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An Exploration of Art Therapy as a Treatment for Cumulative Trauma

Kristina Marie Naff
Loyola Marymount University

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AN EXPLORATION OF ART THERAPY
AS A TREATMENT FOR CUMULATIVE TRAUMA

by

Kristina Naff

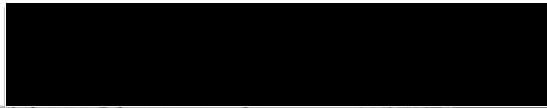
A research paper presented to the
FACULTY OF THE DEPARTMENT OF
MARITAL AND FAMILY THERAPY
LOYOLA MARYMOUNT UNIVERSITY

In partial fulfillment of the
requirements for the degree
MASTER OF ARTS

May, 2013

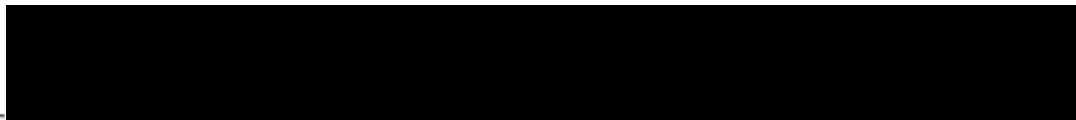
Signature Page

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Abstract

This qualitative research study is informed by a grounded theory approach and explores the use of art therapy as a treatment for cumulative trauma. This paper reviews the current literature focusing on both cumulative trauma and related studies which address the nature and impact of “big T” and “little t” events and accumulated lifetime adversity. There are remarkably few studies which highlight the concept of cumulative trauma in both general psychology and art therapy literature, and there appear to be no existing studies addressing the treatment of the state of cumulative trauma to date. For this study, a series of interviews with three experienced art therapists is presented and accompanied by the researcher’s visual representations of the felt sense of each of the interviews. The artwork is used in conjunction with each of the interview transcriptions to guide the process of data analysis. Axial coding analysis of the artwork and interview data results in the groundbreaking development of an art therapy treatment approach for cumulative trauma in four phases. The theory addresses each trauma according to the client’s level of subjective distress. Through this theoretical model, the client’s state of “allostatic load,” which can be understood as a state of distress which surpasses the individual’s ability for adaptive coping, is addressed systematically according to the trauma that is felt to be most subjectively impactful to each individual client.

Disclaimer

The findings and speculations presented within this research endeavor do not reflect the views of Loyola Marymount University or the faculty of the department of Marital and Family Therapy. An informed consent form was provided to each of the participants in this research, and all names have been changed to protect participant confidentiality.

Dedication

This research study is dedicated to my family, near and far, for their unyielding love, support, and encouragement in my journey to find true purpose. Through bearing witness to the struggles of my mother, father, and sisters, I have discovered the true meaning of love and courage.

Above all, I dedicate this work to my youngest sister, Katie. Her astounding resiliency is a constant reminder that even bruised and broken hearts may heal.

Acknowledgements

I would like to offer special thanks to my faculty mentor, Dr. Paige Asawa, and to the colorful members of our trauma research cluster for the support and inspiration provided throughout this academic journey. Additional thanks to all research participants, my art therapy cohort, and the faculty and staff of the Loyola Marymount University Marital and Family Therapy Department.

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Introduction

The Study Topic

The purpose of this research study was to investigate use of art therapy in the treatment of cumulative trauma. The notion that the accumulation of stressful life events, including events that meet the criteria for trauma as per the DSM IV TR (American Psychiatric Association, 2000) have an unique effect on an individual's well-being was first introduced in a research study by Follette, Polusny, Bechtle, and Naugle (1996). Many authors have recently confirmed the detrimental and additive impact of cumulative trauma on both mental health (Ansell, Rando, Tuit, Guarnaccia, & Sinha, 2012; Kira, Lewandowski, Somers, Yoon, & Chiodo, 2012) and physical wellness (Gustafsson, Anckarsater, Lichtenstein, Nelson, & Gustafsson, 2010). Upon review of the general psychology literature, it is apparent that authors are now becoming interested in risk and resiliency factors with regard to cumulative trauma, although no existing research has been conducted with regard to methods specific to the treatment of accumulated trauma.

