint and seclusion internationally. However, “one in five inpatients are reportedly secluded at least once in the duration of their hospitalization” ((Bullock, McKenna, Kelly, Furness, & Tacey, 2014, as cited in Slemon et al.,
2017, p. 5). Overall, Fisher (2003) summarized that restraint and seclusion reinforced negative behaviors, disrupted therapeutic relationships, and aroused feelings similar to past episodes of trauma (p. 77). Despite the purpose of seclusion being in response to patient violence and establishing overall safety, “the triggers for seclusion use in the clinical setting are primarily associated with non-violent behaviours such as medication refusal, lack of rule following and absconding from the unit” (Bowers et al. 2010b, as cited in Slemon et al., 2017, p. 5).

Appallingly, increased staff aggression was correlated with increased seclusion use (p. 5). It is clear that not only is seclusion and restraint not being used in appropriate situations, but these methods can be traumatizing, nontherapeutic, and have an adverse effect on therapeutic relationships.

In 2003, the Substance Abuse and Mental Health Services Administration (2010) named the reduction and ultimately elimination of seclusion and restraint to be a priority, and subsequently created the Alternatives to Restraint and Seclusion State Incentive Grants program to support States in prioritizing this need (p. 1). The American Psychiatric Association and American Psychiatric Nurses Association also took a similar stance. To evaluate the progress of this goal, Staggs (2015) conducted the first nationwide quantitative study measuring trends in the rates of seclusion and restraint from 2007-2013 following injurious assaults. Staggs (2015) reported that of the 438 adult psychiatric units studied, 8,002 injurious assaults were reported. Of those assaults, seclusion was used in response to 1,362 cases and restraint in response to 2,515. Cases involving both seclusion and restraint numbered 359 (p. 1370).
In analyzing this data, Staggs (2015) rates of seclusion and restraint stayed relatively constant, suggesting no decline in rate of use. The only change recorded was a decrease in average duration of physical restraint and the number of restraints involving devices. An important consideration in regards to this study is that it only accounts for seclusion and restraint in response to injurious assault and does not account for seclusion and restraint in response to other situations. The results of this study indicate that there is improvement that needs to happen in reducing and ultimately eliminating restraints in order to create a trauma-informed hospital environment that is safe for all (Staggs, 2015). In response to emerging knowledge about trauma and severe mental illness, trauma-informed models of care were born.

**Trauma-Informed Care**

Trauma-informed care could be defined as:

“A process of organisational change that creates recovery environments for staff, survivors, their friends and allies, with implications for relationships. It is also acknowledged that experiences of trauma are widespread across all demographics of society and have an impact not on only the service user, but also on staff, allies, family members and others; this knowledge underpins our ability to be compassionate” (Sweeney et al. 2018, p. 321)

It is important to recognize that the shift to trauma-informed is at the organizational level rather than the individual level. It is about creating a broad reaching change and an environment that is safe for those who have experienced trauma. This requires change in the way client’s conditions and behaviors are perceived, how staff should respond, and other changes in day to day
functions. The trauma-informed system takes into account maintaining client safety from physical harm and retraumatization. Clients and their symptoms need to be understood within the context of their life experiences, history, culture, and society. Value is placed on collaboration between clients and their providers (Jennings, 2004, p. 15).

The Substance Abuse and Mental Health Services Administration’s National Center for Trauma-Informed care identified six key principles of a trauma-informed approach:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues (SAMHSA, 2014b, p. 10)

In engaging with all of these principles, a positive, strengths-based focus is placed on client’s recovery. Interest is placed on “what has happened to the person rather than what is wrong with the person” (Jennings, 2004, p. 15). For example, skill building and acquisition are valued over symptom management. Additionally, symptoms are viewed as attempts to cope rather than inherently negative. Furthermore, trauma is understood not as a single discrete event, but instead as a defining and far-reaching experience that can affect the core of a person’s identity (Jennings, 2004, p. 15).

