Spring 5-18-2019

Literature Review on Urban Trauma and Applying a Trauma-Informed Approach

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Capstone Thesis

Lesley University

May 5, 2019

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Art Therapy

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Abstract

Within the United States, there are millions of people living in urban cities. Cities like New York, Chicago, and Los Angeles. This thesis capstone project is a literature review on the trauma that is experienced by the youth residing in those urban communities and the effects it has on their bodies and minds. This level of continuous trauma develops in children as complex trauma and disrupts a child's mental, social, emotional and educational development. This change in trajectory puts these children on a path that can result in Post Traumatic Stress Disorder (PTSD), anxiety, depression, substance abuse, involvement with the criminal justice system, teenage pregnancy, unemployment, poverty, or death. This thesis will also look at the literature on the trauma-informed approach, its guidelines, and how it can be beneficial to this population. In recent years, programs have implemented the trauma-informed approach to treat complex trauma and give traumatized children a chance at healing. In Massachusetts, for example, several such programs have combined the trauma-informed approach with theoretical approaches and have seen successful results. The use of art in art therapy sessions can be used successfully to create paths of communication, understanding, and healing for urban youth.

Keywords: trauma, complex trauma, urban trauma, at-risk population, PTSD, trauma-informed approach, evidence-based treatment, art therapy, ARC model

Literature Review on Urban Trauma and Applying a Trauma-Informed Approach

Introduction

Within the United States, in cities like New York City, Chicago, Washington D.C, Philadelphia, and Los Angeles, there are countless children being exposed to high levels of urban trauma. Children that are witnessing and experiencing gun violence, gangs, drug addiction, domestic violence, community violence, and poverty. As a result, they are developing Post Traumatic Stress Disorder (PTSD), and are at risk for depression, anxiety, addiction, and other mental health issues. Most of them are children of color. And they are living within communities that do not have the resources to provide them with the treatment necessary to meet their developmental milestones and excel in life. The purpose of this thesis is to review the literature available on trauma, urban trauma, how trauma effects the youth residing in these cities, and how the trauma-informed approach can be used to their benefit.

I have an interest in this topic because I, myself, am the product of growing up in an urban community, the city of Paterson, NJ. A city of over 146,000 people, made up of a mixture of people that are African American, Hispanic, Middle Eastern, and Caucasian (Census Bureau, 2018). Growing up in that city, I saw things that most children in our surrounding communities would not have seen. I saw homelessness, the abuse of crack cocaine, heroin and alcohol, and community violence. I and my peers were affected by the stabbing death of a classmate at the end of the eighth grade. Some of my classmates were gang members and a few former classmates are in jail. And I've lost count of the number of former classmates that are now struggling single mothers. I'm one of the lucky ones. Through support and guidance at my high school, I was able to find art therapy, get into college, and began to volunteer. This topic is important to me because I know so many people within my community that struggle with

complex trauma, have made bad decisions as a reaction to their trauma, and have no idea that our experiences in the "hood" were not normal. And within our community, seeking treatment is seen as taboo, we are all expected to push it down and push forward. But as an entire community, we are floundering. As a woman of color, the product of growing up within this environment, and a soon to be an art therapist, I have a responsibility to educate and advocate for youth experiencing complex trauma from living in urban communities. I also strongly believe that it can be a little easier to do this work when you look like the people within the community.

Literature Review

For my capstone thesis, I have chosen to do a literature review on the trauma experienced by urban youth and how using the trauma informed approach may be beneficial to treating their complex trauma. Many of the complex trauma described throughout this thesis, I have witnessed or experienced. And many of my peers in elementary school and through high school did as well. It is a topic that does not have extensive research. And inner-cities are communities that are often misunderstood, criticized, and cast aside by the greater society. As someone entering the field of art therapy, I have come to understand that yet again I am a minority. The field is mostly comprised of middle-class Caucasian women. Therefore, as a woman of color within this field it is vital for me to represent the community I come from and advocate for mental health awareness for those residing in those communities. I cannot work within every urban community or work with every single child experiencing complex trauma, but anyone deciding to work with these communities needs to grasp the complexities of the trauma experienced by its inhabitants or risk re-traumatizing their clients. Through my education at Lesley University, I have come across the Trauma-Informed Approach. It has become the basis as to how I see the individuals I come across at my internship sites and has provided me with a theoretical approach that informs the

matter in which I treat my clients. Writing this thesis has given me the opportunity to continue to learn about this theoretical approach and how it can be applied, not only across institutions, but communities as difficult as that of inner cities. Art is a tool that can give voice to communities that feel voiceless. And art therapy can then be used as the "bridge between their inner world and the world around them" (Sutherland et al, 2011, p.72)

Trauma

There is an abundant amount of information on trauma available to the general public that illustrates how pervasive trauma is within our communities and in this country. The National Child Traumatic Stress Network (NCTSN) has found that more than two thirds of children have reported at least one traumatic event by the age of 16 (NCTSN, 2018). That is roughly sixty-six percent of youth that reported. Another statistic has stated that as many as 46 million children living in the United States have experience psychological trauma (Listenbee et al., 2012).

What constitutes as trauma? And who gets to define trauma? The American Psychiatric Association defines a traumatic event as a person experiencing, witnessing, or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others (American Psychiatric Association, 2013). I find their definition of trauma lacking the depth necessary to evoke the amount of damage trauma can inflict on an individual. Therefore, I found it crucial to include a definition that provides more depth. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a traumatic event as physically or emotionally harmful or life-threatening event with lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being (SAMHSA, 2014, p.8). Through that definition, it is possible to imagine the level of despair youth residing within urban communities would experience daily due to that level of impairment and dysfunction.

