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How Expressive Arts Therapy is being used to treat children with developmental trauma and its
implications for treating community and systemic causes of developmental trauma.

Capstone Thesis

Lesley University

5/5/20

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Expressive Arts Therapy

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Abstract

Adverse Childhood Experiences, or ACEs, are circumstances that occur in a child's life which are either long-lasting or have long-lasting effects due to their traumatic nature.

Developmental trauma is a composite name for the effects of adverse childhood experiences on children. It has been found that, across racial groups, in locations with high poverty, children are more at-risk for scoring high (four or more) on the ACE questionnaire (Choi, Wang, & Jackson, 2019, p. 1). Treatment for developmental trauma begins with establishing a sense of safety in the child, but also within the family and the community. It is also important to build personal, familial, and community resilience in order to combat, or even override the effects of adverse experiences.

Expressive Arts Therapy provides easy access to parts of the brain that store emotion, memory, and sensation, all necessary for treating developmental trauma effectively. Expressive Arts Therapy is uniquely situated to provide individual, family, and community connectivity and relational healing within a systems approach because most art forms are scalable. The efforts that currently exist to provide community-level care to families at-risk for developmental trauma must begin to incorporate Expressive Arts Therapy in order to be more fully effective.

Expressive Arts Therapists should get involved at the systemic level and develop programs that wrap around the whole family and the whole community toward reducing instances of developmental trauma in children.

Introduction

I have been interested in working with traumatized children for most of my adult life. It was not until I heard about Adverse Childhood Experiences (ACEs) and counter-ACEs when I was a camp director that I realized trauma and resilience could be measured. ACEs are potentially traumatizing events or situations that occur in the life of a child and counter-ACEs are measurements of resilience that counterbalance those potentially traumatizing experiences. As I come into my role as an Expressive Arts Therapist, I find that many of the children who come to see me are dealing with adversity that is too big for them, and so their maladaptive coping skills have become too difficult for their parents to deal with. They enter therapy so that their behaviors can be changed to make life easier, but the underlying problem is trauma that perhaps they do not even remember.

Treatment for posttraumatic stress disorder (PTSD) in children, such as the Trauma module of the Modular Approach to Therapy for Children (MATCH) or Trauma Focused Cognitive Behavior Therapy (TF-CBT), often includes establishing safety, telling the trauma narrative, and integrating the experience into memory (Sarah Rigden, personal communication, January 20, 2020). With complex trauma, this is more difficult, because there is not one single circumstance or event that caused the trauma. While the symptoms of developmental trauma, or complex trauma in childhood, and PTSD are similar, the treatment cannot be exactly the same. Traditional therapeutic work in treating complex trauma involves establishing safety, developing distress tolerance, uncovering cognitive distortions, and reprogramming the mind to be more flexible (Sarah Rigden, personal communication, January 20, 2020). This is a very cognitive approach that can be highly effective, particularly for adults looking to heal from and unlearn

their traumatic pasts. However, children do not have fully developed cognitive capacities and are still developing their ability to process the world around them.

I had initially planned on creating an Expressive Arts Therapy intervention that would build resilience in children I work with because resilience is what helps children overcome their trauma. However, as I did my research, I found that the issue of treating developmental trauma is bigger than working with individual children on their symptoms. It is a systemic problem that cannot be truly solved by working on a micro level.

In researching ACEs, I tried to pinpoint exactly which ones were most important to treat, and which ones could be treated on a systemic level. It turns out that when it comes to problem behaviors in children, “parental anxiety or depression was the most commonly reported and the only ACE to significantly predict all five the behavioral outcomes assessed” (Hunt, Slack, & Berger, 2017, p. 400). This speaks to the systemic level of the problem—when caregivers are stressed and traumatized themselves, they cannot provide adequate care to the children in their charge. Psychological and physical abuse are the most common ACEs, and I believe they are tied to parent mental health. Certainly, substance abuse and incarceration (other household dysfunction experiences on the ACE list) are related to mental health issues and unresolved trauma in adults (Dye, 2018, p. 386). This all combines to convince me that working with the entire family unit and the community they live in is the only way to treat developmental trauma appropriately, rather than focusing on the individual child.

Literature Review

I am interested in exploring developmental trauma and the role of systemic factors in creating adverse childhood experiences. Through my research on developmental trauma, I set the stage for exploring what can be done about it. I found that there are consistencies in

treatment across many theories, and that treatment starts with establishing safety, both on a micro and on a macro level. Expressive Arts Therapy is a type of therapy that is extremely well-suited to treating trauma and I look at the work of several Expressive Therapists who are healing trauma through creative modalities. Throughout my research, my aim is to bring focus as much as possible to the systemic issues surrounding developmental trauma.

