Trauma-Focused Art Therapy in Short-Term Inpatient Mental Health Settings

An Experiential Project

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

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April 2017
Abstract

There is a strong correlation between mental illness and trauma (Lu et al., 2013; McDuff, Cohen, Blais, Stevenson, & McWilliams, 2008). Unprocessed trauma leaves people with a loss of empathic ability and a loss of ability to form successful relational connections (Perry & Szalavitz, 2008). Trauma victims are robbed of a sense of belonging and significance (Ansbacher & Ansbacher, 1964, p. 454) and stuck in a heightened state of arousal (van der Kolk, 2014). Trauma almost always accompanies mental health inpatients and is likely the cause of many presenting symptoms (Lu et al., 2013; McDuff et al., 2008). Even though there is a strong correlation between trauma and mental illness, little is ever done to address trauma treatment in short-term mental health settings (Bloom, 2000). Art therapy may provide a unique opportunity for healing trauma in short-term mental health settings (Appleton, 2001; Bloom, 2000; Hass-Cohen, Findlay, Carr, & Vanderlan, 2014; Klorer, 2005; Naff, 2014; Pifalo, 2007; Rankin & Taucher, 2003; Tripp, 2007). Art therapy addresses traumatic material in an efficient and timely manner (Tripp, 2007, p. 178), allows for nonverbal expression (Klorer, 2005), and contains the trauma through art media and products (Hinz, 2009, pp. 174-175). Art therapy promotes the integration of various parts of the brain and integrates the client’s internal and external experience (Hinz, 2009). Art therapy helps process and transform the trauma narrative through creating new meaning making (Hass-Cohen et al., 2014). Finally, art therapy uniquely engages connection to personal symbolic imagery and spirituality (Van Lith, 2014). The author presents guidelines and processes for trauma-focused art therapy in short-term mental health inpatient settings.

Keywords: trauma, art therapy, mental health, short-term, Adlerian
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Trauma-Focused Art Therapy in Short-Term Inpatient Mental Health Settings

The goals of treatment in mental health inpatient settings are often focused on symptom reduction, safety, and stabilization (Sharfstein, 2009). These goals are necessary steps to include in recovery, but they are not sufficient enough (Bloom, 2000; McDuff, Cohen, Blais, Stevenson & McWilliams, 2008). There is increasing research showing a correlation between trauma and mental illness (Lu et al., 2013; McDuff et al., 2008). With this correlation in mind, more trauma-focused care should be offered in short-term mental health care settings instead of focusing solely on symptom reduction, safety, and stabilization (Bloom, 2000; Sharfstein, 2009). Facilitators of trauma-focused programs in short-term mental health settings have been surprised to find success in trauma healing over short periods in inpatient hospital stays (Bloom, 2000). With the unpredictable and relatively short stays in inpatient psychiatric services, healing from trauma is a tall order, however, art therapy may be considered as a viable modality to tackle the challenge. Through its catalytic nature (Tripp, 2007, p. 178) and unique abilities of desensitization (Saltzman, Matic, & Marsden, 2013, p. 226), containment (Hinz, 2009, pp. 174-175), integration (Hass-Cohen, Findlay, Carr, & Vanderlan, 2014), nonverbal expression (Klorer, 2005), meaning-making and spirituality engagement (van Lith, 2014), and its alignment with Adlerian concepts (Saltzman et al., 2013, p. 226), art therapy offers a powerful and safe option for short-term trauma healing.

**Trauma**

At its core, trauma is an experience of utter helplessness (Bloom, 2000, p. 9). Those who experience trauma have inadequate resources to meet the terror of the experience (Millar, 2013). The fifth edition of The Diagnostic and Statistical Manual of
Mental Disorders (DSM-V) defines a traumatic experience as, “Exposure to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013). The Substance Abuse and Mental Health Services Administration (SAMHSA) defines traumatic experiences as experiences causing severe physical and psychological stress reactions (2014, p. 1). Researchers have agreed that it is not the specific events that define traumatic experience, but it is the person’s response to an event that makes it traumatic (Bloom, 2000; Millar, 2013, p.253; SAMHSA, 2014).

**Symptoms of Trauma**

Everyone responds to trauma differently (Bloom, 2000; Naff, 2014). Clinicians acknowledge that trauma symptoms can look very different in different people, and that symptoms are sometimes misleading (Bloom, 2000; Naff, 2014). The strong correlation between mental illness and trauma suggests that trauma may be the cause of much mental illness and also that mental illness predisposes one to trauma and trauma symptoms (SAMHSA, 2014, pp. 50-64).