Sweeney et al. (2018) identified several components of trauma informed approaches. The first is “seeing through a trauma lens” (Sweeney et al., 2018, p. 323). This involves recognizing the prevalence, identifiers, and effects of trauma. This also means acknowledging that someone who isn’t familiar with traumas effects on them can development harmful or
dangerous coping skills. Another significant tenant of trauma-informed approaches is acknowledgment of intersectionality and invisible trauma. Trauma-informed care means working with a broad definition of trauma that includes “social, cultural, and historical traumas such as racism, poverty, colonialism, disability, homophobia and sexism and their intersectionality” (p. 323). In other words, understanding trauma within the context of the individual’s life.

Trauma-informed care places importance on the ways in which patients are asked about trauma. This needs to be done in a sensitive and respectful way. Also, the patient should be given the option of not answering questions about their trauma history. Within an organization, attention needs to be paid to how many different providers an individual is asked to tell their trauma story to. Inquiring about a patient’s trauma history needs to be done sensitively due to the potential of retraumatizing the individual through having them describe traumatic events. Additionally, patients may not recognize traumatic events in their life as being traumatic. They may have normalized them or have an inability to recall these experiences from their past (Sweeney et al. 2018, p. 323). Edwards (2017) explained how “A trauma-informed approach allows ways for these experiences to be understood without necessarily requiring that the therapist glean details, or have the expectation that a child or adult be able to easily create a coherent narrative about these experiences, especially if they occurred prior to the child’s capacity to describe experiences in words” (p. 1). The trauma-informed expressive art therapist recognizes how sensitive asking about a trauma story can be for the individual and takes great care when imploring about an individual’s past traumas.
Expressive Arts Therapy

In order to understand how to provide trauma-informed Expressive art therapy in inpatient psychiatric hospitals, it is first necessary to define what constitutes expressive art therapy. Malchiodi (2004) described expressive therapies as “the use of art, music, dance/movement, drama, poetry/creative writing, play, and sand tray within the context of psychotherapy, counseling, rehabilitation, or health care” (p. 2). For some individuals, verbal therapy alone isn’t sufficient to meet their needs and expressive art therapy is unique because it doesn’t rely solely on verbal communication. With expressive art therapy various art forms are used to process and communicate thoughts and emotions in a therapeutic context.

Trauma-informed expressive arts therapy.

Trauma-Informed expressive arts therapy follows many of the same tenants of the original trauma-informed model. These include safety, a focus on the therapeutic relationship, minimizing power dynamics, collaboration, and recognizing brain/body relationship to trauma. Trauma-informed expressive art therapy also must account for patients’ use of modalities and art materials. For instance, acknowledging the sensory aspect of the expressive arts, the use of the body, resource-building, mindfulness, witnessing, and attunement.

Safety.

Safety and stabilization in the hospital setting is important to uphold for all patients, but vital for patients who have experienced trauma. Trauma experiences “are threats to the person’s safety and often to the integrity of their identity” (Sweeney, 2018, p. 324). Therefore, trauma-informed approaches must ensure that the patient is emotionally and physically safe, following the patients definition of safety as closely as possible within practical means. Sweeney (2018)
explained “this extends to physical, psychological, emotional, social, gender and cultural safety, and is created through measures such as informed choice and cultural and gender competence” (p. 324). This means giving individuals as much freedom and knowledge as possible to make the most informed decisions they can and helping them feel in control of their care. Also, providing care that is appropriate to an individuals’ social context: their race/ethnicity, culture, gender, sexual orientation, and religion.

