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A Time to Play: A Literature Review on Trauma-Informed Play and Expressive Arts Therapy

Approaches for Low-Income Children

Capstone Thesis

Lesley University

May 5, 2019

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Expressive Arts Therapy

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Abstract

Low-income children are often subjected to stressors and traumas such as hunger, abuse, neglect, and mental illness among caretakers. These stressors are a known source of debilitating stress and long-term dysfunction. Stress has been shown to adversely affect the body's immune system, incapacitates one's focus, and cause neurobiological transformation in the human brain. This reaction is particularly pronounced in children during a vulnerable time in their physical, cognitive, social, and emotional development. These changes have been known to manifest as cognitive deficits, emotional disorders, and learning disabilities, along poor physical health outcomes. Managing stress in low-income children is a critical public health issue, as its detrimental impact on children, their families, and our communities can be profound and ever-reaching. To address the complex needs of this population, a multifaceted treatment approach may be beneficial. The literature review revealed numerous benefits for children's self-esteem and potential post traumatic growth when expressive arts therapy approaches, such as art and play therapy, are incorporated with established trauma treatments. Research has shown the effectiveness of each approach as they utilize children's strengths and natural inclinations of creativity and play to explore their feelings and emotions at a safe distance. This thesis provides a literature review and discussion of the benefits of expressive therapies for children with these challenges.

Introduction

Managing the symptoms of trauma in low-income children is a critical public health issue, as traumatic experiences often has adverse impacts on children, their families, and our communities that are profound and ever-reaching through the lifespan and beyond. Studies in neurobiology have shown that experiences of chronic anxiety and fear from trauma exert detrimental effects on the developing brain in humans (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson, van der Kolk, 2005). In other words, the stress-system overload can significantly diminish a child's ability to learn and engage in meaningful social interactions, which will greatly affect their quality of life in the present, along with their families, and their communities, and future generations. This capstone thesis reviews literature regarding topics pertinent to this population. These areas include Adverse Childhood Experiences (ACEs), the neurobiological, cognitive, emotional, behavioral, and physical health impacts, and future health outcomes related to trauma exposure. The thesis will also examine literature describing established trauma-based treatment options and theoretical perspectives utilized by the general mental health professions in this realm. Further, the literature review section explores established trauma-based treatments, defines and discusses expressive arts and play therapy approaches, and examines studies which utilized trauma-informed expressive arts therapy and play therapy tools in therapy to manage and reduce symptoms experienced from trauma during this very vulnerable time in a child's cognitive, social, and emotional development. The final portion of the thesis will discuss recommendations for integration of these modalities with current treatment approaches to allow for a multi-faceted approach to address the complex needs of this population.

Literature Review

This section of the thesis will examine literature related to several topics related to childhood experiences related to trauma, including Adverse Childhood Experiences (ACEs), physical and health impacts on children due to stress exposure, and adult health outcomes based on this exposure. The literature review will then explore established trauma-based treatment options and theoretical perspectives utilized by the general mental health professions for children suffering from symptoms from trauma exposure. The next segment will present expressive arts methods, including studies which utilized trauma-informed expressive arts therapy in therapy to manage and reduce trauma symptoms in children. The final part of the literature review will focus on trauma-informed play therapy modes, and studies utilizing play therapy to treat children suffering from the effects of trauma.

Adverse Childhood Experiences (ACEs)

In 1998, a landmark study was conducted by Felitti et al. which documented the dose-response relationship between adverse childhood experiences (ACEs) and poor health and socioeconomic outcomes. ACEs are stressful or traumatic events as experienced by a child, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, Marks (1998) defined 10 categories of childhood trauma in their study. Five of the categories referred to the individual: physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: an alcoholic parent, a parent who is a victim of domestic violence, an incarcerated family member, a family member with a mental illness diagnosis, and the absence of a parent through divorce, abandonment, or death abandonment (Felitti et al., 1998). Although, there many other types of childhood trauma that are impactful, particularly experiences that low-

income populations are vulnerable to, such as poverty, homelessness, foster system involvement, and community violence, Felitti et al. (1998) selected the 10 types of childhood trauma because of the vast amount of research already conducted on these experiences at the time of the study (Felitti et al., 1998).

Though the Felitti et al. (1998) landmark study is a valuable contribution in the examination of the effects of adverse childhood experiences, there are limitations to the study, particularly in its application to low-income and other marginalized populations (Cronholm et al. as cited in Cohen-Cline et al., 2019). One notable issue is that the study population was comprised of mostly white, upper middle class families with health insurance, whose experiences may differ from populations from different socioeconomic backgrounds (Cronholm et al. as cited in Cohen-Cline et al., 2019). Extensive research has documented a higher prevalence of ACEs in economically disadvantaged populations (Mersky et al., 2017 as cited in Cohen-Cline et al., 2019), which highlights the importance that “models examining the associations between the Felitti et al. ACE score and poor outcomes later in life could be improved by the inclusion of economic adversity and experiences outside the home” (Finkelhor et al.; Green et al.; Cronholm et al.; Mersky, Topitzes, & Reynolds as cited in Cohen-Cline et al., 2019).

Cohen-Cline et al.’s (2019) study examined experiences of childhood adversity in a low-income population by utilizing the original ACEs from the Felitti et al. study, along with additional measures, including socioeconomic and community adversities. Further, to consider the differences one reacts to adversity depending on age, the authors studied childhood and adolescent periods separately (Cohen-Cline et al., 2019).

