Body of Knowledge, Eco-art Therapy and Individual Psychology in the Treatment of Clients
Living with Symptomatic Preverbal Trauma
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Abstract

Children are frequently exposed to abuse, crime, and violence on an annual basis and throughout their childhood (Finkelhor, Turner, Shattuck, & Hamby, 2013). Experiencing at least one traumatic event during early childhood can lead to a diagnosis of posttraumatic stress disorder (PTSD) (American Psychiatric Association [APA], 2013), which often has adverse developmental effects (Sperry, 2016; Willemsen, 2014). This paper provides a review of the treatment of clients who have preverbal trauma with the goal of increasing the client’s quality of life and contribution to the common good. This literature review aims to 1) help readers gain a better understanding of preverbal trauma and its effects, 2) review the processing and transforming of trauma memories, and 3) provide an overview of the use of expressive therapies, the restorative healing power of nature, and other trauma focused treatments. An Individual Psychology perspective on trauma is also discussed. The need for prevention of preverbal trauma as the best treatment, and the need for mental health clinicians to take an ecological perspective when treating children is also reviewed. The research for this paper inspired a preverbal trauma art experiential called, “Out of and Into the Blues”.

Keywords: Art therapy, creative therapies, eco-therapy, Individual Psychology, nature, preverbal trauma, trauma
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Body of Knowledge, Eco-art Therapy and Individual Psychology in the Treatment of Clients Living with Symptomatic Preverbal Trauma

After completing courses for the professional clinical counseling and art therapy tracks at Adler Graduate School, this writer learned how to collaborate with clients to explore and treat a wide variety of life issues through positive, strengths-based talk therapy, and creative expression. This writer is interested in treating clients with symptomatic preverbal trauma, and hypothesizes treatment is more effective when talk therapy is combined with art therapy using natural elements and or natural environments, and is informed by Individual Psychology. Below is a review of trauma and preverbal trauma, an introduction to Individual Psychology, and the Adlerian perspective on trauma. Next is a literature review on trauma treatment, art therapy, and eco-art therapy. The Appendix contains this writer’s research inspired art experiential.

Trauma

“One in four children experience a traumatic event by the time they are 18 years old” (Kaneshiro, 2017, para. 1). Trauma is a terrifying and or painful experience. When trauma significantly interferes with a person’s life tasks, it can become symptomatic. Pathological trauma originates after a person feels horror, completely powerless, hopeless, and or helpless from a painful experience that interferes with the ability to cope, and lowers a person’s sense of wellbeing (Sperry, 2016).

The types of disorders that can develop from trauma vary. Children and adolescents who have experienced a traumatic event or events may meet the criteria for one or more disorders within the trauma and stressor-related disorders (TSRD) category in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association [APA], 2013). The TSRD spectrum includes: acute stress disorder, adjustment
disorder; PTSD with dissociative symptoms, with delayed expression, PTSD for children <6 years; reactive attachment disorder, disinhibited social engagement disorder, other specified TSRD, and unspecified TSRD. This paper focuses on PTSD symptoms in children less than six years old. For PTSD, the DSM-5 defines a traumatic event to be one that exposes a person to serious injury, threatened or actual death, or sexual violence in one of the following ways:

Directly experiencing the event(s), witnessing, in person, the event(s) as it occurred to others, learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental (p. 271).

Other symptoms in addition to traumatic event exposure include: 1) re-experiencing – having distressing dreams or memories, or dissociative reactions; 2) avoidance behavior – sometimes being fixated on reminders, impairment of cognitions and mood, and 3) hyperarousal – aggressive, destructive, high-risk, irritable, or thrill-seeking behavior that may impede peer relationships, be a risk for accidental injury to others or a risk for self-harm, and hinder school performance (APA, 2013).

Effects of PTSD are the loss of one's personal sense of safety and mastery of one’s environment. It is the brain’s dysfunctional response to an overwhelming situation that it cannot handle, such as: intense and prolonged grief, toxic stress from continual high levels of stressful situations, or traumatic event(s). The parts of the brain most affected by PTSD are: the amygdala which is associated with emotions and fear, the hippocampus which is in charge of creating and retrieving everyday memories, and the medial prefrontal cortex which plays a big part in storing beliefs, episodes, and routine memories that are retrieved frequently (Gaensbauer, 2011; Green, Crenshaw, & Kolos, 2010; Millar, 2013; Schwerdtfeger, Larzelere, Werner, Peters,
Preverbal trauma refers to trauma that a child experiences in early childhood before and or during speech and language development, usually from birth to three years of age (Gantt & Tripp, 2016; Green et al., 2010). When a child experiences trauma at about the age of three or younger, it is considered preverbal trauma due to the child’s still developing linguistic and cognitive functions (Green et al., 2010). Early childhood trauma and its effects are a major global issue (Landolt, Cloitre, & Schnyder, 2017). Data collected from 4,503 children ranging in age from one month to 17 years in the 2011 National Survey of Children’s Exposure to Violence show a high prevalence of childhood exposure to violence (Finkelhor, Turner, Shattuck, & Hamby, 2013). Results revealed that 57.7% of the sample group either experienced or witnessed a minimum of one of five types of the following exposures: assaults and bullying, maltreatment by a caregiver, property victimization, sexual victimization, or witnessing victimization in the previous year. This study also stated that, “large gaps exist in the coverage of children’s exposure to violence and abuse” (Finkelhor et al., 2013, p. 7).

Preverbal trauma happens at a time in a child’s life when he or she has limited ability to effectively cope with unpredictable and overwhelming experiences for which they cannot prepare (Willemsen, 2014). A child can become overwhelmed by a single shocking event, like surviving a natural disaster. He or she may have multiple and varied traumatic experiences, such as learning about the sudden death of a parent, being in a serious car accident, or having painful medical procedures. Perhaps the most severe case is when a child has ongoing traumatic events, for example being sexual abused or neglected, or witnessing domestic violence (Gaensbauer, 2011). These experiences can be considered very harmful because they negatively alter the
child’s development and sense of wellbeing (Gaensbauer, 2011).

**Effects of Preverbal Trauma**

Preverbal trauma can have a devastating effect on a child’s neuro and psychosocial development. Its effect varies depending on the child's age and level of development at the time of the trauma event (Landolt et al., 2017). Children cannot fully express their symptoms or stress due to their cognitive and language ability. Trauma symptoms disrupt family life and may include: clingingness, enuresis, excessive and persistent crying, hyperactivity, phobic reactions, separation anxiety, and sleep disturbances (Scheeringa, Myers, Putnam, & Zeanah, 2012). Also, symptoms vary in specificity. They may be part of normal development at certain ages and abnormal at other times. For instance, moderate occasional separation anxiety of an eight-month-old child is a usual part of growth, but the same behavior is more likely a concern when expressed by an eight-year-old, or when it is excessive and persistent. The child's age and developmental level need to be considered when determining if a symptom is abnormal.

**Preverbal Trauma Research**

This writer discovered a lack of research studies on the topic of preverbal trauma. Green et al. stated that, “Despite the importance of therapeutic intervention in instances of preverbal trauma, current literature on this topic for mental health practitioners is scarce” (2010, p. 95). Landolt et al. (2017) also wrote about this research gap, “there is significant lack of studies among preschool-age children, specifically below the age of 4 years” (p. 515).

One complex case study on early childhood trauma (Strati, 2010) described the treatment of a two-and-a-half-year-old girl, who witnessed the murder of her grandfather and experienced chronic abuse. During treatment the child projected helplessness, rage, and shock of her confusing situation onto the therapist. Strati (2010) viewed countertransference responses as a
helpful window into the child’s inner world, and containment of complex feelings as a crucial component of treating early trauma. Examples of countertransference responses were “feelings of shock, nausea, rage and often a state of primitive mindlessness: there was so much unthinkable fear that there was no thinking” (Strati, 2010, p. 17). The child had symptoms of PTSD: avoidance, hyperarousal, numbing, repeated disturbing memories, significant sleep problems, as well as fight, flight or freeze responses (APA, 2013).