Part of trauma-informed care at an inpatient level involves bringing an individual out of crisis and back into a safe and stable level of functioning. For trauma survivors, this may involve bringing them out of an aroused state and back to their baseline level of emotional intensity. Siegel (2010) called the “span of tolerance in which we can function optimally” the window of tolerance (p. 51). Siegel’s (2010) model illustrates a spectrum of emotional states a trauma survivor may experience. Due to their traumatic experiences, survivors of trauma may experience heightened emotions and even have a smaller window of tolerance, meaning they may become overwhelmed quicker. Survivor’s arousal states relate to their nervous system level of functioning and can range from hypoaroused, within the window of tolerance, to hyperaroused (Siegel, 2010, p. 51).

Hyperarousal is characterized by over-activation resulting in symptoms like panic, anxiety, fear, and hypervigilance. Hypoarousal is characterized by being so overwhelmed by emotion that the body is unable to tolerate and shuts down or dissociates. Symptoms can include exhaustion, depression, flat affect, numbness, dissociation, etc. (Siegel, 2010, p. 51). The trauma-informed expressive art therapist should have an understanding of what their client’s window of tolerance is and be able to recognize the signs of when they are becoming hypo- or hyper- aroused. They
should also be able to facilitate an individual’s transition from an aroused state back within their window of tolerance. This is necessary so that the clients’ safety can be maintained and they can effectively stay within their window of tolerance.

**Therapeutic relationship.**

A pivotal part of trauma-informed care is the therapeutic relationship. A strong and safe therapeuetic relationship can be achieved through an expressive art therapy lens with containment - holding space that is safe for everyone. There needs to be a focus on openness, transparency, and respect. This is especially necessary for trauma survivors because they may have experienced the opposite of these qualities in previous traumatic relationships such as secrecy, betrayal, and overpowering. Being authentic and open can foster trust and help model a safe relationship (Sweeney, 2018, p. 323). Collaboration should also be prioritized in the therapeutic relationship. With the individual seeking help and the clinician providing services there can be an imbalance in power which can stimulate feelings of helplessness in the individual seeking help. To level the power dynamics, the relationship should be collaborative with the clinician and patient working together in shared decision-making and realizing goals in care. A strengths-based approach can be fostered through empowering and supporting individuals to have control over their care (Sweeney, 2018, p. 324).

**Sensory tools.**

To be a trauma-informed expressive art therapist an individual must have a working understanding of the sensory aspects of the different art modalities and the ways that they can be activating. Courtois and Ford (2009) explained how “traumatic memories often are encoded implicitly in the form of images, visceral and muscular sensations, movements and impulses,
smells, sounds, feelings without words, and autonomic responses, as well as articulated emotions, thoughts, and life narratives” (p. 318). Therefore it is the responsibility of the trauma-informed expressive art therapist to be aware of how sensations, movements, and speaking about experiences can provoke an emotional and physical response in the body. Although trauma therapy should not be done at the hospital, being in a contained and safe space such as the inpatient hospital is an opportunity for individuals to start cultivating awareness of the ways in which the sensory aspects of modalities can activate them. Malchiodi (2015) described how the trauma-informed expressive art therapy approach can be “used to assist the individual’s capacity to self-regulate affect and moderate the body’s reactions to traumatic experiences, thereby setting the stage for eventual trauma integration and recovery” (p. 29). This ‘setting of the stage’ or laying the foundation is where expressive therapies can operate specifically in an inpatient setting.

Expressive arts therapy methods could be thought of as sensory-based because “they tap tactile, auditory, visual, and kinesthetic experiences to facilitate nonverbal levels of processing” (Malchiodi, 2015, p. 29). The expressive arts can connect individuals to their various senses and help them organize and understand nonverbal information their body holds related to their trauma. These sensory-based experiences can help individuals cope with various aspects related to their traumatic experiences such as “help reduce hyperarousal through stress reduction” (Malchiodi, 2015, p. 30). This and other functions such as recognizing “body reactions to stress and trauma-related memories” can help an individual become more aware of their body and their emotions (Malchiodi, 2015, p. 30).
Therefore, as a trauma informed expressive art therapist it is necessary to understand the sensory aspects of expressive arts therapy. A trauma-informed expressive art therapist recognizes that sensory experiences can be activating for those who have experienced trauma and has a comprehensive understanding of the various art modalities and their use. Malchiodi (2015) explained “creative expression can become a way to rehearse adaptive coping skills and positive experiences of safety, stability, attachment, and self-esteem.” They can be used for “self-soothing, affect regulation, or corrective experiences” (p. 31). Because achieving psychiatric safety and stability is the goal of inpatient crisis care, the expressive arts used in a trauma-informed way could be beneficial in working towards this goal. In situations of crisis that may lead up to a necessary use of force, the use of expressive arts therapy approaches that utilize sensory tools and other forms of nonverbal processing could be used as a premeditative approach to ground and deescalate patients.

