The Use of Art Therapy and Cognitive Behavioral Therapy
To Address Trauma Symptoms in Hospitalized Children
A Paper Presented to
The Faculty of the Adler Graduate School
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In Partial Fulfillment of the Requirements for
The Degree of Master of Arts in
Adlerian Counseling and Psychotherapy
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September, 2013
Abstract

The experience of hospitalization can be a frightening, painful, and potentially traumatic experience for a child. When a child undergoes a hospitalization experience, there are many factors involved in that could be potentially traumatizing. Because of their limited verbal capacity, or because of the challenging content, it may be difficult for the child to accurately describe or verbalize these traumas to caregivers. Art therapy is a treatment modality that can potentially be helpful in working with hospitalized children. A review of the available literature on the use of art therapy with hospitalized children suggests two primary advantages of this modality. The first advantage is that art therapy can be used as a brief intervention, requiring as little as one session. The second advantage is that art therapy has been shown to help individuals recover from traumatic experiences through its ability to give form and meaning to thoughts and feelings. Art making can be a particularly effective intervention for reducing trauma-related problems in hospitalized children because it is both a familiar and accessible activity. It also provides an alternate path to accessing traumatic memories (as compared to standard talk therapy).

The primary difficulty in researching the validity of art therapy as a trauma intervention for hospitalized children is the lack of empirical, efficacy-based studies available on this subject. In order to address this issue, the writer also looked at Cognitive Behavioral Therapy to see how it might intersect with art therapy when working with children in the hospital. Cognitive Behavioral Therapy was chosen as a treatment modality because it is currently the only empirically verified, evidence-based practice shown to have a measured improvement in trauma symptoms with children.
The Use of Art Therapy and Cognitive Behavioral Therapy To Address Trauma Symptoms in Hospitalized Children

There are many milestones, bumps, and hurdles in the normal development of a child from infancy through adulthood. A child’s development is, for the most part, a fun, challenging, and exciting experience that generally follows a consistent and recognizable pattern. Sometimes, however, a significant disruption in the form of an unexpected illness, injury, or accident occurs in a child’s “normal” development. These incidents are often unexpected, and can take children and their families by surprise. Medically significant illness or injury can be painful, potentially frightening, and traumatic experiences for children and their families (Banowsky-Arrington, 2007, p. 3). In the United States, pediatric trauma is the “leading cause of death after 1 year of age” (Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001). The term “pediatric trauma” refers to injuries or illnesses suffered by children and adolescents who are generally between the ages of 0-21. The types of injuries suffered are typically gunshot or stab wounds and other acts of violence, severe child abuse, or unintentional injuries such as motor vehicle accidents, falls, and burns. It can also refer to acute and chronic childhood illnesses such as asthma, sickle cell anemia, and neglect. In addition to the trauma endured by the child before he or she enters the hospital, the hospital itself can be a frightening place for a child; it is full of alien sights, smells, sounds, and it is the location where potentially painful and frightening experiences such as surgery, stitches, and other medical procedures take place. Children generally do not understand or process their hospital experience in the same way that adults do, and often experience feelings of anxiety, fear, longing for “normalcy,” and powerlessness.
Many changes have been made over the last hundred years to improve the hospital experience for children. Up until the 1960’s, many children were separated from their parents while they were in the hospital, and were often kept in open wards where they had little chance to leave their beds, let alone play or interact with their parents or other children. (Markel, 2008). During this era, specialized pediatric units were a rarity, and children were often treated on adult units. During the last thirty years or so, there has been a big push to help make the hospital experience more accommodating to children by giving them specially designed pediatric units and doctors and nurses who specialize in treating children. Hospitals have also sought to improve children’s hospital experience through providing emotional and mental health support through child psychology, play therapy, and child and family life programs.

Due to managed-care and tight budgeting of hospital services, non-medical care for children such as play therapy and child and family life services are not seen to be as “necessary” as the functions carried out by medical staff. This can mean that the trauma children might experience before and after being in the hospital is often not addressed during their stay. A severe illness or injury is a traumatic experience, and can have potentially detrimental effects on the mental health of the child. Being exposed to a traumatic injury can have a longer-lasting influence on a child than just the time it takes for a broken bone to heal, or for a childhood cancer to go into remission. These experiences can result in abnormal behavioral patterns, and even symptoms of Post-Traumatic Stress Disorder (PTSD). The circumstances that caused a child to be hospitalized can also be a source of trauma. Issues such as child abuse and neglect, experiencing violence, serious accidents, or chronic maltreatment can also be significant
sources of trauma, and can have a “pervasive effect on the developing mind and brain…” (Tripp, 2007, p. 178). Traumatic experiences can have a negative impact on a child’s emotional and mental. “Trauma is associated with alteration in cortisol activity and reactivity that may vary in relationship to development, time, predisposition, personality, the nature of a traumatic event, and other circumstances” (Nader & Weems, 2011, p. 318). This means that traumatic experiences can actually change the structure of the brain, and that the developing brain of a child can become ‘programmed’ for stress from a very young age. Researchers have also found that there is a difference in the frontal lobe structure and function in the brains of youth with trauma histories and PTSD symptoms than children without trauma histories. These findings would make it appear that pediatric trauma is indeed an issue that needs greater attention from healthcare providers. While many improvements have been made to the healthcare experience for children, there is still much room for improvement in how trauma symptoms in pediatric patients are addressed and managed.

**Background of the Study**

The hospital is often the first time that many children who might have experienced trauma are introduced to mental-health services. The hospital is often the “first line” of mental health treatment before referrals are made to outside agencies. Since it would appear that pediatric trauma is a potentially harmful and damaging problem for children in the hospital, how might this issue be addressed? Hospitals often do not have the time or resources to quickly and efficiently assess and treat the level of psychological trauma that a child has incurred before admission or after. Children might also lack the necessary language skills or comprehension to effectively process their traumatic
experiences. A practical, effective method of working through traumatic experiences with children in a way that they can understand would be ideal. Art therapy services are a potentially good way to work with hospitalized children in the resolution of trauma. Art therapy can reach a child in a developmentally appropriate way and they can get to “deep” issues faster than traditional talk therapy can. According to Pizarro (2004), “One advantage of art therapy over writing or talk therapy is that art products (e.g., sculpture or drawings) do not require literacy or verbal fluency, yet they can convey emotion, relate a story, and stimulate verbal expression. Thus, individuals who lack the skills to communicate through writing, or are uncomfortable about verbal expression, may be encouraged to disclose by first engaging in an art project about their stressful or traumatic experience” (p. 6). There is also the idea that art and art therapy has the ability to help individuals express themselves in a deeper way than perhaps talking could. There is also the added benefit that art therapy is a strengths-based approach, and that it emphasizes potential and creativity rather than deficits.

Art therapy services are usually offered through Child and Family Life departments or through play therapy services. Art therapy is defined as, “… the therapeutic use of art making within a professional relationship, and the process involved in making art is healing and life-enhancing” (American Art Therapy Association, 2004). Registered art therapists (ATRs) are mental health professionals with master’s degrees who are trained in both art and therapy, and use art to assess and treat individual with disabilities in various settings, including schools.” Art therapy services are generally billed to insurance companies under the umbrella of “rehabilitative services” (American Academy of Pediatrics, 2006). These services include play therapy, therapeutic
recreation, and occupational therapy. Art therapy has the potential to be beneficial for children in the hospital due to its ability to quickly get to the “core” of what a child is dealing with, because it gives children age-appropriate methods of communication, and because it offers them a sense of control and competence in an environment where they might not have any. Art therapy interventions can be quick, relatively inexpensive, and do not require that a child be mobile, verbal, or insight-oriented. Given these benefits, it would appear that art therapy could be a potentially useful intervention for hospitalized children who might have experienced trauma.

**Statement of the Problem**

Given the above information, it would appear that trauma suffered by hospitalized children and adolescents is an issue that requires greater attention. Art therapy could be a potentially useful intervention for this population due to its ease of use with children and adolescents, its applicability to the hospital environment, and its potential for helping clients address and resolve their traumatic experiences. In order to deduce whether or not art therapy might be helpful in these situations, this writer would need to look for a reduction in specific trauma symptoms among hospitalized children after they receive art therapy services. This writer would be looking through scholarly articles for any mention of how art therapy reduces specific trauma symptoms such as hyper-arousal, hyper-vigilance, and sleep disturbances. A potential problem with this route of study is that hardly any of the art therapy papers, studies, or books currently available contain quantitative data. Almost all of the research currently available is qualitative research, often in the form of case studies. The few quantitative studies found so far have ended up having issues such as small sample size, questionable methods of data collection, lack of
repeatability etc. It would be the goal of this writer to find out if art therapy can reduce trauma symptoms for hospitalized children and adolescents, and how its efficacy can be measured.

**Purpose of the Study**

The purpose of this study is to create an investigative background to see if art therapy has any influence on trauma symptoms such as re-experiencing, hyper-vigilance on hospitalized children. There are many qualitative and anecdotal sources that state that art therapy is a useful tool for working with this population, but these claims are not really proven from an empirical, evidence-based viewpoint. This is important because from a medical-model viewpoint, insurance companies or Medicare will not reimburse therapies that aren’t empirically proven. Hospitals in the United States require reimbursement from insurance companies for the service they provide, and insurance companies are generally reluctant to pay for things that aren’t empirically “proven” to work. One trauma intervention that has been empirically proven to be effective in working with children and adolescents is trauma-informed Cognitive Behavioral Therapy. To this end, there are some recent studies that have been done that combine art therapy techniques with the measurable interventions and outcomes of Cognitive Behavioral Therapy (or CBT). These findings show that art therapy combined with CBT would be potentially very useful in working with children with trauma histories, but there are few studies currently available that pertain to this specific research area. While there is a wealth of literature stating how art therapy could be useful with this population, and there are many anecdotal/case-studies that support this viewpoint, there have been very few peer-reviewed quantitative studies on the efficacy of art therapy in
reducing trauma symptoms. One reason that art therapy techniques do not lend themselves to being studied and measured is because art therapy researchers have not quantified the variables tightly enough. There is currently too much subjectivity in art therapy assessments, making it almost impossible to draw definite conclusions on the efficacy of art therapy interventions.

This writer is looking at all of the available information from a medical-model viewpoint. This is because in order for art therapy services to be accepted and implemented by more hospitals, they would need to be evidence-based and medically informed. The hospital needs to be able to bill for specific art therapy services, and the art therapist needs to show client progress in specific goal areas in order for insurance to reimburse for it. This is a difficult task, because art therapy is a loosely structured practice that does not rely upon standard psychometric testing. The results and focus of the work are also subjective and based upon the client’s own interpretation of their inner state. Art therapy cannot be used to diagnose, interpret, or identify disorders or mental problems empirically, so in order to bring more art therapy services to children in the hospital, there would need to be a way to show that it could be an evidence-based practice. Otherwise this potentially useful intervention for hospitalized children may not become widely implemented or utilized.