Who gets to say this or that event is traumatic is the person who experienced the event. Trauma is subjective. It is defined by the person who has "experienced the event in question" (Boles, 2017, p.1). As providers, we can identify a trauma response within an individual that may not be able to verbalize it. Especially when working in multi-cultural communities, we also need to take into consideration the "individual differences in coping, development, culture, social support and resources that can impact an individual's ability to respond to stress: (Boles, 2017, p.2). With that being said, the NCTSN (2018) has stated what could potentially be considered a traumatic event that could negatively impact a child:

> Physical, sexual, or psychological abuse and neglect; Natural and technological disasters or terrorism; Family or community violence; Sudden or violent loss of a loved one; Substance use disorder (personal or familial); Refugee and war experiences; Serious accidents or life-threatening illness; Military family-related stressors.

While this is a general list of possible traumatic events, looking at these examples I can identify five that occur in urban communities on a regular basis; physical, sexual or psychological abuse and neglect, family or community violence, sudden or violent loss of a loved one; substance abuse disorder; and serious accidents.

SAMHSA (2014), through their guide on trauma, has established the three E's of Trauma: event(s), experience of event(s), and effect. The event may include the "actual or extreme threat of physical or psychological harm or severe, life-threatening neglect for a child that imperils healthy development," but each individual decides whether the experience of the event was traumatic or not for them. As such, "a particular event may be experienced as traumatic for one individual and not for another" due to "How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event" (SAMHSA, 2014, p.8).

The final E of Trauma, SAMHSA states, are the effects of it, which "may occur immediately or may have a delayed onset" (p.8). Effects of trauma can be short or long term, and potentially include inability to cope with "normal stresses of daily living," "trust and benefit from relationships," "manage cognitive processes," "regulate behavior," or "control the expression of emotions" (p.8). Further on, I will elaborate more on the presentations of these adverse effects commonly displayed by children and adolescents from inner cities.

Trauma Experienced in Urban Communities

What is of interest to me is the trauma that is experienced within inner cities. Most adults (69%) living in urban areas of the United States report experiencing one or more traumatic events in their lives (Paivio & Pascual-Leone, 2010, p.17). There are "high levels of self-reported violence", "both via witnessing of and victimization by violent events", that are consistently found in young urban children (Delaney-Black et al, 2002, p.1). The most recognized cities in the United States are densely populated centers; New York, Washington DC, Philadelphia, Chicago, and Los Angeles, to name a few. The Census Bureau would define these cities as "core areas containing a large population nucleus, with adjacent communities having a high degree of economic and social integration with that core. And most central cities contain 50,000 or more inhabitants, with a population density of at least 1,000 people per square mile" (Camilleri, 2007, p.15). These centers are considered urban cities, concrete jungles, associated with high levels of crime. In New York, despite many changes that have lowered the crime rate, many people would still to be wary of being mugged. For many years, Washington D.C was known for its "crack" problem within its black community. Riots, gangs, gun violence, and drugs are associations tied to specific neighborhoods in Los Angeles. And now, Chicago is frequently mentioned by the

news and politicians as a murder capital. Yet no one talks about how this level of violence traumatizes its inhabitants, specifically children, nor their lack of resources to cope.

In a study conducted in the early 1990's by Karyn Horowitz (1995) and her colleagues, their findings "indicated that these participants had experienced between 8 and 55 different types of community and domestic violence events, with the mean number of violent events being 28" (p.2). Sixty-seven percent of the study participants met Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–V; American Psychiatric Association, 2013) criteria for posttraumatic stress disorder (Horowitz et al., 1995, p.2).

The trauma experienced by youth in urban communities will most commonly present itself within the PTSD diagnosis in the American Psychiatric Associations DSM-V. Urban youth could experience and exhibit any of the categories within the diagnosis, including

"exposure to actual or threatened death, serious injury, or sexual violence, presence of one or more intrusive symptoms associated with the traumatic event(s), persistent avoidance of stimuli associated with the traumatic event(s), negative alterations in cognition and mood associated with the traumatic event(s), marked alterations in arousal and reactivity, duration of the disturbance, the disturbance causes clinically significant distress or impairment, and the disturbance is not attributable to the physiological effects of a substance" (American Psychiatric Association, 2013, p.271).

What this diagnosis fails to take into consideration is "the clinical and socioenvironmental issues, nor most aspects of violence and the resulting self-altering biopsychic manifestations in behavior (Parsons, 1994, p.4).

Dr. Erwin Parson created the term "Urban Violence Traumatic Stress Response Syndrome" (U-VTS) to clinically describe the behaviors seen in children from urban communities. He developed the theory to describe the unique socio-environmentally induced stress that developmentally impacts urban children after they have witnessed and/or experienced frequent acts of violence within the urban setting (Parson, 1994, p.1). Within the first few paragraphs of his work, Parson describes the violence and trauma experiences in an inner city with brutal honesty. "From an early age, children living in the inner cities are exposed frequently to the use of drugs, guns, arson, and random violence. They witness injury, suffering, and death, and they respond to these events with fear and grief, often experiencing dramatic ruptures in their development" (Parson, 1994, p.1). The information provided by U-VTS can be used to compliment the criteria provided by the DSM-5 in order to get a complete picture of what this person is experiencing.