It is worth noting that because no two persons are the same and nor are their experiences of trauma, it is necessary to use expressive arts therapy methods on an individualized basis, observing and reevaluating individuals’ responses to the interventions used continually throughout the treatment process (Malchiodi, 2015, p. 32).

**Resources.**

Another trauma-informed aspect of expressive art therapy is resource building. Carmen Richardson (2015) developed a four phased model for treating traumatized children and adolescents with expressive art therapy. Her approach was informed by neuroscience and the effects of trauma on the brain. She also called her approach “resource-oriented” due to it heavily involving working with clients to cultivate their own inner resources to cope with trauma (p. 34).
Richardson (2015) explained that both the process and product of art making involve the use of resources. The process can involve resources such as “self-exploration, inspiration, and connection with the body through the imagination and senses” (Richardson, 2015, p. 7). The product can serve as “a symbolic reminder of newfound strength or meaning” (Richardson, 2015, p. 7).

Richardson’s strengths-based approach also emphasizes the power of the individual’s own inner resources. Identifying resources can help individuals create safety and stability. Richardson (2015) identifies resources as inner qualities, and/or things that help the individual feel comfort, joy, grounded, or present. They can also be people, places, things, or imaginings in the client’s world that incite these feelings. As a trauma-informed clinician, it is essential to understand a patient’s vulnerabilities, strengths, baseline level of functioning, and the resources they have already (Richardson, 2015, p. 44).

*Trauma and the body.*

As a trauma-informed expressive art therapist, it is critical to be cognizant of trauma in relation to the body. In looking at trauma and the brain, it is apparent that trauma memories are often integrated in ways that make them difficult to access verbally (Richardson, 2015, p. 40). Malchiodi (2011) discussed how sensations experienced during trauma can be stored in the body and these sensations can be reactivated if the individual is put in a situation similar to their past trauma (p. 4). Individuals who have experienced trauma may not have bodily awareness of the ways in which they can be activated, therefore it is the expressive arts therapists’ responsibility to anticipate how certain activities can be activating. Also, the expressive art therapist is
responsible for observing and checking in with the patient throughout the process to notice their level of arousal and respond accordingly.

Richardson’s (2015) approach with children also involves cultivating body awareness. The goal being that the child is better able to recognize their body state and arousal. Also, whereas previously they might not have had the words to describe their body responses, through Richardson’s (2015) approach they develop a vocabulary and better understanding of how to verbalize their body’s arousal and needs. They are better able to move between stress and relaxation states through personal resources and mindfulness skills. It is through repetition that the child is able to manage their arousal responses while in the safe space of working with the therapist (p. 42). In becoming aware of bodily states and how to moderate arousal responses “clients experience confidence in their bodies as a resource rather than a hindrance or a threat, and are able to develop a sense of mastery over what were overwhelming autonomic states driving their posttraumatic symptoms” (Courtois and Ford, 2009, p. 317). In this way, individuals can change their understanding of their body as a resource rather than something to be feared.