Developmental Trauma

Developmental trauma is not a DSM-5 diagnosis. It is a composite name for the effects of adverse childhood experiences on children. Adverse Childhood Experiences, or ACEs, are circumstances that occur in a child's life which are either long-lasting or have long-lasting effects due to their traumatic nature. The initial combination of ACEs included 10 circumstances in the areas of physical and psychological abuse and household dysfunction (Felitti, et al., 1998, p. 247). The study in which the ACE questionnaire was designed, done at Kaiser Permanente in California, found that ACE scores were linked to major adult causes of death later in life: the more ACEs a person had experienced as a child, the higher the likelihood of them developing serious health problems as adults (Felitti, et al., 1998, p. 250). It was also determined that the presence of one ACE in a person's life significantly correlated to the presence of more ACEs (Felitti, et al., 1998, p. 249). Since it was published in the 1990s, study after study has been done to find out if the results of the Kaiser Permanente study can be replicated across various subgroups and across various outcomes. The results are condemning. The outcomes for people with high ACE scores (4 or more) in all races and socioeconomic status were high rates of mental and physical health issues. People with a history of childhood emotional abuse were 3.51 times more likely to develop Major Depressive Disorder than people who did not experience emotional abuse (Poole, Dobson, & Pusch, 2017, p. 93). There was a dose-response relationship

between ACEs and heart disease and cancer (Felitti, et al., 1998, p. 250). Researchers are calling for public health officials to declare the presence of ACEs a crisis situation for public health because of the clear correlation between ACEs and poor health outcomes.

The presence of one chronic traumatic experience strongly correlates to the likelihood of more experiences. Ability to handle stress is impacted by the experience of complex trauma, particularly developmental trauma, and further traumatization continues to decrease adaptability and resilience. It has been found that symptoms such as anxiety, depression, dissociation, shame, substance abuse, suicidality, avoidance, numbing, hypervigilance, and hyperarousal increase as trauma history increases (Thompson & Jaque, 2019, p. 186).

The impact of ACEs on children while still in childhood has also been studied. ACEs have been linked to behavior issues, substance abuse, and delinquency in children and adolescents. Southwell described the effects of chronic, or complex trauma on children: “Being in a chronic state of stress and fear, as occurs when children are traumatised, means that these lower regions of the brain are perpetually in a state of poor regulation, compromising potentially every aspect of brain development associated with normal child development” (Southwell, 2016, p. 115). The lower portions of the brain are the first to develop, and the parts that are most in charge of emotions. If this area of the brain does not develop properly due to stress, higher order brain functions are not able to develop appropriately. Developmental trauma, as indicated by the name, inhibits proper brain development, and has effects on “identity formation, regulation of emotional states, cognitive processing[...], moral and spiritual development, ability to control behaviour, experience of bodily integrity, trust of self and others, and capacity to form interpersonal relationships characterised by mutuality, empathy and emotional connectedness” (Southwell, 2016, p. 115).

Studies focusing on childhood often look at behavioral issues, which are categorized into internalizing and externalizing behaviors. Internalizing behaviors are internal, such as anxiety, somatization, and depression. Externalizing behaviors are external, such as acting out, antisocial behavior, hostility, and aggression (Association, n.d.). One study by Hunt, Slack, and Berger explored the differences in childhood outcomes for children of various racial groups and found that, adjusting for socioeconomic status, “children exposed to ACEs were more likely to exhibit a higher amount of externalizing and internalizing behaviors and were more likely to have an ADHD diagnosis compared to children who had not experienced any adverse childhood events” (Hunt, Slack, & Berger, 2017, p. 398). These findings are echoed in other studies done on childhood behavior and ACEs (Choi, Wang, & Jackson, 2019, p. 2). In addition, children who had one single ACE in the areas of physical or psychological abuse were “47% more likely to participate in delinquent acts than youth without substantiated maltreatment” (Brown & Shillington, 2017, p. 212). One study found that “exposure to 4 or more ACEs was associated with 33 times the odds of reporting a learning or behavioral problem as compared to children without ACE exposure” (Hunt, Slack, & Berger, 2017, p. 392). Interestingly, high ACE scores (a score of 4 or more) were associated with 19 times the odds of a white child exhibiting externalizing and internalizing behaviors, with the odds dropping to 9 times higher for black children, and no higher for Hispanic children than those who experience no ACEs (Hunt, Slack, & Berger, 2017, p. 398). Resilience and community factors may have something to do with this difference.

Studies have found that it matters to look at the age at which ACEs arrive in a child’s life. According to Hambrick, et al., experiences within the first five years of life was more linked to outcomes in adulthood than were experiences later in life (Hambrick, et al., 2019, p. 239).