Trauma symptoms may show up as post-traumatic stress disorder (PTSD), however, most people who have a traumatic experience do not develop PTSD (SAMHSA, 2014, pp. 4-5, & 38-39). Since there is a significant link between trauma and most mental disorders, it is possible that trauma is the cause of many mental disorders, not just PTSD (SAMHSA, 2014, pp. 50-64). What often happens for those who have prolonged reactions to traumatic experiences is that they remain “stuck” in the traumatic memory (Bloom, 2000, p. 4; Millar, 2013, p. 251; van der Kolk, 2014, p. 44). The trauma remains ever-present and un-integrated into a coherent life narrative (van der Kolk, 2014, p. 47). This makes it difficult for those with trauma symptoms to be present
in their lives: Instead they are constantly living in the reality of past trauma (van der Kolk, 2014).

Trauma also has a vast effect on the brain and development (Perry & Szalavitz, 2008; van der Kolk, 2014). For those with childhood trauma, normal development is interrupted and serious challenges arise (Perry & Szalavitz, 2008). Without consistent caregiving, for example, the ability to empathize with others and self can be severely limited (Perry & Szalavitz, 2008). During trauma experiences the speech center of the brain is inhibited (van der Kolk, 2014, p. 43). Also, traumatic memory is mainly stored in the right side of the brain, which makes it extremely difficult to talk about trauma and to think about it logically (van der Kolk, 2014, p. 43). “The rational brain is basically impotent to talk the emotional brain out of its own reality” (van der Kolk, 2014, p. 47). This is why talk therapy alone for treating trauma is too demanding and not sufficient (Saltzman et al., 2013, p. 226).

**Adlerian Understanding of Trauma**

Adlerian theory sees all individuals as creative individuals and holds each person ultimately responsible for their mental health (Ansbacher & Ansbacher, 1964). A traditional Adlerian lens sees mental illness as an attempt to safeguard oneself from having to face the tasks of life (Ansbacher & Ansbacher, 1964, pp. 273-276). Instead of having to face the tasks of love, friendship, and work one creates a “side show” of symptoms to create distance from the life tasks (Ansbacher & Ansbacher, 1964, pp. 273-276). Alfred Adler described symptoms as being “selected” in service of the lifestyle (Ansbacher & Ansbacher, 1964, pp. 265-266). While this may be the case with some mental illness, it is likely not the whole story for those with trauma symptoms (Millar,
2013, p. 255). Even though each individual is ultimately responsible for their own mental health, Adler also recognized that there were certain situations that limit the free creative power of the individual (Ansbacher & Ansbacher, 1964, p. 454).

The honest psychologist cannot shut his eyes to social conditions which prevent the child from becoming a part of the community and from feeling at home in the world, and which allow him to grow up as though he lived in enemy country. (Ansbacher & Ansbacher, 1964, p. 454).

The free creative power has been oppressed in the person who has experienced trauma, and must be rekindled and cultivated (Millar, 2013). Millar (2013) pointed out how traumatic experience harms the individual’s sense of belonging and worth, and causes a loss in the four “crucial C’s”: the ability to connect, feel capable, to feel that they count, and the ability to have courage (p. 246). Safeguarding may be the purpose of trauma symptoms, but the safeguarding is unconscious and it is biological, social, and psychological in nature (Millar, 2013). The biological responses of hypervigilance and hyperarousal are attempts of the body to safeguard from possible harm (Millar, 2013, p. 255). Dissociation is also a high order coping mechanism to create distance and protection from the self, due to the terror of trauma (Millar, 2013, p. 256).

Many trauma symptoms could be effects of being unable to integrate the trauma into the lifestyle (Millar, 2013, p. 256; Saltzman et al., 2013). Early childhood trauma can severely impact a person’s lifestyle. These are crucial times in a child’s social, emotional and intellectual development. These experiences may cause internally flawed private logic that the child expresses through-ought their lifespan (Saltzman et al., 2013). Trauma during crucial developmental years may cause a child to develop a maladaptive
self-concept and worldview (Ansbacher & Ansbacher, 1964, p. 454). For example, they may come to believe that something is wrong with them, that the world is a dangerous place, and people cannot be trusted (Ansbacher & Ansbacher, 1964, p. 454). The way trauma shapes lifestyle in early childhood has enduring effects on behavior and mental health (Millar, 2013; Saltzman et al., 2013).

The Need for Trauma-Focused Mental Health Care in Inpatient Psychiatric Settings

It has been reported anywhere from 63% to 98% of persons receiving inpatient psychiatric services have a trauma history (Lu et al., 2013; McDuff et al., 2008). Severely mentally ill populations have a higher level of trauma exposure and greater risk for post-traumatic stress disorder (PTSD) symptoms (Lu et al., 2013). Trauma in psychiatric populations usually includes childhood trauma and multiple traumas (McDuff et al., 2008). Populations utilizing inpatient psychiatric services have a much higher rate of trauma exposure than the general public, yet most psychiatric inpatients never receive trauma assessment or treatment (McDuff et al., 2008).