Treatment occurred four times a week over an 18-month time period, and sometimes sessions included the child’s mother or nanny. The child could voluntarily explore a basket of items in the therapy room that held materials for creating art, playing, or using in sessions: a baby doll, crayons, paper, puppets, plasticine, and stuffed animals. Treatment included psychotherapy, play, creating art, role-playing, and games. Strati (2010) found it essential to establish and maintain boundaries with the child and her caregivers frequently throughout treatment. The basket was one example of containment literally and metaphorically. Other forms of containment used in this case were the use of the reflective space of supervision and consultation. Allowing the child to feel her intense feelings, “naming her affects and linking them to the original trauma (of loss) freed her from this encapsulated experience of trauma, and revived her capacity to connect and relate to others, particularly her mother, who felt as if she were ‘dead’” (Strati, 2010, p. 21).

Alfred Adler and Individual Psychology

Developed by Alfred Adler (1870-1937), Individual Psychology is a holistic, practical, positive, strengths focused, and socially oriented psychology founded on the philosophy that people have a basic goal of needing to belong, and to feel a sense of significance. There are four stages of Individual Psychology: encouragement (building a relationship), assessment, insight,
and reorientation. Some key Adlerian concepts that are pertinent to this paper include exploring one’s strengths, early recollections, mistaken beliefs, inferiority feelings, lifestyle, and social interest.

**Strengths-based**

In Individual Psychology clinicians focus on client’s strengths to help clients identify and recognize inner positive qualities. This may improve the therapeutic relationship, increase a more positive mindset, build resiliency, support resourcefulness, and or aid in the client making positive changes. Sutherland (2016) wrote that encouragement “communicates support and motivation by focusing on strengths, effort, and progress; is optimistic in that it makes a task more appealing by inspiring determination, hope and confidence” (p. 208). Encouragement empowers an individual through self-evaluation on how well a task is completed, and self-reflection of feelings.

**Early Recollections**

Early recollections (ERs) are projective and subjective memories or stories expressed in present tense of specific single childhood events that are asked of clients (Griffith & Colker, n.d.). The objective historical facts of these memories are irrelevant for the current purpose of clinicians discovering a client’s inner world of convictions, erroneous beliefs, strengths and values. Gathering a set of ERs is an Adlerian assessment tool used in lifestyle analysis.

**Mistaken Beliefs**

Mistaken beliefs or basic mistakes (Dreikurs, 1950) are distorted conclusions one makes about self-identity, others, and the world. They interfere with development and personal growth, and are the main cause of psychological problems. Mosak and Maniacci (1999) listed five types
of mistaken beliefs: faulty values, impossible or false goals of security, denial or minimization of one’s worth, misperceptions of life and life’s demands, and overgeneralizations.

**Inferiority Feelings**

Inferiority feelings are negative emotional reactions, disturbing, dreadful, shameful feelings that are a result from believing one is of less value, and therefore unequal with others (Dreikurs, 1950). This is sometimes due to thinking one does not measure up to an expected standard, and/or that one’s self-worth is connected to task performance (Ferguson, 2017). When a person compares him or herself to other people, and believes he or she is not as successful, good, and or equal as others he or she may experience feelings of inferiority. Eva Dreikurs Ferguson stated in her plenary session at the 27th Congress of the International Association of Individual Psychology that the basic belief needed is, “I am equal with others” (2017). Ferguson further explained that, “all our successes will never help us feel as an equal. The belief needs to be there and is independent from task performance. Without courage we do not accept ourselves as adequate” (2017).

**Lifestyle**

Lifestyle is one’s way of moving through life. It is a self-created, unconscious fictional plan that starts in childhood. It includes actions, emotions, feelings and thoughts (based on one’s perception of experiences) that helps an individual move in a unique way through life towards his or her goals of how to contribute to the world. The purpose of a lifestyle is to find a place of belonging or security (Dreikurs, 1950) by striving for significance and freedom of having a sense of control over one’s life (Adler, 1963). Questions about a person’s childhood and years growing up help clinicians understand early life contexts, subjective beliefs about self, others, and the world; as well as a person’s assumption of his or her ideal self that may be interfering
Lifestyle analysis is an evaluation of how a person interacts with self and others - the dynamics of a person’s personality (Ansbacher & Ansbacher, 1956).

**Social Interest**

Social interest is the desire to be in proximity to and in cooperation with others. It is the interest in, and act of, benefiting society based on the understanding of the interdependency of people (Ansbacher & Ansbacher, 1956). Adler coined this feeling or desire as *Gemeinschaftsgefühl*, having the need for belonging within social contexts such as a person's family, neighborhood, school, work, city, country, and world (Ansbacher & Ansbacher, 1956). According to Adler, a healthy person is both whole as an individual and at the same time whole as a fully functioning member of society. As cited in Bluvshtein (2016), Dr. Leonhard Seif of Munich supported this view by stating:

> The courageous individual is single-whole and member-whole, free and dependent, dependent on nature, society, culture, and its laws and regulations, freely and responsibly embedded with all his powers in the community and the life tasks (p. 92).

Adler believed people have three basic interconnected social challenges that he referred to as the tasks of life: work, society/friendship, love and sex (Ansbacher & Ansbacher, 1956). These are the largest tasks of life shared by all people under which life problems are grouped. Useful work contributes to the advancement of society. Every person is a member of society and is continually associating with other people. This societal context requires a need to adapt, consider, trust, and cooperate with other individuals. The concept of belonging relates to security, feeling as an equal and at one with others. This begins in infancy between baby and his or her nurturing mother (Sutherland, 2016). This feeling of belonging continues in life through
self-care, and caring for loved ones and others in useful ways. A healthy person feels, on an emotional and somatic level, connected to the community as an equal member of society.

**Adlerian Perspective on Trauma**

Trauma is part of human experience. The meanings that people make about situations, and not the situations themselves, matter most from an Adlerian perspective. Adler’s philosophy was that it is the individual’s interpretation of trauma that is the explanation of his or her distress, not the trauma itself (Ansbacher & Ansbacher, 1956). A person’s perspective of traumatic events, his or her unique way of viewing them, is the explanation for problems. Adler stated that, “we do not suffer from the shock of our experiences—the so-called trauma—but we make out of them just what suits our purposes” (Ansbacher & Ansbacher, 1956, p. 208).

The word pathology is based on the Greek word *pathos* meaning suffering (Harper, n.d., para. 1). Pathological trauma refers to suffering from trauma. Exposure to such events can result in suffering that negatively affects a person’s life, and may create lasting feelings of inferiority (Ansbacher & Ansbacher, 1956). Experiencing a traumatic event is associated with an increase of these feelings, so it is very important to resolve personal feelings of inferiority (Hjertaas, 2013; Millar, 2013; Strauch, 2001). It is possible to help people heal from trauma, especially preverbal trauma, so people can go on to lead more productive and socially functioning lives. According to Adler, there is only one significant conflict (Ansbacher & Ansbacher, 1956), “the incongruity of the mistaken style of life with the fact of human interrelatedness” (p. 292). One example of this main conflict is a person’s subjective view of traumatic experiences and his or her avoidance of making a social contribution, a requirement of social living.
Hjertaas (2013) emphasized the importance of adding neurobiology to the Adlerian perspective for a more holistic understanding of PTSD (APA, 2013). PTSD symptoms “could be viewed as the individual’s neurologically linked “alarm system” signaling (incessantly) that life is more dangerous than first thought and that one might not be able to effectively meet such a threat” (Hjertaas, 2013, p. 192). Social connectedness is important as a protective factor from developing PTSD, and lifestyle guides how an individual tries to find meaning for traumatic events. An example is an adult female client in Hjertaas’s (2013) article who realized that the sexual assault and blame she experienced activated her feelings of not belonging and her core mistaken beliefs of unworthiness. After investing in positive relationships, she began to have hope in the belief that she had a worthwhile place in life of which she was worthy. Next is a review of different treatment methods for preverbal trauma that were found in the literature.