As a clinician himself, Parson wrote of different components, which are symptoms and reactions that can be observed by a clinician. Also keep in mind the child's developmental stage and the specific kind, intensity and duration of the traumatic stimuli. Those components are "damaged self-syndrome, trauma-specific transference paradigms, adaptation to danger, cognitive and emotional stress response, impact on moral behavior, post-traumatic play, PTSD, and post-traumatic health outcomes" (p.4). Parson (1994) describes a child who is experiencing the affects of U-VTS as having a "sense of powerlessness that creates a sense of insecurity and impotence" (p.4). That in turn, leaves a child feeling unable to cope. "Violence and inflicting violence on others, then becomes an issue of self-esteem regulation. A way of unconsciously spreading the violence around and not caring about the consequences" (Parson, 1994, p.4). They may also experience "grief and mourning, a sense of betrayal and defilement, fears of recurring

trauma and violence, expectation of danger and violence, a loss of future orientation, external locus of control over life events, a disposition for self-abuse, detachment and a loss of bonding capacity, and dysfunctional socialization" (Parson, 1994, p.5).

There are distinctions that are made within trauma literature that also need to be considered. The trauma literature frequently distinguishes between "two broad categories of traumatic exposure that differ in terms of type, severity, or breadth of" (Paivio & Pascual-Leone, 2010, p.15). Type I trauma refers to "single episodes, such as a car accident, a natural disaster, or a single assault. Type II or complex trauma refers to repeated exposure to threat of violence, including social and political violence through war or torture, domestic violence (as victim or witness), and childhood abuse" (p.15). The distinctive feature that separates single incident trauma from complex trauma within children is the vulnerability of the "developmental stage and the repeated exposure to trauma over an extended period" (p.15). A traumatic experience becomes complex trauma when the following "interrelated sources of disturbance occur; exposure to trauma, attachment injuries (e.g., abuse, neglect, lack of love and safety), and reliance on experiential avoidance, such as dissociation, as a coping strategy for dealing with the intense negative affect generated by these experiences" (p.15). Examples of complex trauma include "exposure to social or political violence, domestic violence, and childhood maltreatment. In such cases, it is common for victims to be further victimized by societal shortcomings that may be present in mental health, judicial, and social support systems" (p.15). Complex trauma also is associated with "a more complex array of disturbances when compared with single incident trauma; experts agree that the multiple symptoms experienced by survivors of prolonged and repeated trauma are not adequately reflected in the diagnostic formulation of posttraumatic stress disorder" (Khayyat-Abuaita & Paivio, 2019, p.362).

Complex trauma is characterized by three factors that differentiates it from single incident trauma; "it's severity, confluence of victim and perpetrator, and lack of societal support. Frequently, perpetrators of interpersonal trauma are known to the victim. Instances of domestic violence and sexual abuse, for example, most frequently involve friends or loved ones as perpetrators and are followed by shame and minimization or denial, as well as social isolation. These offenses also involve betrayal of trust and unresolved anger and sadness regarding significant others" (Paivio & Pascual-Leone, 2010, p.15).

Although the literature does not use this population as an example, complex trauma is experienced over and over in urban communities. For example, a drive by shooting. It's summer time, two friends are out playing and there is a drive by shooting and one of the friends gets shot and killed. They were the unintended target and hit by a stray bullet. The act of witnessing a friend get shot and die can and will be traumatizing for the person who witnessed the event. But they will continue to be traumatized by the actions of those around them in the coming days, weeks and months. They may not have known the perpetrator, but this happened in their neighborhood. This person will no longer feel safe in their community and neighborhood. That is a pillar of their support system that is now gone. The feeling of safety is crucial to a person's well-being. Their family may not be able to support them or get them the necessary support and help. They may not be able to financially. They must go to work, they can't take any more days off or they could lose their job, etc. They may not believe therapy is necessary or there's no one to take this person to therapy, and if they are struggling financially, there is no money for therapy if there is not enough money to get by. Family and society could also shame and guilt this person for having these feelings because they survived. They tell them to be "grateful, you survived, what are you crying for" and shame them. They now feel like they cannot speak to their family

or rely on their family for the support they need to cope with this traumatic situation. Another pillar of their support system is gone. And in urban communities, it's been proven that there is a lack of resources from governmental agencies. No agency is going to run in to help and treat this person. Violent crimes happen in urban cities all the time. And society will say, they should move, why do they live in such a dangerous community? They put their children in danger, and this is a consequence. When children of color are involved, the outside society isn't jumping in to help or provide any assistance. The society within these communities is already traumatized and does not have the tools to assist one another in these situations. And with that, another support pillar is gone. This is now a person that sees the world in a completely different light. One event that created a chain reaction that took away all this person's support, sense of self, sense of community, sense of place in the world and their safety. Not only were they traumatized by the actual event, they were continuously re-traumatized by those around them after the incident when they really needed the support and guidance to cope.

Reactions to Urban Trauma

Once a child has been exposed to complex trauma, one book would define these children as being "at risk", as in being "in danger of negative future events" (Camilleri, 2007, p.17) Being at risk makes them susceptible to making decisions that have long lasting effects and consequences. These at-risk youth are also susceptible to outcomes that include "depression, educational failure, addiction, unemployment, incarceration, poverty, or death" (p.17). McKay and her colleagues also found that such trauma exposure has been linked to the development of childhood posttraumatic stress disorder, anxiety, conduct difficulties, and adolescent substance abuse (McKay et al, 2005, p.201-202). It has been established that exposure to multiple adversities in childhood increases risk for many negative outcomes in childhood and adolescence

and throughout adulthood. The negative outcomes include alcohol and substance use, health risks such as smoking and obesity, mental health outcomes such as depression and suicidality, and social risks such as engaging in violent relationships and teen pregnancy and paternity. Not coincidentally, many of these problems are predictive of engaging in delinquent or criminal behavior (Ford & Blaustein, 2013, p.3).