In the adverse childhood experience (ACE) study, a high ACE score indicated a greater chance for mental illness (SAMHSA, 2014, pp. 15-18). There is also a correlation between number of traumatic events and depression, PTSD symptoms, and symptoms of culturally specific behavioral health disorders (SAMHSA, 2014, p. 24). A large British study of over 8,000 participants showed that childhood trauma and later psychosis have a strong relationship, and there was an especially strong relationship between childhood sexual abuse and later psychosis (Bebbington et al., 2004). Those with psychosis also have a higher rate of physical and/or sexual abuse (Kilcommons, Morrison, Knight, & Lobban, 2008). There is increasing evidence that trauma and
mental illness are strongly correlated (Lu et al., 2013; McDuff et al., 2008). Although there are many factors that contribute to mental illness, it is clear that trauma plays a major role in the presence of mental illness. Mental health inpatients are traumatized adults needing much more than symptom management (Bloom, 2000). There is a need for trauma-focused mental health care in inpatient mental health settings in addition to the standard care methods of symptom management, safety, and stabilization (Bloom, 2000).

**Trauma-Focused Therapy in Short-Term Inpatient Psychiatric Settings**

Trauma-informed therapy is an approach to treatment that emphasizes awareness of trauma among mental health populations, focuses on strengths, and approaches treatment in a way to avoid re-traumatization (SAMHSA, 2014, pp. 10-11). Direct trauma therapy as opposed to trauma-informed therapy, includes all the tenets of trauma-informed therapy but also focuses on processing and healing of the traumatic event(s) directly (SAMHSA, 2014, pp. 79-91). In the context of inpatient mental health settings, trauma-informed therapy is practiced, but direct trauma therapy is usually not practiced (Bloom, 2000; Sharfstein, 2009). Direct trauma therapy is usually not practical or ethical in short-term mental health inpatient settings due to the briefness of stay and the levels of functioning of the patients; however, more trauma-informed therapy could potentially be integrated in mental health inpatient settings (Bloom, 2000). A safe and efficient trauma-focused approach is needed in inpatient mental health settings even if direct trauma therapy is not involved (Bloom, 2000).

McDuff et al. (2008) conducted a study of a trauma recovery service in a Maryland psychiatric state hospital over a one-year period. They served 161 patients
who were screened for trauma and met the requirements. Programs included psychoeducation about the relatedness of past trauma with present symptoms, developing new coping skills, expressive therapies to explore present symptoms as nonverbal responses to trauma, mindfulness techniques, yoga, and Dialectical Behavioral Therapy. During this trial, group attendance went up and participants showed widespread satisfaction through their reports of wanting to refer other trauma survivors to the program in a self-report post-treatment survey (McDuff et al., 2008). This study demonstrates the successfulness of integrating trauma-focused treatments into inpatient mental health care.

Another inpatient trauma service is The Sanctuary Model (Bloom, 2000). The Sanctuary Model provides a helpful approach to trauma care in short-term inpatient psychiatric settings. Bloom and his colleagues saw it important to adjust the framework of staff to an empathically trauma-informed approach in order to provide the best possible care (2000). In the Sanctuary Model, trauma reactions are seen as “normal responses to abnormal stress” (Bloom, 2000, p. 4). Emphasis is placed on non-pathological care and language as well as an understanding of the effects of traumatic stress on a person (Bloom, 2000). Instead of seeing patients as resistant, manipulative, or deviant, the Sanctuary Model focuses on strengths of the person. “The miracle is not that so many are distrustful; it is, instead, that so many patients are willing to try trusting again, and again, and again, despite past experience” (Bloom, 2000, p. 7).

Bloom and his colleagues were surprised at the amount of healing that could be accomplished in a short-term inpatient setting if the client was willing to partner with the treatment team (Bloom, 2000, p. 5). The emphasis was on creating an overall therapeutic
environment by all of the staff. The treatment focus was on creativity, allowing grief processing, and shifting cognitive structure (Bloom, 2000). Shifting cognitive framework had a significant impact in short amount of time (Bloom, 2000, pp. 5-6).

The role of the treatment environment is to engage enough with the story to understand the script but then to change the automatic roles that are being cued for by the patient so that the story changes instead of being repeated. (Bloom, 2000, p. 11)

Creative forms of therapy such as creating “trauma art” provided a safe way to process and integrate the trauma story in a short amount of time (Bloom, 2000, p. 15).

Since the overwhelming stress [of trauma] has a profound impact on the brain’s capacity to take in and process verbal information, the therapeutic environment must promote the integration of memory and affect, making essential the availability of nonverbal and creative forms of therapy. (Bloom, 2000, p. 10)

It is important to note that trauma cannot be processed directly without a well-established foundation of therapeutic trust and safety. Patients must be stabilized to baseline functioning (Millar, 2013, pp. 248-250). Safety and stabilization can be accomplished by identifying anchors, social supports, basic needs, and learning grounding techniques (Millar, 2013). Prematurely processing trauma can lead to re-traumatization and have harmful effects (Bloom, 2000, p. 16). In the next section art therapy will be discussed as an option for treating trauma.