**Nature of the Study**

This writer is using qualitative research methods to see if there are potential benefits to using art therapy with hospitalized children and adolescents who have experienced trauma. This is a potentially beneficial area of research because there are many anecdotal indications that art therapy might be able to reduce trauma symptoms for
hospitalized children. Art therapy would need to be an evidence-based, empirically proven practice in order for more hospitals to offer it as a therapeutic intervention. It is the hope of this writer to find a connection between art therapy and the reduction of trauma symptoms for hospitalized children.

**Rationale**

In an effort to find art therapy directives that would reduce trauma symptoms for hospitalized children, this writer discovered that this is an area that requires further research. One of the issues encountered thus far is the considerable lack of articles or studies that show art therapy having a consistent, measurable effect on reducing trauma symptoms for hospitalized children. This is most likely due to how art therapy is practiced and used – it does not lend itself well to quantifiable and measurable goals. Art therapy is a creative, subjective practice that allows space for creative problem solving and interpretation on the part of the client, with the therapist serving as a moderator of sorts. This type of practice is difficult to break down into the measurable, individual variables that are necessary to show if an intervention is evidence-based. Another issue is that there are very few data-driven art therapy research studies available for review, and they do not have the same type of reliability and validity as an ‘evidence-based’ practice such as Cognitive Behavioral Therapy, or CBT. In many of the studies that were reviewed, art therapy did not appear to have a measurable effect on the measured outcomes.

**Research Questions**

Is there any way to measure a reduction in trauma symptoms for children and adolescents in the hospital with art therapy based interventions?
**Sub-question 1:** Is there any connection between art therapy and Cognitive Behavioral Therapy?

**Sub-question 2:** Does Adlerian therapy help blend the therapeutic methodology and outcomes of art therapy and Cognitive Behavioral Therapy?

**Significance of the Study**

It is the primary duty of medical staff to treat the medical aspects of a child’s injuries or illness before they focus on the possible emotional or social impacts of a hospitalization. Knowing this, however, it seems that traumatic experiences and injuries can have a profound and long-lasting effect on children that might lead to later emotional or mental health problems. Trauma symptoms are long lasting and potentially detrimental to children and adolescents. Traumatic memories and experiences can occur before, after, or during hospitalization. They are often underreported and are left untreated, after the necessary medical interventions have been made to aid the sick or injured child in the hospital. Trauma can cause memory problems; behavioral problems, flashbacks, sleep disturbances, and can even change the chemistry of the brain. A child’s brain can become “programmed” for stress and anxiety at an early age, and these tendencies can lead children to exhibit damaging or abnormal behaviors later in life. Trauma symptoms are generally assessed in a psychological interview or “debriefing” by a child-psychologist shortly after the child is admitted to the hospital. Issues with this approach include the fact that children are less likely to talk about their feelings and experiences in sophisticated, adult language, the fact that many children might lack the verbal capacity for explaining their experiences, the fact that children do not often connect with abstract ideas and subjective mood states, and that oftentimes, if the hospital lacks play therapy or
child and family life services, this is the only psychological intervention that children receive upon admission to the hospital.

Children and adolescents who are hospitalized might not receive therapy sessions, extended time to discuss and process their experiences, or age and developmentally appropriate outlets for their experiences. This relatively low level of treatment is certainly not the case at many larger, well-funded hospitals, where a wealth of interventions are available for children, but it can be the case at less affluent hospitals and smaller hospitals, where basic medical interventions must be met before more subjective mental health issues can be worked through. Art therapy, with its relatively low cost, and its ability to help children express and connect regardless of age or verbal ability might be an effective intervention to help hospitalized children discuss and process trauma in a way that perfunctory psychological debriefing might not be able to do.

**Definition of terms**

**Play therapy** is the use of child-appropriate toys and props to discuss and express therapeutic issues with a child.

**Art therapy** is the use of art materials such as clay, paint, or pencils within the context of psychotherapy.

**Adlerian psychology** is a school of psychological thought that is based upon the writings and findings of Alfred Adler, a Viennese psychologist, and contemporary of Sigmund Freud. He was noted for originating the concepts of inferiority feelings, birth order, viewing humans as an individual whole, and introducing the social element as an important factor in psychological health. He was also responsible for carrying psychiatry into the public realm through his work in public health.
“Individual Psychology” is the term coined by Adler to describe his psychological school of thought. It deals with the concept that a human and his or her behavior must be examined as part of an integrated whole, rather than as disconnected elements.

Cognitive Behavioral Therapy is a form of psychological therapy that was developed in the 1960’s by Aaron Beck. Beck is a professor of psychology at the University of Pennsylvania, and is the creator of the Beck Depression Inventory, as well as several other psychological assessments. Cognitive therapy techniques are frequently used in the treatment of depression and personality disorders.

“Sand Therapy” is the use of a tray of sand and small objects that symbolize real-life objects in therapy with children and adults.

Trauma, (when used in healthcare settings) refers to physical injuries rather than psychological ones.

“Evidence-based practice” refers to the result of research studies that contain both experimental and control groups, and often multiple trials (Malchiodi, 2008, p. 27).

“Medical model” means practices and treatments that are developed for use in hospitals and healthcare settings, and that comply with hospital and healthcare regulations when they are used.

“Child and Family Life” and “family services” are departments that exist in many hospitals. Medical and psychological practitioners staff these departments, and they strive to create a less-stressful, supportive hospital experience for families and children (From the American Academy of Pediatrics, 2006).
“Best practice” means something different than “evidence based”. Best practices are “… derived from clinical data by practitioners about particular applications or commonly used protocols within a discipline” (Malchiodi, 2008, p. 27).

Assumptions and Limitations

This writer was limited to 30 articles and books for this literature review. This writer used research from 11 books (two of which were 2nd source), 18 first-source journal articles, 1 survey from the NIHM, 1 official press release, and 1 online magazine article.

Research Background

Research Question

The research question posed by this writer is as follows: How can art therapy and Cognitive Behavioral Therapy interventions produce a measurable reduction in trauma symptoms amongst hospitalized children?

Rationale for Research

The initial motivation for researching this topic came from a personal interest on the part of the author. Art therapy is the incorporation of art materials by a trained practitioner into the work of psychotherapy and/or counseling. Art therapy is often mentioned in the literature as a primary intervention for hospitalized children. One of the reasons given is that it is a treatment that interfaces with children on a developmentally appropriate level, and in a way that traditional verbal therapy might not. Art therapy is also noted as being an effective intervention for the communication and resolution of trauma, because it accesses traumatic material in what is thought to be a less-threatening method than traditional talk therapy. One of the drawbacks to the use of art therapy is that
it does not lend itself well to empirical measurement in order to determine its efficacy. This is an issue because in order to integrate art therapy services into more healthcare settings, it must be an “evidence-based” (that is, proven to work) practice – otherwise insurance companies and hospitals will not pay for it.

Regardless of its potential usefulness with children, art therapy services will not be implemented by hospitals if there is no financial incentive to do so. It is the opinion of this writer that art therapy is a useful and appropriate way to work with children who have experienced trauma. Unlike art therapy, Cognitive Behavioral Therapy (CBT) has been recognized by the National Institutes of Mental Health (NIMH) as an “evidence-based,” (that is, proven) therapy method for reducing trauma symptoms in children. It is, in fact, the only therapy currently in use with this population that is considered “evidence-based,” by the NIMH.

Considering this, it was the intention of this writer to find if there were any instances of CBT and art therapy being used together to help reduce trauma symptoms in children. Ideally, this writer would have liked to find research that also used hospitalized children as a study population; this is the case in a few of the studies, but not all of them. It was decided by this writer that research findings regarding trauma reduction for children that utilized both CBT and art therapy were also valid for the purposes of this paper, whether or not they were being treated at a hospital or outside of one. It was the intention of this writer to examine the available literature concerning the interface between trauma, childhood hospitalization, and art therapy. Through completing this research, this writer hopes to determine the efficacy of art therapy in reducing trauma symptoms amongst hospitalized children.
Art Therapy Techniques Designed for Trauma Work

The stated premise of this literature review is to attempt to identify art therapy techniques that are specifically designed for working with hospitalized children that have been exposed to trauma. Some of the criteria that this writer looked for in the literature studied was the location in which the art therapy interventions took place. Were the interventions located in a hospital or elsewhere? It is also important, for the purposes of this research, to determine what types of art therapy techniques were used, and if these techniques were specifically designed for use with children.

Several of the studies found by this writer took place in a hospital, as was hoped for originally. The studies that were described as taking place in a hospital environment were the works by Corbin, Rich, Bloom, Delgado, Rich and Wilson (2011), Lyshak-Stelzer, Singer, St. John and Chemtob (2007), Yorgin, W. J., Carolan, Moore, Sanchez, Belson, Yorgin, L.C., Major, Granucci, Alexander and Arrington (2004), Chapman, Morabito, Ladakakos, Schreier and Knudson (2001), Prager (1993), and Oppenheim-Cameron, Juszak and Wallace (1984). The studies that most closely matched the criteria posed by the research question were the study by Chapman et al. (2001) which took place in an urban hospital trauma center that treated patients under the age of 24, the study by Corbin et al. (2011) that was performed at a hospital emergency room in Philadelphia, and the study by Yorgin et al. (2004) that took place in a pediatric renal transplant department. Oppenheim-Cameron et al. (1984) describes art therapy services that were based in an unspecified hospital setting. Other settings included an “inpatient psychiatric facility for youth,” Lyshak-Stelzer et al. (2007, p. 163), a special education classroom in England that focused on the work of six refugee children, Cumming and Visser (2009)
and finally a study that took place at a college campus on the East Coast of the United States (Pizarro, 2004).

There were several different art therapy techniques that were described and utilized in the literature reviewed by this writer. Some of these techniques were specific, evidence-based, (that is, studied and proven reliable over a long period of time) trauma-focused art therapy interventions that were explicitly intended for use in a hospital setting such as the Chapman Art Therapy Treatment Intervention (the CATTI) created and used by Chapman et al. (2001), and a “trauma-focused art therapy intervention” that was designed to reduce “chronic child posttraumatic stress disorder (PTSD) symptoms” (p. 164) created by Lyshak-Stelzer et al. (2007). Other interventions that were employed were “drawing about stressful or traumatic events” in conjunction with trauma-informed counseling (Pizarro, 2004, p. 6), and using a “modified Eye Movement Desensitization and Reprocessing (EMDR) protocol with alternating tactile and auditory bilateral stimulation,” (Tripp, 2007, p. 178). The team of Yorgin et al. (2004) researched the use of a formally scored drawing directive using the FEATS (the Formal Elements Art Therapy Scale, a measurement system for global variables in art therapy work) in identifying symptoms of depression amongst pediatric renal transplant patients. Cumming and Visser (2009) utilized a series of collaborative drawing assignments that were monitored and moderated by two art therapists, and Oppenheim-Cameron et al. (1984) discussed the use of body tracings as an intervention to be used with hospitalized children.