Exploration of the art therapy literature revealed that the concept of cumulative trauma remains relatively unknown to the field of art therapy. Many authors suggest that art therapy may provide a distinct benefit to individuals impacted by many types of trauma (Lusebrink, 2004; Read-Johnson, 1987). The following research study examined the approaches currently used by art therapists in the interest of developing a framework for the use of art therapy with populations who have experienced cumulative trauma.

Significance of the Study

This study is warranted due to the importance of understanding the impact of cumulative trauma on the individual and the need for appropriate treatment methods to treat this form of

trauma. This study explored which types of art therapy interventions or approaches to treatment tend to be the most effective in their ability to reduce the symptoms associated with cumulative trauma. This study is significant to the field of art therapy because although a number of studies suggest specific treatments for general trauma (Buk, 2009; Eaton, Doherty, & Wildrick, 2007; Rankin & Taucher, 2003), few current studies explicitly outline how one might approach the treatment of the unique experience of cumulative trauma with art therapy (Testa & McCarthy, 2011). This research informed the construction of a framework for art therapy treatment of accumulated lifetime trauma, and may serve as a springboard for future art therapy research in the largely unexplored territory of cumulative trauma.

The topic of cumulative trauma is relevant to me because I have witnessed the profound impact that the accumulation of trauma has had on members of my family and community. Over the years of personal experience with affected individuals, it has become apparent to me that cumulative trauma often inhibits one's ability to sustain meaningful relationships and develop healthy coping styles. Evidence of the negative effects of accumulated trauma have resurfaced in my clinical work as an art therapy trainee. The experience of cumulative trauma appears to be widespread in the most disadvantaged and marginalized populations (Samuels-Dennis, Ford-Gilboe, Wilk, Avison, & Ray, 2010; Schumm, Briggs-Phillips, & Hobfoll, 2006; Sprang, Katz, & Cooke, 2009), including those in treatment at my practicum placement this year. Through this research study, I have solidified my own knowledge of the art therapy methods that have been most effective for clinicians in the treatment of accumulated traumas and gained many insights which will inform my future clinical work. I am confident that the research I have conducted will assist me in facilitating personal healing among my clientele with improved care and efficiency.

Background of the Study Topic

Trauma is defined by the American Psychiatric Association (2000) as an event in which “the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others” and stipulates that “the person’s response involved intense fear, helplessness, or horror.” Many authors (Boals & Schuettler, 2009; Cameron, Palm & Folette, 2010; Cvetek, 2008; Meiser-Stedman, et al., 2012; Mol, et al., 2005) have recognized the need for research which extends beyond this narrow definition of trauma in order to gain a more complete understanding of why specific events elicit symptomology while others do not. A study conducted by Boals & Schuettler (2009) suggested that it is not the event itself, but rather how the individual processes and assigns meaning to the traumatic event that determines its impact on an individual’s daily life. In light of this research, many authors are now exploring the risk and resiliency factors associated with accumulated lifetime traumas. With respect to the art therapy literature, there has been little discussion of the concept of cumulative trauma and its impact on an individual’s quality of life. The single research article located by this author is a qualitative study which is specific to a single demographic, and was published recently (Testa & McCarthy, 2011).

Literature Review

This literature review presents current definitions of trauma (American Psychological Association, 2000; Boals & Schuettler, 2009; Shapiro, 2004; Solomon & Heide, 1999) and discusses the numerous types of traumatic events which commonly contribute to the experience of cumulative trauma (Briere, Kaltman & Green, 2008; Follette et al., 1996; Kira et al., 2012; Maschi et al., 2011). Current developments in the general psychology literature with regard to cumulative trauma are discussed (Cloitre et al., 2009; Follette et al., 1996; Kira et al., 2012; Martin et al., 2011; Maschi et al., 2011; Samuels-Dennis et al., 2010; Schumm et al., 2006; Shevlin et al., 2008; Sprang, Katz & Cooke, 2009) in conjunction with various symptom presentations associated with accumulated traumatic events. These include a collection of symptoms which commonly result from exposure to traumatic events (Kira, et al., 2005;) and include maladaptive reactions to non-traumatic events (Boals & Schuettler, 2009; Cameron, Palm & Folette, 2010; Cvetek, 2008; Maschi, et al., 2011; McEwan, 2008; Morgan & Janoff-Bulman, 1994). These symptoms include depression, generalized anxiety (Meiser-Stedman, 2012;), hypervigilance and hyperarousal (Mol et al., 2005), and clusters of symptoms classified by some authors as sub-threshold Post-Traumatic Stress Disorder (Cukor et al., 2010; Cvetek, 2008).