Once trauma has been experienced, the child or adolescent experiences changes physically, socially, and emotionally. Trauma experienced can accumulate in a child's life to "create serious and debilitating physical, emotional, behavioral, social, and academic outcomes such as anxiety, learning difficulties, and poor social skills" (Camilleri, 2007, p.41). These outcomes have been described "as "externalizing consequences" such as inappropriate aggressive behaviors and drug use, or "internalizing" ones such as depression and post-traumatic stress disorder" (Camilleri, 2007, pp.41-42). Stress associated with violence can be described as "so toxic that a complex mental imprinting process occurs, which can alter the child's personality" (Parson, 1994, p.5). Traumatic stress then "overwhelms the limited coping skills available to developing children" (Arvidson, 2011, p.36). Children who have experienced trauma often feel overwhelmed or constricted with few strategies to modulate arousal states (Arvidson, 2011, p.35). Exposure to psychological trauma, particularly in childhood while the brain and mind are rapidly developing, can lead to a negative cascade that begins with involuntary self-protective shifts in the brain, continues as a preoccupation with detecting and surviving threats, and becomes a chronic condition of allostatic load that can take the form of physical or psychological illness or symptoms as a result of dysregulation in the body's nervous systems (Ford & Blaustein, 2013, p.3). Parson (1994) stated that the most visibly prominent psychological reaction of children after trauma is an "intolerance for strong affective tensions"

(p.6). They may feel and be perceived as "disturbing emotions include fears (e.g., fear of being alone), sadness, grief, guilt, depression, shame, anxiety, anger, belligerence, revulsion, despair, poor impulse control, and persistent, anticipatory fear of being overwhelmed by strong affects and losing control" (Parson, 1994, p.6). Children who experience complex trauma must "invest their energy into survival rather than in the development of age-appropriate competencies" (Arvidson, 2011, p.37).

There are other conditions that are experienced within inner cities that compound stress and trauma, that may not be found at such high rates in neighboring suburban communities. When living in inner cities, families can experience a lack of basic material resources such as food, shelter, and healthcare. They also have inadequate access to community resources such as good schools, safe neighborhoods, and government resources. In these resource-poor environments, seemingly mild physical or psychological vulnerabilities may escalate into more serious disorder for lack of treatment (Camilleri, 2007, p.16).

Within the book, *Healing the Inner-City Child* (2007), outcomes for inner-city children can manifest behaviorally and emotionally (p.41). The behavioral outcomes can include "delinquency, psychosocial adjustment, teenage pregnancy, and academic failure" (Camilleri, 2007, pp.42-45). Camilleri (2007) defines delinquency as involving "antisocial behavior such as acts of defiance, destructiveness, or aggression" (p.42). Children who display some of these behaviors can develop, and are most likely to be diagnosed with, "conduct disorders which can manifest as physical aggression, property damage, deceitfulness, theft, or serious violations of the rules" (p.42). In some extreme cases, "delinquency may require law enforcement intervention, and subsequent court action" (p.42). In an attempt to understand the reasons for why there are such high levels of delinquent behavior exhibited in inner city children, it was

"found that children living in poverty were more likely to be exposed to stressful home and neighborhood situations which instill a culture of violence, and a necessity to respond with violence in order to stay alive(pp.42-43). Additionally, "children living in poverty adopted beliefs that were accepting of aggressive behavior, owing to the normalized and sometimes idealized view of aggression in urban communities. Success through other channels wasn't visible in these communities, making violence the most immediate means of obtaining respect and material rewards" (p.43).

Camilleri (2007) states that "between the ages of six and twelve, children will develop or fail to develop basic academic and social skills necessary to survive and succeed in their environments (p.43). Many at-risk children can "develop inappropriate social responses such as aggression or withdrawal, as a result of poor role-modeling, poor parenting, or traumatization" (Camilleri, 2007, p.43). When the adults or caregivers they depend on "are unable or unavailable to provide support in dealing with stressors, children must rely on their own resources, which are often maladaptive" (p.43). So in turn, these children who have been exposed to violence "demonstrate a variety of socially inappropriate behaviors such as becoming "aggressive in their play patterns with peers as an attempt to imitate behaviors they have witnessed, or simply because they view such activities as 'normal', 'act tough' or uncaring in order to protect themselves from fear, anxiety, or grief (.43). Camilleri (2007) states this behavior of acting tough "serves as a way to distance themselves from difficult emotions and 'untrustworthy' people" (p.43). I also see this behavior as a way of keeping themselves safe. When it concerns their emotional states, traumatized child, "to avoid negative feelings or stimuli associated with a negative traumatic event, children shut down their emotional reactions and demonstrate consistently a flat affect (p.43). This inappropriate "emotional response prevents children from

fully understanding and communicating about events in their lives. And when children can't express themselves appropriately, often their needs go unmet" (p.43).

Inner-city children may experience academic failure for a variety of reasons. They may be "growing up in homes with few books and illiterate adults provides for an academically poor learning environment" (Camilleri, 2007, p.45). Also adding that chaotic homes are not conducive for children who are attempting to read, study, or complete their homework. The adults in their lives may have any combination of stressors in their lives that can contribute to their unavailability to assist. In addition, "children living with stressors such as violence and poverty often demonstrate low academic performance, owing to psychological conditions that impair their ability to succeed academically" (p.45). Anyone can imagine that it would be difficult to concentrate in school if the basic needs of safety and food are not being met. A study conducted in 1994 found that "children who had been abused or neglected affected their academic performance and readiness to learn. They had a lower IQ and a lower reading ability than the control group, and that these deficits persisted into adulthood" (p.45).