**Witnessing.**

A powerful function of expressive art therapy is witnessing individuals throughout their creative process. Richman (2013) explained how “by expressing the internal pain the artist externalizes it, fashions a container for it, and invites others to become witnesses to his suffering. Those witnesses allow the survivor to be known and to feel less alone” (p.3). She explained that witnessing can function in many ways, one of those ways being “the ability to step outside oneself and see the product that one has created, though the eyes of another (i.e., the witness), allows a person to shift perspective and achieve some distance-a state that is
helpful to gain mastery over the chaotic feelings” (p. 3). In relation to trauma, witnessing is especially significant because trauma survivors may have limited awareness of their emotions, body, and triggers. Through witnessing the patient, the clinician can notice these things for the client and provide them valuable knowledge that can impact their treatment and help them foster their own awareness. Also, the act of being witnessed can be beneficial to the patient, helping them feel seen and heard as well as helping them have some distance between themselves and their emotionally charged art.

It’s necessary to distinguish that witnessing involves being in the present moment, paying attention to the patients verbal and non-verbal expression. While as a clinician, attending to inner observations, anticipations, and feelings is valuable, it should not impede the ability to be present with the patient. Witnessing compassionately can help the patient feel acknowledged. It plays a vital role in expressive art therapy in the way the clinician witnesses the patients art-making. This involves observing the relationship the patient has with their art-making, noticing what they communicate with their body and how they interact with materials. (Richardson, 2015, p. 53)

A potentially challenging aspect of providing trauma-informed care relevant to the expressive therapies is witnessing rather than evoking. It may be tempting as an expressive arts therapist to try to evoke a response form the client because as a therapist this may “feel useful, active and helpful” (Edwards, 2017, p. 1). However, Edwards (2017) explained that “it may be contraindicated to simply evoke a response, for example to encourage the person to express a highly emotionally charged narrative about what happened to them during first sessions” (p. 1). This may destabilize and dysregulate a client, pushing them to a place they aren’t ready for. Payne
(2015) said that the therapist “…does not aim to fix anything nor change thought patterns but by ‘being alongside’ makes space for action, imagination, sensations, thoughts and feeling witnessed as they arise” (p. 20). As part of trauma-informed care, the therapist is there to witness and be with the client rather than trying to evoke a response or direct change.

**Mindfulness.**

Adopting a mindful approach to expressive art therapy can be beneficial to trauma survivors. Mindfulness can be defined as “the awareness that arises by paying attention on purpose, in the present moment, and non-judgementally” (Kabat-Zinn, 2013, p. xxxv). Modelling mindfulness can also help patients adopt this approach. Mindfulness is especially appropriate for trauma-survivors because staying in the present moment ensures limited risk of becoming overwhelmed by traumatic memories or becoming stuck anticipating future threats to safety (Richardson, 2015, p. 51). Patients can be more present to what they are experiencing in their body and their art, while staying grounded throughout.

**Reconceptualizing trauma and identity.**

Levine (2009) explained that as a field we need to change our conceptualization of trauma. That as clinicians, we “see all symptoms of psychic disturbance, no matter how mild or common, as traumatic in their origin” (p. 52). Levine postulated that as psychotherapists, there is a tendency to focus on a client’s ‘problems’ or symptoms of disorder in order to ultimately uncover their traumatic origin. Furthermore, Levine (2009) postulated that “trauma victims are themselves victimized through this conception of trauma.” By treating victims as passive perhaps in the same way their victimizer did, this discounts their resiliency and creativity, inhibiting their recovery (p. 52).
Furthermore, Levine (2009) explained that “trauma does not take place outside the orbit of human experience” and that suffering is part of our being. Levine (2009) wrote “trauma theory tends to understand trauma as a foreign body entering a trauma-free being from without; it thus implies a vision of human being as essentially innocent and free from suffering. If we hold to this view, we would run the risk of therapeutic messianism” (p. 61). Levine’s (2009) alternative is to recognize that the trauma ‘belongs’ to the survivor “it is now mine, which means that it is subject to the character of my experience as a human being…I cannot rid myself of it; it is not possible for me to return to an earlier pre-traumatized state of being” (p. 62). Levine (2009) suggested a kind of radical acceptance of a traumatic experience. It is through the arts that the trauma can be repeated differently and shaped into another form. As such “the suffering is not eliminated, but given meaning and value through a transformative act of poetic imagination” (p. 62). It is through art that the traumatic memory can be reexamined and re-experienced, transforming it into something that has positive meaning and value (Levine, 2009, p. 62). In this way, the client can be empowered through reframing their traumatic experience and gaining meaning from it.