This review also describes the different populations and age groups which have been studied in the research of cumulative trauma and provide a comparison of studies which have examined cumulative trauma versus accumulated lifetime adversity and the risk and resiliency factors associated with both traumatic events and stressful life events in general. Additionally, this review discusses current proposed treatments for resolution of trauma and its associated features in the general psychology and art therapy literature, and explores the current availability

of resources linked to cumulative trauma in the art therapy literature (Testa & McCarthy, 2011). Finally, this paper reviews a number of the current trauma-focused, art-based treatments available in the art therapy literature (Buk, 2009; Eaton, Doherty & Wildrick, 2007; Lusebrink, 2004; McNamee, 2003; McNamee, 2006; Rankin, 2003; Read-Johnson, 1987; Sarid & Huss, 2010; Talwar, 2007; Tripp, 2007).

Definitions of Trauma

Trauma is defined by the American Psychiatric Association (2000) as an event during which “the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others” and stipulates that “the person's response involved intense fear, helplessness, or horror.” Many authors (Boals & Schuettler, 2009; Cameron, Palm, & Folette, 2010; Cvetek, 2008; Meiser-Stedman, Dalgleish, Yule, & Smith, 2012; Mol, et al., 2005) have recognized the need for research which extends beyond this narrow definition of trauma in order to gain a more complete understanding of why specific events elicit symptomatology while others do not. To provide an example, Boals & Schuettler (2009) suggest that a traumatic can be impactful in the absence of A1 criterion identifying a traumatic event as directly “life-threatening.” The authors further suggest that a “non-trauma” is especially relevant if the intensity of an individual’s subjective emotional reaction to the event meets A2 criterion described in the DSM –IV-TR as a response which inspires “fear, helplessness, or horror” (APA, 2000). The results of this research suggest “that it is not the nature of the event, but rather the individual’s emotional response to an event that is associated with Post-Traumatic Stress Disorder (PTSD) symptoms” (Boals & Schuettler, p.461, 2009). This finding is corroborated by the most recent studies in the available literature relating to cumulative trauma, including research by Cameron, et al., (2010), Maschi et

al., (2011), and Martin et al., (2011). Martin et al., (2011) suggests that the subjective perceptions of betrayal also have a unique effect on PTSD and its associated features. This finding is supported by a more recent study by Ansell et al., (2012) which suggests that the correlation between perception and symptom development has implications for the impact of emotional stress on overall physical health.

Francine Shapiro (2004), creator of the Eye-Movement Desensitization and Reprocessing (EMDR) treatment technique, suggests that trauma can be defined as “any event that has a lasting negative effect on the self or psyche” (p.14). In the general psychology literature, a number of articles have defined various life events as “traumatic” or “non-traumatic” in accordance with the current DSM-IV TR definition of trauma, while also conceding that a non-traumatic event may affect a person’s quality of life in a very negative way. Shapiro (2004) stated in her introduction to Eye Movement Desensitization and Reprocessing (EMDR) techniques that what constitutes a trauma may be different depending on the origin of the definition. Stressful and ubiquitous lifetime events, such as exposure to bullying, experiences of personal failure or non-traumatic loss fall short of the definition of trauma required to diagnose an individual with Post-Traumatic Stress Disorder, namely in criterion A1 and A2 (Mol et al., 2005). Shapiro refers to these distressing experiences as “small-t” or “little t” traumas. Despite the “small-t” status of these events, they may profoundly affect a person’s quality of life (Shapiro, 2004) and may warrant clinical attention (Mol et al., 2005).

Trauma-Related Symptomology

The current diagnostic focus in the DSM-IV TR regarding traumatic experience is the development of Post-Traumatic Stress Disorder (PTSD). Symptoms of PTSD must follow an event which meets the criteria for a trauma and persist beyond the six-week time frame indicated