**Treating Trauma**

Although there is evidence based-practices established for treating clients affected by trauma (Murray, Cohen, & Mannarino, 2013; Shapiro, Wesselmann, & Mevissen, 2017; Webb, Hayes, Grasso, Laurenceau, & Deblinger, 2014), there is very little research on evidence-based practices specifically for preverbal trauma. A few articles on preverbal trauma are mainly of complex client vignettes and a pilot study. This section provides an overview of some of the treatment modalities found in the literature. Trauma-focused cognitive behavioral therapy (TF-CBT) is considered one of the most commonly used and research supported treatment models for treating traumatized children (Kliethermes, Drewry, & Wamser-Nanney, 2017). Another empirically supported intervention for treating children who have experienced trauma is eye movement desensitization reprocessing (EMDR). Relational-based expressive therapies are also a best treatment standard due to the child’s need for building a therapeutic relationship,
especially with a healthy caring adult, and the child’s more developed and nonlinguistic right brain to express his or her sensations and feelings (Parish-Plass, 2008). Animal assisted therapy (AAT) may support the child’s self-expression through play and interaction with animals. The other types of therapies involving more of the senses and self-expression are eco-therapy, art therapy, and eco-art therapy.

**Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)**

TF-CBT (Cohen & Mannarino, 1996) is the treatment of choice by many mental health clinicians for children from age 3-18 years who have been diagnosed with PTSD (Sigel, Benton, Lynch, & Kramer, 2013). It consists of separate individual sessions for the child and caregiver. In addition, there are joint sessions with both for the purpose of supporting the relationship between the child and his or her caregiver to help them cope with trauma. This model addresses stress management, gradual exposure to traumatic content, cognitive interventions, and caregiver involvement (Kliethermes et al., 2017). It has nine components: psychoeducation and parenting, relaxation, affective expression and modulations, cognitive coping, trauma narrative and processing.

After a trauma-focused assessment is completed, psychoeducation is given to the child and caregiver in the feedback section for the purpose of increasing client involvement, decreasing stigma, and modeling a comfort level with discussing trauma-related information. The clinician provides information about the type of trauma involved, e.g.: common misperceptions, others who typically experience it, prevalence statistics; behavioral and emotional challenges, common trauma reactions, and typical feelings one might have like guilt and shame. Caregivers are trained on parenting skills to help with managing difficult behaviors that either started after the child experienced trauma, or intensified: consequences, contingency
reinforcement options, effective commands, praise, and selective attention. The caregiver and child also learn a variety of relaxation techniques to use in different, sometimes stressful, situations. These techniques both help recognize and “reduce their bodies’ physiological response to stress- and trauma-related cues” (Kliethermes et al., 2017, p. 172). Relaxation exercises help clients get in tune with their bodies and their physical feelings through focused breathing, guided imagery, meditation, and or mindfulness. Some clients find creating art, gardening, or playing music relaxing activities.

The affective and modulation component of TF-CBT explores the child’s ability to identify their emotional feelings with emphasis on those related to trauma: helplessness, terror, hopelessness, and rage so he or she can recognize, name, regulate, and express them. Clients learn that all feelings are valid. Art therapy techniques, journaling, feelings charades, and games are some of the activities used to help the child with affect identification and expression. The child learns skills, like affirmations and problem solving, to more effectively manage emotions.

The cognitive coping component focuses on the child’s thoughts, and the connection between behavior, feelings, and thoughts. It begins with thought identification followed by teaching the child the differentiation between thoughts and feelings, and bridging the influence of thoughts on behavior and feelings. The child can become empowered knowing that one can change one’s thoughts to change how one feels and behaves.

Gradual exposure is explained during the trauma narration and processing component. The therapist introduces elements of the trauma to the child and caregiver. The child creates, expresses, and processes their trauma story in a format of their choosing: comic book, lyrics, poem, puppetry, skit, or timeline in a contained space and safe way within the support of the therapeutic relationship. The child’s narration is revised with further detail, as are cognitive
distortions.

Incremental real-world exposure to trauma-related cues happens as part of the in vivo mastery component of TF-CBT. The effectiveness of this component is dependent on caregiver approval of the exposure plan, which involves the child experiencing a feared stimulus between sessions in settings outside of the therapist’s office. The caregiver also needs to actively support the child in order for the child to feel a sense of success. Parental support and positive communication are the reasons for conjoint parent-child sessions. It gives the pair opportunities to talk about the trauma together, and to practice skills during most of the other components.

Enhancing future safety and development is the last component, which usually happens towards the end of treatment. It focuses on prevention of revictimization, and “is intended to provide the child and caregiver with the necessary skills to safely cope with future stressors” (Kliethermes et al., 2017, p. 174). The child and caregiver learn personal safety skills intended to help them feel more prepared. Possible future scenarios of trauma reminders are identified. The child and caregiver create a self-care plan as a way to help cope with these future situations.

A study by Webb et al. (2014) on the effectiveness of TF-CBT with 72 youths suggested TF-CBT could be used effectively in community settings. All of the participants had a documented trauma history of community or domestic violence, physical or sexual abuse, or traumatic loss, and experienced symptoms of PTSD. After an average of 10 sessions, “symptoms of PTSD, as well as internalizing and externalizing problems, decreased significantly over the 6 months after intake” (Webb et al., 2014, p. 555). These improvements maintained up to one year after the start of TF-CBT treatment. In addition, Murray et al.’s (2013) TF-CBT study suggested that youth with continuous trauma as found in environments of community or domestic violence, or war “can be treated with TF-CBT and significantly improve symptoms”
The introduction of four strategies in Murray et al.’s (2013) case-based study resulted in enhanced use of coping skills when traumas arose, and helped to reassure safety. The four strategies were: prioritize safety, enhancing engagement (of supportive people in the youth’s home and community), real danger versus trauma reminder, and providing advocacy.

**Eye Movement Desensitization and Reprocessing (EMDR)**

Another empirically supported intervention for treating children who have experienced trauma is EMDR. It is “based on the adaptive information processing (AIP) model, which posits that memories of disturbing events may be physiologically stored in unprocessed form, leading to problems in day-to-day functioning” (Shapiro et al., 2017, p. 273). The AIP model is used to describe EMDR’s clinical effects, and to guide clinical treatment planning and processes. The core of this model is that the information processing system of the client helps him or her interpret present experiences by linking current experiences with similar past experiences. In the case of a traumatic event, the information processing system malfunctions and does not process the event, so linking to previous similar events does not happen. The unprocessed event becomes static or frozen. Associated negative beliefs, affects, and sensations with the adverse event also become stuck and stimulated by triggers resulting in disturbing behaviors, beliefs, and emotions. The AIP model views erroneous self-concepts; e.g., “I’m a bad person”, as symptoms of emotional dysfunction from unprocessed memories, and of the emotional and perceptual associations with them.