Implicit in the research criteria for this literature review is the identification of trauma-reducing art therapy techniques that were designed specifically for use with
children. The CATTI (the Chapman Art Therapy Treatment Intervention) was designed and developed for use with children (Chapman et al. 2001). Other techniques that were specifically meant for use with hospitalized children were the play and creative arts activities described by Oppenheim-Cameron et al. (1984). Most of the other studies and articles included in this review utilized art therapy directives that may have been modified for use with children and adolescents, but that weren’t specifically designed for use with this population. The work of Lyshak-Stelzer et al. (2007) focused on engaging with children that showed symptoms of “chronic child posttraumatic stress disorder (PTSD)” (p. 164), but they did not specify which art therapy techniques they employed. The team of Yorgin et al. (2004) did a quantitative analysis of artwork using the FEATS scales in an attempt to “identify depression in the pediatric medical population” (p. 52), but they did not specify which art therapy directives were assigned to the research population.

It was the intention of this writer to identify art therapy techniques that were specifically designed for working with hospitalized children that have been exposed to trauma. In many of the studies found by this writer, the art therapy interventions did indeed take place in a hospital environment, and many of them focused on work with children. While many of the studies took place in a hospital environment and used children as a study population, very few of the techniques examined were designed specifically for children.

Another drawback identified in the research was that most of the studies did not specify which techniques were used, instead mentioning vague interventions such as “a trauma-focused directive”. It is hypothesized by this writer that many of the techniques
used in the studies were not specified due to copyright restrictions. This made answering the primary research question difficult, as most of the literature mentioned generalized, non-specific art therapy techniques, and those that utilized a specialized technique were intentionally vague about its methodology, possibly due to copyright concerns. According to Malchiodi (2008) “creative” counseling methods must ultimately be able to become established as “effective” (p. 4) if they are to continue being used. “Using creative methods in counseling or psychotherapy comes with the responsibility of learning established and emerging information on the use of these approaches with children and trauma” (p. 4-5). This same author goes on to state that in order for a treatment to be considered “well-established,” there must be “two or more” studies that demonstrate that the treatment is better than the placebo, and that it is equal to or better than the existing treatment for the issue in question. From this initial investigation, it appears that there are not many specialized, empirically tested art therapy techniques available that are meant to reduce trauma symptoms amongst hospitalized children. Of the few studies found, hardly any of them have been performed more than once, thus making it difficult to determine whether or not the technique is “well-established,” or effective across different sample groups. This could indicate that this is an underserved patient group, but it could also signify that there is simply not a recognized need for specialized art therapy interventions in working with this patient population.

**Cognitive Behavioral Therapy and its Uses in Trauma Work:**

Cognitive Behavioral Therapy was outlined in the NIMH review as the only “evidence-based” treatment for children with trauma symptoms (NIMH, 2008). The term ‘evidence-based practice’ refers to “… a body of scientific knowledge about specific clinical
interventions or treatments… In brief, for an intervention or treatment to be classified as well-established, two or more studies must demonstrate that it is better than placebo, medication, or alternative treatment or that it is equal to another established intervention. Interventions or treatments are classified as “probably efficacious” if at least one study demonstrates their superiority to placebo or shows efficacy via other methods” (Malchiodi, 2008, p. 25).

In a 2008 survey, the National Institutes of Mental Health listed individual and group cognitive behavioral therapy (CBT) interventions to be the “only two interventions found effective… to reduce the harm to youth who experience trauma” out of seven commonly used interventions (NIMH, 2008). The other interventions studied were play therapy, art therapy, psychodynamic therapy, pharmacological therapy, and psychological debriefing. These interventions were all found to be “insufficient to judge effectiveness” (NIMH, 2008). Also stated in the NIMH article, “for both individual and group CBT, there was strong evidence (demonstrated in published studies) that the use of these interventions in children exposed to trauma reduced overall psychological harm. With the 5 other interventions, there were too few studies of each that met the standard set for community guide reviews” (NIMH, 2008). This sentence seems to imply that while the other five interventions have been established as “best-practice, they are not “evidence-based” for the purposes of the study. It should be noted that there is a different between the terms “evidence-based,” and best-practice.” Evidence based is “the result of research studies that contain both experimental and control groups, and often multiple trials”. Best practices are “derived from clinical data by practitioners about particular applications or commonly used protocols within a discipline” (Malchiodi, 2008, p. 27).
Cognitive Behavioral Therapy Background

Cognitive Behavioral Therapy, or CBT, is a therapeutic intervention created in the 1960’s. It is credited to Aaron Beck, a behavioral psychologist. CBT is a methodical intervention that involves strategies such as using discussion or imagery to revisit a traumatic event, stress management and relaxation techniques, and “rethinking counterproductive trauma-related thoughts and associations” (NIMH, 2008). Beck’s theory came about as a reaction to traditional psychoanalysis and behavioral theory. He stated that, according to behavioral therapy and psychoanalysis, the source of a patient’s mental disturbance lay “beyond his awareness,” and consequently, the patient cannot “modify these conditioned reflexes simply by knowing about them and trying to will them away.” In response to this approach, Beck argued “… the patient has at his disposal various rational techniques he can use, (and) with proper instruction, (he can) deal with these disturbing elements in his consciousness,” and that, “Man has the key to understanding and solving his psychological disturbance within the scope of his own awareness” (Beck, 1979, p. 3). This premise stated by Beck argued that an individual’s problems are derived largely from, “certain distortions of reality based on erroneous premises and assumptions” (p. 4). Beck went on to say that these, “incorrect conceptions originated in defective learning during the persons cognitive development” (p. 4). Beck’s proposed method of treatment was for the therapist to help the patient recognize his or her distorted thoughts and to “learn alternative, more realistic ways to formulate his (or her) experiences” (Beck, 1979, p. 3). Since its conception, Beck’s relatively straightforward treatment method has been used effectively with many diverse populations around the world. It is consistently named as an intervention of choice for
hospitals, treatment centers, and other mental health organizations. For the purposes of this paper, CBT has been found to be particularly helpful for the treatment and resolution of trauma symptoms with children and adolescents.

**Trauma, and its Lasting Effects**

For the purposes of this literature review, “trauma” is defined as “… an experience that creates a lasting, substantial psychological impact on a child. Traumatizing events may be single occurrences such as an accident or witnessing injury to another (person) or several experiences that become traumatic in their totality. Extensive exposure to neglect and abuse, experience of terrorism and/or war, or survival of a disaster and subsequent loss of home, possessions, and/or family members are examples of repeated or chronic trauma experiences” (Malchiodi, 2008, p. 4). According to national survey data from 2002 to 2003 that focused on children aged twelve through seventeen, one in eight children (in the United States) experienced a form of child maltreatment, such as abuse and neglect; one in twelve experienced sexual victimization, and one in three witnessed or indirectly experienced violence or victimization via rioting, assault and/or theft (NIMH, 2008). The types of psychological harm that can result from exposure to trauma are “… Post-Traumatic Stress Disorder (PTSD), anxiety, depression, suicidal thoughts, risk-taking, aggressive behavior, and substance abuse” (NIMH, 2008). Trauma can, and does have physiological effects as well as emotional/psychological ones. Trauma is also “… linked to altered cortisol reactivity… (which is) associated with physical, emotional, and behavioral disturbances” such as anxiety and depressive disorders (Nader & Weems, 2011, p. 318). “Trauma is associated with alteration in cortisol activity and reactivity that may vary in relationship
to development, time, predisposition, personality, the nature of a traumatic event, and other circumstances” (Nader & Weems, 2011, p. 320). It has also been found that there is “… a difference in frontal lobe structure and function in youth with trauma histories and PTSD symptoms than ‘normal’ children” (Nader & Weems, 2011, p. 321). When viewing brain scans of children with trauma histories, trauma is found to be “… expressed in right brain hemispheric deficits in the processing of social-emotional and bodily information” (Malchiodi, 2008, p. 47). The same author goes on to state that, “Using magnetic resonance imaging (MRI) technology, brain development in medically healthy clinically referred children with chronic posttraumatic stress disorder (PTSD) … had smaller MRI-based brain structure and measures of intracranial volume than did the non-abused controls… a negative correlation of intracranial volume with abuse duration suggests that childhood maltreatment may have a cumulative effect on brain development” (Malchiodi, 2008, p. 49). This research suggests that the brain (especially those of children) is susceptible to trauma, and can be ‘programmed’ for stress from a very young age, thus impacting brain development. This research “… highlights the need for early intervention with exposed youth” (Nader & Weems, 2011, p. 330). These findings in the medical and psychiatric literature support the conclusion that trauma is “… at the center of much physical and psychological pain and has a direct connection to many significant health, mental health, and social [issues]” (Corbin et al., 2011, p. 511).

In light of the information about the negative effects trauma has on the brain development of children, it should also be noted that children are vulnerable to many types of traumatic experiences. “Epidemiologic studies indicate that the majority of children in the United States have experienced exposure to potentially traumatic events…”
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(Mannarino & Cohen, 2011, p. 24). These same authors go on to state that “… over 90% of children seen in an inner city pediatric clinic had experienced traumatic exposure” (Mannarino & Cohen, 2011, p. 25). Mannarino and Cohen also state that children who experience core PTSD symptoms such as intrusive re-experiencing, persistent avoidance of reminders of the traumatic event, hyper-arousal, hyper-vigilance, and sleep disturbances have probably experienced multiple types of traumas before coming to treatment.

Cognitive Behavioral Therapy, as used with Children and Adolescents

Trauma-Focused Cognitive Behavioral Therapy, or TF-CBT is often used with children with trauma histories. “Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is based on learning and cognitive theories. It is designed to help reduce the negative emotional and behavioral responses of the traumatized child who has been [sexually] abused” (Pifalo, 2007, p. 170). Goals of TF-CBT include, “… rapport-building, anxiety-management, affective identification and processing, psycho-education, development of coping skills, construction of the narrative, and the identification and reduction of future risk” (Pifalo, 2007, p. 171). According to this same author, negative emotions and problem behaviors are “…assumed to be directly related to maladaptive beliefs and attributions associated with the abusive experience” (p. 173). The author also states that TF-CBT is useful with these types of issues because it works on recognizing and challenging the maladaptive behavioral responses and cognitions that are symptomatic of youth with trauma histories. Art Therapy can also be used with this client population, particularly with children who have limited language ability, or who may not have the vocabulary to fully express their traumatic experience. “… Creative arts therapies are
effective interventions with psychological trauma in children, individuals with mental illness or developmental delays, and older adults with neuro-degenerative disorders or speech problems… the fields of neurobiology, psychiatry, and psychology confirmed that trauma has profound effects on the part of the brain that controls language or more fully identified the roles of explicit and implicit memory in trauma-related disorders” (Malchiodi, 2008, p. 13).

The same author also states that “… for young trauma survivors with limited language or who may be unable to out ideas into speech, expression through art, music, movement, or play can be a way to convey these ideas without words and may be the primary form of communication in therapy” (Malchiodi, 2008, p. 13).

