Art Therapy and Trauma Focused-Cognitive Behavioral Therapy

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Abstract

Art therapy can provide an effective non-verbal means to express and integrate the impacts of trauma (Malchiodi, 2008). Trauma Focused-Cognitive Behavioral Therapy is an effective, evidence-based program used to treat trauma (Cohen, Mannarino, & Deblinger, 2006). This literature review explores the usefulness of art therapy overlapped within the TF-CBT framework. Various neurobiological research is reviewed to illustrate the impacts of trauma on the brain, and the specifics of how art therapy can be more effective than verbal means in therapy. Evidence supporting cognitive behavioral therapy and art therapy will be shown, as well as the Adlerian contributions to the development of cognitive behavioral therapy. Finally, this review will show an example of an art therapy and TF-CBT specific integrated program to demonstrate how these models can be applied together.
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Art Therapy and Trauma Focused-CBT

Introduction

Georgia O’Keeffe stated “I found I could say things with colors and shapes that I couldn’t say any other way—things I had no words for” (2011). Neurobiological research is now showing traumatic experiences are stored in the brain in a way that is not accessible through speech, but that can be expressed through art (Malchiodi, 2008). This connection between art and trauma is showing to be important in the treatment of trauma related symptoms (Malchiodi, 2008). Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) is “nationally recognized as an exemplary evidence-based program” in the treatment of trauma with children and adolescents (Degges-White & Colon, 2012, p. 254; Cohen, Mannarino, Deblinger, 2006). TF-CBT creates a useful, flexible treatment framework that can be bridged with art therapy approaches (Malchiodi, 2008). This literature review will explore the support for the use of art therapy within the structure of the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) model. Evidence supporting cognitive behavioral therapy and art therapy will be shown, as well as the Adlerian contributions to the development of cognitive behavioral therapy. Additionally, this review will integrate current evidence supporting the neurobiological implications of art therapy in the treatment of trauma, as well as the limitations of this writing. Finally, this review will show an example of an art therapy and TF-CBT specific integrated program to demonstrate how these models can be applied together.

Trauma

It is important to define trauma, so a clear understanding is made for the purposes of the remainder of this review. Trauma is defined as “an autonomic, physiological and neurological response to overwhelming events or experiences that creates a secondary psychological
response” (Malchiodi, 2008, p. 4). The physiological response is just as important to treat as the traumatic event itself (Malchiodi, 2008). Trauma related symptoms in the diagnosis Post Traumatic Stress Disorder (PTSD) in children and adolescents as defined by the Diagnostic and Statistical Manual, Fifth Edition include a variety of symptoms. These symptoms are often intrusive, including recurrent, involuntary, distressing memories of the traumatic event as well as recurrent distressing dreams related to the traumatic event. Additionally, dissociative reactions where individuals feel as if the event were happening again, and in children, trauma-specific reenactment may occur in play (American Psychiatric Association, 2013).

Additional symptoms include physical distress and internal or external cues related to the event. Avoidance symptoms often present related to memories, thoughts or feelings that remind one of the event, as well as avoidance of external reminders. Many individuals experience negative changes in thoughts and mood following traumatic events. Often survivors of trauma have difficulty remembering specifics of the event, or they have “persistent and exaggerated negative beliefs or expectations about oneself, others or the world” (American Psychiatric Association, 2013, p. 272).

Other symptoms can include beliefs that the victim caused the event or feels responsible, as well as a “persistent negative emotional state such as fear, horror, anger, guilt or shame” (American Psychiatric Association, 2013, p. 272). Physical symptoms can occur following traumatic events, such as irritable behavior and becoming angry with little or no provocation, reckless or self-destructive behavior, hypervigilance, increased startle response, difficulty concentrating and sleep disturbance (American Psychiatric Association, 2013). To meet full criteria for Post-Traumatic Stress Disorder (PTSD), symptoms must also occur for more than one month following the traumatic event (American Psychiatric Association, 2013). Trauma
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Focused-Cognitive Behavioral Therapy treats PTSD, however the diagnosis is not necessary to provide treatment, as many clients needing treatment display some variety of trauma related symptoms (Cohen, Mannarino, Deblinger, 2006).

**Trauma and the Brain**

It is important to understand the basics of brain development, and how experiences help shape the developing brain bearing in mind the impacts of traumatic experiences. These experiences and their impacts on the structure of the brain are called neuroplasticity. As infants, about 100 billion neurons are present in the brain and some are not used (Balbernie, 2001). A further explanation of the brain development process is given by Klorer:

>A synapse is the junction across which an electrical impulse passes between neurons creating neuropathways. When a neuropathway is stimulated, all the synapses become engaged and store a chemical pattern, which if repeated, becomes strong enough that it forms a permanent circuit (2005, p. 214).