Relational ACEs, such as physical and psychological abuse (as well as neglect, though neglect is not measured in the ACE questionnaire) are particularly harmful during the perinatal period because the relational health of the infant to the caregivers is so important for adequate development of the infant (Hambrick, et al., 2019, p. 244). This research into the perinatal period validates what is known in attachment research, that infants are wired for attachment, developing their attachment style by age one. Malchiodi wrote, “Freud (1920/1955) himself observed that traumatic experiences shatter the “protective shield” and threaten the core of the attachment relationship” (Malchiodi, 2014b, p. 10). The attachment of a child to their caregivers, when disrupted, causes stress not only for the child, but for the caregivers. The relationship, being damaged, no longer provides comfort to the child and negative behaviors will increase in an attempt to call out for help, which makes the child harder to parent.

Some have called for bullying by peers to be included in the criteria for determining ACEs, as the impact of bullying on the brain is the same as from other sources of complex trauma (McGuinness & Schnur, 2015). Much like being in an abusive relationship, bullying is a relational experience that the child cannot control or get away from. As mentioned previously, one traumatic experience strongly predicts more, so children with high ACEs have a higher likelihood of peer victimization than those without ACEs.

Poverty doubles the likelihood of a child being exposed to three or more ACEs, which “is significant because exposure to three or more ACEs is twice to five times more likely to increase the risk of experiencing behavior problems” (Choi, Wang, & Jackson, 2019, p. 1). Behavior problems then increase caregiver stress and decrease relational health, both of which increase the risk of further, or chronic, ACE exposure. Because resources are limited for poor families, “stressful life events for low-SES families and their children tend to be uncontrollable. Poor

children are more likely to be exposed to family dysfunction and environmental hazards” (Choi, Wang, & Jackson, 2019, p. 3). Choi, Wang, and Jackson reported that in their sample of poor children, the average ACE exposure was nearly one ACE per child (0.9) (Choi, Wang, & Jackson, 2019, p. 3). This means that the “culture of poverty is one of the largest predictors of child abuse and neglect” (Collins, et al., 2011, p. 31).

With all of these factors weighing heavily against children’s positive development, it is important to find out what can be done about them. Poverty is a systemic issue that causes problems for anyone affected by it, yet not every single child in poverty experiences developmental trauma. The answer to why may be resilience.

Resilience as Protective Factor

Resiliency theory works within the ecological framework, meaning determining how “multiple systems (e.g., individual, family, neighborhoods, schools, etc.) interact to affect the course of development” (Crandall, et al., 2019, p. 2). Resilience is a combination of abilities and characteristics such as “tenacity, self-efficacy, emotional and cognitive control under pressure, adaptability, tolerance of negative affect, and goal orientation” (Poole, Dobson, & Pusch, 2017, p. 90). Awareness of what creates resilience is coming to the forefront of trauma treatment. McGuinness and Schnur, in their developmental trauma work reported that resilience is built from “self-reflection, perspective taking, connection, flexibility, and self-regulation” (McGuinness & Schnur, 2015).

One study from 2019 focused on resilience factors (or counter-ACEs) and how they related to ACE outcomes. This study reported that those with higher resilience were actually unaffected by their ACEs, and in some cases, had better outcomes than people with no ACEs but low resilience scores (Crandall, et al., 2019, p. 7). It also reported that “in simple regression,

counter-ACEs were associated with lower scores in stress, depression, and sleep difficulties and higher scores for executive functioning, locus of control, forgiveness, gratitude, familial closeness, and daily fruit and vegetable consumption” (Crandall, et al., 2019, p. 5). This indicated that not only does resilience buffer the effects of trauma, but it also increases the likelihood of positive health outcomes. In other research, resilience was found to moderate the relationship between ACEs and depression, as “cumulative ACEs were more strongly associated with total symptoms of depression among individuals with low resilience than among those with high resilience” (Poole, Dobson, & Pusch, 2017, p. 95). Because of this research, providers are now using resiliency as a more important metric than ACEs by which to measure childhood experience and on which to base trauma treatment.

This ecological work within interpersonal relationships to improve social support was linked to success at treating developmental trauma symptoms (Hambrick, et al., 2019, p. 239). Relational health was found to be the strongest predictor of behavioral and symptom outcomes in children (Hambrick, et al., 2019, p. 243). Counter-ACEs are mostly relational in nature, highlighting supports a child has grown up with or has currently. Because of the impact of these relationships on ACE mediation, the counter-ACEs study confirmed what other relationship researchers have been saying: without positive relationships, a child cannot develop effectively. Brown and Shillington reported that “much of what contributes to the long-term consequences associated with prolonged exposure to early adversity is the lack of a supportive buffering adult” (Brown & Shillington, 2017, p. 212). Protective adult relationships also reduced the relationship between ACEs and substance use in youth (Brown & Shillington, 2017, p. 214). Delinquent acts decreased with higher counter-ACE scores: “The count of delinquent acts increases by 24% when youth have more ACEs. However, as youth identified more protective adult relationships

they are 13% less likely to engage in delinquent acts” (Brown & Shillington, 2017, p. 215).

Positive relationships with caring adults are what impacts a child’s development most.