Malchiodi also states that “externalization of traumatic memories and experiences” is considered “… central to the process of relief and recovery. Creative interventions encourage externalization through one or more modalities as a central part of therapy and trauma intervention…” and that “… using arts in counseling may speed up the process of externalization…” (Malchiodi, 2008, p.14)

Some techniques utilized by cognitive behavioral therapists when working with children and adolescents (as well as adults) are: testing cognitions (or “reality-testing”), substituting rational self-statements, de-catastrophizing, thought-stopping, and homework assignments. According to Aaron Beck cognition-testing is done by “Learning (a) to distinguish ideas from facts and (b) to check observations for possible cognitive distortions. Clients are taught to discriminate between thought and reality and to shift from deductive to inductive analysis of experience, i.e., to treat thoughts as theories or hypotheses to be tested rather than as statements of fact” (Foreyt & Rathjen, 1978, p. 59).
CBT therapists also substitute rational “self-statements” for irrational statements to control anger and blaming on the part of the client. For example, the thought that “I want something and I must have it”, or “it is my right to have it,” can be substituted with “because I want something very badly does not mean that I must have it, or that others must give it to me. I am entitled to ask for it or try to get it by any means that respects others rights. However, one of the rights (of myself and others) is to refuse any request without justifying myself” (Foreyt & Rathjen, 1978, p. 62). De-catastrophizing is having the client go through catastrophe situation step-by-step, saying ‘what if’ each time. The therapist and client then logically explore the consequences of a catastrophic event step by step (Foreyt & Rathjen, 1978, p. 63). “Thought-stopping” is “… when the client is asked to focus on the anxiety-inducing repetitive thoughts that have been disturbing him. The therapist waits a short period of time and then shouts, “Stop!” or makes a loud noise. After several repetitions of this procedure, when the client reports that his thoughts were interrupted, the locus of control is shifted to the client. He is asked to say, “Stop!” to himself when the obsessive thoughts occur. He can do this out loud at first and then sub vocally” (Foreyt & Rathjen, 1978, p. 66). This procedure is very similar to the Adlerian concept of “spitting in the soup.”

CBT therapists also make use of “homework assignments,” meant to shape and restructure a client’s thoughts and behaviors when they are outside of therapy. For example, if a client has compulsive thoughts of self-harm, they are instructed to write down each thought in a journal, and then repeat a series of positive self-statements about themselves until the urge passes. Finally, a therapist who practices CBT must, “… establish a good relationship with the client so that they will share their problems and
cognitions. The therapist must be flexible, open, non-judgmental, and wiling to see things differently or from clients’ point of view.” It is also recommended that the therapist participate in a certain amount of therapeutic self-disclosure, in order to engender trust with the client (Foreyt & Rathjen, 1978, p. 64).

In addition to these established techniques, there are other reasons why CBT is widely used with children and adolescents. “Cognitive-behavior therapy (CBT) is a widely accepted approach among trauma therapists with children who have experienced a traumatic event… Trauma-Focused Cognitive Behavioral Therapy is considered… one of the few well-established evidence-based practices for trauma intervention with children. TF-CBT consists of conjoint child and parent therapy and incorporates cognitive-behavioral, family, and humanistic concepts” (Pifalo, 2007, p. 172). Creative arts therapists, play therapists, and expressive therapists often use CBT in combination with their approaches, but creative interventions themselves have not yet been extensively studied to determine if they qualify as evidence-based practices in the field of trauma interventions with children. In the 2007 work by Pifalo, TF-CBT lists the use of “artistic narrative” within its protocol, indicating that art and play approaches may be applied during this particular evidence-based intervention. Another benefit of using CBT with children and adolescents is that CBT focuses on behavior self-regulation. “When using CBT with children, their acquisition of (these) skills has to do with their use of langue and of cognitive controls. Children seem to “learn by doing,” and pattern their self-regulating behaviors through their observations of, and experiences with, significant others. Children observe these adults and caregivers’ problem-solving methods, and they acquire these “idiographic ways of perceiving the world and ways of attempting to
control events and feelings and solve problems” (Kendall, 1993, p. 240). It would seem that this “hands-on” form of CBT that is used with children could thus be quite useful.

It is mentioned in some of these studies that art therapy is often combined with CBT when working with children and adolescents. The 2007 study by Pifalo in particular focuses on the intersection of art therapy and Cognitive Behavioral Therapy as it relates to the reduction in trauma symptoms among children. “Because of the visual nature of traumatic memories (often experienced with photographic clarity), an image-based therapy may offer the most efficient means of accessing, processing, and integrating these split-off fragments that otherwise may continue to result in flashbacks and nightmares” (Pifalo, 2007, p. 171). According to the same author, “Traumatic memory becomes encoded as an abnormal form of memory that often breaks spontaneously into consciousness both as a flashback during waking hours and as a nightmare during sleep” (Pifalo, 2007, p. 172). “Art therapy in conjunction with cognitive behavioral therapy reduces symptoms and enhances the potential for positive outcomes for sexually abused children in trauma-focused treatment” (Pifalo, 2007, p. 173).

In addition to this, “CBT offers clear goals for trauma-focused therapy; art therapy helps the traumatized child quickly focus on critical issues in a way that talk therapy alone cannot because art therapy does not rely strictly on a verbal mode of communication” (Pifalo, 2007, p. 173). According to practitioners of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), one of the first steps towards mastering the memories and reactions of a traumatic event is to identify the emotions associated with that event. “Once emotions are identified and expressed, art therapy provides an effective mechanism for developing problem-solving and coping skills. The creative process is
natural to children; in fact, they tend to cope with life’s everyday difficulties through creativity and fantasy. Thus the art protects the child and makes the entire process of desensitization less threatening” (Pifalo, 2007, p. 174).

One of the reasons CBT is used for this type of work is because “CBT sets clear goals for trauma-focused treatment and art therapy interventions facilitate the achievement of those goals in a non-threatening, efficient and organized manner. The unique properties of art therapy interventions give traumatized children a powerful tool to identify, express, and process complex and often conflicting emotions. Art therapy interventions are effective because they do not rely strictly on words that a child may not possess or depend on cognitive skills that may be, at least temporarily, unavailable due to the effects of trauma” (Pifalo, 2007, p. 174).

**How are Changes in Trauma Symptoms Measured?**

In preparing this review of the available literature on the intersection of art therapy and trauma reduction, it is necessary to have a means with which to determine the efficacy of the many art therapy interventions mentioned in the literature. This writer has identified three primary questions to aid in determining the efficacy of the art therapy interventions being researched. The articles make mention of several different types of trauma, so the first question posed by this writer is what kinds of trauma are mentioned in the articles? Second, what are the reported trauma symptoms? Third, how are these symptoms shown to change? It is through answering these three questions that this writer hopes to decipher what the therapeutic outcomes are for trauma patients who are offered art therapy interventions.
There were many types of trauma that were listed in the literature. For the purposes of identifying dependent variable(s), it is important to know which types of trauma were being worked with. The study by Corbin et al. (2011) focuses on youth victims of community violence at a hospital in Philadelphia. In a study by Mannarino and Cohen (2011), the focus was on Childhood Traumatic Grief, which the authors describe as a “… condition in which children whose loved ones die under traumatic circumstances… [and] develop trauma symptoms that interfere with their processing of grief” (p. 24). In a paper by Learmonth and Gibson, (2010) the authors write about the resolution of early childhood trauma, and describe such trauma as “[overwhelming] experiences of terror from which [the child] cannot escape” (p. 54). Beers-Miller (2007) writes about “complex trauma,” and defined the term as, “… the experience of multiple, chronic and prolonged developmentally adverse traumatic event, most often of an interpersonal nature and early-life onset” (p. 185). Lyshak-Stelzer et al. (2007) discussed different types of trauma that would “range from a one-time traumatic event, such as natural or man-made disaster, to chronic traumatization in which a person is exposed to multiple stressors such as community violence, physical injury, and/or maltreatment (physical/sexual abuse) over months and years” (p. 164). The study conducted by Tripp (2007) centered on the pervasive effects of “Chronic maltreatment or repeated trauma [that is] caused when a young child experiences an ongoing failure of attunement with a caretaker or when distress is overwhelming…” (p. 177). The study by Yorgin, et al. (2004) investigated “depression and emotional trauma” (p. 54) on the part of pediatric patients that could be attributed to chronic illness. Chapman, et al. (2001) states in their study “Seventy percent of the patients… were trauma patients, victims of gunshot or stab
wounds and other acts of violence, severe child abuse, or unintentional injuries such as motor vehicle accidents, falls, and burns. The other 30% were admitted for acute and chronic childhood illnesses such as asthma, sickle cell disease, and neglect” (p. 100). The trauma described in the paper by Prager (1993) was primarily from severe illness.

The symptomatology addressed by the reports available in the literature reviewed for this project was often un-specific, and fell under the realm of general “psychological problems”. Some of the specific symptoms of childhood trauma reported in the reviewed studies were “acute stress symptoms,” and “… emotional phenomena that include a defensive behavioral pattern, a grief reaction, and a psychological retreat” (Chapman, et al., 2001, p. 100). Chapman, et al. (2001) also stated in their work with pediatric patients that “… some patients exhibit PTSD symptoms including re-experiencing the event, avoidance of thoughts and feelings about the event, and hyper-arousal in the presence of relevant stimuli,” (p. 100) and that “Re-experiencing phenomena were observed in post traumatic play, psychobiological reactions, and recurrent intrusive images. Avoidance symptoms were exhibited in gaze aversion, withdrawal, dissociative episodes, apathy toward primary caregivers, refusal to comply with treatment plans, and regressed developmental skills. Symptoms of increased arousal were observed in nightmares and sleep disturbances, irritability, new aggressive behaviors, exaggerated startle responses, and anxious attachment” (p. 102). The effects of trauma on the developing brain were examined in the study by Tripp, (2007), where it was stated that a “ …person who has been neglected, deprived, or abused will actually experience neuronal cell death in the affective centers of the limbic system of the brain” (p. 177). The same author also states “It appears that trauma … is often expressed in disturbing flashbacks that are not
connected with explicit information” (p. 181). Beers-Miller (2007) discusses the “severe learning disabilities” that can result from developmental trauma, as the imaginative and abstract-thinking skills of the developing brain are not able to develop because of external stressors (p. 185). Similar to the findings of Tripp, Nader and Weems (2011) note that the “frontal lobe structure and function in youth with trauma histories and PTSD symptoms than [those of] normal kids” (p. 325), and that “Anxiety and depressive disorders are generally associated with higher cortisol levels” (p. 325). Mannarino and Cohen (2011), in their study of Childhood Traumatic Grief (CTG) find that “… core PTSD symptoms such as intrusive re-experiencing of the deceased’s death, persistent avoidance of death reminders… hyper-arousal… or hyper-vigilance… [are] very characteristic of CTG” (p. 24). Yorgin, et al. (2004) states that many young renal transplant patients may have problems with trauma and PTSD because of stressors including: “… frequent blood draws… hospitalization…surgical trauma with scars… inadequately treated pain… procedures without pain medication… fear of acute rejection, changes in body image and feeling different or isolated from their peers” (p. 53). Weber, (2009) identifies dissociation and traumatic re-experiencing as common symptoms of psychological distress observed among children. “Dissociation is believed to be one of the most common underlying psychological processes among children and adolescents receiving mental health treatment…” (p. 2), and that “Traumatic re-experiencing may take the form of flashbacks in which the child or adolescent experiences past events as if they were really happening” (p. 3). It was not until 1987 in the DSM-III-R (American Psychiatric Association, 1987) that specific features of children’s PTSD emerged that account for developmental differences between young clients and adults. In brief, some
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symptoms of PTSD in children are hyper-arousal, re-experiencing, and avoidance. The term hyper-arousal includes intense psychological distress and-or physiological reactivity when exposed to something that resembles an aspect of the traumatic event, difficulty concentrating, sleep problems such as difficulty falling or staying asleep, hyper-vigilance, and irritability or outbursts of anger. Re-experiencing entails suddenly acting or feeling as though a traumatic event is recurring in the present, having intrusive thoughts about the event, and having nightmares that include sensory or declarative aspects of the events. Avoidance symptoms include attempts to avoid thoughts or feelings associated with the traumatic event, inability to recall aspects of the event, attempts to avoid activities or situations that evoke memory of the trauma, detachments from family and friends, difficulty sleeping due to nightmares associated with the event, decreased interest in previously pleasurable activities, and a foreshortened sense of the future (Greenwald, 2007, p. 8). Finally, Högberg, Nardo, Hällstrom and Pagani (2011) characterize trauma-related symptomology as “… a dis-regulated balance between inhibitory and excitatory impulses at trauma-trigger-related exposure” (p. 88), that most-often manifests as anxiety symptoms.