**Art Therapy and Trauma**

Creativity lives in all of us: we were created to create (Hinz, 2009, p. 169). Creativity is the making of something new, or the ordering of chaos (Hinz, 2009, p. 173).
In those who have experienced trauma, the free creative power of the individual has been oppressed (Ansbacher & Ansbacher, 1964, p. 454), and without a witness and a place to voice emotional pain, great damage can be done and a cycle of trauma may continue (Hinz, 2009, p. 179). Making art and having an art therapist to witness can be a way for individuals to reclaim their creative power and to voice emotional turmoil (Hinz, 2009, p. 179). Art has long been used to express the inexpressible (Appleton, 2001). The cathartic and transforming power of art has been present since ancient times (Appleton, 2001). More recently, art has combined with psychotherapy to provide powerful healing through art therapy. Art therapy is defined by the American Art Therapy Association (AATA) as:

A mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem. (2016)

In a review of 15 randomized control trials studying the effectiveness of art therapy on mental health outcomes, Uttley and colleagues (2015) found the majority of studies to have favorable mental health outcomes for art therapy groups over control groups. In another systematic review of six different controlled and comparative research studies on art therapy’s effectiveness with clients with trauma, half of the studies showed a reduction in trauma symptoms and one study showed a significant reduction in depression (Schouten, de Niet, Knipscheer, Kleber, & Hutschmaekers, 2014). Art therapy with clients with trauma is a promising approach (Schouten et al., 2014). There
are several unique advantages of art therapy that contribute to its effectiveness: its catalytic nature (Tripp, 2007, p. 178), its ability to help with desensitization (Saltzman et al., 2013, p. 226), the encouragement of nonverbal expression (Klorer, 2005), and the ability to contain trauma through material and media (Hinz, 2009). Art therapy also has the ability to integrate different parts of the brain (Hinz, 2009), connect inner and outer experience, and provide a context for the trauma narrative (Hass-Cohen, Findlay, Carr, & Vanderlan, 2014). Finally, art therapy uniquely engages a sense of meaning, purpose, and spirituality (van Lith, 2014). It is these unique abilities combined that make art therapy a more timely, powerful, and safe way to heal trauma (Klorer, 2005; Pifalo, 2007).

**Catalytic Nature**

Art therapy brings up traumatic memory quicker than verbal therapy (Tripp, 2007, p. 178). Catharsis is powerful and happens sooner in art therapy, and this release clears the way for more work to be done (Appleton, 2001). Veterans with PTSD found that art therapy helped them to be vulnerable in ways that talk therapy could not (Lobban, 2014). This is likely because trauma is stored mainly in the right hemisphere of the brain and because the speech center of the brain shuts down during traumatic experience (van der Kolk, 2014). Art therapy accesses the right hemisphere and allows for nonverbal expression (Klorer, 2005). This ability of art therapy to quickly bring up material makes it a good fit for short-term inpatient settings. Also, art therapy can be viewed as more accurately reflecting the inner world of the client than talk therapy alone, leading to a quicker case conceptualization and therefore timely and accurate treatment approach (Naff, 2014, p. 82).
Desensitization

Many trauma therapies involve desensitization in their protocols (SAMHSA, 2014, pp. 79-91). The main concept of desensitization is the repeated exposure to traumatic memory while simultaneously having the client engage in relaxation techniques (SAMHSA, 2014, pp. 79-91). This coupling of repeated exposure to traumatic memory with relaxation techniques decreases the intensity of the trauma memory (SAMHSA, 2014, pp. 79-91). Desensitization is the philosophy behind Eye Movement Desensitization and Reprocessing (EMDR) and Exposure Therapy (ET): both effective approaches in reducing PTSD symptoms (SAMHSA, 2014, p. 83). Art therapy similarly supports desensitization by having the client engage directly with the traumatic memory through art materials and media (Saltzman et al., 2013, p. 226). By making the memory concrete, and making repeated art products as needed, the traumatic memory loses some of its power (Saltzman et al., 2013, p. 226). The continuous exposure to creating traumatic memory in a concrete and tangible art form allows the client to re-shape and re-learn the trauma story, thereby decreasing the impact and power the traumatic memory has had for the client in the past (Hass-Cohen et al., 2014).

Nonverbal Expression

Traumatic memory is often unspeakable (van der Kolk, 2014, p. 44). When a person has a traumatic experience, the speech center of the brain, known as the Broca’s area, goes offline (van der Kolk, 2014, pp. 42-43). In fact, the majority of the left side of the brain is inactive, and the right hemisphere takes over (van der Kolk, 2014, pp. 44-45). This puts a person in a “speechless terror” (van der Kolk, 2014, p. 44). Trying to access trauma through verbal therapy alone can be too demanding (Saltzman et al., 2013, p. 226;
van der Kolk, 2014, p. 233), and important parts of the brain where trauma is stored are not being accessed in verbal communication (Klorer, 2005; van der Kolk, 2014). Sometimes clients are not able to recall their traumatic stories (van der Kolk, 2014). It is only through symptoms that the body expresses the story of pain (Bloom, 2000, p. 5). “Creative arts therapies provide a nonthreatening entry into traumatic memories that tend to be inaccessible after a traumatic experience” (Saltzman et al., 2013, p. 226). Art therapy also helps bring this nonverbal component of trauma into verbal communication by bridging “the gap between the nonverbal affective experience and the verbal, cognitive, conscious mind” (Bloom, 2000, p. 16). Verbal processing alongside nonverbal expression is important for containment and integrating the traumatic memory with the rest of the self.