It is not enough, however, for an adult to just be present in order to have a positive impact on a child’s behavioral and health outcomes; quality of the relationship was found to be an extremely important factor (Brown & Shillington, 2017, p. 217). Thankfully, though early experiences with caregivers might cause developmental trauma, Hambrick, et al. reported that relational health later in life may increase positive functioning (Hambrick, et al., 2019, p. 244). This finding shed hope on middle childhood and adolescent interventions, as well as on the efficacy of foster and relative care placements to support developmental trauma healing. As Brown and Shillington reported, “mentoring relationships can produce positive outcomes and foster resilience in youth if the bond includes trust and mutual benefit” (Brown & Shillington, 2017, p. 217).

Common PTSD Treatment/Best Practices

In the treatment or prevention of PTSD, the first step is always to establish safety. McGuinness and Schnur wrote, “Feeling safe, engaging in repeated activities that promote self-empowerment (mastery), and finding consistent peer support (connection) are crucial to developing resiliency to trauma” (McGuinness & Schnur, 2015). Without safety, the mind is unable to access higher levels of thinking and is stuck in more basic emotional functioning. The four things a child needs in order to feel safe are: “(1) my body is safe; (2) my feelings are safe; (3) my thoughts, words, and ideas are safe; and (4) things I make are safe” (Malchiodi, 2015b).

When safety has been established, emotional experiences must be contained. Perry and Malchiodi explained that containment is there “to provide an experience that allows for more control because it taps executive functioning rather than lower, sensory parts of the brain”

(Malchiodi, 2015b). In PTSD treatment, this is when distress tolerance skills are practiced and pieces of the trauma narrative begin to come forth and be processed.

The trauma narrative is then pieced together and used in conjunction with distress tolerance skills to expose the brain to the experience again and again in a contained way that results in desensitization (Sarah Rigden, personal communication, January 20, 2020). Because developmental trauma is often a result of experiences that occurred pre-verbally or chronically, there is no one narrative that can help a child process their experience. Therefore, in order to facilitate healing from this type of trauma, new experiences must be facilitated which re-teach the brain what to expect from the world. Including caregivers in this process is highly important for developing a child's relational health. This frequently must include showing empathy for and supporting the caregivers, because parenting a child with trauma is stressful, confusing, and exhausting (Smith, 2017, p. 60).

Building resilience through connection and repairing attachment are known as best practices in order to mitigate the effects of developmental trauma. Relationships are built in community, so the problem is not just an individual one, but a community, systemic one. If a caregiver has no support, has acquired poor attachment styles themselves, has poor mental health, and has a life full of stress from socioeconomic or racial inequity, the children raised by that caregiver are at high risk of developmental trauma. The work cannot be done with children alone or with caregivers alone, but with the entire system in which they live. Otherwise, providers will always be racing to keep up with the rates of developmental trauma and will never get ahead of it.

Efforts to reduce poverty and its effects must improve, though, provided families can access them: "current poverty-reduction programs would be partially beneficial to children and

families, particularly when poverty and ACEs combine” (Choi, Wang, & Jackson, 2019, p. 8). Choi, Wang, and Jackson wrote about the need to intervene with families dealing with poverty and ACEs so that outcomes are improved. However, it is too little too late to address these issues when ACEs have already occurred. At that point, providers are working with people already at a deficit. Building resilience in children and families and decreasing the chronic stress of poverty are the best ways to prevent negative outcomes from experiences outside a child’s control.

ARC framework. The Attachment, Regulation, and Competency (ARC) framework has been developed for working with children with developmental trauma and their caregivers. It is “designed specifically to address the multi-layered diagnostic presentation observed among children who have experienced complex trauma, as well as associated caregiver difficulties” (Hodgdon, Blaustein, Kinniburgh, Peterson, & Spinazzola, 2015, para. 4). The basic idea is to support the caregiver-child relationship, support distress tolerance skills in children, build resilience, and develop a life narrative to integrate trauma into a cohesive story (Hodgdon, et.al., 2015). The parenting portion “actively targets caregiver safety and parenting capacities, addressing caregiver regulatory abilities and resources; ability to accurately read and effectively respond to child cues; effective parenting skills; and use of routines to build rhythm and predictability” (Hodgdon, et.al., 2015). Working with parents on their own distress tolerance allows them to work more effectively with their children.

In a study done on the ARC framework, Hodgdon, Blaustein, Kinniburgh, Peterson, and Spinazzola reported that externalizing behaviors decreased with administration of ARC treatment, and that caregiver functioning improved (Hodgdon, Blaustein, Kinniburgh, Peterson, & Spinazzola, 2015). One of the main goals of ARC is to build resiliency, and this study also

showed that “ARC treatment was associated with improvement in caregiver-reported child adaptability and adaptive functioning” (Hodgdon, et.al., 2015).