>“Neurons that fire together wire together” (Courchesne, Chisum, & Townsend, 1994, p. 699). Babies’ brains continue to develop strong circuitry through the neuropathways that are used most often. These pathways create the foundation for later use, and help inform us of the ways traumatic experiences may impact the brain’s development. When brains develop with overuse of pathways linked to the stress response, and less development of an ability to self-sooth through secure attachment with an attuned caregiver, traumatic symptoms are more likely to pervade (Glaser, 2000; Klorer, 2005; Perry, Pollard, Blakely, Baker & Vigilante, 1995; Schore, 2001).

>A variety of intense responses occur in the brain and body as a result of trauma, and continue to reoccur when traumatized individuals develop Post Traumatic Stress symptoms. “Trauma affects the entire human organism, body, mind and brain” (van der Kolk, 2014, p. 53). Images, sounds, thoughts or feelings associated with the initial trauma trigger physiological
responses from the brain to the body. The amygdala, or emotion center in the brain becomes activated resulting in a distressing emotional response as if the trauma were reoccurring. The higher, executive functioning parts of the brain become deactivated and the more primitive survival portions of the brain take control. Stress hormones are secreted throughout the body resulting in increased breathing, rapid heart rate, higher blood pressure, and other distressing responses (van der Kolk, 2014). In reference to the heightened sensitivity of children and individuals with PTSD symptoms, Bruce Perry states “full-blown response patterns (e.g. hyperarousal or dissociation) can be elicited by apparently minor stressors” (Perry et al., 1995, p. 275).

Bessel van der Kolk (2014) completed functional-magnetic resonance imaging (fMRI) scans of the brains of some of his patients with traumatic stress symptoms. He read narratives of their initial traumatic experiences in order to trigger these individuals into a heightened traumatic symptom response, and take brain scans of their brains while in this heightened state to learn more of what occurs in the brain in order to develop more effective treatments. The results held important information for therapists who work in non-verbal modalities.

The limbic system, or emotional brain, shows heightened activation, as well as the visual cortex. Additionally, it is noticeable in the scans that during flashbacks, the brain only lit up in scans on the right side and deactivated the left side. The left side of the brain is responsible for more logical, organizational functions. The right side is intuitive, feeling and emotional (van der Kolk, 2014). Additionally, the heightened activation in the visual cortex showed specific activation in the Brodmann’s area. This is an area that register’s visual images as they enter the brain. Brodmann’s area 19, usually diffuses raw incoming images into other areas of the brain rapidly to make meaning out of them. In the fMRI and PET scans, patients experiencing trauma
triggers Brodmann’s area 19 were lit up as if patients were seeing the events again, and the brain’s speech center has very low activity. “Our most surprising finding was a…white spot in a region called Broca’s area. … Without a functioning Broca’s area you cannot put your thoughts and feelings into words” (van der Kolk, 2014, p. 42). Learning that trauma triggered brains have difficulty putting experiences into words, as well as the heightened visual input and reduced ability to organize their experience is important when addressing treating trauma using art therapy (Malchiodi, 2008).

**Art Therapy in Trauma Treatment**

Art therapy engages different types of brain activation in trauma treatment. A recent paradigm shift is noted by renowned neuropsychoanalyst and psychiatrist Allan Schore in his book *The Science of the Art of Psychotherapy* when he states “the paradigm shift from behavior, to cognition, to bodily based emotion has acted as an integrating force for forging stronger connections between the disciplines of psychology, social neuroscience, and psychiatry, all of which are now focusing on affective phenomena” (Schore, 2012, p. 4). This new focus on affective information is well addressed by art therapy. Due to the brain’s heightened activation with visual and affective memory storage following traumatic experience, image-based therapy “may offer the most efficient means of accessing, processing and integrating split off fragments that otherwise may continue to result in flashbacks and nightmares” (Pifallo, 2007, p. 171).

The American Art Therapy Association identifies “four major contributions of art therapy to the treatment of PTSD, which include reducing anxiety and mood disorders; reducing behaviors that interfere with emotional and cognitive functioning; externalizing, verbalizing, and resolving memories of traumatic events; and reactivating positive emotions, self-worth, and self-
esteem (AATA, 2012)” (Gussak & Rosal, 2016, p. 377). The use of art therapy can treat many layers of traumatic symptomology at once.