EMDR has three main goals: working through disturbing memories that interfere with the child’s life, identifying current situations that trigger problematic behaviors, emotions, and thoughts; and learning effective skills to be used during future possibly stressful situations. Skill building is similar to the strengths-based focus of Adlerian therapy, where the client’s inner
resources are acknowledged to support the therapeutic relationship, and to meet life challenges (Ansbacher & Ansbacher, 1956). Effective skills and a strengths-based focus help clients navigate other intense events that may happen. Eight phases with bilateral sensory stimulation are used in EMDR to meet these three goals, and are shown to reduce negative emotions. The eight phases are: history taking, preparation, assessment, desensitization, installation, body scan, closure, and reassessment (Shapiro & Laliotis, 2011).

Bilateral sensory stimulation involves back and forth eye movement when the client tracks a lit red dot on an electronic eye scan machine. For children, the therapist may move an object back and forth like a puppet, toy, or a wand. The client might also hold an electronic tactile pulsar, a small oval shaped pod, in each hand that vibrates gently and produces a soft buzz sound alternating between the right and left side of the client each time the lit dot crosses the center of the machine. An accommodation for children of the tactile pulsar is to gently tap the top of the child’s hands or knees alternately. Audio stimulation can be provided by tones playing from headphones in one ear at a time (Shapiro et al., 2017).

When there is one adverse event to process, traumatic memories are modified and stored in one to three sessions through the use of these phases and types of sensory stimulation. More sessions are needed to address multiple adverse experiences. The number of sessions needed varies depending on the severity of traumatic events, and the child’s development stage. Parents are involved at the comfort level of the child. It may be more common to have parents in the session with younger children (Kliethermes, et al., 2017).

A randomized controlled trial in an outpatient setting compared the effectiveness and efficiency of EMDR and TF-CBT treatment with 48 children ranging in age from 8 to 18 years diagnosed with PTSD, or who had partial PTSD as defined as either satisfying a symptom in all
three symptom groups or two of the three symptom groups (Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015). The Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA) (Nader, Kriegler, Blake, Pynoos, Newman, & Weathers, 1996) was used as a measurement tool. It “showed large reductions from pre- to post-treatment on the CAPS-CA” (Diehle et al., 2015, p. 227). The difference of the PTSD symptom reductions between the treatment types was small and not statistically significant. Diehle et al. (2015) found both treatment types to be effective, and EMDR was not significantly shorter in treatment duration compared to TF-CBT (2015). Children who experience a traumatic event may develop post-traumatic stress syndrome (PTSS) (Miller-Graff & Howell, 2015). “TF-CBT and EMDR are effective and efficient in reducing PTSS in children” (Diehle et al., 2015, p. 227).

Campagne (2016) conducted a study with 35 adults to see if eye movement itself, a component of EMDR, helps alter disturbing memories while memories are being cognitively accessed thereby reducing distress. The therapist provided minimal active listening with guided eye movement (GEM), which involved moving a small light illuminated from an LED flashlight continuously and slowly horizontally in a dark room between the extreme left and right of the participant’s field of vision, while the participant told a traumatic experience in detail and visually tracked the moving light. Campagne used the Primary Care PTSD (PC-PTSD) screen (Prins et al., 2003) to measure symptoms in pretest, posttest and at follow-up of the GEM treatment. Results showed “significant positive effects on the traumatic symptoms as measured by the PC-PTSD questionnaire” (Campagne, 2016, p. 346). GEM may be an effective treatment for some posttraumatic symptoms. Data from this study “indicate that the treatment of psychological trauma, including PTSD, with a combination of GEM and active or empathic listening, had a possible efficacy comparable with or better than medication or commonly
applied psychotherapies” (Campagne, 2016, p. 346). Further research with larger sample sizes is needed on the effectiveness and efficiency of GEM versus EMDR in the treatment of trauma symptoms.

**Animal Assisted Therapy (AAT)**

AAT is an effective method for treating children with insecure attachment, and who have experienced preverbal trauma from abuse and/or neglect (Parish-Plass, 2008). AAT is a type of psychotherapy that uses animals in the therapy session. It is practiced by academically trained clinicians whose client specific goals guide treatment plans to address problems, and to provide paths for bypassing them. The client remains the focus. The animal is the tool that helps with emotional connection and building interpersonal relationships between the client and therapist, client and animal, therapist and animal, and animal and animal (Kelly & Cozzolino, 2015).

Often these children experience difficulties in symbolization, distrust adults, empathize at a lower level than normal with others, develop insecure attachment, and have a higher likelihood than the general population of becoming abusive parents (Parish-Plass, 2008). Additional challenges this population may have are: limited emotional language, lower ability to decipher correctly the emotional body language of others, and decreased self-esteem. There are numerous unique aspects of AAT that aid in reaching therapy goals: enabling connection, friendliness, normalcy, and safety of the therapy context; acceptance, self-esteem, empathy, need for control, touch, regression of problematic defenses and strengthening the ego, and processing bereavement, loss and separation (Dietz, Davis, & Pennings, 2012). The flexibility to go between reality and play with animals “is especially important for maltreated children whose levels of anxiety tend to be so high and who often have a lower ability to use symbolization in play in order to work through their issues” (Parish-Plass, 2008, p. 27). After working with the
animals during therapy, children are likely to learn to appropriately behave in nurturing ways, increase their frustration bar, develop healthy attachment, trust adults, reduce anxiety, and improve the ability to symbolize.

Dietz, Davis, and Pennings (2012) evaluated the use of dogs with group treatment for children who experienced sexual abuse. A total of 153 clients ranging in age from 7 to 17 participated at a child advocacy center. Results showed that “children in the groups that included therapy dogs showed significant decreases in trauma symptoms including anxiety, depression, anger, post-traumatic stress disorder, dissociation, and sexual concerns” (Dietz et al., 2012, p. 665). Participants in the group with both dogs and therapeutic stories showed the most significant changes. Although this study made dogs available in the lobby 30 minutes before start of group therapy for two of the three group types, the dogs with their handlers joined the sessions for only 10 to 15 minutes. This writer notes the limitations of confidentiality when using the same animals in the context of the lobby, a public space, as in the therapy room; and of most likely non-clinician animal handlers joining the therapy groups.

A study on the use of horses in the treatment of PTSD and anxiety with 16 adults in six 2-hour weekly sessions showed significant decreases in PTSD and anxiety symptoms, as well as significant increases in mindfulness (Earles, Vernon, & Yetz, 2015). Although there were no significant changes on coping strategies, life satisfaction, optimism, physical health, self-efficacy, or social support, Earles et al. reported a significant reduction of “emotional distress, anxiety symptoms, depression symptoms, and alcohol use” (2015, p. 150). Limitations of this study are the lack of both a control group and follow-up.

AAT would not be a good fit if a child has had a painful experience or trauma with an animal, has a severe aversion to animals, is allergic to the animal(s) used, and the use of the
animal is not part of systematic desensitization for treating zoophobia (Parish-Plass, 2008). However, an encouraging AAT therapist who inspires confidence in the child, paired with interactions with an animal the child is responsible for to some degree strongly supports the mitigation of intergenerational transmission of neglect and abuse (Dietz et al., 2008).