Trauma Adapted Family Connections. A model for systemically treating developmental trauma in children is Trauma Adapted Family Connections (TA-FC), based on Family Connections, which is used as a preventative treatment for child abuse and neglect (Collins, et al., 2011, p. 30). In addition to working on symptoms and narrative building, Family Connections involves family work including assessment of all members, emergency assistance, and case management, as well as wrap around mental health care (Collins, et al., 2011, p. 32). TA-FC utilizes a treatment team rather than individual providers to reduce risk factors for maltreatment of children and enhance protective factors, which improves child safety and child behavior (Collins, et al., 2011, p. 32). By working with the family unit on a multi-level approach, teams are able to see up close what effects multigenerational trauma has had on caregivers and how to heal the cycle of trauma by altering patterns of response (Collins, et al., 2011, p. 33). Collins, et al. reported that “in many instances a limited emotional repertoire has developed over multiple generations as caregivers transmitted their emotional processes to the subsequent generation. Increasing identification, expression, and regulation of emotion heightens inter- and extrafamilial connectivity and may facilitate managing the impact of larger social problems” (Collins, et al., 2011, p. 39). Teams help families meet their basic needs, working on a systemic level to establish family safety and reduce stress for the caregivers and thus, their children.

A study showing the efficacy of TA-FC reported that “Caregivers and children both reported clinical levels of post traumatic stress symptomatology that decreased significantly at closing” (Collins, Freeman, Strieder, Reiniker, & Baldwin, 2015, p. 519) Living conditions for

the families were greatly improved through this model, including financial conditions, community support, and child development (Collins, Freeman, Strieder, Reiniker, & Baldwin, 2015, p. 519). In the study, children had begun with “clinical levels of the risk factors of trauma symptomatology (e.g., PTSD, depression, anxiety, dissociation) on two self report measures at pre-test” which fell significantly to nonclinical levels at post-test (Collins, Freeman, Strieder, Reiniker, & Baldwin, 2015, p. 519). Clearly, working with the entire system is highly effective at improving outcomes for children at risk for ACEs.

Expressive Arts Therapy

Expressive Arts Therapy is a combination of art, music, dance, drama, narrative, and play therapies that are used to treat emotional and psychological needs. Expressive Arts Therapy is not just one experience, but uses multiple modes of creativity, one after the other, to deepen emotional attunement and understanding. Some claim that Expressive Arts Therapy is ideal for treating trauma because it can bypass the prefrontal cortex and get at emotions and memories stored in the limbic system, where trauma is also believed to be stored (Malchiodi, 2015a). Cathy Malchiodi writes, “Trauma-informed expressive arts therapy is based on the idea that the creative arts therapies are helpful in reconnecting implicit (sensory) and explicit (declarative) memories of trauma and in the treatment of posttraumatic stress disorder (PTSD)” (Malchiodi, 2014b, p. 10).

The simple act of performing creatively “is often associated with an increased capacity for resilience and adaptability” (Thompson & Jaque, 2018, p. 2). This increased capacity allows the work of trauma treatment and resilience building to deepen. On the other side of this, it has been found that artists who had experienced high ACEs (four or more) experienced more intense creative experiences when performing than those who had fewer than 3 ACEs (Thompson &

Jaque, 2018, p. 5). Expressive therapies provide healing experiences by lowering stress arousal, building capacity for secure attachment, enhancing self-regulation, facilitating processing, and enhancing self-efficacy (Southwell, 2016, p. 116).

Creative experiences can cause the brain to enter a flow state, which can regulate symptoms of trauma such as anxiety, depression, and hypervigilance. Dimensions of flow include “challenge–skill balance, merging action and awareness, clear goal setting, unambiguous feedback while performing, undivided concentration on the task at hand, a sense of control while performing, a loss of self-consciousness, a sense of time transformation, and an autotelic experience” (Thompson & Jaque, 2018, p. 2). High ACE reporters in Thompson and Jaque’s study had more negative psychological factors than low ACE reporters, but the creative process and flow states were often experienced as more intense and highly valued in those artists who reported high ACEs (Thompson & Jaque, 2018, p. 7). Not only did flow states improve functioning and decrease symptoms, but those who most needed it found flow particularly helpful.

Malchiodi wrote about working with children from violent homes and how expressive therapies is, at its core, able to establish safety through the materials used. For self-soothing and regulation, she reported using “more sensory-based materials such as clay, paints, fabric, tactile papers, yarn, feathers, and glitter” (Malchiodi, 2015b). Safety is, as explored earlier, the first step in treating traumatized children. Malchiodi explained that the art experience should be predictable and consistent. This means, “introducing parents and children to the art therapy room and its contents, which may include an array of materials for drawing, painting, and constructing, as well as props for creative play.” (Malchiodi, 2014a, p. 57) Predictability

increases safety and associates the therapy relationship and space with a sense of safety for future work.