Cathy Malchiodi is an art therapist who has significant experience in working with traumatized children, reminds us of trauma’s impacts on memory storage. Typically an experience (implicit memory; such as riding a bike) becomes stored as explicit memory (our ability to describe the steps of riding a bike). “Speculation that PTSD may result when implicit memory of trauma is excluded from explicit storage. An individual may not have access to the context in which the emotions or sensations arose. Additionally language (a function of explicit memory) is not generally accessible to trauma survivors after a distressing event” (Malchiodi, 2008, p. 10). Malchiodi (2008, p. 10) goes on to articulate the impacts of traumatic experience on the brain saying:

Because trauma is stored as somatic sensations and images, it may not be readily available for communication through language. Perhaps this inability to verbalize trauma relates to the human survival response; when an experience is extremely painful to recall, the brain protects the individual by literally making it impossible to talk about it. Adding more information to the importance of body-based interventions, neuroscientist and psychiatrist specializing in the treatment of child trauma, Bruce Perry, notes:

the neural systems altered by trauma originate in the lower parts of the brain. These brainstem and midbrain systems will only be modified effectively by patterned repetitive neural activity that gets to the brainstem and midbrain from primary somatosensory experiences—rhythmic auditory, tactile, visual, and motor-vestibular stimulation—such as massage, music, dance and repetitive visual and tactile stimuli (Perry in Malchiodi, 2008, p. ix).

Perry goes on to caution practitioners toward the current over-focus on evidence based practice in lieu of real human experience. He warns:

Amid the current pressure for “evidence-based practice” parameters, we should remind ourselves that the most powerful evidence is that which comes from hundreds of separate cultures across thousands of generations independently converging on rhythm, touch, storytelling and reconnecting to community as the core ingredients to coping with and healing from trauma (Malchiodi, 2008, p. x).
In her book *Neurobiologically Informed Trauma Therapy with Children and Adolescents*, registered art therapist Linda Chapman talks about asking patients to draw out their traumatic experiences and then to tell the story that goes along with their drawings. She reminds readers of the difficulty children and adolescents have with responding verbally following the creation of an image from the nonverbal right hemisphere; the very place trauma is stored. These same themes around the difficulty expressing traumatic experiences verbally is illustrated in *Art Therapy and Clinical Neuroscience* by Noah Hass-Cohen and Richard Carr (2008). Chapman also discusses the usefulness the art process in containing the traumatic experience. She states “the concrete image on the paper allows the child to objectify the images, creating distance and allowing her to speak about an external event, rather than an internal one. This objectification of the image eliminates the flooding and disturbing images and sensations” (Chapman, 2014, p. 28). Additionally, in the article *Healing Trauma Through Art* the author states “art provides youth with a medium to express and explore images of self that are strength-based and resilience-focused” (Kuban, 2015, p. 19, 2015). Another article about group work with survivors of incest reflects on the importance of art in healing trauma, stating “creativity reactivates flexibility and playfulness, reconnecting cognition, emotional experience, and physical sensation, and helping to counteract the rigidity of traumatic reactions” (Huss, Elyozayel, Marcus, 2012, p. 402).

A study comparing standard TF-CBT to trauma-focused art therapy for adolescents who had experienced complex (or cumulative) trauma, found that, comparatively the trauma-focused group art therapy was “more effective for treating trauma related symptomology” (Naff, 2014, p. 80). Another article supports the use of neurobiologically based art therapy trauma intervention for a woman with post-traumatic stress symptoms following the attacks on 9/11. In this treatment “a comparison of pre- and posttreatment assessments showed decreased anxiety and
avoidance behaviors and improved resiliency” (Hass-Cohen et al., 2014, p. 69). Additionally, related to sexual abuse, another source states “not only does art therapy provide victims with the necessary tools, it also allows them to become immersed in the creative process—a powerful antidote for the devastating and poisonous effects of this particular type of trauma” (Pifalo, 2002, p. 12). There are many examples of the use of art and body based treatment options showing positive treatment outcomes for trauma related symptoms.

Dr. Bruce Perry provides additional guidance on the importance of using appropriate treatment methods which correlate with the developmental stage the trauma occurred (Perry, 2006). This is important to clarify as it does not mean the developmental stage the individual is currently at, and may indicate a shift away from more cognitive material to more body based interventions. Trauma which occurred between birth and nine months addresses the brainstem whose primary function is regulation of arousal, sleep and fear states. Samples of therapeutic activities for trauma that occurred at this age include massage, rhythm such as drumming, reiki touch and EMDR. For trauma that occurred between age six months and two years focuses on the diencephalon whose primary function is the integration of multiple sensory inputs and fine motor control. Examples of therapeutic activities include reiki touch, therapeutic massage and equine or canine interaction. Trauma which occurred between ages one and four years old specifically impacts the developing limbic system, which is organizing emotional states, social language and interpretation of nonverbal information. Sample therapeutic activities include play and play therapies, performing and creative arts and therapies and parallel play. Following age three to four, the cortex develops, and its primary goal is abstract cognitive functions and socioemotional integration. Here storytelling and traditional insight-oriented or cognitive behavioral interventions can be used. (Perry, 2006). It is often children have experienced
complex trauma which has occurred at various ages and stages of their development, impacting multiple areas of brain development. Perry’s work suggests the use of various therapeutic approaches address the brain regions impacted when the traumatic event occurred