**Challenges and Limitations**

There are challenges and limitations regarding the diagnosis of PTSD in children, the presence of preverbal trauma, talk therapies, and many of the treatment methods mentioned above. Some of the less obvious and more internal symptoms of PTSD are under-reported (Wimalawansa, 2013). Not as visible symptoms can be unrecognized. Children “may develop different reactions at the time of exposure to a traumatic event and in the manner in which they present intrusive symptoms” (Goldbeck & Jensen, 2017, p. 12), and may not meet the avoidance symptoms requirement. There is also much more emphasis on adults having PTSD than children. Combat events during military service are commonly associated with PTSD even though the range of traumatic events varies in type and severity (Goldbeck & Jensen, 2017). A client might not be cognizant of having preverbal trauma or even of experiencing PTSD, especially if this is all the client has known, e.g., being hypervigilant seems normal to the client because it has been a constant state. The limitation with talk therapies is that the client needs to have developed linguistic abilities. Access to fragmented somatic memories primarily through the use of language, and thinking without the involvement of physically experiencing body sensations, is limited. The success of TF-CBT is dependent on committed caregiver involvement (Landolt et al., 2017), and this type of therapy is for children who are at least three years old. Some challenges with EMDR include the therapist getting tired from manually moving a toy, or other child-friendly object, back and forth repeatedly. And even though EMDR therapy is
effective for children with intellectual disability (Mevissen, Lievegoed, Seubert, & De Jongh, 2012) or autism spectrum disorder, there are a lot of reservations for offering trauma treatment out of fear that psychiatric symptoms will increase (Shapiro et al., 2017). Another challenge is when a child’s primary caregiver also has experienced trauma and goes untreated. “Children need to feel safe and supported by their parents in order to access vulnerable emotions and memories, but stuck negative interactions create an unsupportive emotional environment” (Shapiro et al., 2017, p. 287). Thus, separate therapy sessions for parents are paired with EMDR sessions for the child. Individual Psychology is not a good fit for clients who do not want to explore early childhood memories and experiences, and or who want immediate solutions.

There is a need to integrate body and somatic experiences, and creative expression with psychotherapy in the treatment of preverbal trauma (Desmond, Kindsvatter, Smith, & Stahl, 2015). The degree of spoken and written language therapeutically needed depends on the client’s developmental age. The right and left-brain hemispheres need to bridge information in order to process traumatic memories to store integrated narratives into long-term memory. Research supports the use of expressive arts interventions involving the sense of touch, more dimensional physical mediums, and elements of nature as more healing than only traditional psychotherapy, or the use of two-dimensional media. Reconnecting clients with nature is a natural way to reconnect him or her with their inner nature, others, and the earth (Beery, 2013; Westlund, 2015). Below is a description of some of these alternative expressive therapies.

**Eco-therapy**

Eco-therapy, also known as Applied Ecopsychology, helps clients improve their relationship with the natural world through interacting with nature-reconnecting activities (Farmer, 2014). Clients learn in and from the natural world, and connect with their inner nature.
through their feelings, thoughts, and relationship with the outdoors. This type of therapy fosters stewardship of the environment, and increases a sense of belonging on earth and a connection to the earth (Weinstein, Balmford, DeHaan, Gladwell, Bradbury, & Amano, 2015). This discipline helps clients learn from nature to grow healthy and sustainable relationships, and to increase responsibility, self-esteem, and wellness.

Eco-therapy is an international and interdisciplinary field that sees people as interdependent with their physical environments, and focuses on the relations between people and their environments (Nasar, 2015). “The quality of contact with nature can improve the social connections and the well-being of individuals” (Weinstein et al., 2015, p. 1150). People interact more socially, feel an increased community connection, as well as contribute back to society when they have access to nature.

Neighborhoods with more nature have fewer crime reports, so it is important for nature be more available in urban settings as a way to reduce crime and increase community cohesion (Weinstein et al, 2015). Interacting with natural environments or materials provides a cognitive break, relieving cognitive processes from excessive stress allowing for gradual recharging (Joye, Pals, Steg, & Evans, 2013). Natural environments have fewer multiple stimulating elements simultaneously competing for attention than urban environments. The lowered expenditure of effort in natural settings is restorative.

The benefits of being physically active and out in nature, such as doing conservation work, gardening, or growing food, produces impressive results for mental and physical wellbeing (Farmer, 2014). Exercise is a form of an antidepressant, as is sunlight and fresh air, but without any unpleasant side effects some clients experience from medication. Farmer (2014) found that 69% of participants of an eco-therapy program, Ecominds, increased mental wellbeing, recovery,
and resilience. Clients “experienced significant increases in mental wellbeing by the time they left the project” (Farmer, 2014, p. 19). Clients have a chance to develop new skills, feel more connected to where they live, increase confidence, and socialize through this community-based, non-clinical nature project (Farmer, 2014). General practitioners in Europe are prescribing community-based nature programs that have wellbeing and health outcomes for patients living with mental health problems to get them out of their homes, and to reduce isolation (Ryan, 2013). Fifty-seven percent of project participants felt more socially welcomed, and had more people who cared about them in their lives. Four in five people became more involved in community activities. This is similar to Adler’s concept of social interest where there is a desire to be in proximity in positive ways with others, and therefore increases social connections and a sense of belonging to a community. The eco-projects, like planting gardens, are group activities where participants are with others on a team instead of alone contributing individually.

Eco-therapy involving water has been used for survivors of sexual abuse, emotionally disturbed children, people with PTSD, and patients recovering from an addiction or cancer (Nichols, 2014). One program is Rivers of Recovery for veterans, which has had a self-report rate of 19% reduction in PTSD symptoms and stress in a study (Wynn, 2009, para. 7) with 69 veterans diagnosed with PTSD. Another eco-therapy program is Heroes on the Water (2014), a kayak fishing program founded in 2007 that has served more than 37,000 wounded veterans and their family members to rehabilitate, reintegrate, and relax. Nichols (2014) wrote about how being in or near water enhances mood, self-esteem, general health, physical activity, social interactions, relaxation and decreases cortisol levels, pain, and muscle tension in his book called, BLUE MIND The Surprising Science That Shows How Being Near, In, On, or Under Water Can Make You Happier, Healthier, More Connected, and Better at What You Do. Blue is by far
people’s favorite color around the world, and it is associated with confidence, dependable strength, and trust. Nichols (2014) emphasized the physiological and psychological importance of water, and suggested to “get in the water. Walk along the water. Move across its surface. Get under it. Sit in it. Leap into it. Listen to it. Touch the water. Close your eyes and drink a big glass” (2014, p. 276).

Exposure to water can significantly lower anxiety levels, relax overactive minds while stimulating our senses; and the sounds of the ocean have remarkably calmed fearful patients (Nichols, 2014). Kjellgren, Edebol, Nordén, and Norlander (2013) found that flotation in water benefited a 24-year-old woman with ADHD, autism, depression, and PTSD. Kjellgren et al. found increased healthy behavior, quality of life and wellbeing with no apparent negative effects from treatment after the participant floated regularly for one and a half years. “Results suggest that floating may have beneficial therapeutic effects on mental health” (2013, p. 134).

Hoag, Massey, Roberts, and Logan (2013) completed a 3-year pilot study with 297 clients ranging in age from 18 to 34 years old on the efficacy of wilderness therapy, therapy that combines nature and outdoor settings with therapeutic interventions to support clinical changes. Results showed a clinically and statistically significant change on the Outcome Questionnaire-45.2 (Lambert et al., 2004), a 45-item screen that measures functioning in interpersonal relationships, social role performance, and subjective discomfort. Participants’ alliance with their therapist, attitudes, motivation for therapy, and sense of life effectiveness improved in statistically significant ways while distorted cognitions reduced. This study found that “wilderness therapy has a positive effect on young adult’s mood, interpersonal relationships, social skills, and behavioral difficulties” (Hoag et al., 2013, p. 302).

**Art Therapy**
Art therapy is the combination of art and therapy. It is a mental health profession that involves a credentialed art therapist who collaborates with and encourages clients to express feelings and thoughts through the use of art media, artistic expression, the creative process, and the end product. It engages the body, mind, and spirit in ways beyond the limitations of verbal communication. Alternative modes of expressive and receptive communication unfold through kinesthetic, perceptual, sensory, and symbolic opportunities giving voice to the past, and empowering transformation within people, communities, and societies (American Art Therapy Association, 2017).