Building resilience through Expressive Arts Therapy is done by developing ways for a child to experience mastery. This means “providing various opportunities for the individual to engage in creative experimentation that integrate experiences of unconditional appreciation, guidance, and support – experiences found in families with secure attachment relationships” (Malchiodi, 2014b, p. 10). This builds self-esteem, supports identity formation, and enhances connective capacity. Any creative experience has the potential to build resilience in this way.

Expressive therapies continuum. Malchiodi and many others have used the concepts present in the Expressive Therapies Continuum to guide understanding of materials use, subject exploration, and containment. The Expressive Therapies Continuum (ETC) is “a means to classify interactions with art media or other experiential activities in order to process information and form images” (Hinz, 2009, p. 4). There are four levels to the ETC: the Kinesthetic/Sensory level, the Perceptual/Affective level, the Cognitive/Symbolic level, and the Creative level. The Kinesthetic, Perceptual, and Cognitive side of each level are left-brain functions, more tied to the use of language and organization. The Sensory, Affective, and Symbolic side of each level are tied to right-brain functions, which have more to do with expression, emotion, and experience (Hinz, 2009, p. 5). Hinz posited that the lower level of the ETC is associated with the lower levels of the brain, the pre-verbal levels. This is where much of the developmental trauma is stored for children, so stimulating this area of the brain using the lowest level of the ETC can be very activating of a trauma response. The higher levels on the ETC are used to contain and regulate the effects of the lower levels of the ETC, and the right and left sides of the brain can be used in conjunction with one another to do the same thing. For instance, if a child is

overwhelmed by sensory input, a way to regulate them would be to move to the left of the ETC and use kinesthetic means of regulation. The same can be done in the opposite direction: regulating high kinesthetic experience can be accomplished through raising the sensory experience of the child (Hinz, 2009). This framework was designed to inform use of creative materials, activities, and methods to access and regulate internal experiences, which is enormously useful for treating trauma.

McGuinness and Schnur explained, in their work on bullying, that processing experiences and forming connections with others can easily happen non-verbally in expressive therapies. They reported that activities that maintain consistent beat, such as drumming, dancing, and singing are helpful in activating both hemispheres of the brain, which helps new pathways of functioning to form (McGuinness & Schnur, 2015). This illustrates combining the Kinesthetic and Sensory sides of the first level of the ETC. When done with another person, the experience creates relationship, connection, and can help develop attunement. Connection, particularly with caregivers, is a large part of building resilience in children, as mentioned previously. Malchiodi wrote, “Attunement between parent and child or adult partners enhances feelings of happiness, mutual understanding, and trust” (Malchiodi, *Art Therapy*, 2014a, p. 58). In Malchiodi’s group work with children from violent homes, she included the non-abusive caregivers in part of the group experience in order to help the children repair their ability to attach and connect. Making art together, she wrote, was a natural way to build connection (Malchiodi, 2015b).

Focusing-Oriented expressive arts therapy. Laury Rappaport wrote about Focusing-Oriented Expressive Arts Therapy (FOAT), which is “a mindfulness-based approach that [she] developed by integrating Eugene Gendlin’s (1981, 1996) mind-body Focusing method with the arts therapies” (Rappaport, 2015). The method is a way of establishing and maintaining safety

throughout treatment. The principles of the method are “fostering safety; presence; listening, reflection, and mirroring; grounding; the Focusing Attitude; and clinical sensitivity” (Rappaport, 2015). Safety, as always, is the first step in treating trauma. FOAT focuses on three areas of safety: “the therapeutic relationship between therapist and client, in the client’s sense of self, and in the external world” (Rappaport, 2015). FOAT does this by mindfully exploring a client’s “felt sense” of their experience and encouraging them to express that felt sense in creative ways. Not only do clients then gain insight about their trauma, they also gain the ability to remain focused on their own lived experience, which builds self-awareness and identity, both factors of resilience.

yourtown’s expressive therapies intervention. Another report by a non-profit organization known as *yourtown* described developing the *yourtown’s* Expressive Therapies Intervention (YETI) to treat preschool-aged children with exposure to trauma. YETI uses expressive therapies, play therapy, relational therapy, and work with the neurosequential model of therapeutics to treat trauma (Southwell, 2016, p. 117). Through child-centered work and a wide array of provocations such as toys, art materials, dress up items, and musical instruments, YETI establishes a relationship between the child and the therapist and/or the caregiver that allows a child to re-develop positive attachment. In Southwell’s research, YETI was found effective at improving children’s emotional self-regulation, “such as enhanced ability to express emotions in words rather than actions; self-soothe; recover from upsets; reduce internalising and/or externalizing behaviours; and draw on carers to co-regulate emotional states” (Southwell, 2016, p. 123).