*Power dynamics.*

Another way trauma-informed clinicians can empower their clients is through considering their own power and what role it plays in the clinician-client relationship. Actively preventing individuals from being traumatized while consumers of the mental health system is a responsibility of a trauma-informed clinician. Trauma-informed clinicians “understand that the fundamental operating principles of coercion and control in mental health services can lead to (re)traumatization and vicarious trauma. Deliberate steps are taken to eliminate and/or mitigate potential sources of coercion and force, and accompanying triggers” (Sweeney, 2018,
p. 323). Consequently, inpatient hospitals as organizations tend to have hierarchical power dynamics with one person having the power as the treater and the other having limited power as the consumer. Providing trauma-informed services means minimizing that power gap and refraining from methods of treatment that involve coercion and force. Furthermore, it is necessary as a treater to follow through on finding appropriate trauma-specific services and coordinate with these agencies to enable smooth transitions of care.

When working with individuals that have experienced trauma, crucial values to uphold include trustworthiness and transparency. Forming an open, empathetic, and honest rapport with patients is imperative because patients who have a trauma history may have experienced the opposite of those values in past relationships – betrayal, secrecy, and power dominating relationships (Sweeney, 2018, p. 323). Another imperative consideration is reducing power imbalances. In most mental health settings, there are power imbalances in the way one person is the ‘helper’ and the other is the ‘helpee.’ This power imbalance can echo that of past traumatic relationships, therefore it is necessary to work towards a relationship with patients that is collaborative, with both parties having influence in the direction of treatment.

Having a strengths-based focus is also crucial to help empower and support patients. This reinforces the idea that patients have control over their own lives, combating traumatic experiences that may have involved a total lack of control. To achieve this “adaptations to trauma are emphasized over symptoms, and resilience over pathology” (Sweeney, 2018, p. 324). It is more empowering for the client to focus on their growth and the ways in which they have coped than focusing on negatives such as symptoms.
Neuroscience.

Perryman, Blisard, and Moss (2019) explained how as part of being a trauma-informed counselor “A basic understanding of the neuroscience of trauma is crucial for counselors. Therapists must now consider how their theoretical framework fits with neuroscience knowledge in order to be successful with clients” (p. 1) Perryman et al. (2019) explained how theoretical frameworks need to evolve as neurological understanding evolves, citing the example of how CBT has evolved since incorporating new neurological findings (p. 1). Perryman also explained how “some clients find it beneficial to have a neurologic explanation for their feelings and reactions.” Providing this explanation could have therapeutic benefit such as normalizing the feelings they are experiencing and helping them to better understand the biological symptoms they are experiencing (Perryman et al. 2019, p. 2).

Richardson’s (2015) approach is unique because it involves teaching children the neurobiological effects trauma can have. For instance, understanding the effects trauma has on implicit and explicit memory and why it matters. Explicit memory is “expressed through language reason, and logic” whereas implicit memory is experienced unconsciously through sensations and images (p. 39). Therefore, trauma is “the inability to move the sensory memories of those traumatic experiences from implicit to explicit memory” (p. 40). Richardson (2015) explained that “Expressive arts have the ability to access implicit memory, which is coded in sensation and imagery, and offer nonverbal processes to express these iconic portrayals through dance, drawing, sculpture, or the sound of the drum. There is no need for words or cognitive processes.” (p. 40). Additionally, expressive art therapy provides containment, distance, and playfulness for
children to process their trauma memories in a safe way without provoking too much arousal (Richardson, 2015, p. 40).