**Containment**

It is important that proper containment is achieved in order to maintain safety in the session when working with trauma (Appleton, 2001). Containment can be achieved in several ways: through use of different media, through more structured tasks, and the setting of limits and rules (Hinz, 2009, pp. 174-175). The appropriate amount of limits actually frees the client to be able to create: too many choices or possibilities may be overwhelming and paralyze the client (Hinz, 2009, pp. 174-175).

Much time in art therapy is spent encouraging the ‘opening up’ of clients, but just as important as the opening and releasing is the closing (Hinz, 2009, pp. 174-175). Due to the powerful catalytic nature of art therapy, great care and proper training must be taken in providing containment for clients. Art therapy provides unique and safe opportunities for containment that are not available in verbal therapy alone (Hinz, 2009).
An art product can contain the difficult memory or emotion: the client no longer has to be the sole container of the memory, and the art can take some of this burden off of the client (Saltzman et al., 2013, p. 228). The expressive therapies continuum (ETC) is a framework used by art therapists to navigate levels of creative expression and brain functioning (Hinz, 2009). The ETC allows the art therapist to move along the continuum of brain functioning and creative expression as needed to provide containment (Hinz, 2009, pp. 13-15). Structured materials that promote the perceptual and cognitive levels of brain functioning, such as collage or pencil drawing, can be used to bring emotional regulation or distancing from the intensity of the affect related to trauma (Hinz, 2009).

Directed tasks focused on representing self-strength, resiliency, or hope for the future helps clients to transform and re-author their personal trauma narrative (Hass-Cohen et al., 2014).

**Integration**

Trauma symptoms stem from being unable to integrate the traumatic experience into the rest of the life narrative (Millar, 2013; Saltzman et al., 2013). The traumatic memory remains ever-present in the here-and-now instead of being properly placed in the past like all other memories (van der Kolk, 2014). Art therapy provides integrative healing through safe memory processing (Hass-Cohen et al., 2014). Art therapy also offers the synthesis of inner and outer experience (Hinz, 2009, p. 169). What has been kept inside can be externalized and examined: bringing one’s own private world into the outside world.

Art therapy also allows for integration of different levels of brain functioning and the use and formation of new neuropathways (Hinz, 2009; Lusebrink, 2004).
Brain structures provide alternate paths for accessing and processing visual and motor information and memories. Art therapy is uniquely equipped to take advantage of these alternate paths and activate them through the use of various art media in therapy. (Lusebrink, 2004, p.133)

Through engaging with various art media and methods in art-making all levels of brain functioning can potentially be engaged and fully optimized (Hinz, 2009). Kinesthetic movement can provide a release of energy, emotional expression can provide a cathartic experience, and symbolic representation can provide insight (Hinz, 2009, p. 173). Art therapy has the potential to involve the whole person, and the whole brain: “It is the meeting place for all areas of the human experience, the trauma narrative, and the sensory, kinesthetic, and cognitive processes” (Saltzman et al., 2013, p. 227). The right hemisphere is activated through creative expression where trauma is stored, and the left hemisphere is also called upon with cognitive processes and perceptual functioning through art-making (Hinz, 2009, pp. 6-7). This allows for engagement of the traumatic memory, which is primarily stored in the right brain (van der Kolk, 2014). Through reflective distance and verbal processing, the traumatic memory can finally be processed and logically examined (Hinz, 2009, pp. 6-7, & 176). Art therapy invites engagement and integration to all parts of the person, and if the invitation is courageously accepted, the individual can emerge as integrated and present. “Survivors, who feel disconnected, detached, and numb, are able to experience connection, unification, and accessibility within the process of art making” (Saltzman et al., 2013, p. 227).
Meaning Making/Spirituality

When an individual authentically and courageously makes art, new possibilities and potentialities are opened up (Hinz, 2009). There is a significant relationship between art-making and self-actualization (Appleton, 2001; Hinz, 2009, pp. 170-171). Creativity may be the antithesis of being ‘stuck’, which is so often the experience of traumatized individuals. "Working with art media helps individuals experience their own potential in a concrete manner; the product of their labor is evident, tangible, and meaningful" (Hinz, 2009, p. 172). While making art, people come in contact with core values and their greater purpose in life: a powerful factor for surviving and healing from traumatic experiences (Appleton, 2001; Hinz, 2009; Frankl, 1984). Engaging in art therapy allows for post-traumatic growth: fostering meaning, purpose, and hope (Appleton, 2001; Hinz, 2009; van Lith, 2014).