**Expressive Therapies Continuum**

The Expressive Therapies Continuum (ETC) is a conceptual model used in creative therapies to identify which brain functions are being addressed with various media (Chapman, 2014, p. 22). The ETC was originally created in 1978 by Vija Lusebrink and an updated version was written by Lisa Hinz in 2009. The ETC contains four primary levels beginning at kinesthetic and sensory which stimulate the lower structures of the right hemisphere and the brainstem. Chapman notes that in her clinical experience, the brain naturally shifts information processing to the affect/perceptual level and individuals express emotions through art and become aware of their affect and are better able to organize incoming stimuli like “intrusive images, sensations or memories” (2014, p. 22). The next aspect of the ETC is cognitive/symbolic information processing which allows for the generalization of concrete experience and focuses on the intuitive aspects of concept formation. This level also involves language, logic and analytical thought and brain activity is focused in the cerebrum. The fourth aspect of the ETC is the creative level of information processing which integrates all previous levels. Chapman states in her experience this level correlates with symptom reduction and stimulates the prefrontal cortex in the brain (2014, p. 23). The ETC seems to provide important information toward the treatment of trauma using art therapy.

Through the art making process, kinesthetic engagement activates the lower structures of the brain. This is followed by activation of the limbic structures which lead to the expression of emotional fragments of the self in visual, concrete form” (Chapman, 2014, p. 106). Chapman
goes on to state that the art making process tends to speed up the therapeutic process by engaging right brain affective regions. It seems the left brain holds the interpretation of the experience, which is subjective whereas the right brain holds the more accurate body-based memories of the experience (2014). In reference to the importance of exploring and processing traumatic memories, Lusebrink suggests using art, saying “the cognitive and symbolic aspects of memories can be explored through the activation of their sensory components” (2004, p. 125). The role of the art therapist is to facilitate the dialogue that will engage the client to reflect upon and discover the meaning of the symbolic content of the image. Therapists responses can emerge from body based affective clues (Chapman, 2014).

**Art Therapy and Cognitive Behavioral Therapy**

The focus of this writing will be on a specific form of Cognitive Behavioral Therapy (CBT); Trauma Focused-CBT, and the use of art therapy with this model will be further explored. However, the initial theory of Cognitive Behavioral Therapy (CBT) has a lengthy beneficial history with art therapy (Rubin, 2016). Because TF-CBT inherently follows the theory of CBT, it is reasonable to conclude that literature supporting art therapy and CBT also correlates with TF-CBT.

Personal constructs are a term used in CBT which refer to a person’s belief about themselves or how the world works (Rubin, 2016). A basis for CBT is identifying client’s personal constructs, and it was discovered this could be done nonverbally (Rubin, 2016). Goals of CBT include identifying constructs, such as “I always make mistakes” exploring them fully, and replacing or transforming them to be more accurate and rational (Rubin, 2016). Rubin (2016) explains that several art therapists view client art work as expressions of their constructs, which when explored with clients can provide additional insight, strengthen the connection
between thoughts and feelings, and further illuminate solutions to problems. Rubin (2016) states:

Art therapy is particularly suited to CBT because making art is a cognitive process that uses thinking, sensing and identifying, as well as understanding emotions. When creating, the artist is uncovering mental images and messages, recalling memories, making decisions and generating solutions (p 341.)

Art additionally lends itself to cognitive behavioral interventions because it creates an immediate feedback loop, with results visible as they are being created. These results are also easily changed, to illustrate a change in the artist’s view or construct (Rubin, 2016). Similar verbiage exists in an article sharing the usefulness of cognitive behavioral interventions and art therapy interventions to help clients manage the stress response, stating “although CBI and art therapy stem from different theoretical orientations, they both utilize a multi-faceted intervention that creates flexible pathways between physical, emotional, and cognitive aspects of the traumatic experience…These pathways help to modify the stress levels so as to enable to restructuring of more positive memories” (Sarid, Huss, 2010, p 11).

**Adlerian Individual Psychology and CBT**

Adlerian psychology is based on ideas that individuals are goal driven, or teleological, in their need to find safety, significance and belonging (Ansbascher, & Ansbacher, 1956; Carlson, Watts, & Maniaci, 2006; Mosak, & Maniaci, 1999). The way individuals reach these goals is called their lifestyle. Lifestyle can be detected by gathering early memories, or early recollections, about clients and finding themes about their beliefs about themselves, others and the world, very similar to constructs in cognitive behavioral therapy (Freeman, Urschel, 1997). While Adler created his primary theoretical ideas at the same time as Freud, he is often overlooked as a founder of many psychological theories such as CBT. Alfred Adler’s theory focuses on themes of encouragement, mistaken beliefs and social interest. Individuals are seen
as discouraged, not mentally ill, and mistaken beliefs connect to beliefs about the self that are not fully true (Ansbacher, & Ansbacher, 1956; Carlson, Watts, & Maniaci, 2006; Mosak, & Maniaci, 1999). It is noticeable the similarities between Adler’s Individual Psychology and Cognitive Behavioral Therapy.