The participants were referred to the study per the results of a cross-sectional survey analysis Cohen-Cline et al. (2019) conducted on adult Medicaid members in the Portland, OR

metropolitan area. The sample of participants was comprised of 9176 individuals between the ages of 18-65. Cohen-Cline et al. (2019) obtained an oversampling of African Americans, individuals with multiple medical needs, and individuals who utilized health care services at a high frequency. The assessment tool in the study was a life-course survey that inquired about various childhood experiences and events, including the ACE domains of abuse, neglect, and household dysfunction, along with relationships and support, educational challenges, housing and employment stability, neighborhood environment, and discrimination. The questions in the survey were asked for 6–12 and 13–18 years of age (Cohen-Cline et al., 2019). The surveys were mailed and a \$5 incentive for completion was offered. The authors received 2348 completed surveys, which equated to a response rate of 26% (Cohen-Cline et al., 2019).

Factor analysis was utilized to measure and identify underlying constructs of adversity in the two age ranges, which were *Inadequate Emotional Support* and *Instability* (Cohen-Cline et al., 2019). The authors of the study found the collective factors pertaining to *Inadequate Emotional Support* remained consistent in both age groups, but composition of factors comprising *Instability* changed from household-centric variables in earlier childhood, to encompassing a larger set of experiences, including those outside of the home (Cohen-Cline et al., 2019). From these results, the authors concluded that childhood adversity as a whole, and instability specifically must be considered in a broader view than what was offered by Felitti et al.'s study, as knowledge gaps occurred in traditional ACE measures.

There were several limitations to their study, according to Cohen-Cline et al. (2019). One issue the authors cited was that the low response rate may impacted the sample accuracy in reflecting the Portland, Oregon Medicaid-enrolled population at large (Cohen-Cline et al., 2019). The largest portion of responses were from older, non-Latin American females, thus the

generalizability of the study's results may be limited and not reflect the experiences of the population on the whole (Cohen-Cline et al., 2019). Also, the authors noted that some potentially impactful experiences may not have been included in the factor analysis, as every possible adversity could not be documented by their survey (Cohen-Cline et al., 2019). Related, Cohen-Cline et al. cited that though their survey considers data regarding the timing of adverse experiences, it does not assess for frequency or intensity of the experiences of each respondent. (Cohen-Cline et al., 2019).

Regardless of the limitations of the original ACE study in terms of addressing the full extent of traumatic experiences for marginalized populations, extensive research has documented a higher prevalence of ACEs in economically disadvantaged populations (Mersky et al., 2017 as cited in Cohen-Cline et al., 2019). The study conducted by Cohen-Cline et al. (2019) illuminates important points why more extensive research is necessary to formulate more knowledge and appropriate treatment approaches for this population. Earlier interventions in the lifespan would be most beneficial. Also, this population possess a dire need of more medical and support services in general, to address their unique, multi-faceted needs.

Halfron et al. (2017)'s report examined how income inequality effects on ACEs in children in the United States. Data from the 2011 to 2012 National Survey of Children's Health were used to examine the prevalence of 9 ACEs in U.S. children, across 4 levels of household income. The sample to complete the survey was obtained through a stratified random digit-dial sampling design in order to achieve a normative sample from the U.S., obtained across demographic variables of region, income, and ethnicity (Halfron et al. 2017). The sample consisted of 95,677 parents of children between 0 to 17 years of ages. The study used bivariate

analyses and multivariable logistic regression models to assess the relationships between number of ACEs and children's health outcomes across the 4 income groups.

As a result of the analyzed data, Halfon et al. (2017) discovered that their findings replicated Felitti et al. (1998)'s key finding regarding the correlation between ACEs and negative health and well-being outcomes in adulthood has been replicated by numerous studies since Felitti et al. (1998)'s key finding. In regards main research question, Halfon et al. (2017) found that there was a correlation between income and ACE prevalence, as "Children who live below the FPL (Federal Poverty Level) are 5 times more likely to experience ≥ 4 ACEs than those who live in families whose income is approximately 400% of the FPL" (p. 71).

Per the reviewed literature thus far, the relationships between income, childhood trauma, and poor outcomes later in life indicate that further research is needed to include a larger, more inclusive set of early adversity experiences to understand the scope of trauma in childhood, and how those experiences may influence poor health outcomes later in life. This knowledge, in turn, can inform effective treatment approaches and support for low income populations in all systems in their lives. The next section will review literature that examines the extensive impact chronic stress from trauma has on early in life and on adult health outcomes

The Effects of Trauma on Children's Development

Neurobiological Development. Delima and Vimpani's (2011) report examined current studies on the neurobiological effects of childhood trauma utilizing various methods of brain injury assessment. They also discussed neurodevelopment of the brain and the stress response systems in relation to neurobiological trauma.

Per Delima and Vimpani (2011), assessments of neuropsychological development, such as the Wechsler Intelligence Scale for Children and the Bayley Scale of Infant and Toddler

Development measure the correlation between observed behavior and the brain's functional processing. In relation to children who have trauma histories, these assessments have shown proof of cognitive, learning and memory deficits (Delima & Vimpani 2011). Further, as cited in Delima & Vimpani (2011), "the advent of neuro-imaging of children with documented child maltreatment histories has provided irrefutable evidence of the structural and functional changes that occur within the brains of these children, corroborating observations about their behaviors and cognitive functioning" (De Bellis, Keshavan, Frustaci et al., 2002; De Bellis, Keshavan, Shifflett et al., 2002; Kumar et al., 2009; Thomas & De Bellis, 2004).