for a diagnosis of Acute Stress Disorder (ASD). A diagnosis of PTSD is made when an individual is affected by involuntary re-experiencing of the traumatic event, is compelled to avoid any associated stimuli, and is in a perpetual state of hyper-arousal (American Psychiatric Association, 2000). One group of researchers found that PTSD symptoms could develop in absence of what is defined in the DSM-IV TR diagnostic criteria for PTSD as a traumatic event (Boals & Schuettler, 2009). Another group (Follette, Polusny, Bechtle, & Naugle, 1996) specifically studied the emotional impact of events they categorized as High Betrayal Trauma (HBT), Medium Betrayal Trauma (MBT) and Low Betrayal Trauma (LBT) based on the nature of the relationship between perpetrator and victim. It was found that subjective appraisals of traumatic impact had more significance with regard to development of dissociative and depressive symptoms than the objective categorization of the trauma as LBT, MBT, or HBT. This finding suggests that the development of certain types of symptoms is not solely dictated by the objective severity of the trauma, but is also shaped by subjective perception of damage caused by the specific event (Follette, Polusny, Bechtle, & Naugle, 1996).

In the event that an individual does not meet the full criteria for PTSD but experiences a state of hyper-arousal, emotional numbness, patterns of avoidance of stimuli or re-experiencing of the event, his or her unique collection of symptoms may be classified as *subthreshold* PTSD (Zlotnick, Franklin, & Zimmerman, 2002). Several studies discovered the presence of *subthreshold* PTSD in populations who experienced both traumas fitting the DSM-IV TR criteria and lifetime stressors which did not “involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others” (Meiser-Stedman, Dalgleish, Yule, & Smith, 2012; Mol, et al., 2005; Morgan & Janoff-Bulman, 1994).

Cumulative Trauma

Cumulative trauma indicates the presence of two or more different types of trauma occurring in one's lifetime (Samuels-Dennis, Ford-Gilboe, Wilk, Avison, & Ray, 2010). Experiencing multiple types of traumas, such as physical assault in addition to childhood sexual abuse, are thought to have an additive effect on symptom complexity (Cloitre et al., 2009) and severity (Martin, Cromer, DePrince, & Freyd, 2011). A large portion of the literature attending specifically to the impact of cumulative trauma suggests that the diagnosis of PTSD fails to recognize the traumatic impact of non-traumatic events (Gustafsson, Anckarsater, Lichtenstein, Nelson, & Gustafsson, 2010; Martin, Cromer, DePrince, & Freyd, 2011; Maschi, Morgen, Zgoba, Courtney, & Ristow, 2011).

Cumulative adversity includes experiences of trauma, but cumulative trauma only includes those specific instances where the criteria are met for DSM-IV TR trauma. Cumulative adversity is noteworthy because any build-up of stress has the potential to significantly impact mental health (Lloyd & Turner, 2008). In their study of cumulative adversity, these authors also included potentially but not definitively traumatic events such as learning of the death or severe abuse of a loved one. The specific focus of the study conducted by Lloyd and Turner (2008) was to determine the likelihood of the future development of alcohol dependence in children and adolescents. The authors discovered a significant difference in the rate of development of alcohol dependence in relation to ethnic groups, which suggests that marginalized groups are likely to be exposed to more cumulative adversities. "Lifetime adversity" is another term used in the literature to indicate exposure to both traumatic and non-traumatic life events (Hagenaars, Stins, & Roelofs, 2012; Lloyd & Turner, 2008). There are a number of authors whose research suggests

that accumulation of both traumatic and non-traumatic events can produce symptoms related to Post-Traumatic Stress Disorder.

With regard to cumulative traumas which meet the DSM-IV TR criteria for a traumatic event, Lloyd and Turner (2008) found that distal stress had a major influence on the development of alcohol dependence. This finding has important implications for the concept of developmental trauma (Van der Kolk, 2005) and the importance of therapeutic interventions at earlier stages of life. Interestingly, the study conducted by Lloyd and Turner (2008) found that although African American children and adolescents showed more exposure to cumulative adversity than any other ethnic group in the study, which included various traumatic experiences, they also displayed relatively low rates of alcohol dependence. The results of this study (Lloyd & Turner, 2008) may indicate that certain resiliency factors can be embedded in individual cultural values and traditions, such as the development and use of a large support network which extends beyond the scope of immediate family members. The importance of social support for individuals exposed to both traumatic and non-traumatic events was also noted in a study involving income-assisted single mothers (Samuels-Dennis, Ford-Gilboe, Wilk, Avison, & Ray, 2010) and a study involving inner-city women (Schumm, Briggs-Phillips, & Hobfoll, 2006).