The final component to be examined in determining whether or not the therapeutic interventions being considered produce change is to see what therapeutic outcomes are presented in the literature. In the study by Pizarro, (2004) “Participants in the writing condition, but not the art therapy condition, showed a decrease in social dysfunction. However, participants who completed art-work reported more enjoyment, were more likely to continue with the study, and were more likely to recommend the study to family and friends” (p. 10). The team of Chapman, et al. (2001) stated, “An early
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analysis of the data does not indicate statistically significant differences in the reduction of PTSD symptoms between the experimental and control groups” (p. 103), in their evaluation of whether or not a specific art therapy intervention helped reduce PTSD symptoms among hospitalized youth. The same authors did go on to say that “… there is evidence that the children receiving the art therapy intervention did show a reduction in acute stress symptoms” (p. 103). Lyshak-Stelzer et al. (2007) reported “There was a significant treatment-by condition interaction, indicating that adolescents in the TF-ART (the art therapy intervention that was being studied) condition had greater reduction in PTSD symptom severity than youths in the ‘Treatment as Usual’ condition” (p. 168). The exploration of Eye Movement Desensitization and Reprocessing described by Tripp, (2007) stated that the intervention showed a “… rapid and dramatic shift in awareness and cognition that can accompany a negatively held somatic memory, monitored through art imagery… [And that] the result is the adaptive resolution of trauma” (p. 178).

Learmonth and Gibson, (2010) wrote that art therapy helps to emphasize the most “… adaptive and resilient aspects of the person, while honoring and containing distress and disturbance, it is an inherently resilience and salutogenic-friendly approach” (p. 56). They attribute these positive factors as to why art therapy is effective in resolving past traumas. As for quantifiable research, Yorgin, et al. (2004) reported “Sensitivity for the FEATS was 22% - The results suggest that while art therapy may be of utility in the identification of pediatric and young adult transplant recipients who are suffering from depression, FEATS analysis appears to lack sufficient sensitivity to warrant its use in this population” (p. 55). And that, “Study of other quantitative art-based assessment techniques may be warranted” (p. 56). This could be due to the fact that “The FEATS score was previously
validated in the diagnosis of patients with severe depression, not mild or situational
depression that many renal transplant patients experience” (Yorgin, et al., 2004, p. 56).
Cumming and Visser, (2009) in their work with school-age refugee children found that
“The results show that the children appeared to be presenting significant improvement
over the six weeks in their social participation. This would suggest that they were gaining
in confidence and developmental the skills enabling them to interact successfully with
other members of the group” (p. 155). The study by Lyshak-Stelzer et al. utilized both art
therapy and CBT in its treatment design. Because of this, the results of this study cannot
be considered as specific to art therapy, but they do show a connection between the use of
art therapy and Cognitive Behavioral Therapy. “However, because the study design did
not include a comparison group, results could have been due to generalized improvement
or to increased treatment attention. The fact that art therapy was combined with CBT
(cognitive behavioral therapy) does not permit testing the effectiveness of art therapy
alone as a specific treatment in reducing trauma symptoms” (Lyshak-Stelzer et al., 2007,
p. 163).

There were a few other studies that combined art therapy with Cognitive
Behavioral Therapy when working on reducing trauma symptoms with children and
adolescents. According to a 1993 study by Prager, “… it appears that the most effective
means of helping children who are in psychological distress due to illness is by
addressing the negative and disorganized feelings and images of the unconscious right
brain. It is there that the true emotional plight of the child may be found. The art therapist
is well-equipped to intervene because of his or her abilities to accept raw, primary
process material and to help externalize and organize it through artistic expression”
(Prager, 1993, p. 3). Using art therapy with CBT has been shown to have promise. “Art therapy in conjunction with cognitive behavioral therapy reduces symptoms and enhances the potential for positive outcomes for sexually abused children in trauma-focused treatment” (Pifalo, 2007, p. 170). “CBT offers clear goals for trauma-focused therapy; art therapy helps the traumatized child quickly focus on critical issues in a way that talk therapy alone cannot because art therapy does not rely strictly on a verbal mode of communication” (Pifalo, 2007, p. 170). According to the NIHM, “Individual and group cognitive behavioral therapy (CBT) interventions were the only interventions found effective in an evaluation of seven commonly-used approaches to reduce the psychological harm to youth who experience trauma. The other five interventions studied were play therapy, art therapy, psychodynamic therapy, pharmacological therapy, and psychological debriefing. They were all found ‘insufficient to judge effectiveness’” (NIMH, 2008). “… for both individual and group CBT, there was strong evidence (demonstrated in published studies) that the use of these interventions in children exposed to trauma reduced overall psychological harm. With the 5 other interventions, there were too few studies of each that met the standard set for community guide reviews” (NIMH, 2008). While other studies have shown art therapy to be ‘effective,’ like the Wikström study from Sweden, their methods of data collection do not meet the criteria to be “evidence-based,” or “best-practice,” by NIMH. “The approach described in this study lacks a systematic approach to expressive arts in play therapy. However, a systematic approach does not have considerable merit in offering a flexible intervention that can be tailored to meet the individual needs of children…. Nonetheless, the findings from this study suggest that expressive arts can be regarded as valuable tools as a means to
understand and interpret how a child expresses mood and feelings of being ill and hospitalized” (Wikström, 2005). The NIMH study also found traditional play therapy to be “insufficient to judge effectiveness,” even though its use is generally accepted as appropriate treatment for children. “One of the long-established and highly effective treatment methods used in working with children is traditional play therapy…” “Play therapy with trauma patients tends to involve more active interventions for reworking of traumatic themes than other kinds of play therapy” (Weber, 2009, p. 3). “Children can be reinforced for identifying changes in moods or states, interrupting dysfunctional impulsive habits, and engaging in drawing, writing, talking to adults, or other expressive alternatives” (Weber, 2009, p. 4). Perhaps the reason for this dissonance is because of the difficulty in quantifying trauma symptoms with children and adolescents. While there are specific parameters for PTSD symptoms with children, there aren’t any for a term as broad as “trauma”. “Thus PTSD might be defined as an anxiety disorder with a dis-regulated balance between inhibitory and excitatory impulses at trauma-trigger-related exposure” (Högberg et al., 2011, p. 90). “We suggest that instructions that activate both hemispheres of the brain help in arousing both negative and positive emotions. Activities engaging sensory stimulation such as movement, drawing, listening to music, specifically looking at something, or following a moving object with the eyes are such examples” (Högberg et al., 2011, p. 92). This study also points out the shortcomings of psychotherapy in working with PTSD symptoms “…affective psychotherapy focused on reconsolidation. The meaning of reconsolidation is that an emotional memory, when retrieved and made active, will rest in labile form, amenable to change, for a brief period of time, until it reconsolidates in the memory. This leads us to
the conclusion that emotions, affects, must be evoked during the treatment session and that positive emotion must comes first, because safety must be part of the new memories” (Högberg et al., 2011, p. 87).

There is some existing research that shows that art and visual methods of communication might be useful in working with children and adolescents with trauma symptoms. “Kaplan (2000) reviewed the findings of other neuroscientists who noted that graphic representation is a complex activity, involving areas of the brain associated with language. For example, Restak (1994) reported that more brain neurons are devoted to vision than the other senses. Kaplan suggests that studio art can facilitate problem-solving abilities, stimulate pleasure and self-esteem, and provide opportunities for successful functioning in children and adults with cognitive impairments.” (Silver, 2005, p. 13) The ability of art therapy to be a visual metaphor format in which to express oneself makes it potentially useful in treating trauma symptoms. “In trauma intervention, externalization of trauma memories and experiences is considered central to the process of relief and recovery. All therapies, by their very nature and purpose, encourage individuals to engage in externalizing troubling thoughts feelings, and experiences. Creative interventions encourage externalization through one or more modalities as a central part of therapy and trauma intervention… using arts in counseling may speed up the process of externalization and that expressive modalities allow people to experience themselves differently” (Malchiodi, 2008, p. 14). “Creative interventions serve as a catalyst for individuals to explore thoughts, feelings, memories, and perceptions through visual, tactile, olfactory, and auditory experiences.
Some forms of creative activity actually can enhance trauma intervention with children. Drawing, for example, facilitates children’s verbal reports of emotionally laden events in several ways: reducing anxiety, helping the child feel comfortable with the therapist, increasing memory retrieval, organizing narratives, and prompting the child to tell more details than in a solely verbal interview (Gross and Haynes, 1998)” (Malchiodi, 2008, p. 15). It would appear, from the quoted works, that art therapy and CBT both attempt to access and resolve some of the same trauma symptoms with children. Some of the common factors between art therapy and CBT are that both strive to build the client-therapist relationship, both strive to reduce anxiety, and both attempt to help the child or adolescent explore and examine the traumatic memory in hopes of resolving the traumatic material. It would stand to reason that art therapy and CBT could be used in tandem when working with children and adolescents who exhibit trauma symptoms. This appears to be an established practice, as several of the quoted studies mention utilizing both CBT and art therapy when working with this population.

This writer has identified three primary questions to aid in determining the efficacy of the art therapy interventions being researched. The articles make mention of several different types of trauma, so the first line of investigation followed by this writer was to identify the types of trauma are mentioned in the articles. The next section focuses what the reported trauma symptoms are in the article reviewed. Finally, this writer hoped to identify how are the trauma symptoms reported in the literature were shown to change. It is through following these three lines of inquiry that this writer hoped to determine what the therapeutic outcomes were for trauma patients who were offered art therapy interventions.
The different types of trauma mentioned in the literature reviewed were victimization due to community violence, Childhood Traumatic Grief, early childhood trauma, complex trauma, chronic traumatization, chronic maltreatment or repeated trauma, and finally the depression, physical and emotional trauma that resulted from severe illness or injury. The reported trauma symptoms mentioned in the literature were acute stress symptoms such as psychological retreat, re-experiencing the event through play or “flashbacks”, avoidance of thoughts and feelings related to the event, hyper-arousal, and avoidance symptoms such as gaze aversion, and regressed developmental skills. Other physical symptoms of trauma included the neuronal cell death in the affective centers of the brain observed by Nader and Weems (2011).