Delima & Vimpani (2011) also discussed the development of a normal brain, and how between the ages of 5-18, the most growth and development activity occurs. The limbic system, which is comprised of the amygdala, hippocampus, and hypothalamus, are the parts of the brain that control fear, memory, and sex drive and other bodily functions such as appetite and sleep cycles, respectively (Delima & Vimpani, 2011). The cortex is the area of the brain that maintains executive functioning, such organizing and comprehending information, and behavior regulation (Delima & Vimpani 2011). The corpus callosum communicates cognitive, sensory, and motor information between the two hemispheres of the brain (Delima & Vimpani 2011). The cerebellum is a structure in the brain that regulates coordination and motor skills, and is "involved in emotion, cognitive development and autonomic regulation through a biofeedback response" (Delima & Vimpani, 2011, p. 46).

Acute stress, which is a reaction to an immediate threat, is a normal and beneficial physiological response in a human brain, as it "enables emotional and intellectual growth and development" (Delima & Vimpani, 2011, p. 45). In contrast, chronic stress caused by continual trauma and life stressors negatively impact the structure and function of the brain (Delima &

Vimpani 2011). According to Delima & Vimpani (2011), the developing brains of children are particularly vulnerable to the effects of prolonged stress. Further, Delima & Vimpani (2011) stated, “The level of impact of maltreatment on a child’s biological stress system is reflected in the child’s subsequent cognitive and behavioral development, the extent of which is dependent upon the age of first exposure and the duration of the maltreatment suffered” (p. 49).

The amygdala, the area of the brain that processes fear, increases in size and amount of neural connections, also becomes more active. The exposure to stress through the stress hormone cortisol can cease the generation of new neurons and cause shrinkage in the hippocampus, the area of the brain that stores memories. The prefrontal cortex, which regulates decisions making and working memory can also decrease in size due to exposure to stress. This negatively affects decision making, working memory, impulse control, and mood regulation. As a result of these areas of the brain being impacted by chronic stress, children exhibit “poor self- regulation, increased impulsive behaviors, and emotional responses such as high levels of experienced anxiety, aggression and suicidal tendencies and, in some, a learned helplessness from the constant impairment of self-regulation” (Delima & Vimpani, 2011, p. 45). The grim conclusion illustrated by Delima & Vimpani (2011) is exposure to stressful and traumatic events can negatively impact children’s neuroanatomy and cognitive function.

Cognitive, social, emotional, and physical development. Shonkoff and Garner’s (2012) report examined the relationship childhood adversity, stress, and their effects on physical and mental health across the lifespan. According to Shonkoff and Garner (2012), the changes in the structure of the brain due to prolonged stress exposure in turn contributes to impairment in cognitive, social-emotional skills. They also cite several studies that have shown that due to the decrease in size in prefrontal cortex, executive functioning, such as decision-making and

working memory, which are important components of academic success, is greatly impaired (Shonkoff and Garner, 2012). Also, the ability to develop adaptive responses to future adversity is negatively affected by this change (Shonkoff and Garner, 2012). The atrophy of the hippocampus also impacts memory functions (Shonkoff and Garner, 2012). Further, because of its decreased state, “the ability of the hippocampus to promote contextual learning, making it more difficult to discriminate conditions for which there may be danger versus safety, as is common in posttraumatic stress disorder” (Shonkoff and Garner, 2012, p. 236).

In regards to social and emotional impairments, the change in structure of the prefrontal cortex impacts the brain’s ability to regulate mood and self-control (Shonkoff and Garner, 2012), which negatively effects one’s ability to meaningful engage and function in social situations. And the decrease in the volume of the brain as a whole as indicated changes in children’s behaviors such as difficulties in sleeping, concentration, and general irritability (Shonkoff and Garner, 2012).

Shonkoff and Garner (2012) also shared the physiological effects of trauma-induced stress. In contrast to the prefrontal cortex and hippocampus, the size and activity of the amygdala increases due to chronic stress, which has been shown to lead to “a hyper-responsive or chronically activated physiologic stress response, along with increased potential for fear and anxiety” (Shonkoff & Garner, 2012, p. 263). In either of these states, the body’s organ and regulatory systems, as the cardiovascular, metabolic, immune and nervous systems are predisposed to adverse effects. (Shonkoff and Garner, 2012).

Long-term outcomes. Shonkoff and Garner’s (2012) report also cites several studies which have documented how stress experienced from adversity in early childhood is a vital factor in susceptibility to future life problems due physical, cognitive, behavioral and emotional

impairments. All areas of an adult's life are greatly impacted, including health-related behaviors, educational achievement, economic productivity, and physical and mental health (Shonkoff & Garner, 2012). In regards to risk-taking and unhealthy life choices, the authors stated that the decrease in the volume of the hippocampus due to chronic stress is associated with the increased propensity of such behaviors, such as the risk for drug and alcohol misuse due to decreased self-control and impaired decision making. Also, because of the increased difficulty in emotional control, such individuals may elect to use alcohol and illicit substances to self-medicate for symptoms they are struggling through (Shonkoff and Garner, 2012). In addition, these individuals are predisposed to dependence and addiction in the long term (Shonkoff and Garner, 2012). The authors stated that it has been widely documented how chronic stress in childhood predisposes one to a plethora of health issues in adulthood, including sexually transmitted diseases, cardiovascular disease, cancer, asthma, and depression (Shonkoff and Garner, 2012). Impairment in cognitive, and social-behavioral skills have been shown to affect educational attainment, thus increasing the likelihood of being either unemployed or underemployed in low-wage job positions (Shonkoff & Garner, 2012). Also, adults who become parents themselves may be less equipped to provide supportive relationships in order to protect their own children from the adverse effects of chronic stress and adversity (Shonkoff & Garner, 2012) Consequently, early life experiences with chronic stress affect later outcomes in two key ways, as Shonkoff & Garner (2012) stated:

This intergenerational cycle of significant adversity, with its predictable repetition of limited educational achievement and poor health, is mediated, at least in part, by the social inequalities and disrupted social networks that contribute to fragile families and parenting difficulties (p.237).