Adlerian Concepts

Art therapy offers a way to integrate important Adlerian concepts in a more holistic way (Saltzman et al., 2013). Visual representations of mistaken beliefs, cognitive schema, and lifestyle can be externalized and examined in art therapy in a way that they cannot in talk therapy (Saltzman et al., 2013). A person’s lifestyle can be difficult to witness in the self because it is so close to a person, but through coming in contact with it in the artwork, a certain “spitting in the soup” can happen and the person may be able to see their own reflection clearly (Saltzman et al., 2013).

Trauma can impair the creative power of an individual, especially if it is a child, and can infringe on typical lifestyle development (Saltzman et al., 2013). “Adaptation to trauma involves construction of new self- and world-perspectives that are different from
those prior to the trauma” (Rankin & Taucher, 2003, p. 138). Through art therapy
cognitive restructuring and lifestyle adaptation can be more easily attained with the
ability to first release energy and emotion (Pifalo, 2007). Engaging in the creative
process also engages the creative problem solving skills, engages the free creative power
of the individual of the client and it opens opportunity for new growth, and new cognitive
schemas.

Social interest is promoted through engagement with the art therapist in art
making and in discussing the art process and product (Saltzman et al., 2013, p. 229).
Trauma often happens within relationships, therefore it is suggested that trauma is treated
through focusing on healing relationships (van der Kolk, 2014, pp. 212-213). The
therapeutic relationship can be a corrective experience by increasing social interest and a
sense of belonging (Saltzman, et al., 2013, p. 229).

**Trauma-Focused Art Therapy in Short Term Inpatient Psychiatric Settings**

The high prevalence of trauma in those with mental illness (Lu et al., 2013;
McDuff, et al., 2008) and the severe and lasting effects of trauma (Perry & Szalavitz,
2008, van der Kolk, 2014) on these individuals call for a short-term trauma-focused
treatment. Art therapy is a promising approach to healing trauma (Schouten et al., 2014)
through its catalytic nature (Tripp, 2007, p. 178), its ability to support desensitization of
traumatic memory (Saltzman et al., 2013, p. 226), its support of nonverbal expression
(Klorer, 2005), its powerful ability to contain traumatic memory through materials and
media (Hinz, 2009), its unique ability to access different parts of the brain and integrate
traumatic material into the greater life narrative, (Hass-Cohen et al., 2014), and its ability
to engage with spirituality and meaning (van Lith, 2014). A trauma-focused art therapy
program for short-term inpatient mental health settings would provide a solution to the problem of integrating trauma-focused therapy into short-term inpatient mental health settings. Due to the shortness of stay in mental health inpatient for most patients, trauma-focused art therapy may offer the most direct and robust healing in short-term inpatient mental health settings. The following section will highlight how trauma-focused art therapy may be used in inpatient mental health settings.

**Essential Elements of Trauma-Focused Art Therapy**

There are certain foundational conditions that must be met in order for trauma-focused art therapy to be effective (Naff, 2014). First, the art therapist must show an unconditional positive regard for the client (Naff, 2014). This can be achieved by consistently being encouraging of the client no matter what his or her current status is. This may be shown in an art therapists acknowledgement of the courage it takes to “face a blank piece of paper” at times when artistic expression is harder to access (Appleton, 2001, p. 8). Also, art therapists have a unique ability to show concrete unconditional positive regard by unconditionally accepting the artwork, as the artwork is an extension of the client. Second, providing predictability is an essential element for trauma-focused art therapy (Naff, 2014). This includes consistency with meeting times and session formats and providing the appropriate amount of structure to meet the client’s needs (Appleton, 2001; Hinz, 2009, pp. 174-175; Naff, 2014). Third, an authentic healing connection based on trust between the art therapist and client is paramount in supporting the client’s sense of safety and security (Appleton, 2001; Naff, 2014). Finally, it is important that trauma-focused art therapy is a collaborative experience based on the client’s best interests (Naff, 2014). This is achieved through collaboratively setting goals.
with clients, consistently eliciting feedback from the client, and constantly assessing the needs of the client (Naff, 2014, p. 82).

**Stages in Trauma-Focused Art Therapy**

Along with establishing the essential elements of trauma-focused art therapy, the research suggests a multi-stage approach to trauma-focused art therapy is best in short-term mental health inpatient settings (Appleton, 2001; Naff, 2014; Rankin & Taucher, 2003). The first stage includes ensuring safety and security through building tools and coping skills, engaging in safety planning, and building a strong therapeutic alliance (Appleton, 2001; Naff, 2014; Rankin & Taucher, 2003). The second stage includes an opening up of the traumatic memory and grief processing (Appleton, 2001; Naff, 2014; Rankin & Taucher, 2003). The third stage includes identifying strength, sources of meaning, and the fourth stage includes building a vision for the future (Appleton, 2001; Naff, 2014; Rankin & Taucher, 2003).