**Vicarious trauma.**

Not only is there a possibility for patients to be traumatized or retraumatized at an inpatient hospital, but staff can also. Vicarious trauma involves staff members or practitioners and occurs when working with individuals who have experienced trauma. Vicarious trauma can include compassion fatigue, countertransference, and burnout, all terms that can refer to psychological distress as a result of exposure to another person’s traumatic experiences (Sweeney et al. 2018, p. 322, SAMHSA, p. 195). Sweeney et al. (2018) explained how organizations that aren’t trauma-informed can cause vicarious trauma in staff. They go on to say “clinicians may learn to rely on power rather than their relational capacity to engage collaboratively, particularly where trauma-uninformed organisations place a high priority on risk management” (p. 322). This improper use of power can have a negative effect on the therapeutic relationship staff have with patients. It can shift staff members overall attitudes from one valuing compassion to one that is more self-involved. Not only that, but it can create an atmosphere of fear between patients and staff. This can result in patients being more distrustful and resistant to engage with staff which can frustrate staff further, causing staff to rely more on power and control (Sweeney et al. 2018, p. 322-323).

Witnessing a seclusion or restraint is only one example of a situation that could cause vicarious trauma in staff. Vicarious traumatization is important to consider because it can have a negative impact on hospital staff, causing them to become emotionally or psychologically impaired. It can also adversely affect job performance and damage therapeutic relationships
with patients (SAMHSA, 2014c, p. 193). To combat this, organizations need to create safe and supportive environments for clinicians that acknowledge the potential for vicarious traumatization and provide trauma-informed supervision. It is also the responsibility of the clinician to engage in their own self-care, ideally having a holistic plan that addresses physical, psychological, emotional, and spiritual domains of care (SAMHSA, 2014c, p. 206). Trauma-informed expressive art therapists recognize the ways in which patients and staff can be traumatized by hospital practices, especially the power dynamics at play, and work to collaborate with patients to provide compassionate care.

**Discussion**

Ultimately, trauma is a serious condition that often goes in conjunction with severe mental illness. That being so, many individuals who have experienced trauma are hospitalized at inpatient psychiatric wards at some point in their lifetime. Consequently, it is necessary to develop an overall model of care that is appropriate for those that have experienced trauma. Trauma-informed treatment fulfills that need.

Current day practices at inpatient psychiatric hospitals have the potential to be traumatizing or retraumatizing for individuals receiving services. The most concerning practices include seclusion, restraint, forced medication, body searches, and constant observation. Although these practices are thought of as risk management strategies and were put in place to maintain safety for patients and staff, these practices can have a negative impact on patient and staff experiences at the hospital. In some cases, they can even be traumatizing. This is because the experience and power dynamics of these practices can often mirror an individual’s
past traumatic experience. Specifically, they can lead to individuals feeling afraid, overpowered, a coerced, and a loss of control.

Trauma-informed treatment has the potential to remedy these issues. Through creating change at the organizational level, care at an inpatient hospital can be modified to be beneficial for all, including individuals with a trauma history. The trauma-informed model is strengths-based and involves having knowledge of trauma, its prevalence, identifiers, and effects. Also, the trauma-informed model is intersectional, viewing the individual within the context of their life.

As a trauma-informed expressive art therapist, there are several components of the trauma-informed model that should be followed. These can include establishing safety, assisting with emotional regulation through the use of sensory tools, building inner resources, understanding trauma and the body, the use of witnessing in the therapeutic relationship, the role of power dynamics, and an understanding of the neuroscience of trauma and its effect on the brain. Overall, the trauma-informed expressive art therapist is committed to learning about trauma and mental illness, as well as providing compassionate care sensitive of the ways in which trauma can effect someone in their daily life.
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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.

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