Art therapy is used in didactic, couple and group therapy and has many benefits. Some of the benefits are: whole person involvement using multiple senses beyond mainly cognitive functioning, access to preverbal memories, an easier way to express one’s shadow side, new ways of self-expression, flexibility, normalization of psychotherapy, a learning experience, and “art is a “Natural High” that also heals” (Rubin, 1999, p. 153). Verbal communication and nonverbal creative expression in an art therapy session ranges on a spectrum from silence and/or minimal artistic activity, to dialog and/or creating during the full session.

The foundation of art therapy is psychoanalytic theory (Hanley, 2008), a framework for understanding the influence of the unconscious on behavior, feelings, and thoughts. This theory explores both healthy and dysfunctional human experience, emphasizing the negative impact of adverse childhood events on psychosocial development and personality.

Margaret Naumburg (1890 - 1983), one of the pioneers of art therapy, “saw art as a form of “symbolic speech” coming from the unconscious like dreams to be evoked in a spontaneous way, and to be understood through free association while always respecting the artist’s own interpretations” (Rubin, 1999, p. 98). Thus, Naumburg worked with nonverbal subconscious
symbols and verbal stories about the art.

Another equally important art therapy pioneer Edith Kramer (1916 – 2014), viewed art as therapy. Kramer believed that the activity of creating art itself is therapy, and that the creator of the art benefited from the end product (Malchiodi, 2014). In a video interview at 83 years old, Kramer stated that making art is a universal need shared by all people and abilities. She defined art therapy as, “using art materials in such a manner that it is helpful to the person who uses it” (Institut for Kunstterapi, 2014, 2.00). Kramer explained in order to be an art therapist, a person needs to be a good artist, a good teacher, and a nice person who knows psychic processes in illness and health, the power of the unconscious, the power of transference, and the hazards of countertransference. An art therapist also needs to know how to integrate psychological and theoretical knowledge “with the understanding of the inner workings of art”, because otherwise “you’re going to paint yourself into a corner working with disturbed people” (Institut for Kunstterapi, 2014).

Becker (2015) conducted a pilot art therapy study with five adult clients with PTSD. It involved art interventions integrated with cognitive behavioral therapy, grounding, narrative therapy, and exposure group treatment. All participants survived childhood emotional, physical, and sexual abuse. Participants received paper, crayons, markers, paint, and pastels with which to create reflections of their personal stories while completing a variety of art tasks, followed by an opportunity to discuss their art with each other. The exposure exercise was to journal for twenty minutes about the trauma once weekly for five weeks. Weekly themes were “becoming a member, understanding emotions, boundaries, trust, safety, secrets, nightmares, guilt and shame, moving forward, and becoming future motivated” (Becker, 2015, p. 193). The treatment manual used in this study was based on Karp and Butler’s (1996) work, which involved art tasks as part
of treatment strategies for abused children. The art tasks were modified to meet the needs of the adult participants, and integrated with cognitive restructuring and psychoeducation. At the start of the 9-week treatment participants scored at a clinical level on the PTSD Checklist-Civilian Version assessment (Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013), a self-report 17-item measure of PTSD symptoms. By post-treatment participant scores “became sub-threshold for a PTSD diagnosis” (Becker, 2015, p. 194). The study resulted in reduced PTSD and depression symptoms (Becker, 2015).

Two factors were of clinical significance from this study. It is possible to recruit and retain adults with multiple childhood traumas and PTSD for group treatment that integrates art and cognitive behavioral therapy. The results indicate there is a need for this type of treatment. Often clients with these symptoms can “be treated for years without any substantial lasting benefits” (Becker, 2015, p. 194). This study suggests that brief integrated treatment can be helpful for clinicians working with these individuals. Limitations of this study were the small sample size, no control group, and no long-term follow up beyond a month posttreatment. Further research is warranted on the benefits of this type of group treatment integrated with art.

An article on treating trauma through haptic perception, “the use of the hands as a tool of perception” (Elbrecht & Antcliff, 2014, p. 19), at a healing place in Australia called the Clay Field® (Elbrecht, 2012), explains a sensorimotor art therapy approach with the use of clay for healing trauma. This research helped to fill the gap of the tactile experience - haptic perception - in art therapy versus the historical main emphasis on the visual aspects in art therapy. “The clay field is a rectangular box filled with non-gritty clay” (Elbrecht & Antcliff, 2014, p. 19). This touch haptic perception focused art therapy treatment for trauma has predominantly nonverbal processes, and emphasizes the use and movement of hands with clay for healing the brain in
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three-phases.

The first phase of healing trauma establishes safety and centers the client. During this phase, the client creates a safety resource that is either an intervention or a safety object. An intervention that might bring a sense of safety is to have the client submerge their hands in a bowl of warm water. This is similar to taking a relaxing warm bath. Another example is to find and hold the edge of an open top box made of wood. The stability and immobility of a strong box can be perceived as permanency. A safety object is something the client preserves as a resource of calm, safety, and strength. It establishes a feeling of safety for the client, grounding them with security to move forward. Symptoms need to be reduced, and psychological, emotional, and social resources built in this initial phase before trauma can begin to be processed. Some examples of safety objects are: a beaded necklace, doll, a felted wool mini pocket ‘safety blanket’, rock, or sculpture. With a chosen safety intervention and or object within reach, the client is ready for the next phase. Trauma processing is in the second phase. Integration and consolidation happen in the third phase (Cloitre et al., 2012; Kezelman & Stravropoulous, 2012).

A total of 85 children ranging in age from 7 to 17 with traumatic physical injuries participated in a study conducted by Chapman, Morabito, Ladakakos, Schreier, and Knudson (2011) at an urban hospital trauma center. All of the children had been admitted to the level one trauma center. Participants were divided into three groups: Art Therapy, Standard Therapy, and No PTSD Symptoms group. The members of the Art Therapy group received the Chapman Art Therapy Treatment Intervention (CATTI), a drawing directive to help treat trauma. The CATTI is “designed for incident-specific, medical trauma to provide an opportunity for the child to sequentially relate and cognitively comprehend the trauma event, transport to the hospital,
emergency care, hospitalization and treatment regimen, and posthospital care and adjustment” (Chapman et al., 2011, p. 101). The Standard Therapy group members received the typical course of pediatric trauma treatment as well as art therapy, child life services, psychiatric consultations, and social work services. The children in the Art Therapy group “did show a reduction in acute stress symptoms” (p. 100).

A study by Hill and Lineweaver (2016) with 54 children ranging in age from 6 to 13 who experienced the death of a family member compared affect responses of art making to puzzle making - a non-creative, non-expressive yet visuospatial task. This study also compared the effectiveness of making art individually or collaboratively with peers. Each child participated in one of four different groups in a clinical setting: art created collaboratively with peers using oil pastels and watercolors on one large canvas, art created individually with the same media on separate small canvases, puzzles completed collaboratively with peers, or puzzles put together individually. Each group worked in the proximity of peers in the same room simultaneously. The results showed that "art making significantly improved the effect of grieving children only when the art was created individually, not collaboratively" (Hill & Lineweaver, 2016, p. 95). It is interesting to note that in the collaborative art making group several children created individually by marking off a separate space within which to create on the large collective canvas. Also of importance is that this study was not conducted by art therapists, it so warrants repeating with the involvement of art therapists. The collaborative art making group and both puzzle groups showed no significant negative affect reduction due to the intervention.