The emotional outcomes described in the book are depression, anxiety, and PTSD. There is a high number of inner-city children reporting feeling depressed. Living in poverty predisposes children to develop depressive symptoms, due to the constant exposure to uncontrollable stressful situations such as domestic conflict and violence. They experience a reduced sense of control that is needed in order to feel safe, feeling incompetent, which can lead to hopelessness. They may also experience anxiety, which can come in several different forms. There is separation anxiety, the fear of being without their mothers, extreme worrying that they might get shot or die, fear of going outside. And touching on PTSD again, children in inner-cities are at constant risk of being a victim of, or a witness to, violent events, with consequent high rates of

PTSD. Schools with high rates of murder, assault, or robbery, have a high incident of PTSD amongst the student body, especially in girls (p.45).

Other Possible Consequences

There is a spectrum of possible consequences of the failure to treat complex trauma. When an individual does not have the coping skills, education, or support necessary to make the best decisions for themselves, they mirror the behaviors of their environment. Within urban communities, that mirroring of behaviors can include putting themselves in situations that involve law enforcement, subsequent incarcerations, that then make it difficult to find a job, can lead to poverty, and the use of substances to cope. It is important to keep in mind that there are racial disparities that also play a major part in the traumatization of those residing in urban communities.

Inner city communities have spoken out many times about police policies that negatively impact people of color and their mental health. For a very long time, society didn't believe it. Recent research has demonstrated how "police-involved injuries and the mental stress of intensive policing practices like "stop and frisk" disproportionately impact communities of color" (Jacoby et al, 2018, p.1). There is also an array of "health consequences that result from inequalities in the broader criminal justice system. Black people are more likely to be suspected of crimes, arrested for crimes, and to receive harsh sentences. In their article, Jacoby et al. (2018) have "theorized, this continuum of systemic bias has perpetuated intergenerational poverty and health risks by limiting access to political, social and economic opportunity. A criminal record, for example, can lead to unemployment and disqualification from a range of social services, like food and housing assistance" (pp.1-2).

In terms of statistics on incarceration in the United States, it is a well-known fact that our system disproportionately incarcerates people of color than in any other part of the world and compared to their white counterparts. As of March 2019, the Prison Policy Initiative's website states " the American criminal justice system holds almost 2.3 million people in 1,719 state prisons, 109 federal prisons, and 1,772 juvenile correctional facilities" (Prison Policy, 2019). The NAACP also provides some statistics on the racial disparities in incarceration trends within the United States stating, "in 2014, African Americans constituted 2.3 million, or 34% of the total 6.8 million correctional population" (NAACP, 2019). They also found that although "African Americans and Hispanics make up approximately 32% of the US population, they comprised 56% of all incarcerated people in 2015" (NAACP, 2019). In one large-scale study, 92.5% of a sample of detained youth had experienced at least one type of psychological trauma at some point in their lives, and over 50% of the sample- youth with an average age of 14-had been exposed to six or more potentially traumatic adversities by the time of their detention in the juvenile system (Ford & Blaustein, 2013, p.1).

Substance abuse is common within urban communities. Many have linked the arrival of crack cocaine led to increases in central-city crime and accelerated trends toward general urban decay. Popular and "ethnographic reports link crack to gang violence, high murder rates, urban unemployment, poverty, and family disruption" (Grogger & Willis, 2000, p.1). Using two different sources of information to date the emergence of crack in 27 metropolitan areas across the U.S., "analysis shows that the arrival of crack cocaine led crime to rise substantially in the late 1980s and early 1990s. The most prevalent form of violence-aggravated assault-rose significantly" (Grogger & Willis, 2000, p.1).

Intergenerational Trauma

I believe that it is important to touch upon the aspect of intergenerational trauma and how that affects communities of color and minorities who reside within urban cities. Time and time again, I have seen my peers, who have experienced trauma, have been unable and sometimes unwilling to get treatment for said trauma, go on and have children. Many times, they have children when they are not ready financially or emotionally, their partner or "baby daddy" is also not ready and more often than I can count, they relinquish their responsibilities as a father. These peers will continue to live in the city, and so begins the cycle again of living in poverty, living from paycheck to paycheck, depending on a flawed system for food stamps, section 8, any other assistance, and child support. All while being surrounded by gang violence, drugs, and crime. These conditions do not allow them to be the parents that they could be, so they repeat the same behaviors they have learned from their own parents. So when a traumatic event happens, a child looks to their parent for guidance as to how to deal with that trauma, to find a parent that hasn't dealt with their own and is ill equipped to guide their child through the onslaught of unknown fears, worries, and emotions that arise from a traumatic event.

Research into intergenerational trauma considers the long-lasting effects of trauma within families and through time. Intergenerational trauma can be defined as "trauma passed from one generation to the next through genetics and through experiences. This form of trauma often affects large groups of people who have experienced collective trauma" (Mohn, 2019). Camilleri (2007) writes "most single mothers face major challenges in raising their children alone and being a teen mother brings additional obstacles. Teen mothers typically drop out of school and are unemployed" (p.44). They are forced to go on welfare because often it is the only way to support themselves. And "very few teen mothers marry or receive financial support from the child's father, and most remain on welfare and live in poverty for extended periods of time

(Camilleri, 2007, p.44). The idea of transgenerational trauma is that trauma can be passed from one generation to the next. Transgenerational trauma can occur in a variety of situations. The trauma from "singular events, such as the death of a child, can be passed onto future generations. Social trauma, which affects entire groups of people, can also be handed down" (Mohn, 2019). When professionals "discuss and study transgenerational trauma, they often focus on social trauma, as they can study large groups of people, all of whom experienced similar traumas" (Mohn, 2019).