Given that a state of cumulative trauma and cumulative adversity both imply re-victimization and a state of being exposed to stressful experiences more than one time, these experiences appear to be related to the concept of “allostatic load.” Where allostasis is the ability of an individual to effectively cope with the stress of his or her circumstances, a state of “allostatic load” occurs when the stress of an individual’s environment and situation overwhelm his or her capacity to formulate an adaptive response. Examples of behavior changes which result from allostatic load include lack of exercise, poor quality sleep, an increase in smoking or

drinking and use of illicit drugs. Individuals who have reached a state of allostatic load may also have an increased risk of developing symptoms of depression and anxiety (McEwan, 2008; Sprang, Katz & Cooke, 2009).

General Treatments for Trauma

Treatments specifically geared towards remediation of symptomatology resulting from the experience of a trauma, singular or cumulative, include EMDR, bilateral stimulation, and short-term or long-term psychotherapy (Cvetek, 2008; McNamee, 2003; McNamee, 2006; Wigren, 1994). Most recently, trauma-focused cognitive behavioral therapies (TF-CBT) have been developed for the treatment of trauma and have proven to be effective in reducing the severity of distressing symptoms (Deblinger, Mannarino, Cohen, Runyon & Steer, 2011, Kleim et al., 2012).

Treatment with TF-CBT involves progression through various stages of therapy which include safety planning, introduction of coping and relaxation strategies, development of a narrative outlining details of the traumatic experience, a cognitive restructuring process and finally, reintegration of the trauma by helping the client to generalize skills gained in therapy to his or her primary support system. Parallel caregiver involvement is recommended when those involved can provide stability and appropriate support to the client (Cohen, Mannarino, Kliethermes and Murray, 2012; Murray, Cohen & Mannarino, 2013). In a study by Cohen, Mannarino and Murray (2012), made suggestions are for adapting TF-CBT treatment for youth who have experienced “complex” trauma, which is characterized by repeated traumatic interpersonal relationships in early childhood. A few of the same authors adapted TF-CBT for treatment with youth who experience “continuous” traumas, given that severely and repeatedly traumatized individuals often experience continuing traumas even while they are in treatment for

exposure to other traumatic events. Their adaptation involves an additional component of treatment which reinforces positive coping skills and strategies for dealing with repeated traumatic exposure (Murray, Cohen & Mannarino, 2013).

It has been suggested that the development of a narrative is an essential component of trauma-focused psychotherapy (Wigren, 1994) and that narratives which include positive, complex descriptions of self are greater agents of change in the therapeutic process of the traumatized individual (Morgan & Janoff-Bulman, 1994). The research reports that self-appraisals of traumatic experience were the best indicators of impaired functionality in trauma survivors, and that the development of complex and positive narratives may serve to mitigate the severity of Post-Traumatic Stress Disorder and its associated symptoms (Kleim et al., 2012). In a recent study conducted by Deblinger et al. (2011), it was found that inclusion of the trauma narrative component of TF-CBT had significant reparative impact on symptoms of anxiety and general fearfulness experienced by children who had been sexually abused when compared with a course of CBT that did not include the creation of a narrative.

Van der Kolk (2005) has also stated that there may be a need for development of a treatment protocol directed specifically at the unique symptomatology experienced by children affected by complex trauma. The Affect, Self-Regulation and Competency (ARC) model focuses on treatment of childhood complex traumas by creating a framework which addresses interruptions in the affected child's developmental trajectory as a result of living in a hostile or chaotic environment. The ARC model was designed in consideration of the specific developmental needs of children to promote resiliency and healthy emotional development overall (Kinniburgh et al., 2005).

Art Therapy Literature

A number of articles in the art therapy literature have addressed the unique benefits of creative arts therapies in both the diagnosis and treatment of trauma (Read-Johnson, 1987), and the benefits of art therapy, specifically (Buk, 2009; Eaton, Doherty, & Wildrick, 2007; Lusebrink, 2004; Rankin & Taucher, 2003). Read-Johnson (1987) noted that all creative arts therapies provide a unique opportunity for traumatized individuals to express emotions related to the event non-verbally. One of the essential first steps of general trauma treatment, according to Read-Johnson (1987) is an individual's ability arrive at complete recognition of the traumatic event, a process frequently inhibited by the inability to access emotions, known as alexithymia. Artistic processing may allow an individual to revisit thoughts and feelings directly or indirectly and may circumvent alexithymia in the trauma survivor (Read-Johnson, 1987; Lusebrink, 2004). Lusebrink (2004) suggests that this unique benefit may be attributed to the ability of the art process to utilize different neuropathways when accessing traumatic memory. Additionally, Read-Johnson (1987) recognized the usefulness of visual distancing which art-making may provide to traumatized individuals.