Using individual modalities to treat trauma. Work utilizing drama is particularly useful at re-wiring the brain’s ideas about relationships and connection because it relies on the

relationship between players. Drama therapy is also being used to develop cognitive capacity in people who have experienced developmental trauma. Frydman and McLellan reported that executive functioning was the least well developed in people with high levels of developmental trauma and the quick thinking and decision making required in improvisation helps support executive functioning growth (Frydman & McLellan, 2014, p. 152).

Creative Alternatives of New York (CANY) is a drama therapy organization that “focuses on the ongoing development and implementation of a trauma-informed model, responding to the prevalence of traumatic stress among a client base that is increasingly composed of children and youth” (Frydman & McLellan, 2014, p. 153). CANY’s goal is to encourage people dealing with developmental trauma to re-learn how to play and how to express themselves freely, which is at the resilience and narrative building stages of recovery, or the Perceptual/Affective level of the ETC. By working in stages, CANY establishes safety through check-ins and warmups before diving into building a collective narrative by exploring the combined experience of an image or spoken word piece. Reflections end the sessions to help cognitively integrate the experiences of everyone in the room. In this way, experience is contained and progress can be made within the group.

As previously explored, developing healthy attachment is one of the main foci of treatment for developmental trauma, especially when the client is a child. Art therapy is easily able to contain attachment and relationship building options. In dyadic work with caregivers and children, Hendry and Buck have explored child-led art making and how it can increase connection between the two people. Because the “caregiver is present and can witness the child’s process at first-hand, and the therapist can model attuned responses for the caregiver”, there was ample opportunity to establish safety and containment for the child while allowing

them the freedom to express their experiences (Hendry & Buck, 2017, p. 121). By helping the caregiver to see, respond to, and reflect on the art making with the child, the focus “is on enhancing the caregivers’ sensitivity and understanding of their child” (Hendry & Buck, 2017, p. 121). Hendry and Buck have also explored joint art making in the caregiver/child dyads to encourage connection building. As they reported, “when engaged in joint parent-child activities, toddlers can begin to compare their own feelings about an event with the adult partner’s emotional reaction to it, and they can experience their adult partner as an intentional being” (Hendry & Buck, 2017, p. 124). This emotional reciprocity builds trust, an essential component of attachment.

Hasler discussed developing healthy attachment through music and play. Hasler wrote, “music offers parents and children opportunities to co-regulate so that they can play – play with sounds, rhythms and dynamics” (Hasler, 2017, p. 138). Co-creation of music also allowed the caregiver and child to play together. Hasler pointed out that making positive memories together was one way to establish better connections between caregiver and child. Music connects to the memory part of the brain better than words so positive memories are even more connected to brain growth when experienced musically (Hasler, 2017, p. 138). Music uses all parts of the brain, which is essential for developing secure attachment in later childhood (Hasler, 2017, p. 141).

Music provides containment as much as it provides a means of expression. Robarts wrote that the process of making music is regulatory and containing, not just in producing music, but in the way it is heard, listened to, and understood (Robarts, 2014, p. 72). Robarts explained that self-regulation occurs and is learned through music because the “rhythm, pulse, or groove of the music” is itself regulatory (Robarts, 2014, p. 73). Practicing music works with the brain to

practice regulating body systems, which is part of developing distress tolerance so that trauma can be processed calmly and safely.

In Summation

Adverse Childhood Experiences can cause developmental trauma in children due to their chronic and stressful nature. ACEs occur more often in families experiencing poverty because of the chronic and stressful nature of living in poverty. Treating individuals who have experienced developmental trauma involves establishing safety for the person, increasing resilience factors in their life both internally and externally, and reducing the stress response by both increasing distress tolerance and by creating a personal narrative that is strengths based. Using Expressive Arts Therapy and applying the Expressive Therapies Continuum framework to individual treatment, clients can be helped to complete these steps in a way that gets at the parts of the brain which have stored the trauma in the first place. Treating trauma on a systemic level involves the same steps, only on a larger scale. Establishing safety involves meeting basic needs and mitigating the dangers of poverty and community violence. Increasing resilience factors involves improving connections among family and community members.

Discussion

Treatment is easier to do on an individual level than with the whole community, and so there is little writing that I have been able to find about community and systemic efforts to prevent and control developmental trauma, particularly within Expressive Arts Therapy literature. I have searched through Lesley University's research databases using terms such as *trauma, community, systemic, developmental trauma, complex trauma, expressive arts therapy, creative therapies, poverty, racism, and family*. The resulting research has been presented here in its entirety. Working on a community level to identify group-wide experiences and treat those

in community should be an area of growth for the profession. Prevention efforts for at risk families need to focus on the systemic challenges facing these families, not just on individual resilience and strength.

TA-FC is an effective model for treating the systemic issues facing children at risk for high ACEs. Expressive Arts Therapy is uniquely situated to provide individual, family, and community connectivity and relational healing within a systems approach because most art forms are scalable. What is needed is a program that connects poor families to services, funding, and Expressive Arts Therapy groups to alleviate the stresses caused by poverty and systemic oppression and to build community resilience.