If we consider this perspective of intergenerational trauma, how does that affect a child who cannot make sense of what's happening to them? Charles Portney (2003) wrote that "in clinical practice, patients with parents suffering with PTSD often describe damaged, preoccupied parents who are emotionally limited (no p.). He describes some of the symptoms experienced by these parents such as "traumatic reliving, emotional numbing and dissociative phenomena do not help a child develop a reasonable sense of safety and predictability in the world" (Portney, 2003). As a result of their untreated trauma, "these parents are also less able to respond optimally during usual developmental crises and help the world to be more comprehensible to the child" (Portney, 2003). Due to their PTSD symptoms from untreated trauma, these parents would have "difficulty modeling a healthy sense of identity and autonomy, appropriate self-soothing mechanisms and affect regulation, and maintaining a balanced perspective when life challenges arise. Instead, they can model catastrophic or inappropriately numbed and disassociated responses" (Portney, 2003). Therefore, the "parent's high levels of anxiety can significantly interfere with the child's developmental progress" (Portney, 2003). And to tie this into a clinical theoretical framework, this type of behavior would lead to a child not having a secure attachment. And when a child does not have a secure attachment to their parents and there isn't a

level of safety that a child can depend on, it's makes it more difficult to function, and develop in the world. Every child needs a secure "base" to come back too when they are fearful and struggling. Parents with unresolved PTSD from intergenerational trauma, from living within an urban community, and not having the resources to get the appropriate help, are parents who have a hard time being a secure "base."

Limitations in Conventional Treatment

Dr. Mary M McKay (2005) and her colleagues out of Columbia University have conducted research on the impact of urban trauma on inner city children. They found that their study provided "a beginning understanding of the complexity and severity of mental health needs among urban children. But in doing so found a gap within services being provided" (McKay et al, 2005, p.201). That gap being in outpatient treatment, noting "the current delivery system of child mental health services does not appear to engage and retain most youth, despite at least an initial outreach effort to seek services by the adult caregivers" (McKay et al, 2005, p.202).

Misdiagnosis can also pose as a limitation within treatment. Bessel Van Der Kolk in his book *The Body Keeps the Score* wrote that "eighty two percent of traumatized children seen in the NCTSN did not meet the diagnostic criteria for PTSD because they were shut down, suspicious, or aggressive they now have received diagnoses such as "oppositional disorder," or "disruptive mood dysregulation disorder" (Van Der Kolk, 2014, p.159). These are children that may have "accumulated numerous diagnoses over time by their twenties" (Van Der Kolk, 2014, p.159). In terms of treatment, "and if they receive treatment at all, they receive a method of management: medications, behavioral modification, or exposure therapy" (Van Der Kolk, 2014, p.159). Parson (1994) also wrote in his paper on U-VTS stating "attention deficit disorder is frequently found in cases of chronic exposure to violence stress. The existence of regressed

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states or attention deficit disorder causes a number of academic deficiencies in traumatized children" (Parson, 1994, p.5).

In their research Julian Ford and Margaret Blaustein (2013) also spoke to the limitations of seeking treatment experienced by adolescents in the juvenile detention system and their families. They found that "most detained youth, about 85% of the survey, did not perceive mental health services as important (p.2). What they did feel was important in the present moment was "immediate health needs rather than longer-term mental heath or substance use problems" (Ford & Blaustein, 2013, p.2). The parents of these adolescents in the juvenile detention system were surveyed and "reported feeling a general sense of hopelessness, inadequacy, and stigma that may reduce their confidence in or willingness to seek mental health services for their child" (Ford & Blaustein, 2013, p.2). Confusingly, these same "parents have also been found to not define their child's problems in mental health terms despite seeks (but often not accessing) other services for their child and family" (Ford & Blaustein, 2013, p.2). It's also been found that "trauma-exposed older adults in public care systems are often less likely than younger populations to seek out and receive care when in need, extending disparities in the initiation and use of mental health services for individuals as they age, especially among minority older adults" (Hanson & Ghafoori, 2017, p.85).

Taking a Trauma Informed Approach

Trauma is a public health epidemic. So, what can be done when entire communities of children are living in traumatizing environments, are possibly suffering from mental illness, and are still expected to go to school, learn, and eventually go out into the world, into the workforce, and lead healthy, productive lives. A change needs to be implemented in the entire system. Thus far, the trauma-informed approach has proven to be an integrative and successful model in dealing with this

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public health issue. A trauma-informed approach "maximizes children's ability to benefit from interventions by creating a supportive and safe environment in which professionals collaborate with one another as well as the child's caregivers and other important adults in the child's life" (John et al, 2018, p.5).

Trauma-informed care was first introduced in inpatient and juvenile mental health facilities. It has been expanded to a variety of settings, including "juvenile justice systems, addiction treatment centers, and foster care, and has been suggested for use in developmental disability populations, homelessness services, and long-term care facilities" (Hales et al, 2017, p.1). The trauma informed approach is the idea that trauma needs to be dealt with in a multi-level system. It is taking the stance that everyone, at one point or another in their lives, has experienced trauma. In its most basic understanding the trauma-informed approach represents a "systems-level framework for realizing, recognizing, and responding to the impacts of trauma in ways that promote healing and avoid retraumatization" (SAMHSA, 2014, p.9). That allows for every person, regardless of whether or not they have experienced a traumatic event, to be seen, to be heard, and to grow, within a supportive system.