As previously mentioned, there is vast amount of scientific literature supporting that low-income children a higher rate of traumatic childhood experiences compared to other populations, and how the chronic stress caused by these experiences has detrimental effects on their cognitive, social, mental, and physical well-being which leads to poor adult outcomes. Ideally, the sources of stress should be addressed by communities, their leaders, and the government to provide the support and services that this population needs. Supporting the welfare of all children is only advantageous to society as a whole, because healthy children grow up to be healthy and productive adults who can positively contribute to communities economically, culturally and civically. It would be an understatement to state that the current U.S. administration and their policies do not support marginalized citizens and their families. Which is why it is imperative that the mental health field should not only be poised with well-established approaches to treating trauma, but only be open minded to also incorporate newer, though effective trauma-informed approaches as well, as the complex needs of this population should be addresses through a multi-faceted approach. The following section will review literature on an established trauma-based treatment, which has been documented by the following studies to support children to manage and reduce symptoms experienced from trauma.

Effective treatment interventions for traumatic disorders in children

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). One research-supported trauma treatment model for children is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Cohen et al. (2010) defined and discussed the suitability and effectiveness of this method. TF-CBT addresses and treats symptoms that are directly related with traumatic events that children experience or witness (Cohen et al., 2010). Traumatic events are defined by Cohen et al. (2010) to be frightening, shocking, abrupt, and potentially threatening to one's safety. Some

examples of traumatic events cited by Cohen et al. (2010) include sexual, physical abuse or assault, violence, accidents, natural disasters, and medical traumas. TF-CBT addresses Post-Traumatic Stress Disorder (PTSD) symptoms as well as other trauma-related indicators. Per Cohen et. al (2010), children are suitable candidates for TF-CBT treatment if they develop significant PTSD symptoms without meeting full PTSD criteria, and benefit greatly from this treatment approach. Studies have shown that traumatized children may experience physical, cognitive, and behavioral impairment after trauma exposure. TF-CBT includes elements that support reregulation in these three areas of functioning (Cohen et al., 2010). The goals of TF-CBT include: cultivating skills to manage stress and improve trauma-related symptoms; make meaning of traumatic experiences through emotional and cognitive processing; and augment and support safety, family communication, and developmental outcomes (Cohen et al., 2010). Further, TF-CBT has proved successful and effective with children who have significant emotional problems due to traumatic experiences (Cohen et al., 2010). The needs and goals of low-income children align with the objectives and themes of TF-CBT, thus making it an appropriate treatment method to utilize with this population.

Jensen et al. (2014) conducted a randomized study comparing the effectiveness of TF-CBT with an TF-CBT in community mental health clinics settings compared with therapy as usual (TAU). TAU is defined as treatment approaches utilized in the past by clinicians. Jensen et al. (2014) cited that past randomized trials measuring the efficacy of TF-CBT have been only in specialized, university-affiliated clinics. The motivation to set their study in community care settings was due to studies indicating that “children and adolescents who are referred to community clinics often have higher levels of co-occurring problems and less family support than samples from university-based research clinics” (p. 358). The sample of participants was

comprised of 156 youth (124 girls, 32 boys) ages 10-18, referred to one of eight community mental health outpatient centers in Norway between April 2008 and February 2011. The majority of the children were of Norwegian (73.7%) and Asian (10.9%) descent, or had one Norwegian parent (8.3%). From the 128 participants that reported annual family income, 15.6% of the households had an income of <USD 35,000, 38.3% of the household had incomes ranging between USD 35,000 and USD 87,000, and 29.7% of households had incomes ranging between USD 87,000 and USD 147,000. They were referred to participate in the study by Child Welfare Services, or their primary physicians and were eligible for the study by meeting the criteria of experiencing at least one traumatizing event, and suffering from acute stress symptoms (Jensen et al. (2014). Per Jensen et al. (2014), 77 were randomly assigned to the TAU group and 79 to the TF-CBT group. The hypothesis of the study was that daily functioning would improve for more for the TF-CBT than the TAU group (Jensen et al. 2014).

A checklist, based on items included in Ribbe's (1996) Traumatic Events Screening Inventory for Children was developed by the authors was used to measure qualification to participate in the study. If there was a reported exposure to at least one of the items, the child was then assessed for Posttraumatic Stress Symptoms using the Child PTSD Symptom Scale (Jensen et al. 2014). The cutoff score was 15, and out 454 children being screened, 156 scored above the cutoff score and agreed to participate in the study (Jensen et al. 2014).

For the TF-CBT intervention, 26 TF-CBT-trained therapists provided care for 12 sessions to group from the sample. Per Jensen et al. (2014), the TF-CBT treatment included the following components: psycho-education, teaching relaxation and affective modulation skills, teaching cognitive coping skills, working through the trauma narrative, cognitive processing, enriching safety, and future development. In addition, the parent received interventions aimed at improving

parenting skills. 45 TAU therapists also conducted their intervention for 12 weeks. The children in the TAU group received individual therapy, and in 55.3% (42 participants) of the cases, parents also met with TAU therapists (Jensen et al. 2014).