I work in the children's department of a community mental health center, which works on the systemic model, wrapping around (particularly poor) families with case management, functional support in the family, school, and community, as well as therapy. The problems we face with getting children the support they need is lack of funding for poverty relief and caregivers who are not able or willing to participate in creating change. Were we to implement an attachment-promoting systemic model with Expressive Arts Therapy family groups, I am curious how many families would participate.

In my experience, not only is there a stigma to "therapy", but there is also a sense among parents that they are doing the best they can and that admitting to needing help is tantamount to saying they are bad parents. Designing the support to address their physical and emotional needs rather than their parenting deficits seems to me to be important for getting buy-in. The chronic stress of poverty is hard on parents, and trickles down into their parenting, and so establishing safety must be the first step to working through other needs (Collins, et al., 2011, p. 29). It is difficult to establish emotional safety when physical safety is at risk. When basic needs such as

housing, healthcare, and food are met, that stress is relieved and the constant threat of more poverty-related problems is taken away.

As previously explored, resilience comes from connection, so families in similar circumstances in the same community should be brought together and helped to support one another (Poole, Dobson, & Pusch, 2017, p. 90). Churches, schools, sports teams, and community organizations can be great spaces in which to build self-esteem, identity formation, and competency or mastery, all components of resilience (Poole, Dobson, & Pusch, 2017, p. 90). Some of the most at-risk children are those with uninvolved parents. Working with teachers on developing resilience and community through school attendance is one way to access those children who otherwise would not be able to access community resources through their parents. Finding the funding to maintain an Expressive Therapist on staff at high-poverty community schools would further increase the potential for resilience building opportunities.

One large barrier to attendance in therapeutic services, even for involved parents, is transportation. Therapeutic groups would need a location that is accessible to everyone within the community, so I propose using schools, libraries, and community centers. Using a school cafeteria provides ample space for a large group and for dividing into smaller groups. If use of classrooms can be limited, teachers do not need to be worried about their improper use. Families are often more comfortable in spaces they know well, and neighborhood schools are frequently well-known.

In an Expressive Arts Therapy wrap-around program, there would need to be, at minimum, a case manager and a therapist for each family. There would need to be an organization willing to take in money and other resources for supporting families with securing their basic needs. Therapists would need to be available in the evenings and during the day to

provide group experiences at a central location and to check in individually with their families at their homes. All of this happens in community mental health, but there are not enough Expressive Arts Therapists in community mental health centers. Expressive Arts Therapists need to imagine how to do case management in a creative way. We need to bring creativity into the organizations doing this work. Creativity is a necessary addition to policy making spaces and fundraising spaces.

Setting up a program like this in a homeless shelter for families would certainly meet families where they are. The transportation barrier, as well as the buy-in barrier would be surmounted by making it part of the program at the shelter to rehabilitate families experiencing homelessness. One issue with this setup would be that families who graduate from the shelter into their own housing would then lose the support of the program.

Another option could be a residential program at college dorms or a camp over the summer. The largest barrier to this would be that parents would need to miss work. If the program happened over the weekend, it would still cut into work time because many families who live in poverty work in food service and retail, which schedule seven days a week. If the program were able to pay parents for their time in workshops, it may offset the fears parents might face about missing a weekend's worth of work. This would be an enormously expensive undertaking, but, I believe, enormously therapeutic because it is far easier to build community and connection in concentrated programs like a camp or conference. Another issue with a residential experience is that it happens once, or maybe even once a month, but it does not wrap around the families long term. This program would need to be part of a larger program rather than a standalone experience if it were to be effective.

Conclusion

The fact that ACE scores are dangerous to the health outcomes of children and that they have the same effect on children as a natural disaster or act of war means that mental health professionals should be doing all we can to treat and prevent these experiences in the lives of children. There are programs which wrap around families and communities at risk for child maltreatment, but none that I have found incorporate Expressive Arts Therapy.

Expressive Arts Therapy is uniquely appropriate for fostering attachment, building resilience, and building community because of its use of all of the creative options for reaching people on a deep level. Expressive Arts Therapy is being used mostly on an individual level to address these issues, but I think that it needs to be available on a community-wide scale to treat systemic-level sources of developmental trauma.

Safety and resilience in community comes from connection. Expressive Arts Therapy is able to build connection through shared experiences of creativity and flow. If we can bring the creative therapies to bear at a community level, we should be able to reduce the impacts of ACEs on the children who face the most adversity.

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THESIS APPROVAL FORM

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Student's Name: Cheri Haire

Type of Project: Thesis

Title: How Expressive Arts Therapy is being used to treat children with developmental trauma and its implications for treating community and systemic causes of developmental trauma

Date of Graduation: May 16, 2020

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

Thesis Advisor: Elizabeth Kellogg, PhD