Within the United States, organizations, hospitals, mental health treatment centers, and federal organizations are implementing the trauma-informed approach through specific models. One such model that is being used here in the state of Massachusetts is the ARC model, created by the Justice Resource Institute. The ARC model, which stands for Attachment, Self-Regulation, and Competency, is touted as "a theoretically grounded, evidence-informed, promising practice used to treat complex trauma in children and adolescents (Arvidson et al, 2011, p.35). The ARC model makes its theoretical basis on "attachment, trauma and developmental theories and specifically addresses three core domains impacted by exposure of chronic, interpersonal trauma (p.35)

Each letter within the ARC model represents a phase, with attached goals, which they build upon. When working with a traumatized child, the next step within the model cannot be taken without first acquiring a specific skill. It's first letter stands for attachment. Within the attachment phase, there are four key building blocks that need to be targeted with the child's caregiving system. They are "caregiver affect management, attunement, consistent response, and routines and rituals" (Arvidson et al., 2011, p.35). The goal of this domain is to "provide the child's caregiving system, whether that is biological parents, extended relatives, foster or adoptive parents, residential staff, school personnel, and the clinician, the tools to provide safe attachment for the child" (p.35). That safe attachment then allows the child to go about in the world knowing that there is a safe "base" that they can come back to for regulation.

The second domain within the ARC model is self-regulation. The goals within self-regulation are "affect identification, modulation and affect expression" (Arvidson et al., 2011, p.36). This domain targets a child's ability to "identify, modulate, and express their internal experience" (p.36). This is possible through building a child's "vocabulary to describe their emotional experience, teaching the child the ability to tune in, tolerate, and sustain a connection to internal states, and develop a child's ability to identify safe resources" (pp.36-37). Self-regulation is acquired through "social learning, that is, by modeling (observational learning) and reinforcement (consequences that enhance the motivational value of behavior) from key persons in youths 'support systems" (p.37). Also put into place are "specific educational or mental health services (e.g., groups, classes, counseling, therapy) can provide youths with preparation and guidance for self-regulation (e.g., teaching basic concepts or skills, coaching to facilitate practice and application of skills, enhancing motivation and trust, medications that reduce affective, cognitive, or biological instability)" (Ford & Blaustein, 2013, p.5). The final domain of the ARC model is competency. This domain focuses on a child's "ability to acquire foundational skills for ongoing

development" (Arvidson et al., 2011, p.37). In order to achieve that, there are two goals, "executive functioning and self-development and identity" (p.37). Through these two goals, "clinicians would work towards increasing a child's ability to effectively engage in problem solving, planning, and anticipation, while also developing a sense of self that is unique, positive, and incorporates experiences from the past and present" (p.37).

A study (2015) on the use of the ARC model with children "ages 6 to 17 years in adoptive or pre-adoptive placement, who were referred from adoption and community mental health agencies in their area found that 16 weeks of individual and group based ARC treatment was associated with improvement in both child and caregiver functioning"(Hodgdon et al, 2015,p.5). They found that "changes in child symptoms included reductions in internalizing, externalizing, posttraumatic stress, depression, anxiety, anger and dissociative symptoms from pre- to post-treatment gains, which were maintained over a 12-month follow up period. Youth also demonstrated change in PTSD diagnosis" (p.9). ARC also showed promise for "reducing externalizing behavioral problems, and externalizing behaviors, such as acting out, oppositionality, and aggression, which are a driving force in child mental health service referral, and at its extreme, of placement instability" (p.9).

Another study (2011) using the ARC model was conducted in Alaska at the Alaska Child Trauma Center at the Anchorage Community Mental Health Services on 93 children. For clients who completed the treatment, the child and caregivers participated in an average of 50 sessions. The outcome from program evaluated "preschool-age American Indian, Alaskan Native, Caucasian, and African American children involved in the child protective system which suggested that the ARC would be a promising practice for young children" (Arvidson et al., 2011, p.48). They felt that this study and its preliminary findings were different from other studies conducted on the ARC model's effectiveness because of the "rich ethnocultural diversity of our clinical sample and their wide-ranging trauma exposure history. These

observations are consistent with and expand upon emerging empirical evidence in support of the ARC model in treatment of complex trauma in latency-aged children and adolescents (p.48).

I sought out my current internship because I knew that many of its students were of color and coming from urban communities like myself. They are middle school to high school students with behavioral issues, much of it stemming from complex trauma. They are referred to our school by their districts, who cannot meet their needs. They are also at an age that is difficult developmentally, emotionally, and socially, let alone dealing with trauma on top of it. At that age, I was struggling with my chaotic home life too, so I understand how they feel. Instinctively, I also knew that we could develop a bond and a sense of trust because we came from the same type of communities and we spoke the same language. I was right and, in the process, we've used art in simple and extraordinary ways. Sutherland and her colleagues (2011) spoke of that alliance stating, "we assert that strong relationships that are developed during art therapy make the biggest difference in the student's life and well-being" (p.71). For one student, that level of safety and trust has allowed her to create art that illustrates her life; the death of both of her parents, her racial identity, her grieving process, and her love of basketball. It's allowed her the space to develop a language for her experience and try to figure out who she is at this moment in her life. A few months ago, I had a powerful moment with a middle schooler a few days after he told staff he wanted to commit suicide and had a plan to do so. He asked to work with clay during his scheduled art class the following week. I was teaching him how to center clay on the wheel when the perfect opportunity came up to just tell him, "you're in control, kid. You control the clay; it doesn't control you." His face changed and he just looked at me thinking "I've never thought of it that way". With support from his peers, his teachers, and giving him that space to create, has been so helpful to him. Time and time again, I have had experiences with these students that illustrates how powerful creating their own art work

can be for them. It gives them a sense of power and control they do not have in their lives. Art allows them to be children, when circumstances have forced them to grow up faster than we'd like them too. And a lot of times, it allows them to get out of their heads. I will see a change in their body language, facial expressions, and demeanor when they get into the creative process. Even if it's for five, ten, or fifteen minutes, they are out of their minds and in the present moment. For survivors of trauma, it can be so hard to be in the present moment, when they're constantly trying to make sure they are safe. When it's time to go to their next class, they walk out of there with a smile on their face and much calmer than how they walked in. I may not be able to come in and solve all of their problems. But what I can do is help them find a form of expression they can use to tap into themselves and their experience and release it in a healthy way.