The review of the available literature attempted to identify whether or not these symptoms were shown to change due to the use of art therapy interventions. While many of the studies reported a reduction in symptom severity and acute stress symptoms among children who were given art therapy as a treatment method, it appears that the way in which the efficacy of the art therapy interventions was established was problematic. This could be due to the fact that art therapy is not an effective treatment intervention, but this conclusion seems unlikely in the opinion of this writer. Rather, the difficulty in establishing efficacy in art therapy as a treatment modality could be due to the fact that art therapy is an idiosyncratic intervention that requires an established rapport and one on one interaction between the client and the practitioner. The client mostly initiates the change created in art therapy sessions, and the definition of client change is subjective, in this sense. The inherent gestalt of art therapy does no lend itself to being broken down into small, quantifiable pieces that can be measured in isolation. Art therapy is an
experiential process, and it does not conform well to traditional testing and study methods. Because of this, there is a lack of traditionally tested, data-driven research material available. The art therapy studies that showed the most utility were more phenomenological in their construction and approach, and the results were gathered from observing children’s overall well being in a holistic fashion.

**What are the Unique Features of this Patient Population?**

During the course of completing this research, it was discovered by this writer that the subject of trauma in the literature is vast, as is its impact on mental health. In attempting to answer the stated research question of ‘What brief art therapy interventions produce a measurable reduction in trauma symptoms and/or feelings amongst hospitalized children?’ this writer first looked at art therapy techniques that were designed for trauma work, and then examined how changes were measured for each technique. The common factor between both of these research areas was the population studied, (which was hospitalized children). Hospitalized children are a unique population, who can potentially exhibit trauma symptoms, and who face unique challenges not experienced by other groups. Art Therapy is often mentioned in the literature as being an effective intervention for this group, and this writer hopes to identify the precedent for which art therapy is utilized with this unique population.

There are different types of trauma that developing children are exposed to, and their reactions to these traumas are expressed in different ways. Mannarino and Cohen, (2011) discuss the role of traumatic grief and its connection to other trauma symptoms. They state “…childhood traumatic grief (CTG), which is the encroachment of trauma symptoms on the grieving process and prevents the child from negotiating the typical
steps associated with normal bereavement” (p. 29). Nader and Weems (2011) examined cortisol reactivity in children, and its link to trauma. They state “Trauma is linked to altered cortisol reactivity, and altered cortisol reactivity is associated with physical, emotional, and behavioral disturbances” (p. 318), and that “Importantly, the data suggesting that cortisol may effect brain development highlights the need for early intervention with exposed youth” (p. 325). Finally, Corbin et al. (2011) discuss adolescent trauma in conjunction with youth violence, stating, “Most young people who suffer intentional injury have witnessed violence prior to their injury” (p. 511). They further suggest that young people who either witness violence, or who are victims of violence, are more likely to be re-traumatized in the future.

Pediatric patients are a specific group, and they exhibit unique features and challenges. Some of the features displayed by the pediatric population are symptoms such as dissociation, which “…is believed to be one of the most common underlying psychological processes among children and adolescents receiving mental health treatment…” (Weber, 2009, p. 2). There is discussion in the Weber article of the difficulty in finding comprehensive treatments designed to help children in resolving trauma symptoms because “…child trauma treatments have been developed and tested for specific traumatic experiences, so-called ‘silo-treatments’” (p. 3). This means there are certain treatments for sexual abuse, community violence, war, etc., but that “…the vast majority of children being treated have probably experienced multiple types of traumas” (Mannarino and Cohen, 2011, p. 24). It is theorized that trauma could have a severe impact on children’s developing brains, and that different types of trauma affect certain age groups more strongly. “Findings for normal children… might suggest that prolonged
or ongoing separations (e.g. the death of a parent) may be traumatic for children under the age of five, whereas intense shame and humiliation stressors may be more potent for older children and adults” (Nader and Weems, 2011, p. 320). The same authors theorize that the developing brain of a child could become ‘programmed’ for stress “from a very young age.” They state “There is a difference in frontal lobe structure and function in youth with trauma histories and PTSD symptoms than normal kids” (p. 325), and that “Some findings suggest that variations in reactivity are related to the type or nature of trauma” (p. 326). Corbin et al. (2011) discuss the so-called ‘cycle of trauma’. “Many of the youth who are most at risk for violent injury use the emergency department as their primary point of access to health care” (p. 514), and that “A trauma-informed approach to violence intervention recognizes that trauma feeds the cycle of violence” (Corbin et al., 2011, p. 515).

The literature also emphasizes the impact that illness and hospitalization can have on the child’s developing sense of self, self-image, and body image. “Though the effects of an illness and hospitalization on body image development are dependent on many variables, they almost always contribute to a heightened sense of vulnerability and powerlessness” (Oppenheim-Cameron et al., 1984, p. 108). The same authors encourage the use of play and the creative arts with this population. They state, “Play and the creative arts can be helpful as preventative, therapeutic, and assessment techniques for helping children with their body image. It is a way of allowing children to deal with potentially difficult issues at a safe distance and of providing opportunities for making choices and feeling in control” (p. 108).
There is an established precedent of using art therapy techniques with pediatric patients. Högberg et al. (2011) state, “… There is a natural link to art therapy and to the mode of play, which can rehearse and fantasize new positive actions” (p. 93), and that “The view of emotional memory as a scene opens up the use of the arts in the treatment. The use of the arts in psychotherapy can be summarized as activating the “play mode,” the ability to get into a memory and/or fantasy with emotional content, but still knowing that it has an ‘as if’ quality” (p. 96). Weber, (2009) states “One of the long-established and highly effective treatment methods used in working with children is traditional play therapy…” (p. 3), and that “Play therapy with trauma patients tends to involve more active interventions for reworking of traumatic themes than other kinds of play therapy” (p. 3). The same author writes, “The goal with art therapy is to strike a balance between art that encourages and mastery of art that is regressive, limiting the latter if it simply becomes a form of traumatic reenactment without trauma resolution.

Most child therapists use some art in their work, and art therapy from a licensed art therapist may be a useful adjunct to individual treatment in some cases” (p. 4). Lyshak-Stelzer et al. (2007) echo this statement, saying, “Using art products as the starting point for sharing traumatic experiences reduces the threat inherent in sharing experiences of trauma by permitting a constructive use of displacement via the production of imagistic representations” (p. 163). Art therapy is also used for identifying resilience in traumatized children. “Children with hope for the future generally include one or more of these elements (rescue, caregiving, or protection) in their art expression” (Malchiodi, 2008, p. 288).
Hospitalized children are a unique patient population, and this population was the connective variable in attempting to answer the stated research question of ‘What brief art therapy interventions produce a measurable reduction in trauma symptoms and/or feelings amongst hospitalized children?’ This writer first identified art therapy techniques that were specifically designed for trauma work, and then examined how therapeutic changes were measured for each technique.

The common factor between both of these research questions was the population studied. It has been established, through review of the literature, that hospitalized children are a unique patient population who can potentially exhibit trauma symptoms. Hospitalized children might also face unique challenges that are wither not experienced by other groups, or that are not experienced as frequently. Art therapy is often mentioned in the literature as being an effective intervention for this particular group, and this writer sought to identify the precedent for which art therapy is utilized with this unique population.

The special types and symptoms of trauma denoted in the reviewed articles were: childhood traumatic grief, the altered cortisol reactivity observed in the brains of traumatized children, intentional injury (that is, being seriously hurt by another person) and witnessed violence. There are several factors mentioned in the literature that make hospitalized children a unique population to work with. Children who require hospitalization as a result of physical trauma have a high likelihood of already having experienced multiple traumas in their life before becoming hospitalized. The illness or injury that required the child to be hospitalized will often have a large impact on the child’s developing sense of self, self-image, and body image. Trauma also affects the
developing brains of children, shown, for example, in the difference in frontal lobe structure and function in youth with trauma histories and PTSD symptoms mentioned by Mannarino and Cohen, (2011). The effects of different types of trauma vary between age groups, as well as between demographic populations, with the victims of youth violence in an inner-city emergency room described by Corbin et al. (2011) having potentially fewer resources available that could help foster trauma resilience than more affluent children.

Finally, this writer sought to examine the established precedence for doing art therapy with this unique population. The features of art therapy that make it akin to play are seen as desirable in working with children. In working with children who have experienced trauma, art therapy can also access memories and emotions that might seem overwhelming to a child in a less threatening, developmentally appropriate way. Art therapy encourages mastery and trauma resolution through engaging children in tangible, constructive activities that can help displace traumatic memories.

**Summary of Findings**

The intended purpose of this research as stated by the author was to determine if there were any art therapy techniques currently in use that produced a measurable reduction in trauma symptoms amongst hospitalized children. During the course of the research, it was found that many studies that measured reduction in trauma symptoms with children utilized both art therapy and CBT. There were several techniques mentioned in the literature that were used with hospitalized children, but there were very few that were specifically designed for use with this population. One issue observed by this writer is that many of the art therapy techniques that were tested in the studies are
copyrighted, and as such do not include a detailed description of their testing criteria or methodology. Another issue with researching the efficacy of art therapy interventions was that the symptoms that were treated and the observed had very broadly worded and subjective outcomes. It was difficult to quantify the art therapy interventions and results in a way that could be accurately measured. In the studies that used CBT, however, their therapeutic goals and outcomes were clearly stated and quantified, even when art therapy was utilized as part of the study. It is the opinion of this writer that the subject of trauma-focused, child-specific art therapy interventions requires more research in order to have sufficient data to identify its utility.

It was the objective of this writer to identify art therapy techniques that were specifically designed for working with hospitalized children that have been exposed to trauma. While many of the studies focused on work with hospitalized children, very few of them featured art therapy interventions that were specifically designed for use with this population. Another challenge presented by this research was that most of the studies did not go into specifics about the techniques that were being assessed, and often employed vague descriptions about the intended uses of the techniques, rather than thoroughly explaining each technique. It is hypothesized by this writer that the details of many of the techniques mentioned in the studies were not indicated due to copyright restrictions. This made it somewhat difficult to answer the primary research question. This difficulty is partly due to the fact that art therapy is difficult to quantify and qualify, and this makes its evaluation challenging. From this initial investigation, it appears that there are not many specialized, empirically tested art therapy techniques available that are meant to reduce trauma symptoms amongst hospitalized children. This could mean that hospitalized
children who present trauma symptoms are an underserved patient group. In regards to art therapy techniques that are meant for use with this population, it could mean that there is either not a recognized need for specialized art therapy interventions in working with this patient population, or that specific interventions have yet to be developed because the area of study is too new.

Looking at the newer research found for this literature review, it seems that there are several studies that use CBT in conjunction with art therapy to treat trauma symptoms in children. This is most likely because CBT is an established and proven method for treating trauma symptoms with children and adolescents, and many Art Therapists work in hospitals and clinics where therapeutic interventions need to be “evidence-based” in order to receive insurance reimbursement.