Moving through each stage sequentially and completely is ideal, but with limitations in inpatient mental health settings, sequential movement and completion of each stage might not always be realistic, and thus the stage approach can be adapted for each client’s situation (Rankin & Taucher, 2003). Time may be solely spent in the first phase of establishing safety and security with some clients who are not ready to move to the middle stage. Likewise, time may be solely spent in the third and fourth stages of identifying strength and resiliency or creating a vision for the future. Focusing solely on the first, third, or fourth stages will still be beneficial for the client in healing from trauma, even if the second stage is never addressed. The second stage should never be addressed without going through all of the stages (Rankin & Taucher, 2003). Jumping to
the second stage of helping the client to open up without first establishing safety could be detrimental to the client. The client must have resources of safety to be able to face the difficult task of opening up the trauma narrative. Also, addressing the second stage without finishing with the third and fourth stage may leave clients in a state of chaos with their uncontained traumatic material (Rankin & Taucher, 2003). The third and fourth stages are important stages in achieving containment of the traumatic material, giving clients control over their trauma, and allowing clients to re-author their trauma narrative (Hass-Cohen, et al., 2014; Rankin & Taucher, 2003).

Rankin and Taucher’s (2003) tasks of trauma art therapy, although sequential, do not necessarily all have to be followed in order, time may be spent on only part of the tasks, depending on the length of time with the client. Rankin and Taucher also mention that the tasks can be adapted for short-term settings. Rankin and Taucher’s tasks include: safety planning, self-management, telling the trauma story, grieving losses, self-concept and worldview revision, and self and relational development (Rankin & Taucher, 2003, p. 139). In an inpatient psychiatric setting, depending on the level of functioning of the client, one, several, or all of these tasks could be addressed. However, as has been stated previously, safety, security, and a therapeutic alliance must be in place before the telling of the trauma story and grieving losses tasks. Safety should always be established and proper containment offered for the purposes of closure and future-orientation (Rankin & Taucher, 2003).

**Art Therapy Techniques and Approaches to use in Inpatient Settings**

Rankin and Taucher (2003) have identified five types of art therapy interventions that support trauma-focused art therapy. These include art directives that encourage
management of symptoms, expression of current states, narration of events, exploration of meaning, and integration of traumatic and non-traumatic autobiographical material (Rankin & Taucher, 2003, p. 139).

As has been discussed in the previous section, developing a sense of safety in stage one is a key component to managing symptoms of trauma. Several art therapy projects can help reach this initial goal. The creation of a ‘safe place’ through a guided meditation by the art therapist and the use of art materials by the client can help ground the client to prepare for deeper trauma work (Cohen, Barnes, & Rankin, 1995). This safe place can be accessed throughout the work if any regression starts to happen (Cohen et al., 1995). A second directive is to create a continuum of images ranging from protection to vulnerability, and with each phase to add words or images of steps to be taken when encountering these varying degrees of protection and vulnerability (Rankin & Taucher, 2003, p. 139). On a similar note, an art therapy directive of artistically representing potentially threatening or triggering events can be made, and subsequent actions to be taken at the time of being triggered can be included (Rankin & Taucher, 2003, p. 139). Having safety established in place before recalling and working with the traumatic memory will help ground the client and provide an opportunity for safety (Rankin & Taucher, 2003, p. 139). Finally, Rankin and Taucher (2003) have found that it is important for clients to be able to identify current feelings. Art media can be used to express a variety of feeling states, and this is a helpful tool to have in stage two of trauma-focused art therapy (Rankin & Taucher, 2003).

The “Check, change what you need to change and/or keep what you want” art therapy protocol, based on neurobiology and other established trauma treatment
approaches, offers safe and timely processing of traumatic memory (Hass-Cohen et al., 2014). The protocol moves through the all of the stages of trauma-focused art therapy mentioned in the previous section. The protocol starts with securing grounding techniques and coping skills to guide the client through the protocol should they be activated (Hass-Cohen et al., 2014). The next step in the protocol is making an autobiographical trauma timeline (Hass-Cohen et al., 2014, p. 73). This step helps to put the traumatic memory back in context in the past (Hass-Cohen et al., 2014). The next step in the protocol is to make a trauma image drawing with a narrative (Hass-Cohen et al., 2014, p. 73). After the trauma image, the client is asked to change anything about the trauma image they would like (Hass-Cohen et al., 2014, p. 73). The last step is to make a self-strength image, and to create an optimistic future image (Hass-Cohen et al., 2014, p. 73).