   As I graduate and will begin working within this field, I hope to work within an urban community, and continue to collect information on how to best work and treat complex trauma as an art therapist of color. Language is not required to make art. And when a child is experiencing complex trauma, many times they do not skills to communicate what is happening to their body and minds. When describing how art can be the language of expressions, Sutherland et al. (2011) wrote "feelings that a student is unable to express verbally can be released while creating art. The way an idea or experience is expressed gives the student and the art therapist clues into understanding what the student is experiencing and feeling" (p.71). Based on the research I've done and from my own personal experience I believe art therapy can be used in urban communities in two ways; individually and as a community. Any child that has experienced complex trauma should be seeing a therapist on a weekly basis. With the array of presentations that can manifest from complex trauma, the use of art can be a perfect way to release internal energy. I personally like to paint with my fingers on large pieces of paper that I tape onto the wall that allows me to process through my

feelings and the energy that comes along with them. I also found my own mind and body connection when I began working on the wheel and eventually became a ceramics major. Working on the wheel gave me the sense of control I needed when I felt like I had absolutely none in my life

Art can be used to bring communities together. In high school, I volunteered to help paint a school playground. This was 15 years ago, and I still remember this sense of togetherness and community, we all had a good time, and everyone walked away that afternoon feeling so proud of their work. In the article Sutherland et al. wrote "social interest can become the action line of community feeling, so establishing a sense of belonging through social interest becomes an important component of human development" (p.69). When I think of creating a community project(s), I want everyone within the community participating. From the littlest ones to the elders of our community. What if I was able to do this in Paterson in communities all throughout the city? Giving the children, adolescents, and adults an opportunity to change, enrich, and add their own touch to their community? Something they could be proud of. How would that change our city if we were all invested in it? What would that do to our crime rate? Or the drug and alcohol problem? School attendance and participation? What amazing things can we accomplish when more people are invested in the city they live in?

Discussion

This literature review took a critical look at the trauma experienced by urban youth and how using the trauma informed approach may be beneficial to treating their complex trauma. This thesis examined literature on trauma, complex trauma, reactions to trauma, limitations in treatment, the basic tenets of the trauma-informed approach, and the ARC model. In the process of researching for this literature review I found the statistics and basic information backs up the knowledge I already have; children and adolescents who live in urban communities experience high levels of violence

that in turn puts them at risk of developing complex trauma. Youth that are at risk of outcomes that include depression, educational failure, addiction, unemployment, incarceration, poverty, or death (Camilleri, 2007, p.17). And exposure that has been linked to the development of childhood posttraumatic stress disorder, anxiety, and conduct difficulties (McKay et al, 2005, p.201-202). The research has also shown that these communities lack the resources to effectively treat complex trauma, and do not have the appropriate systems in place to curb future trauma incidents. The trauma-informed approach has shown early promise to developing programs and systems that can effectively treat complex trauma in youth. But the research into this approach is still young and has a long way to go. I have observed that there may be gaps in the research on applying the trauma-informed approach within communities of color and the racial, political, and oppressive systems in place that do not allow them to receive the treatment they need. I also found more resources on the ARC model than I did on the use of art therapy with urban youth. When searching for articles using a combination of art therapy, trauma-informed approach, and inner-city youth, it yielded zero results. That is disappointing given that there are programs in some of these inner cities, like New York City and Chicago. But I was able to find articles on using art therapy in a trauma-informed way, just not specifically inner-city youth. The topic of inner-city youth might possibly be too broad for a researcher, therefore, needing to concentrate on a specific population. My goal for this capstone thesis project is to potentially contribute a clinical view of the mental health concerns that are evident in urban communities and therefore communities of color. And provide a theoretical approach that I believe would be useful and beneficial to these communities.

As a woman of color and now adding art therapist to the dimensions of my identity, I ask myself how can I make space for my brothers and sisters of color to health their trauma. How can I include them into this Western post-colonial idea of mental health treatment that many times does not

include us in the discourse? I would like to see more models that combine the trauma-informed approach and artist expression, one that caters to people from inner cities, people of color, and our experiences. Being able to express oneself artistically is trauma-informed. It allows the person to express their true selves, and their world view that has now changed because of the experience of traumatization. I also believe that it is important to develop an approach that also takes into consideration intergenerational trauma, as well as intergenerational knowledge. As written throughout the thesis, many of the people residing in inner cities are of color. There is so much pain and suffering that a person of color carries with them due to colonization. There is also a strength that needs to be acknowledged from surviving generation after generation. But there is also dance, art, and religious practices that comes with those cultures that should be embraced and given the space to flourish within the individual. Writing this thesis, I am further interested in learning about culture, it's representation, the oppression of cultures, and how that affects mental health, the language that children and adolescents currently use and embracing that change in language and including that into art work without judgement, indigenous religions and practices, as a way of treating complex trauma.

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ds-live&scope=site

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Art Therapy, MA

Student's Name: __Ashley E Corazon_____

Type of Project: Thesis

Title: __Literature Review on Urban Trauma and Applying a Trauma-Informed Approach_____

Date of Graduation: _____May 18th, 2018_____
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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