In order to research the efficacy of art therapy in working with trauma patients, this writer sought to identify the types of trauma mentioned in the literature, what the reported trauma symptoms were, and how those symptoms were shown to change. There were many different types of trauma mentioned in the articles, and the reported trauma symptoms ranged from anxiety and PTSD symptomatology to physical differences observed in the brains of trauma survivors. It was somewhat of a challenge to identify change in trauma symptoms in an attempt establish efficacy of Art Therapy interventions. While many of the studies showed a reduction in overall stress and symptomatology among their research population, it was difficult to accurately measure or quantify the impact that art therapy had on patients due to the fact that art therapy is an idiosyncratic modality that depends on both client-therapist interaction and the patient’s own
interpretation of their sense of change and well being. This makes data-analyses of art therapy a challenge.

The third area of research focused on the unique features of hospitalized children as a patient population. The patient population was the connective variable between the research regarding art therapy techniques and about whether or not they produced a measurable reduction in trauma symptoms. It has been established through the research that hospitalized children are a unique patient population who can potentially exhibit trauma symptoms, and who face unique challenges as a group. Art therapy is often mentioned in the literature as being an effective intervention for this particular group, and there is an existing precedent for using art therapy with this unique population.

Conclusion

It appears that art therapy is a useful intervention for resolving trauma, and it is an established intervention in working with hospitalized children. The primary difficulty in establishing efficacy in art therapy practice is that art therapy does not lend itself to quantifiable, evidence based research techniques. Art therapy is also a relatively new field, as is shown by the very recent publication dates of most of the studies included in this review, and as such, it has a limited amount of studies and research available for review. Another challenge is that most of the studies identified for this review do not report specific art therapy techniques; rather, they identify more generalized techniques whose efficacy is largely determined by individual patient outcomes. Most of these techniques were also copyrighted, and the studies that they were included in were deliberately vague in their discussions regarding the methodology of said techniques.
From the literature reviewed, it did not appear that the specific, data-researched art therapy techniques mentioned in the literature were helpful in bringing about trauma-resolution for clients. The studies that showed promise in this area were the ones where a combination of art therapy and Cognitive Behavioral Therapy were used in order to reduce trauma symptoms in children and adolescents. These studies are fairly recent, and might perhaps represent a new trend in combining the “evidence-based” methodology of CBT with the more abstract, expressive techniques used in art therapy.

In the opinion of this writer, it seems as though art therapy would be a worthwhile intervention for hospitalized children, and could be potentially useful in the reduction of trauma symptoms and the resolution of trauma. However, due to the relative newness of this field, there is a great need for the completion of more research on the subject. More recent research on trauma and its connection to neuroscience indicates that art therapy and art interventions might be a useful method for helping patients reprocess traumatic memories. Ultimately, the resolution of trauma is important for the overall mental health of children in order to prevent further symptomatology.

At this point, it is still difficult to prove the efficacy of art therapy interventions because they do not test well under traditional psychological testing conditions. This is largely due to the fact that inherent in the design of most art therapy interventions, the patient is in charge of creating meaning for their trauma symptoms, and that they are ultimately responsible for deciding when and how their symptoms resolve. Studies that attempt to make art therapy adhere to a data-driven model are generally ineffective. This does not, in this writer’s opinion, mean that art therapy is an ineffective treatment intervention for the resolution of trauma; however, it does reveal the need for an
alternative method of examining or measuring the results of art therapy interventions. It would appear, in the opinion of this writer, that the current trend in art therapy as it relates to trauma work is the combination of art therapy with the framework and techniques of Cognitive Behavioral Therapy. One potential benefit of this new trend might be the expansion of art therapy services into arenas that they might not have previously been offered, and the greater recognition of the benefits of art therapy as it relates to trauma work.

**Methodology**

This research project started out as a personal interest on the part of the researcher. This writer has completed two art therapy internships with children who are hospitalized. It was the experience of this writer that art therapy exercises worked well with children who have been hospitalized. Initially, the primary interest was to figure out how art therapy could be beneficial to children and adolescents in the hospital because it pertained to the author’s internship experience and it seemed like a promising intervention. This writer realized that many of the negative psychological effects sustained by children who have been hospitalized were due to trauma acquired either before or after their hospitalization. “Trauma” was a term that this writer found appearing as a symptom of hospitalized children across many different treatment modalities and focuses. This allowed for an expanded pool of research for this writer to draw from when looking for data for this project.

Through researching the effects of trauma on children, it was found that the long-lasting effects of trauma could have a significant impact on the life of a child if they were left un-treated. Because of this new information, this writer decided to tighten the focus
of the current project to look for art therapy intervention that reduced trauma symptoms for children and adolescents in the hospital. Another reason for this decision was that there was already an abundance of existing research on the use of art therapy with hospitalized children, but relatively little research existed on art therapy and the treatment of trauma symptoms in children and/or adolescents.

With this new focus in mind, it did not appear that there were many studies that offered specific results or techniques for reducing trauma symptoms with hospitalized children and adolescents using art therapy. From there, this writer looked into what treatments were found to work the best with children who have experienced trauma, to find that Cognitive Behavioral Therapy was mentioned repeatedly in the literature. In fact, according to this writer’s research, Cognitive Behavioral Therapy was the only treatment that has been found to be truly “effective” in this area (according to a recent study by the NIMH). In this same study, art therapy is mentioned as a promising intervention, but this writer could not really find anything in the art therapy literature that was a numbers-based, peer-reviewed study that showcased its efficacy in reducing trauma symptoms in children.

In order to expand art therapy services, and to encourage more hospitals to offer treatments like art therapy, art therapy needs to be shown to be an “effective” entity that has measurable goals and consistent results in treating trauma symptoms with children. Thus, it was the effort of this writer to determine what CBT has been shown to accomplish in terms of trauma resolution, and to show that art therapy could be used in combination with CBT achieve the same results, or to improve upon them. This writer has found some more recent research that uses art therapy and CBT together that has
shown good results when working with children and adolescents who have experienced trauma, whether in the hospital or in a different setting.

**Summary, Conclusion and Recommendations**

**Summary**

This research project was an informative and exciting experience for this writer. In the personal experience of this writer, both from internships and classes completed, art therapy has been found to be an effective, uplifting, and powerful modality with which to help individuals overcome, express, and reconcile traumatic memories and experiences. Given that this writer spent much of her internship experience working with hospitalized children, it follows that hospitalized children and adolescents are the population in focus. Hospitalization is an unexpected event in the life of a child, and can be a potentially traumatizing experience for a child or adolescent. Children and adolescents who require hospitalization, whether because of disease, injury, or an accident, can become potentially traumatized from the event that caused their injury, or from the experiences they have while in the hospital. According to a 2001 study by Chapman et al., pediatric trauma (in this case, injury that requires medical intervention) is the leading cause of death after 1 year of age in the United States.

The same author goes on to state, “Physical traumatic injuries generate emotional phenomena that include a defensive behavioral pattern, a grief reaction, and a psychological retreat. Additionally, some patients exhibit PTSD symptoms including re-experiencing the event, avoidance of thoughts and feelings about the event, and hyper-arousal in the presence of relevant stimuli (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders IV, 1994)” (Chapman et al. 2001, p. 100).
According to authors Mannarino and Cohen “… over 90% of children seen in an inner city pediatric clinic had experienced traumatic exposure” (Mannarino and Cohen, 2011, p. 22). According to another author, “Research has shown that traumatic stress has negative effects on overall health and well-being. Traumatic exposure has been linked to higher rates of psychological and physical health problems” (Pizarro, 2004, p. 5). Given this information, it would appear that traumatic exposure experienced by hospitalized children is not only a common occurrence, but also one that could be potentially harmful to their mental health. It would also seem that increased awareness about this issue and interventions designed to help reduce or resolve the effects trauma on hospitalized children and/or adolescents would be helpful.

Ideally, there would be an efficient, evidence-based and cost-effective method of helping these children and adolescents mitigate or avoid lasting symptoms of psychological trauma while they are hospitalized. Understandably, the medical issues of these patients often take precedence over meeting their psychological needs. This is especially the case in emergency departments of large urban hospitals, one of which was an internship site of this writer. Due to the high volume of patients that come in with severe, life-threatening injuries, and a lack of funding for non-medical interventions, children and adolescents often go through their hospitalization with a brief psychological interview at most, and often no specialized therapeutic interventions at all. It has been the experience of this writer that art therapy can be a potentially helpful intervention for this patient population. Art therapy has the benefits of being relatively low in cost (based on the materials and resources required), flexible in its methodology, and efficient to administer. It also does not require proficiency with the English language on the part of
the patient or high-level verbal skills, and it can be an effective method of gaining a child or adolescent’s interest and participation, as art is often seen as more “fun” than talk-based therapy. It is the opinion of this writer that art therapy would be a beneficial method of treating trauma symptoms in hospitalized children and adolescents.

According to Pizarro, “The creative arts therapies, like art and writing therapy, have been shown to be effective in helping individuals recover from traumatic experiences” (Pizarro, 2004, p. 6). Unfortunately, art therapy has not yet been found to be an “evidence-based” practice in treating symptoms of trauma. There are many reasons for this, but the primary issue is that art therapy is a fundamentally fluid and subjective discipline, whose results and interventions are not easily scored and measured using standard psychological metrics. This presents a problem, because hospitals will often not provide services that are not found to be evidence-based, and thus potentially helpful modalities such as art therapy are often unavailable.

Allowing for this issue, the author identified Cognitive Behavioral Therapy as a therapeutic intervention that has been proven as an effective and reliable method to treat and resolve trauma symptoms with all age groups and across many different settings. Cognitive Behavioral Therapy is a highly structured form of treatment that utilizes measurable goals and techniques; it has been proven to be effective in resolving or reducing trauma symptoms in many different studies all over the world since its creation. Due to the effectiveness of CBT and its acceptance by a wide variety of private and public programs, there have been some recent studies done that examine the effectiveness of art therapy when combined with CBT programming. Many newer studies have used the framework of CBT in order to administer art therapy interventions to children and
adolescents with symptoms of trauma in an effort to provide evidence-based treatment in while still allowing space for creative and non-verbal expression. “CBT offers clear goals for trauma-focused therapy; art therapy helps the traumatized child quickly focus on critical issues in a way that talk therapy alone cannot because art therapy does not rely strictly on a verbal mode of communication” (Pifalo, 2007, p. 171). This combination of the evidence-based structure and methodology of CBT and the expressive techniques of art therapy might provide “evidence-based” treatment to children and adolescents in the hospital, while still allowing for creative expression. This combination of methodologies would have the dual benefits of being engaging and accessible for this patient population, and would also be seen as an evidence-based, structured modality.

**Adlerian Theory as it Relates to Cognitive Behavioral Therapy and Art Therapy**

The research and views of this writer are informed by Adlerian psychology, as this is the educational background of this writer. Utilizing this theoretical outlook, it was the intention of this writer to use Adlerian concepts to connect the different techniques and therapeutic styles that were researched for this project. This writer found many theoretical similarities between the methodologies that were being researched, and discovered that Adlerian therapy could potentially inform, or be combined with, Cognitive Behavioral Therapy and art therapy. To the knowledge of this writer, a trauma intervention for children that combines Adlerian theory with Cognitive Behavioral Therapy techniques and art therapy does not yet exist. Based on evidence from other studies, such a treatment model could be a viable and useful intervention with this patient population.
The theoretical perspective of this writer is informed by the work of Alfred Adler. Given this theoretical orientation, one of the intentions of this writer was to determine if there was any connection between the theoretical structure of CBT and Adlerian psychology.