**TF-CBT**

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) is a comprehensive, evidence-based treatment for children and adolescents experiencing trauma related symptoms (Cohen, Mannarino, & Deblinger, 2006). TF-CBT is comprised of multiple steps which make up the acronym PRACTICE.

**Psychoeducation and Parenting Skills**

Psychoeducation involves providing specific education around the impacts of trauma. This includes facts about the type of trauma that occurred, how often it occurs for others, who abuses others and how those who are abused typically feel. In addition, specific information around clearly naming body parts is included if sexual abuse is part of treatment. Additional psychoeducational material includes common reactions to traumatic experiences for both children and their caregivers, as well as a description of the child’s diagnosis (PTSD, or related diagnosis) in practical terms (Cohen, Mannarino, & Deblinger, 2006).

Following trauma specific psychoeducation is parenting skills. The goals here are to address parenting deficits that may exist and target specific problematic behaviors, to develop hope and trust in the clinician, as well as build the therapeutic relationship between therapist and caregiver (Cohen, Mannarino, & Deblinger, 2006).

**Relaxation**
Relaxation skills are clearly taught to address specific traumatic reactions including increased heart rate, breathing and activated behavior, among others. Relaxation techniques include mindfulness, guided meditation, use of music, yoga and more. These techniques should specifically fit the child’s needs regarding age, ability level and specific interests (Cohen, Mannarino, & Deblinger, 2006). Relaxation techniques can be taken home and built into parenting skills and daily routine.

**Affect Expression and Modulation**

The purpose of this step is to teach children to identify and regulate their emotions. Oftentimes children and adolescents can become overwhelmed by emotions, and this step teaches skills to be able to successfully express and manage their feelings. This step can include things like positive self-talk, thought stopping and positive imagery, naming feelings, and enhancing problem-solving and social skills (Cohen, Mannarino, & Deblinger, 2006).

**Cognitive Coping**

This step involves identifying the connections between thoughts, feelings and actions and helping clients develop the ability to choose thoughts that could bring them to their desired feelings and actions. This step can also involve education on the types of inaccurate and unhelpful thoughts (Cohen, Mannarino, & Deblinger, 2006).

**Trauma Narrative**

The trauma narrative is part of gradual exposure and develops the client’s ability to manage affective responses and process their traumatic experience(s). Gradual exposure provides desensitization toward the child’s specific traumatic memories and triggers, and is the primary means of active treatment to reduce symptoms within the TF-CBT model. The goal of this step is to have clients clearly tell their story as if it were happening again, from a specific
sensory point of view, not an objective euphemistic stance. Additional processing of the narrative occurs, with focus on additional thoughts and feelings. The therapist’s goal is to eventually process the story and address issues of fault, blame and responsibility the client may hold around the event(s), and explore and correct inaccurate or unhelpful cognitions (Cohen, Mannarino, & Deblinger, 2006).

**In Vivo Mastery of Trauma Reminders**

This step involves building a managed, step by step gradual plan for exposing clients to specific trauma triggers, in order to reduce arousal and trauma related symptoms (Cohen, Mannarino, & Deblinger, 2006).

**Conjoint Child-Parent Sessions**

Conjoint parent-child sessions occur throughout TF-CBT, and the goal of the witnessing session is for the caregiver to experience and begin to be a container for the child’s narrative. Parents or caregivers are involved in hearing the trauma narrative with the therapist only prior to the conjoint session to develop their own ability to tolerate it, and be able to provide praise and positive responses. In the conjoint witnessing session, the child reads aloud their narrative to their parent(s) or caregiver, followed by the caregiver providing praise and positive feedback to the child. The caregiver must meet specific criteria to be approved by the therapist for being an appropriate witness to the child’s narrative, such as being able to be child focused, positive and more. The therapeutic goals for the specific witnessing session in which the child reads their narrative serves to further desensitization, as well as aid in the child feeling seen, heard and validated related to their trauma by a person whom they have a caring relationship with outside of therapy (Cohen, Mannarino, & Deblinger, 2006).
Enhancing Future Safety and Development

This step focuses on developing a sense of safety regarding specific fears children may experience regarding traumatic experiences, as well as address particular vulnerabilities the child may hold due to their traumatic experiences such as domestic violence, physical and sexual abuse and exposure to drug use and neglect. Assertive communication skills, as well as accurate language around body parts are important here, as well as explaining to children their rights to have feelings of safety. The therapeutic goals for enhancing safety are to empower children with knowledge on what action to take should they be faced with a threatening situation in the future. Additional safety planning can be done around sexual abuse or exposure to violence. Language used often sites “your brain woke up too early” related to sexuality or violence due to abuse, and now specific actions need to be taken and education provided to reorient children to appropriate social skills and sexual boundaries. Interventions used should target specific trauma or abuse the client has experienced. Parents may need to be included in these sessions to be aware of specific behaviors to address and in what ways, as well as increase some of their own safety measures to prevent future traumatic experiences (Cohen, Mannarino, & Deblinger, 2006).