Rankin and Taucher (2003) provide a similar narrative art-intervention that follows the stages of trauma-focused art therapy including three parts: a check-in period to process what happened recently in the client’s life in between meetings, narration of trauma events, and a closing component of identifying strengths and practicing self-management techniques as needed. It is key that art therapists do not interrupt or interpret trauma narrative images, but simply prompt with comments such as, “Say whatever comes to mind” (Rankin and Taucher, 2003, p. 142). Rankin and Taucher also suggest have a folder for clients to place the trauma narrative images in to promote a sense of safety. Also, Rankin and Taucher emphasize the importance of creating a cover with an image, title, and date to support placing the trauma narrative in its proper context.
Mask-making in art therapy may also be a powerful directive for addressing maladaptive beliefs associated with trauma and gaining awareness and integration between inner and outer reality (Saltzman et al., 2013, p. 236). Specifically, the client may encounter mistaken beliefs tied with trauma and through encountering them concretely, can examine and alter them (Saltzman et al., 2013, p. 236). Another directive to encourage self-concept revision is to have clients make a representation of their pre-traumatized self, their traumatized self, and then a combination of both (Rankin & Taucher, 2003).

Trauma can arise at any time in art therapy with a client due to the nature of art therapy to access parts of the brain where trauma is stored (Klorer, 2005). In trauma-focused art therapy in short-term mental health inpatient settings, the art therapist is always aware that trauma is just below the surface of presenting symptoms, and that the effects of trauma or the trauma narrative itself may appear at any time (Naff, 2014). The art therapist in this setting must always be cultivating safety, trust, and unconditional acceptance so that when the trauma surfaces, it can do so in a safe place (Naff, 2014). The art therapist must also always be carefully attuned to patients in order to direct the patient towards more exposure to trauma and acknowledgement, or towards containment and closure (Hinz, 2009). Whenever trauma has been accessed, whether the client is aware or not, containment is necessary. This containment can be achieved in many ways, but usually includes an element of verbal processing, use of more restrictive materials higher on the expressive therapies continuum (Hinz, 2009), and themed directives that guide patients towards hope, resiliency, strength, and meaning (Hass-Cohen et al., 2014).
Discussion

It was difficult to find research on trauma-focused treatment in inpatient mental health, which probably points to the problem that trauma-focused treatment is lacking in inpatient mental health settings. More research into what types of trauma-focused treatments are practical and effective is needed. An even smaller amount of research on trauma-focused art therapy in short-term mental health settings was found. More research investigating trauma-focused art therapy in short-term mental health settings would help validate the effectiveness of art therapy in these settings. The combined theory and research on the effects of trauma, trauma treatment, and art therapy helps to infer that a trauma-focused art therapy approach is an effective strategy for mental health inpatients, however more specific research in this area would help to confirm this conclusion and possibly benefit many inpatients in mental health setting. Art therapy may be an extremely successful approach to the treatment of trauma by offering an opportunity to heal from trauma and the possibility for a reduction in the need for future mental health services. These research topics would be the focus of wonderful contributions to the fields of art therapy and mental health.

Conclusion

Symptom reduction, safety, and stabilization are often the focus of mental health inpatient treatment (Sharfstein, 2009). Mental health inpatients most often have a background of trauma (Lu et al., 2013; McDuff et al., 2008), and they need more than symptom reduction, safety, and stabilization: They need profound healing from trauma that establishes the reoccurring need for mental health inpatient services (Bloom, 2000). Recent research shows a strong correlation between mental illness and trauma (Lu et al.,
While completely healing from trauma in a short-term setting is unlikely, more could be done to promote healing by treating the root of problems rather than just focusing on symptom management (Bloom, 2000). Art therapy offers a unique approach to short-term trauma therapy (Appleton, 2001; Hass-Cohen et al., 2014; Klorer, 2005; Naff, 2014; Pifalo, 2007; Rankin & Taucher, 2003; Saltzman et al., 2013; Tripp, 2007). In trauma-focused art therapy, it is important to provide safety first, expressing the trauma story second, and finally ending with a focus on the client’s strengths and their future orientation (Appleton, 2001; Hass-Cohen et al., 2014; Naff, 2014; Rankin & Taucher, 2003). Trauma has a profound negative impact on individuals (Bloom, 2000; Lu et al., 2013; McDuff et al., 2008; van der Kolk, 2014). Trauma can leave individuals stuck in symptoms, unable to make meaningful relationships, and disconnected from their bodies (van der Kolk, 2014). Treatment for such a destructive force must be met with a complex, powerful, and holistic approach such as art therapy (van der Kolk, 2014). Through art therapy, individuals can express the horrors of their experience, they can move away from isolation, they can integrate the parts of themselves that have been split-off, they can find balance in brain-functioning, they can identify strengths, and tap into sources of deeper meaning and resilience (Appleton, 2001; Bloom, 2000; Hass-Cohen, Findlay, Carr, & Vanderlan, 2014; Klorer, 2005; Naff, 2014; Pifalo, 2007; Rankin & Taucher, 2003; Tripp, 2007).
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