A mixed effects model was used to analyze the differences in results between children in the TAU and TF-CBT groups. Between pre-intervention and post intervention, results indicated that both groups experienced a significant decrease in symptoms of PTSS, depression, anxiety, and improvement in general mental health functioning (Jensen et al. 2014). However, in terms of total PTSS scores, participants in the TF-CBT condition scored significantly lower compared to those in the TAU group post intervention. (Jensen et al. 2014). Also, the authors found that in the TF-CBT post-treatment group, significantly less participants met the diagnostic criteria for PTSD (Jensen et al. 2014). Thus, Jensen et al. (2014) were able to conclude that their hypothesis was correct, as the TF-CBT interventions are more effective than usual care in reducing symptoms in traumatized children.

Jensen et al. (2014) noted that they did not adapt the TF-CBT interventions to reflect Norwegian norms, indicating to them the flexible nature of the approach, it is promising that the treatment results appear to hold up across trauma experiences that include multiple and severe interpersonal traumas” (Jensen et al., 2014, p.367) The effectiveness of TF-CBT program, along with its flexibility to be altered accordingly to unique needs of children who have suffered from multiple traumas makes this approach to be an important and appropriate treatment for low-income children.

The following section will focus on literature which defines and discusses expressive arts approaches and its effectiveness as a treatment model for children who have experienced trauma.

Expressive arts therapies and its efficacy with children

Donahue (2011) defined expressive art therapy (ExTH) as an intervention that “connects the creative arts, the imagination, arts rituals, and the creative process into a therapeutic approach” (p. 497). The objective of the ExTH approach, according to Donahue (2011) is “to ignite the creative process in each person or group through the use of creative expressive techniques to facilitate healing and growth” (p. 497). Per Donahue (2011), ExTH practitioners may differ in their implementation, but there are 12 established elements that form the foundation of the practice for all. Donahue (2011) defined and described these elements as follows.

The 12 tenets of ExTH. I. Multi-arts imagination: our imaginations are not limited to expressive through a single modality. II. The creative process: supporting and developing the creative process is central to ExTH. III. Temenos and play space: in order for the creative process to fully develop, a trusted relationship and a safe, sacred space must be provided. IV. Imagery: Symbols, and images enables one to hold several ideas at the same time. V. Power of each art discipline or modality: Music, movement, art, and drama therapeutic approaches are their own separate entities. VI. Direct action-oriented experience: The central to this approach is the direct experience of art creation. Per Donahue (2011), “this focus on direct experience guides the practitioner to emphasize the process more than the product” (p. 497). VII. Phenomena of the image: A vital part of the creative process is exploring imagery through art making. VIII. Potentials of image: Imagery has multiple meanings. IX. Intermodal theory: using different art approaches increases creativity and healing. X. Therapy as art: Defined by Donahue (2011) as, “the therapeutic process itself is experienced as art” (p. 497). XI. Approaches to intermodal processes: The practitioner can elect to implement art approaches in any manner. XII The power

of play: Within the safety of the play space, play opens the potential to creativity and freedom of expression.

In addition to extensively defining ExTH, Donahue (2011) also discussed the benefits of utilizing this approach with people experiencing trauma. Because of the manner in which trauma infiltrates physical and mental processes, where it disrupts narrative memory, art approaches rather than verbal approaches may be a better means to process traumatic experiences, where this new understanding can lead to healing and regulation of trauma-induced symptoms. In consideration of this, ExTH appears to be an appropriate approach for youth from low income populations.

Coholic, et al. (2009) utilized ExTH in their qualitative research to examine the effectiveness of group-based art therapies with traumatized children in foster care between the ages of 8-15. The authors cited past studies that illustrate poor long-term functional outcomes for this particular population as a result of trauma, which were the motivations for this specific research. As other literature has cited similar outcomes for low-income children, this indicates that there is likely to be similarities and/or overlap with both low-income and foster care youth populations. The authors cite their understanding of children in foster care through a lens of trauma which is defined as “a way of describing a range of experiences that have some lasting impact for the individual” (Paton, Crouch, & Camic, 2009, as cited in Coholic, et al., 2009, p. 64), which is also relevant to the experience of low-income children.

Coholic, et al (2009) discussed the numerous benefits for children’s self-esteem and potential post traumatic growth when art-based approaches are incorporated with established trauma treatments. The authors utilized an arts-based group program model, where arts-based methods were used to teach the children skills such as paying attention, understanding and using

mindfulness techniques; exploring their feelings and behaviors, and cultivating their personal strengths (Coholic, et al 2009). In the groups, the authors utilized arts- based exercises such as painting, drawing, sculpting with clay, along with relaxation exercises. The activities were centered around a theme related to the group's objectives, such as expressing feelings, building community within the group, and learning mindfulness skills (Coholic, et al 2009).

Their study found that children are much more receptive to art-based therapies rather than talking about their life experiences. Further, they discovered that art-based therapy methods were effective in increasing the children's coping skills, self-esteem, and self-awareness, and potentially growing from dealing with the struggle of trauma in helping the children. In post-group interviews, the children were asked to provide any feedback regarding the session, and none were able to cite anything negative. The processes and approaches described by Coholic, et al (2009) could easily be implemented and integrated in child practitioner services in the future.

Cumming and Visser's (2009) qualitative study examined the effectiveness of art-based workshops on the psychological well-being of refugee children in a school setting in Britain. Like low-income youth, studies have documented that refugee children have experienced multiple traumas in their lives. The objective of the workshops was to increase self-confidence and help in the children's healing process. Children from Afghanistan and Kosovo, who did not speak nor understand English, participated in a 60-minute workshop session once a week for the duration of 6 months. The authors found that through the participation in these workshops, their self-esteem and sociability improved. Further, Cumming and Visser saw that the children's enthusiasm and skills in the art processes and creation also increased. Follow up studies may be needed to examine if the benefits that the children obtained from the study would be sustained in the long-term without further art-based workshops.