Limitations

It is important to note that this review is not a substitute for full TF-CBT training by a certified trainer nor is it a substitute for full art therapy training by a credentialed teaching program.

Art Therapy and TF-CBT

While little literature exists on the use of art therapy specifically within the TF-CBT framework, it is understandable how art therapy can be important in addressing specific non-verbal aspects of the impacts of trauma. In one of the few articles that specifically references art
therapy and TF-CBT, *Jogging the Cogs: Trauma-Focused Art Therapy and Cognitive Behavioral Therapy with Sexually Abused Children*, the author provides many advantages through the use of art combined with TF-CBT treatment. He states “the use of imagery directly contributes to cognition by increasing concentration on trauma specific issues and provides quicker access to and processing of information—a critical issue in brief trauma-focused therapy” (Lusebrink, 1990 as cited in Pifalo, 2007, p. 171). It seems creating art around traumatic issues aids containment, reduces traumatic, dissociative responses, and increases the ability to access and process affect (Pifalo, 2007). The importance of accessing these affective aspects of treatment parallel what Chapman is quoted as saying regarding neurobiologically informed trauma treatment earlier in this paper. Pifalo (2007) goes on to state that because art is not a dominant form of communication, less defense patterns are established, allowing more information to “slip under the normal radar of resistance” (p. 172). The use of art therapy with trauma survivors is important both for “the integration of the nonverbal sensory-motor-based traumatic memories and the temporal organization of segmented verbal memories” (King, 2016, p. 63). The use of art therapy within TF-CBT may be important for a variety of reasons.

In the book *Trauma Focused CBT for Children and Adolescents, Treatment Applications*, authors and creators of TF-CBT share a variety of instructions on how to progress through each step of treatment. While not specifically identifying the directive as art therapy, authors reference creating a “Gingerbread Person Feelings Map” in the affective expression and regulation step of treatment (Cohen, Mannarino, & Deblinger, 2012, p. 113). This directive involves identifying a variety of feelings and corresponding colors, and then coloring them throughout a gingerbread shaped body outline and discussing with the therapist. In this book,
specific use of art and creative directives are recommended to meet the needs of various ethnicities of clients, such as Alaska Native or American Indian individuals.

Judith Cohen suggests specifically paying attention to art and creativity when working with different cultures. Related to the affect modulation stage, she states

Traditionally, direct verbal emotional expression is less favored over such creative forms as song, dance, and artistic symbolic representations. Alaska Native/American Indian youth may be supported in the development of healthy emotional expression skills through a variety of traditional activities, …the development of physical emotional representations such as beading, painting, drawing, masks, totems, or shields;…singing or playing traditional musical instruments; and dancing.” (Cohen, Manarrino, Deblinger, 2012, p. 295).

Additionally, art is a traditional form of storytelling in other cultures, which naturally lends itself to the Trauma Narrative portion of TF CBT. Cohen suggests “creating a journey stick, totem, song, carving, beading, mask, pottery or traditional dance” (Cohen et al., 2012, p. 297). This literature on the use of art within TF-CBT framework is minimal and yet important.

Cathy Malchiodi (2008) states that creative art therapists often use cognitive behavioral therapy in combination with their approaches, however “creative interventions themselves have not yet been extensively studied to determine if they qualify as evidence based practices in the field of trauma intervention with children” (p. 26). She goes on to explain that research in this area is developing. Malchiodi references an overlap in the TF-CBT framework where an artistic narrative is referenced as part of the trauma narrative protocol. This means “art and play based approaches may be applied during this particular evidence-based intervention” (Malchiodi, 2008, p. 26).

**Art Therapy and TF-CBT Example Program**

The following is a 16 week example program of utilizing Art Therapy within the TF-CBT framework. The program is designed for individuals aged eight to 14 who have experienced
single event or complex traumatic events. This program is designed for individual and family therapy sessions, as TF-CBT is designed for individual and family sessions, and little research was explored on the use of TF-CBT in groups. This example program could be further developed in the future to be applied within a group setting.