**Eco-art Therapy**

Eco-art therapy (Sweeney, 2013) is the integration of Applied Ecopsychology with art therapy. Clients create art in relationship to nature, and items from nature are usually part of the
media choices offered to them. A clinician sometimes conducts sessions outdoors in natural settings. Eco-art therapy helps people create visible and inner changes through stewardship of the natural environment, and increasing a sense of belonging on and connection to the earth. Dr. Theresa Sweeney (1961-2014), one of the pioneers in this field, created activities to help connect client’s feelings and thoughts with the restorative quality of the earth. She helped close the gap between the way clients learn to think and the restorative power of the earth (Sweeney, 2013). Eco-art therapy is a creative and fun way of tapping into nature’s restorative healing powers.

**Adlerian Art Therapy**

Adlerian art therapy is traditional art therapy from the perspective of Individual Psychology, which sometimes focuses on encouragement, strengths, lifestyle analysis, early recollections, mistaken beliefs, and increasing social interest. Sharing and witnessing art created in a group is very healing (Sutherland, 2016; Sutherland, Waldman, & Collins, 2010). Observing group members’ and client’s traumatic experiences expressed through art can carry emotions into consciousness, increasing the likeliness of group members and clients to then be able to express those feelings with words, and process the trauma (Sutherland, 2016). From this therapy perspective, the therapist strives to understand the client’s idiosyncratic response to subjectively experienced trauma. The social context of trauma in art therapy from an Individual Psychology point of view is important as well. One of Sutherland’s adult clients who experienced childhood trauma shared with her therapy group, “that only by drawing the images and feelings that were now coming to her in her adult life could she move beyond the unending pain of abuse, isolation, terror, and dissociation to integration and relationships” (2016, p. 93). Drawing moments of resilience or terror is part of trauma treatment.

A yearlong high school Art Therapy Connection (ATC) program for at risk students in
inner city Chicago (Sutherland, Waldman, & Collins, 2010) resulted in 78% of ATC participants graduating, whereas the graduation rate for the whole student body was 56%. The ATC program emphasized developing group cohesion, cooperation, and identity. As a result, participants felt an increased sense of belonging, and established trust in relationships. The ATC therapists collaborated with the students’ teachers, and students began to collaborate together within group art therapy. A group art therapy directive used called “Hand Mural”, came with the instructions to “trace your hand on a piece of paper and then cut it out. Create an image or images on your hand that represent what you are willing to tell us about yourself’ (Sutherland et al., 2010, p. 72). All willing students put their hand art on one large piece of paper, then determine a title for the mural. Next the students share stories, learn about each other, and reflect on what the art experience meant to him or her. This directive of creating one’s open hand art, physically reaching out to the other art hands when adding one’s hand art to the collective sheet of paper, and the following conversation helped students increase a sense of belonging and confidence out of which social interest grew.

Sutherland (2011) wrote on creating early recollections (ERs) with colored construction paper and pastels by group art therapy members. The directive starts with the art therapist telling the clients “to find a comfortable place to work, to close their eyes, relax, and think about an Early Recollection” (Sutherland, 2011, p. 470). Group members take turns sharing an ER while the other members listen, and are welcomed to draw it while imagining it is their own ER. After the drawings are done, the group re-gathers for each member to share their drawing’s story. Like ERs, the art reflects the current life of the person who shared the ER. “With self-disclosure and group support each member has a chance to change the mistaken goals that interfere with feelings of belonging” (Sutherland, 2011, p. 471).
An article on three cases about treating sexual abuse and assault survivors with Adlerian art therapy (Rosen Saltzman, Matic, & Marsden, 2013) states that Adlerian art therapy is a “holistic approach to healing as it accounts for the physical, cognitive, emotional, and social components of life” (p. 223). Creating art elicits a kinesthetic, nonverbal, sensorial, and symbolic process, elements which are usually negatively impacted by trauma. The clients in this study were able to project their lifestyles in the safe creative space with the engagement of both body and mind.

The art directive for one of the cases was collaborative mark making. The client and therapist use a set of standard washable markers on a large sheet of white paper. Each person takes a turn making a mark on the paper, alternating mark making on it. This directive focused on engaging the client relationally, to help increase social interest, and reduce the isolation often found with trauma survivors. Rosen Saltzman et al.’s (2013) study resulted in revealing client lifestyles and mistaken beliefs, and increased interconnectedness with others. Clients were able to “speak volumes without words while simultaneously providing the therapeutic benefits of a cognitive, sensory, and relationally-based trauma therapy” (Rosen Saltzman et al., 2013, p. 241).

**Conclusion**

Knowledge gained from this research project, and concluding art experiential, may help facilitate healing of preverbal trauma through unique creative self-expression using evidence based methods, materials found in nature, and the integration of art therapy and eco-therapy. Research supports an integrative treatment approach that matches the client’s developmental age through the use of somatic, creative, nonverbal experientials followed by psychotherapy. The results of a study by Dahl, Kingo, and Krøjgaard (2015) showed that children were able to use newly learned words to describe nontraumatic preverbal memories when in an environment with
props that provided a high level of contextual support. According to Seifert (2012) a client may still experience symptoms from trauma exposure when he or she does not have the ability to give a memory-based, verbal report of the event.

Based on past research, directives for creating safety interventions that are ‘art as therapy’ (Kramer, 2000) and safety resource objects should be part of treatment plans for clients healing from preverbal trauma. Also in focus is: pairing clients with environments, being conscious of the therapy environment and the client’s perception of the outpatient office setting, sessions “en plein air”, and adding elements from nature to the client’s media choices. Using metaphors for water in treatment should be explored, such as: birth, bottomless tomb, emotion, death, destruction, play, sacred haven, and the unconscious; as well as tapping into the restorative and powerful energy of water as part of the therapy environment, medium, and or suggested activities between sessions or post-therapy.

This writer proposes the ecological treatment of preverbal trauma, specifically through eco-art therapy with an Adlerian lens. Combining the nonlinguistic creative expression in art therapy and the connection with the natural world in eco-therapy supports the need for grounding and for self-expression of memories without words, which is often the case for clients who have experienced trauma (Desmond et al., 2015; Green et al., 2010). Adding the Adlerian mode of therapy to this treatment combination supports the psychosocial piece necessary for clients to heal from trauma, and to live a socially useful life. Correcting mistaken beliefs related to trauma increases the expression of social interest within the tasks of life, and may result it altering the client’s lifestyle (Ansbacher & Ansbacher, 1956). An increased sense of belonging, and the understanding that one is a social equal among equals, most likely will result in the client feeling safer in the environment and around other people. The Adlerian strengths-based focus by paying
attention to the client’s abilities and talents, use of encouragement, and holistic treatment approach may help clients become more resilient and adapt better to life’s challenges.

This writer created an art experiential (see Appendix) based on research discovered in this project. It is influenced by Kramer’s belief in 'art as therapy' (2000). “Out of and Into the Blues” is a five-piece series of 42” diameter mixed media mandalas created as a way to process preverbal trauma which became activated during this project that naturally had no words. The pieces also help anchor information learned from the research discovered. Integrating this art therapist’s non-linguistically stored trauma through art making helped her become more available to better treat future clients.
References


Ferguson, E. D. (2017, July 11). *Inferiority feelings and social interest*. Plenary session lecture presented at 27th Congress of the International Association of Individual Psychology (IAIP) Inferiority Feelings: New Manifestations and New Approaches at University of St. Thomas, Minneapolis, MN.


based treatments for trauma related disorders in children and adolescents (pp. 3-28).

Cham, Switzerland: Springer International Publishing.


Joye, Y., Pals, R., Steg, L., & Evans, B. L. (2013). New methods for assessing the fascinating


Landolt, M., Cloitre, M., & Schnyder, U. (Eds.). (2017). *Evidence-based treatments for trauma*
related disorders in children and adolescents. Cham, Switzerland: Springer International Publishing.


Nichols, W. J. (2014). *Blue mind: The surprising science that shows how being near, in, on, or*
under water can make you happier, healthier, more connected, and better at what you do.