When treating traumatized children, both of these studies illustrated that the effectiveness approaches that utilized children's strengths and natural inclinations of creativity to explore their feelings and emotions at a safe distance. Also, both Coholic, et al. (2009) and Cumming and Visser's (2009) showed the therapeutic benefits of group therapy as group settings in therapy, by supporting safety and connection, and in alleviating feelings of isolation. However, there is further need for study in the field of ExTH based approaches for the treatment of children experiencing trauma in the current day.

Efficacy of Play Therapy

One well-established treatment model, as it has been utilized extensively by clinicians for over 60 years with children is play therapy (Hall et. al. 2002). In their article, Hall et al. (2002) defined play therapy and discussed 15 play therapy approaches that have been proven to be effective in the clinical treatment of children. The authors stated that the objective of their article was to provide practitioners a variety of play modes that are developmental appropriate for 4-12 year olds that are easy to apply, along with being affordable and enjoyable (Hall et. al. 2002). Hall et al. (2002) defined play therapy as:

an interpersonal process wherein a trained therapist systematically applies the curative powers of play (e.g., relationship enhancement, role-playing, abreaction, communication, mastery, catharsis, attachment formation, etc.) to help the clients resolve their current psychological difficulties and help prevent future ones. (p. 515)

Hall et al. (2002) present a variety of play approaches, which include art-making, Fantasy, and game play. The authors stated that their motivation to share the 15 techniques is the effectiveness of these modes in addressing problems experienced by children, such as anxiety, depression and impulse control difficulties (Hall et. al. 2002).

Substantial amounts of literature have cited the advantages and benefits in utilizing play therapy approaches. Haen's (2008) article regarding his play therapy approaches for treating traumatized children describes many of these strengths. For example, he stated that one advantage to play therapy is children's resistance to such treatment approaches are much less of an issue since they are fun to engage in, and "because these games are fun, many children readily engage despite their fears" (Haen, 2008, p. 232). Related to this, play therapy approaches align with the natural state of being of a child, as it "draws on the client's capacity to play" (Haen, 2008, p. 226).

In the article, Haen (2008) describes a monster role play, which he used with children who had lost their parents in the terrorist attacks on the World Trade Center. His approach clearly worked within a framework of three stages for dealing with trauma (Haen, 2008): pretending to be a monster in externalization, where their feelings and emotions could be explored at a safe distance through a different character/persona; hiding under the table as a container which acts as a psychological safe space within the group to retreat to; and building connection, when the children banded together to face and defeat the monster, and share in the triumph of this accomplishment. Haen's (2008) methods illustrate the use of children's strengths and natural inclinations of play and imagination in order to heal, through "accessing and expressing "internal conflict, achieving insight, rehearsing alternative choices, and cognitive reworking habitual patterns of response to stressful situations" (p.226).

Another notable advantage of Haen's approaches in play therapy, is its potential to build connection and safety, to further implement and enhance the great therapeutic benefits of group therapy as group settings in therapy supports in the alleviation of feelings of isolation that are associated with the exposure to trauma (Nader, 2004, as cited in Haen, 2008). Through Haen's

play activities with the children, the feeling of safety and unity are created within the group and as a result, the children feel safe, supported and empowered to “overcome the damage of the traumatic events that have been forced upon them” (Haen, 2008, p. 227).

As Haen (2008) illustrated, play therapy offers a safe, risk-free container for clients to experiment with different behaviors and responses to events. As a result of all of these benefits, children are free to use play therapy as a means “for accessing and expressing internal conflict, achieving insight, rehearsing alternative choices, and cognitively reworking habitual patterns of response to stressful situations” (p. 226).

Muro et al. (2006) conducted an exploratory study to measure the effects that long-term Child Centered Play Therapy (CCPT) had on elementary school aged children’s behaviors and “teacher-child relationship stress” (Muro et al., 2006, p. 38). The sample of participants consisted of 23 students (6 girls; 17 boys) ages 4-11 from three Title 1 elementary schools from the southwestern United States, who were referred to play therapy intervention by their school counselors. Title I is a U.S. Federal program where supplemental funds are provided to schools where 40% of students are low-income. Per Muro et al. (2006), the ethnicity distribution was the following: 3 African-American, 12 Hispanic/Latin American; 5 Caucasian; and 3 Bi-racial (African-American/Caucasian). Two assessment instruments were utilized. One was the Teacher Report Form (TRF), a parental questionnaire to report and measure problematic child behaviors. The other instrument was the Index of Teaching Stress (ITS), a self-report which measures stress a teacher experiences when interacting with a specific student (Muro et al., 2006).

The study used a repeated measure design. Pre-intervention, educators completed the Teacher Report Form (TRF), the Index of Teaching Stress (ITS), and demographic forms on each participant. Mid-intervention, which was after 16, 1x per week sessions of Child Centered Play

Therapy (CCPT), the educators completed the TRF and ITS again on each participant. Post-intervention, after another 16 sessions at the same duration, the educators completed the TRF and ITS once more on each child. In total, the children participated in 32 CPPT sessions. One play therapist was assigned per child, and the play therapists facilitated the CCPT sessions in appropriately playrooms located at each of the elementary schools. The playrooms contained an array of toys to encourage a full range of expression (Muro et al., 2006). The play therapists utilized CCPT response sets, which include verbal and non-verbal responses with the objective to encourage the child's emotional growth (Muro et al., 2006).