**Session 1: Psychoeducation**

This session will occur following trauma assessment indicating trauma focused treatment. The use of creative directives combined with more cognitive approaches will be useful. Utilizing psychoeducational materials such as a common reactions to stress and trauma handout, with the client using specific colors for which symptoms they experience more can incorporate a creative element. Developing the common reactions into a game where a client throws a ball (safely) at targets representing none, some or often to indicate their experience. An additional option can be for the therapist to engage the client in a ball-toss game where the therapist’s arms are the hoop, and for each miss, a question is asked related to common reactions to trauma and validation and normalization is provided. The therapist’s goal is to provide normalization, validation and fact based information regarding specific traumas experienced. Common parent, caregiver and foster parent reactions handout can be provided and reviewed with the caregiver at this stage.

**Session 2: Psychoeducation and Parenting Skills**

The *What Do You Know* game works very well for a creative, cognitive approach to psychoeducation. It contains cards with animals to be matched with questions on topics such as physical and sexual abuse, domestic violence, common reactions, safety and general questions. This game works well to play with the child alone for the beginning of session, and then with the caregiver to provide normalization and help develop a language to discuss traumatic events. A
good art based directive can be the child and therapist working together to create their own game of traumatic symptoms they experience to share with caregivers. A simple question and answer format could be used where the child gets to practice leading, as well as sharing more about their own traumatic stress symptoms.

Additional psychoeducation can occur through future steps by the therapist providing normalization and reminders related to feelings expressed in art work related to traumatic experiences, as well as common body-based responses which may come up in therapy. Another art directive that could be incorporated would be creating art of what happens ‘in my body’ when experiencing a trauma reminder. The client can elaborate on their thoughts, feelings, and physiological experiences when they are triggered into fight or flight mode. Additionally, simple drawings of what gets hard now because of their trauma can be created.

Parenting skills are important to address specifically, however several examples can be useful. Prompting parents to develop increased praise and encouragement of their child for positive behavior is often an underutilized skill. The therapist can encourage parents to provide positive responses for their children’s artwork, play and bravery to discuss difficult material in session. A simple way of creating these positive responses through art is through encouragement cards or notes the parent creates with art materials for the child as a visual, lasting image of their warm feelings for their child. These can be given in session, and at any time they witness their child doing something noteworthy or coping in a healthy way. An additional parenting skill art directive is the creation of child books, specifically with the purpose of having the parent document positive aspects or behaviors of their child. The child is asked to create the cover for their book, which can be laminated and stapled with multiple sheets of multi-colored paper. Future sessions can revisit the progress made in this book by parents and children.
Additional parenting skills can be done using art to create a safe place for all the family members, symbolically. Learning how to work together can be done through scribble art, where a scribble is transformed into something beautiful, or any type of joint project can be included with reflections provided on communication and dynamics expressed (Kerr, 2008; Liebman, 2004; Rubin, 2005).

**Session 3: Relaxation**

Many creative options can be explored through the use of art to promote relaxation. Creation of a safe place box or container is often helpful to aid the child in establishing a sense of relaxed safety in the therapy office. Safe place boxes can be created using a box approximately the size of a shoe box with various found objects and art materials added to aid the child to promote relaxation. Specific objects added may be related to safe people, food items (made out of clay, paper or non-perishable), items for protection, including symbols for fire, clothing, soft comfortable elements, and more. Paint, paper, fabric and other objects can be added to create the type of environment desired.

Another artistic option for promoting relaxation is to paint a calm image. This may be similar to a mandala, or a client may have a landscape or particular place in their mind they wish to create through art materials. A relaxing atmosphere can be made in the therapy studio with dim lighting, soothing sounds and a calm focus on art making to promote the soothing experience of relaxation through the art process, as well as the development of the image. More fluid material is welcome here if clients can tolerate it, such as paint, oil pastels or clay.

**Session 4: Affect Expression and Modulation**

The options seem endless of ways for art therapy to promote affect expression, exploration and management. Art provides an inherent ability to manage emotion and the use of
art materials in any form are often encouraged coping skills for children to practice at home. Specific directives to use in this TF-CBT step can include: inside outside drawings, exploring internal feelings about the self and the sides of the self-shown to others following abuse. The creation of masks using plaster strips on the child’s face can be done as alternative way to explore internal and external feelings about abuse (Liebman, 2004). Specific directives can be used to create an image of the self with feelings in the body in response to the traumatic event, with various colors representing specific feelings.

Session 5: Affect Expression and Modulation continued

Many additional directives to promote expressing and managing feelings can include the creation of a coping skills tool kit, with children creating images or three dimension objects out of clay to represent coping skills they can use. Feelings thermometers are useful to help a child begin to develop an awareness of where they are at on their thermometer by how activated or calm their body is. Using body mapping or tracing: color where you feel various feelings in your body, exploring their color and size. Create a safe or brave coat or cape to literally try on a different feeling to cope with a situation. Sock buddies can be sensory tools to provide weight and promote regulation by filling a sock with rice and essential oils. Draw feelings faces to explore different feelings and develop a feelings vocabulary. Create clay feelings people exploring their size, and body positions and expand on conversation about times the client has felt these feelings. Create an invisible suitcase using a box to explore what beliefs or feelings children carry about themselves following traumatic events. Create two-sided art of how does the client act in and out their anger, depression, or other feelings. Using clay or model magic, create anger (or other feeling) monsters. This is certainly not an exhaustive list, and many
directives can be created to aid clients in the development of emotion vocabulary and management (Rubin, 2005).