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Appendix

Welcome to this writer’s experiential called, “Out of and Into the Blues”, a series of five 42” mandalas inspired by research discovered for this master’s project, and by the creative process. The series is made of elements of nature and three-dimensional media. The art is presented in the order in which it was created. Lastly, a written and a creative reflection is shared. The following topics are covered in the written reflection: what learning was like through this process, how this project will help this writer as a clinician, and how this writer hopes to benefit other clinicians. The nonverbal reflection on this project is in the form of an ephemeral mandala that was created in the rain.

This artist embraces the creative process, enters mystery - that world of experiencing one’s senses, emotions, and the elements that is often void of logical understanding; is guided by the materials being used, and guides the art process and product with her intuition and vision. The journey and destination are both important to this artist, who values how the process happens as well as the rendering quality of the end product. This artist chose to work with mandalas because they bring a sense of healing and wholeness. This series began with the challenge of making a structure for three-dimensional mandalas. When a neighbor put out a couple of unwanted homemade hula hoops, the answer came to use the same type of lightweight plastic tubing of the hula hoops for the mandalas. So this artist made five circles out of a 100 foot coil of black plastic tubing for art on healing preverbal trauma to develop.
Nonverbal Memories Pieced Together

Cynthia A. Parson, 2017

42” diameter circle

Woven mandala with mixed media: strips of cotton flannel, twine, wheat stalks, and wood beads

Minneapolis, MN

“Nonverbal Memories Pieced Together” started out as a web of twine while contemplating the effects of trauma on a cellular level. It is inspired by the neurobiology on the negative effects of the release of cortisol and other hormones on cells due to trauma (Elbrecht & Antcliff, 2014; Sperry, 2016), and influenced by a cross section of a human cell. This piece is a reference to Finnish rag rugs which are traditionally made of leftover fabric scraps tied and woven together, and sometimes washed in a river or lake.
**Generational Trauma**

Cynthia A. Parson, 2017

42” diameter circle

Coffee bean and birch wood mandala with mixed media: di noce roasted coffee beans, white birch disks, eucalyptus leaves, burlap, acrylic paint, and walnut shell

Minneapolis, MN

Research on the transmission of trauma from one generation to the next (Schwerdtfeger et al., 2013) influenced this mandala. The eucalyptus covered birch disks form the general outline of a tree, a reference to family tree symbolism. Each disk holds a place for a healthy male or female on both sides of a person’s lineage going back seven generations. The red painted walnut shell represents the trauma being asked of healthy ancestors to heal so it no longer negatively impacts following generations.
**Witnessing Violence**

Cynthia A. Parson, 2017

42-inch diameter circle

Plastic and metal tubing piece with mixed media: water pressure tubing, copper tubes, clear crystal round beads, wire and aluminum tape

Minneapolis, MN

This piece made of copper tubes, quartz crystal beads, clear tubing, and wire emerged from contemplating the epigenetics of trauma. Inherited genes can shape a person’s wiring, and one’s view of the world changes after seeing or experiencing trauma. A diagram of the human DNA helix influenced this piece, as did the hypervigilance symptom of PTSD (APA, 2013).
Saved by My Senses
Cynthia A. Parson, 2017

42” diameter circle

Wrapped branches mandala with mixed media: driftwood, hawthorn branch, twine, glue, acrylic paint, pine cone, turkey feather, seed pod, beeswax rolled candle, sage bundle, cardinal feathers and ocean carved shell

Minneapolis, MN

Two branches wrapped and bound by rope are stuck suspended within a wobbly shaped circle frame for this mandala. The vulnerability a person feels during trauma, and the “freeze” phase of the fight, flight or freeze reaction in traumatic situations influenced this piece. Around the edges are objects that engage the senses that may “unfreeze” it: a seed pod from a rattle for sound, a feather to feel, an ocean smoothed seashell to touch, a bundle of sage to smell, and a beeswax candle to illuminate the way.
**Ocean View**

Cynthia A. Parson, 2017

42” diameter circle

Fabric mandala made of cotton, denim, wool, and silk and linen fabric

Minneapolis, MN

The last piece in the “Out of and Into the Blue” series is called, “Ocean View”. It is made of blue cotton, wool, and silk and linen fabric strips sewn horizontally on blue denim stretched over a hoop. Research by Nichols (2014) on the healing effects of water and the color blue inspired this piece. It represents this art therapist’s natural, gentle, continuous, and enduring pace, similar to that of water.

**Written Reflections on this Healing Preverbal Trauma Project**

This project unfolded in an organic way, alternating between nonlinguistic and linguistic activities similar to the ecological treatment of preverbal trauma, which combines nonverbal
creative expression and talk therapy. The nonlinguistic art making and time spent in nature helped this writer access and process memory fragments from trauma. The importance of being in tune with somatic sensations necessary for the treatment of preverbal trauma peaked this writer’s curiosity to explore more body based self-care activities, and to pay more attention to where there is tension or other types of sensations in her body.

A necessary part of this researching and writing process so heavily reliant on cognitive processes, and for the most part solitary activities, was to rest the mind through connecting with nature outdoors and socializing with others. This writer went on grounding mindfulness walks, walks with the purpose of connecting with nature regardless of the setting, sometimes barefoot, and noticing parts of nature along the way. A highlight of this learning process was talking with several attendees at the 27th Congress of the International Association of Individual Psychology on Inferiority Feelings at the University of St. Thomas in Minneapolis, Minnesota.

This writer took the opportunity to further transform fragments of the past that surfaced as a result of this project through body-based self-care and art making. Self-care is essential for clinicians to best serve clients. It may be even more important when treating clients living with symptoms from preverbal trauma due to the apparent prevalence of countertransference. Doing this inner work, and being more in tune somatically, will help this writer ground clients to feel safer in his or her body and on the earth, in addition to providing research-informed care.

This writer hopes to become a resource for other colleagues as she gains experience with the directives used for treating trauma that were discovered in this research project. She envisions herself leading a workshop on vicarious trauma (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015) and trauma prevention self-care.
Reflections on Healing Preverbal Trauma

Cynthia A. Parson, 2017

56” diameter circle

Grass mandala created in gentle rainfall with mixed media: bird’s nest lined with an oak leaf and cosmos sprigs, filled with green milkweed pods, pink geranium and pink phlox flowers; surrounded by eucalyptus stems, orange mountain ash berries, natural white horsehair, red dogwood branches, sticks, walnut shells, elderberry purple stems, red sumac seeds, geranium leaves, oak leaves, and gray dogwood white berries with leaves.

Minneapolis, MN
The gathering of materials used in this reflection mandala began when broken walnut shell pieces started coming to this artist on outdoor walks. Again and again these broken nutshell pieces with their rough painful edges kept appearing along the way. A collection started. The resulting pile of walnut shell pieces ended up being used to form the perimeter of this ephemeral, contemplative mandala. This piece was made entirely out of elements from nature, and inspired by Sweeney’s “Wholeness” (2013, p. 131) eco-art therapy directive on making a mandala from found objects in a peaceful natural setting. The remaining nature items were harvested on a hike around a lake with the exception of the horsehair, eucalyptus stems, and the nest - a gift from someone who found it on the ground. Each January, this writer finds out what animal she will learn from for the year. For 2017 it is Horse, so the horsehair added to this piece represents this animal medicine (Sams & Carson, 1999). The long white horsehair continuously weaves throughout the mandala.
Close-up Detail of “Reflections on Healing Preverbal Trauma”

This is a closer view of the last mandala for this project. The horsehair is now a keepsake. The rest of the natural elements have been recycled. This photograph was taken after the rain left and the sun shone again.