A repeated measures approach was used to analyze the quantitative data obtained from the TRF and ITS results. Muro et al. (2006) elected to utilize this method because of its several advantages, such as an ability to achieve a significant statistical effect with a small number of participants, and per Kraemer and Thiemann (1989), its design makes it a suitable instrument to measure "soft data" (as cited in Muro et al., 2006). For the duration of the study, improvement was statistically steady. The data from the TRF results showed a significant improvement in the Total Problems scale for participants in the 32 sessions of Child Centered Play Therapy (CCPT) (Muro et al., 2006).

Muro et al. (2006) cited that there were several limitations in their study, including a lack of a control group to compare results from no intervention or an alternate intervention. Muro et al. (2006) also noted that their use of a single population was another limitation, along with only utilizing teachers to report on the child. Although the study cannot conclude that CCPT offers more benefits than another or no intervention, Muro et al. (2006) were able to report that CCPT appeared to have a positive effect on the children who participated in the study.

Schottelkorb et al. (2012) conducted a study comparing the effectiveness of Child Centered Play Therapy (CCPT) to with an evidence-based approach, trauma-focused cognitive-behavioral therapy (TF-CBT) traumatized refugee children. The sample of participants was comprised of 31 refugee children (17 boys, 14 girls) ages 6-13 from 15 different countries who were students at three elementary schools in the northwest United States. The majority of the children were from the regions of Africa (67.7%), the Middle East (16.1%), Asia (9.7%), and Europe (6.5%) They were referred to participate in the study by their English Language Learner (ELL) teachers. Per Schottelkorb et al. (2012), 14 (45.2%) children were randomly assigned to the CCPT group and 17 (54.8%) were randomly assigned to the TF-CBT group. The hypothesis of the study was that severity in symptoms would decrease for both the CCPT and TF-CBT groups, and that there would be no difference in outcomes between the groups (Schottelkorb et al., 2012).

The instruments used to measure qualification to participate in the study were the child reported UCLA PTSD Index for *DSM-IV* (Pynoos et al., 1998, as cited in Schottelkorb et al., 2012) or the Parent Report of Posttraumatic Symptoms (PROPS; Greenwald, 2005, as cited in Schottelkorb et al., 2012). The UCLA PTSD Index assesses criteria for PTSD per the *DSM-IV*, along with children's exposure to trauma (Schottelkorb et al., 2012). The PROPS is a parent-report measure used to assess posttraumatic symptoms in children (Schottelkorb et al., 2012).

For the CCPT intervention, nine child-centered play therapists set up playrooms which contained toys and materials that reflected the children's cultural background (Schottelkorb et al., 2012). For 12 weeks, the children participated in 2x weekly 30 minute sessions of CCPT. During the study, six 15-minute parent consultations were also conducted. All sessions occurred at the children's respective schools. Nine TF-CBT therapists also conducted their intervention for

12 weeks. The children in the TF-CBT group participated in 2x weekly 30 minute sessions, and the parents met with the therapists on the average of 2x over the 12 week of treatment.

A repeated measures approach was used to analyze the differences in results between children in the CCPT and TF-CBT groups. Between pre-intervention and post intervention, results indicated that both groups experienced a significant decrease in severity, and that there were no differences between the CCPT and TF-CBT groups (Schottelkorb et al., 2012). Thus, Schottelkorb et al. (2012) were able to conclude that CPPT inventions are equally effective as the evidence-based approach, TF-CBT in reducing PTSD symptoms in refugee children.

There were several limitations to their study, according to Schottelkorb et al. (2012). One issue was that the sample size held limited statistical power (Schottelkorb et al., 2012). Also, since the largest percentage of participants were from Africa, “generalizability of results may be limited to this refugee population (Schottelkorb et al., p. 68, 2012). Additionally, Schottelkorb et al. (2012) cited a lack of a control group to compare results from no or an alternate intervention placed limitations on their study.

Post et al.’s (2019) article explores literature pertaining to CCPT’s efficacy on marginalized children. They discuss the relationship between race and poverty, where 21% of U.S. children live in poverty, the minority groups of children live in poverty at higher rates; 50% of African American children; 51% of Native Americans, and 57% of Latin American children (Post et al., 2019). As a result, per Post et al. (2019), “the intersectionality of oppressive forces, that include culture, race, and socioeconomic status, create a group of marginalized students” (p. 88). Post et. al (2019) also discuss that minority and low income populations are disproportionately affected by ACEs, thus leading to poorer life outcomes for these populations in the future.

For treating these groups of children, they stated that past literature has shown that consistent and caring relationships with adults can help mitigate the effects of ACEs, as children develop the skills to self-regulate and being resilient (Post et al, 2019). Because CCPT is a relationship-based approach between the practitioner and the child, Post et al. (2019) state that “it is an ideal approach for children who have experienced ACEs” (p. 89) They examined several studies utilizing CCPT with marginalized children, and their results indicate that this intervention is very effective for this population (Post et al, 2019).

The literature review revealed the effectiveness of established trauma treatments along with expressive arts and play therapy approaches for children suffering from trauma symptoms. In regards to expressive arts and play therapies, the studies reviewed demonstrated the benefits and advantages of each approach as they incorporated children’s strengths of play and imagination to connect with their feelings and emotions at a safe distance. The final portion of the thesis will discuss recommendations for integration of these modalities with current treatment approaches to allow for a multi-faceted approach to address the complex needs of this population.