**Session 6: Cognitive Coping**

This is a more difficult step to bring into the art making process, however the use of creativity can go a long way toward client’s engagement and understanding with this step. Clients will create their own cognitive triangle, using art materials with which they will begin to identify thoughts, feelings, and actions and add them using words or images to each corner of their triangle for a specific problem. Practice transforming the cognitive triangle identifying and adding other thoughts they could choose to gain a more pleasurable feeling and outcome. One way to transform this into a more elaborate and creative outcome is to allow the child to draw alternate endings to their problem, possibly by trying on a different attitude or view of themselves about it. Art directives could include comic strips to illustrate the thought, feeling action sequence.

**Sessions 7-12: Trauma Narrative**

The creation of the trauma narrative can be guided by the art making process. Prompting clients to create art of a time before the traumatic experience occurred, or of a good memory (for complex trauma) should be the beginning of the narrative. This can be created using paint, clay, colored pencils, oil pastels or any variety of objects. Specific attention can be paid to the use of material to enhance or limit affective expression. Children can begin to create a map of what occurred following, using images or sculpting. More resistant clients tend to enjoy this non-verbal option, and can be prompted to create anything they can remember from their experience to begin. Following creating a fairly cohesive story, the therapist will prompt and begin to write
or type the narrative which correlates with their images with the client. Specific attention should be paid toward identifying feelings and thoughts in each experience.

During this time, parents should be involved in sessions without the child present to aid in their own process of learning and processing their child’s trauma narrative. Additional focus near end of trauma narrative sessions should address issues of fault, blame and responsibility and images can be redrawn or recreated to express this (Rubin, 2005).

Session 13: In-Vivo Mastery of Trauma Reminders

Art can be used to specifically address trauma reminders, by creating them out of art if it is a specific item, as well as using art to cope with and gain mastery over transforming these items referencing the affective modulation step. Triggering items could be sculpted, painted or drawn and transformed to promote control over and mastery of these items.

Session 14: Conjoint Witnessing Session

Here the child shares their art work and illustrations with their caregiver. The caregiver and child should be appropriately supported to feel comfortable with this stage in TF-CBT.

Session 15: Celebration

Celebrating the hard work and passage of sharing the trauma narrative should be done as a sensory based experience incorporating food, music and art making. Suggestions for art making can include members attending to add an image or phrase to quilt pieces and attach them together. Additional options could be creating a totem or family crest solidifying and celebrating the family or caregiver values. Oftentimes children are part of the foster care system, and are living with non-familial caregivers. It is important, particularly if the child is of a minority ethnicity to address their specific culture if it is relevant, in their celebration. Aiding the child to develop a sense of belonging to their caregivers, as well as recognizing their own unique
significance is important and can be done by offering clients an opportunity to plan the celebration and invite those that are appropriate to join in.

Session 16: Closure and Safety Planning

This session will review all progress made and address future safety needs. The use of art can be involved to create images of the child being assertive and strong. Roll play can also be useful to practice how to call 911. Specific books such as *My Body Belongs to Me* and *No Means No* can clearly address future safety.

Conclusion

This writing has explored a variety of topics related to art therapy and TF-CBT. Neurobiological research provides evidence to the brain’s inability to access speech when experiencing heightened traumatic stress symptoms (van der Kolk, 2014). Trauma-focused art therapy has shown the importance of using art to treat trauma to access the heightened visual content and allow clients the ease of expression without speech (Malchiodi, 2008). The expressive therapies continuum provides insight on how to guide the client through the therapeutic process based on their expressive level (Hintz, 2009). The usefulness of art therapy and CBT provides rich avenues to explore and reframe clients’ experiences and beliefs (Freeman, Erschel, 1997). Additionally, the foundations of CBT were explored through the lense of Alfred Adler’s Individual Psychology, teaching the goal directedness of client behavior and information about mistaken beliefs (Ansbacher, & Ansbascher, 1956). Finally, the TF-CBT model was explored, and bridged with art therapy directives to aid in each aspect of the model (Cohen, Mannarino, & Deblinger, 2006). Additional research in the areas of art therapy and TF-CBT, including additional specific directives and their effectiveness is called for. As evidenced
through this review, the marriage of art therapy and TF-CBT can bring to life meaning and healing for clients that otherwise may go unexpressed (Malchiodi, 2008).
References