It was found that there were many similarities in techniques used by Adlerian therapist and Cognitive Behavioral Therapists. Where practitioners of CBT speak of "cognitive distortions," Adlerians reference "mistaken beliefs," which is essentially the concept that faulty learning early in life creates maladaptive behavior patterns for an individual later in life. For example, CBT uses technique where the therapist vocally interrupts "thought distortions" expressed by the client during a session. The therapist also looks for the client to express distorted thoughts and beliefs, and continually challenges these thoughts while offering alternative ways of looking at these thoughts and beliefs (this technique is known as "re-framing"). This technique is very similar to the Adlerian concepts of mistaken beliefs and mistaken goals, and the practice of "spitting in the soup." Mistaken beliefs and goals can be considered as analogous to "distorted thoughts and beliefs," and the practice of the therapist actively stopping, identifying, and reframing these distorted thoughts is similar to the Adlerian practice of "spitting in the soup," (that is, making a client consciously aware of a distorted thought or belief that they were unconsciously accepting as 'true').

The focus of CBT on the behavior of a client is also in line with the Adlerian concept of movement. “… as Adler often stated, “Trust only movement,” for that tells one peoples true intentions. … if we want to understand a person, we have to close our ears. We only have to look. In this way we can see as in a pantomime” (Mosak &
Maniacci, 1999, p. 87). According to Foreyt and Rathjen, two Cognitive Behavioral therapists, “If nothing else, the term ‘behavior’ is consistent with the fact that behavioral methods are the most effective in altering psychological functioning. It (behavior) serves as a reminder that in the ultimate analysis the effects of therapy must be evaluated, at least in part, by direct behavioral measures” (Foreyt & Rathjen, 1978, p. 27).

As stated previously, the “mistaken beliefs” of Adlerian theory and the “cognitive distortions” referenced in CBT would appear to be essentially the same concept. Both theories hold that early, faulty learning on the part of the client has much to do with how they view themselves and the world around them, whether for good or for ill. “As Dreikurs and Soltz (1964) have discussed, children are excellent observers, but horrible interpreters. As we have attempted to point out, this comment applies not only to children, but to adults as well. We, like children, “see” a lot of what goes on around us, but the meaning we attach to it can vary tremendously. The life style is the set of rules, the cognitive map” (Mosak & Maniacci, 1999, p.33). Cognitive Behavioral therapists discuss “thought-distortions” and “automatic thoughts,” in the same way that Adler described “biased apperception,” that is, seeing the world based upon personal values and biases that are subjective, and may or may not be true for the rest of the world (Griffith & Powers, 1987, p. 6). According to CBT, “Automatic thoughts are self-statements or images that precede a negative affective state. Ultimately, the client will learn to reason with or modify cognitions that generate negative affect through the use of related methods such as testing cognitions empirically, and (utilizing) positive self-statements” (Foreyt & Rathjen, 1978, p. 57). Adlerian therapists do much the same thing in their practice. “Adlerians actively search for, and confront cognitive distortions in their
clients… Adler’s view of emotion, and of its cognitive or reasoning correlates, was unusually incisive, perceptive, and to my way of thinking correct” (Shulman, 1985, p. 152).

Much like Adlerian theory, CBT utilizes concepts of “soft-determinism,” albeit under a different name. In Adlerian theory, “soft determinism” is the idea that an individual is neither completely the creation of their heredity or the environment. This concept maintains that character and personality are determined as much by conscious and unconscious choices on the part of the individual as much as other, outside influences (Griffith & Powers, 1987, p. 63). In keeping with this theme of conscious decision-making on the part of the individual, Aaron Beck, the founder of Cognitive Behavioral Therapy, stated “… let us suppose that the patient has at his disposal various rational techniques he can use, with proper instruction, to deal with these disturbing elements in his consciousness. If these suppositions are correct, then emotional disorders may be approached from an entirely different route: Man has the key to understanding and solving his psychological disturbance within the scope of his own awareness” (Beck, 1979, p.3). Beck goes on to state: “This new approach – cognitive therapy – suggests that the individual’s problems are derived largely from certain distortions of reality based on erroneous premises and assumptions. These incorrect conceptions originated in defective learning during the person’s cognitive development. Regardless of their origin, it is relatively simple to state the formula for treatment: the therapist helps a patient to unravel his distortions in thinking and to learn alternative, more realistic ways to formulate his experiences” (Beck, 1979, p. 3).
Art Therapy is a tool that could be potentially effective when used in conjunction with both Cognitive Behavioral Therapy and Adlerian therapy. Art therapy could be helpful to both of these disciplines as it helps to give tangible form and shape to thought distortions or mistaken beliefs. For example, an art therapist working in either discipline would probably ask a client to create a piece of artwork that represented their distorted thoughts or beliefs. The art piece could then be changed or manipulated in order to explore or reconcile this belief. It could also be kept by the therapist and referenced in later sessions with the same client in order to measure progress and change, and compare it with other art pieces made by the same client. “The art work produced becomes a tangible series that can visually track the steps and progress made by the client” (Tripp, 2007, p. 178). Another benefit of artwork is it ability to help the client distance him or herself from potentially distressing thoughts or memories by creating tangible representations of these thoughts that can be manipulated and changed as the client’s perspective changes. CBT uses the terms “distancing” and “decentering” to refer to looking at thoughts and ideas objectively. According to Foreyt and Rathjen, “Distancing” is the process of regarding thought objectively. “Decentering” is the ability to separate oneself from the occurrence and impact of external events” (Foreyt & Rathjen, 1978, p. 16).

Much like Adlerian theory, art therapy works with the world “as if.” This is to say, “While one thing might be true, another thing might be true as well.” This is inherent in the artwork made by clients, and is reinforced by the idea that artwork can always change, and it will always mean different things to different viewers. There is no any one way to make or understand art. Adlerian theory uses the concept of imagining the world
“as if” because it means that things are not concrete and unchangeable. CBT uses this concept as well – it strives to help the client get out of extreme ways of thinking and patterns thinking where things must always be a certain way and are not subject to change. CBT trains people to say to themselves, “just because this (thought) seems true, something else might also be true.” This helps them to be more realistic in their outlook, and to more successfully face and navigate challenges in life. This “creative potential” for changing the way a client sees the world offers much flexibility in treatment, and empowers the client to be an active force in his or her own treatment. According to Adler, “If the person is continually acting on, and not simply reacting to, his or her environment, and that person is actively creating his or her own perceptions, goals, and movements through life, then the Adlerian conception sees development as an ongoing process; the person is continually creating (or recreating) him- or herself” (Mosak & Maniacci, 1999, p. 20).

Another hallmark of Adlerian theory is the concept of “social interest.” This is the belief that connection with others and giving back to the community around you is essential for good mental health. According to Adler, “The individuals’ opinion of himself and the world, his “apperceptive schema,” his interpretations, as all aspects of the style of life, influence every psychological process. The individual cannot be considered apart from his social situation. All important life problems become social problems” (Ansbacher & Ansbacher, 1956, p.127). Cognitive Behavioral Therapy shares many of these same concepts of “social interest,” in the sense that all learning is, to some extent, social learning, and that a client’s faulty learning or behaviors have an impact on those around them. Referring to CBT as used with children, “Children develop in a social
context. Parents, peers, and media influence the development of adaptive problem-solving skills, affect regulation capacities, and beliefs among children. CBT acknowledges that the child’s social environment may play a role in the development of maladaptive beliefs about the self, weight, and appearance. Thus, clinical practice with children and adolescents requires that we attend to the social, emotional, and cognitive developmental level of the patient” (Dattilio et al., 2006, p. 251). Additionally, CBT considers social interaction and relationship-building to be key elements of optimal mental health, which seems to be very much in agreement with Adlerian theory. Art therapy can help to encourage “social interest” through engaging clients through group or partnered projects, or in projects where they can “give back” to their communities by making holiday cards or public artwork, for example.

Ultimately, it appears that there is quite a bit of crossover between the theoretical structures of Adlerian therapy and Cognitive Behavioral Therapy. Both of these approaches share similar features. Some of these common techniques and concepts include active engagement by the therapist in noticing and challenging distorted thoughts on the part of the client, regarding the client as a creative being who holds the ability to solve to his or her own problems, and through encouraging social and civic interaction on the part of the client. Art therapy has been shown to be a useful tool when used in tandem with both of these therapeutic modalities, and could possibly continue its efficacy if utilized in a program that combined the concepts of both Adlerian and Cognitive Behavioral therapy. To the knowledge of this writer, such a program does not yet exist, but it might be an avenue worth exploring.
Conclusion

It was the intention of this writer to research art therapy techniques that showed a decrease in trauma symptoms among children and adolescents that have been hospitalized. During the course of this research, it was found that art therapy was not generally found to be an “evidence-based” intervention for trauma symptoms, generally due to the fact that art-based interventions are difficult to measure and score due to their subjective content. Many hospitals require interventions to be “evidence-based” or proven to be effective before they will provide them as a service. In order to increase the number of hospitals that offer art therapy services to children, art therapy would need to be shown as an “effective” intervention for this patient population. Keeping this in mind, the author then researched Cognitive Behavioral Therapy, which is considered an “evidence-based” and proven method for reducing or reconciling trauma symptoms with children. The author then went on to research the use of art therapy techniques used along with Cognitive Behavioral Therapy – this type of intervention is relatively new, but has been shown to have promise in working with children who have experienced trauma symptoms.

The theoretical background that this writer has been informed by is Adlerian psychology. It was discovered by this writer that there are many similarities in technique and style between Adlerian therapy and Cognitive Behavioral Therapy. To the knowledge of this writer, there are no existing interventions that combine Adlerian theory with the structure of Cognitive Behavioral Therapy and the techniques of art therapy. It is the opinion of this writer that art therapy effectively bridges the disciplines of both Adlerian and Cognitive Behavioral therapies because of its flexibility of use and intent. Art therapy
also appears to be an appropriate intervention to use with children and adolescents, as it is often seen as a less-threatening and more “fun” method of discussing potentially traumatic material than traditional therapeutic interviews.

This writer has completed this research utilizing a top-down point of view. In short, it has been found by this writer that art therapy requires a solid, accepted framework for delivery to a wider audience. Public hospitals and clinics (such as the one this writer interned at) generally do not receive funding for treatments that are not proven to be “effective,” and as a result, the children being treated there do not regularly receive interventions such as art therapy. Cognitive Behavioral Therapy provides a solid, accepted theoretical framework that could be used in conjunction with art therapy services. Cognitive Behavioral Therapy also has a great deal in common with the principles of Adlerian psychology that this writer has been informed by.

**Recommendations for Further Study**

Ultimately, more research will need to be done to measure the efficacy of the combined modalities of art therapy and Cognitive Behavioral Therapy as it pertains to the reduction in trauma symptoms amongst hospitalized children. This field of study appears to be relatively new, and it may be several years before the results of any long-term studies are available. Proving the efficacy and validity of such an intervention is vital if art therapy services are to be offered at more hospitals that rely upon public funds for treating patients.
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