Discussion

The stress and anxiety evoked by hardships for a child growing up in poverty occurs during a time of marked vulnerability in all facets of their development. Studies in neurobiology have shown that “experiences of persistent fear and chronic anxiety likely exert similarly adverse impacts on the developing brain in humans. Thus, stress-system overload can significantly diminish a child’s ability to learn and engage in typical social interactions throughout their lives. Many children would likely become fully actualized, highly productive adults in society if children receive the appropriate interventions to overcome these traumas that accumulate into

grave problems in all aspects of one's life in the adult years. However, through helping children and families with effective, integrated approaches such as trauma-informed expressive art and play therapy methods, these interventions could empower children and help protect them from being impacted in a detrimental way, and can have a profound and ever-reaching positive influence on children, their families, and our communities. The literature describes how children are much more receptive to expressive art-based and play therapies rather than talking about their life experiences. For example, according to Haen (2007), children can "often lack the developmental capacity to verbalize cohesively what has happened to them or how they feel about it" (as cited in Haen, 2008, p. 229). The advantage of the expressive arts and play therapy approaches is that they both offer alternate ways for children to process and express negative experiences, rather than in merely a direct, concrete manner. Another strength of these approaches is it allows room for a client to feel safe to explore feelings, as "the trauma itself is projected, separated from the client, so that it can be viewed from a safe distance" (Haen, 2008, p. 227). This is helpful if a client feels anxious and scared about talking about experiences directly, whether they have the ability to verbalize these experiences or not. These approaches can also empower children, as both modes offer valuable tools to help identify and develop coping strategies and mechanisms from the experience of stress and anxiety, and use for the rest of their lives. The literature reviewed revealed that these arts and play based therapy methods were effective in increasing the children's coping skills, self-esteem, and self-awareness, and potentially growing from overcoming adversity. Having a variety of methods to help these children which can be implemented in consideration of their developmental needs and capacities is a large strength for clinicians to have.

In addition to being open and knowledgeable to these array of approaches, clinicians should also be aware of how one's own social class, both in their formative years and in their current social class as therapists, inform their present therapeutic practices and relationships with their clients. It is vital for therapists to gain awareness regarding their own experiences and perceptions related to social class. Social class can inform the therapeutic relationship between client and therapist, and the therapeutic community as a whole to strive for opportunity for growth and further development in cultural competency. The development and awareness in cultural competency within the counseling community is particularly needed in the social class realm. From reviewing the literature that is currently available, it appears is often neglected and acknowledged by the profession in research, as there seems to be a dearth of research related in class in therapeutic encounters, such the original ACE study conducted by Felitti et al. This attention to class has been ignored in practice as well, as and "the near invisibility of the poor in psychology as well as psychologists' lack of attention to social class in general continues even when there is a direct focus on multiculturalism and diversity" (Lott, 2002, p.101). The focus of therapeutic theories and research illustrates the "us," rather than "them" mentality of the "haves" towards the "have not's." The "Haves" are typically white, middle and upper middle class, and "Psychological theories are preoccupied with people who are like those who construct the theories, that is, those in the middle class (and primarily European Americans)" (Lott, 2002, p. 101).

The United States likes to tout that "All men are created equal," and as a result, social mobility is accessible and with the same amount of ease to everyone. Per Lott et al. (2003), attitudes of Western therapists often reflect these tenets. Though there are countless indications that a class system in the United States is very alive today, "it is difficult to see the class divisions

in a society that presents itself as classless. Thus, to speak of class identities means to deny or defy part of the myth of American identity” (Lott et al., 2003). But along with race, gender, and sexual orientation, our class position in the social strata affects our lives every waking minute, so it is quite surprising that there has not been more research in such a huge component in one’s life. Further, though “psychologists distance themselves and the discipline from the poor by generally ignoring social class as a significant variable in research and theory, cognitive distancing more typically takes the form of stereotyping” (Lott, 2002, p. 102). Along with the rest of society, therapists, though unwittingly, are complicit in perpetuating negative stereotypes regarding the poor and working classes. There should be more done in both practice and research to understand and alleviate some of the more harmful results of classism, both in a therapeutic context and from a social justice context. A therapist can improve cultural competency in their counseling process by broadening their awareness and understanding of the roles that a client’s culture, ethnicity, race, gender, religion and spirituality, sexual orientation, age, and of course, socioeconomic class, that play in their client’s identity.

From a personal perspective, the research that was reviewed in this thesis certainly influenced my own practice at my current internship. Great Youth and Families is a branch of the Housing Families organization that provides individual and group counseling, along with school tutoring and summer enrichment activities for children from displaced families. I work on both an individual and group basis with these children. Because of the trauma they have experienced, these children are challenging due to their behavioral and emotional challenges. Nevertheless, I have found that in utilizing trauma-informed expressive arts therapy and play therapy approaches I have learned about, fruitful therapeutic relationships between clients and myself were achieved. What I perceive as elements of containment that a therapist should strive to hold for clients

include: attunement, protection, safety, support, belonging, nurturing, trust, kindness, empathy, curiosity, self-awareness, openness, flexibility, acceptance and dependability. In this container, we, as client and counselor, were then free and unencumbered to connect, identify, explore and express feelings through expressive arts and play therapy approaches. I feel grateful to have a multitude of applications at my disposal to work with this population that means so much to me. And along with further cultivating my knowledge and competence of these approaches, it my hope and future duty to also advocate for these clients at a public and policy level, to inspire permanent solutions and social change.

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THESIS APPROVAL FORM

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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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