In contrast to Read-Johnson (1987), Rankin (2003) focuses her attention on reduction of specific symptoms to move toward the general improvement of the quality of life of the trauma survivor. The improvement of quality of life is closely aligned with what Read-Johnson (1987) conceptualized as reintegration of the self after a trauma. Rankin (2003) further suggests that the use of a narrative in art therapy interventions may facilitate reorganization of the narrative to include the traumatic event. These art therapy tasks are all formulated in the interest of reducing symptoms associated with PTSD.

A number of recent articles introduced the integration of art therapy into evidence-based treatments of trauma, including trauma-focused cognitive-behavioral interventions (Pifalo, 2007), EMDR and bilateral stimulation (McNamee, 2003; McNamee, 2006; Sarid & Huss, 2010; Tripp, 2007). According to Lusebrink (2004), art creation stimulates the senses and activates one's physical being. This concept is also cited as having profound importance with regard to the treatment of trauma survivors using modified EMDR and bilateral stimulation and the art process (Tripp, 2007).

Literature available addressing the specific treatment of cumulative trauma using art therapy-based interventions is recent and limited. The only available study in the art therapy literature which mentions "cumulative trauma" focuses on the creation of a mural with a group of adolescent trauma survivors (Testa & McCarthy, 2011). The article is a qualitative presentation of how trauma was addressed with this group and does not describe the specifics of treatment. There appears to be a need for quantitative, generalizable research with regard to art therapy in the treatment of cumulative trauma, specifically.

Conclusion

Review of the literature in the field of general psychology indicates that there is a growing interest in the effects of accumulated traumas over time. Whether placed within the context of cumulative trauma (Briere, Kaltman & Green, 2008; Dulin & Passmore, 2010; Follette et al., 1996; Kira et al., 2012; Martin et al., 2011; Maschi et al., 2011; Samuels-Dennis et al., 2010) or the more general notion of accumulated adversity (Ansell et al., 2012; Gustafsson et al. 2010; Lloyd & Turner, 2008), it is clear that the individuals who experience multiple types of highly stressful events are at risk for entering a dangerous state of allostatic load (McEwan, 2008; Sprang, Katz & Cooke, 2009). Consequences of reaching allostatic load include development or

worsening of mental illness, general impairment in daily functioning, substance abuse, and may even predispose an individual to re-traumatization. While there is still marked variability in definitions of trauma across the literature, it is clear that researchers now recognize the importance of the impact of both “traumatic” and “non-traumatic” events on an individual’s ability for adaptive coping (Morgan & Janoff-Bulman, 1994; Meiser-Stedman et al., 2012; Mol et al., 2005). With respect to the art therapy literature, the majority of trauma-related research is focused on using art therapy techniques to treat isolated traumatic events, and have yet to address issue of cumulative trauma, specifically (Buk, 2009; Rankin & Taucher, 2003; Talwar, 2007). While the lack of information about cumulative trauma in the art therapy literature may be disquieting, it also signals an important opportunity for discovery. There appear to be many benefits to using art therapy in the treatment of isolated traumatic events (Read-Johnson, 1987; Tripp, 2007). Art therapy possesses a unique ability to facilitate both “top-down” and “bottom-up” processing of traumatic memory, and provides a visual record of treatment progress (Lusebrink, 2004). Additionally, the current trend of successful integration of art therapy within evidence-based treatment protocols for trauma (EBTs) is encouraging (Pifalo, 2007). The research suggests that art therapy may have special benefits to offer within treatment of isolated events and may be directly applicable to the treatment of cumulative trauma as well. Certainly, there are strides to be made in the research with regard to the role of art therapy in treating cumulative trauma.

Research Approach

This qualitative research study was informed by a grounded theory approach. According to Kapitan (2010), qualitative studies are conducted for the purpose of “ understanding a

phenomenon rather than testing it” (p. 212). Because so little is yet known about best practices in treatment of accumulated trauma, specifically, qualitative study proved to be a suitable approach towards developing a richer conceptualization of how clinicians are currently addressing cumulative trauma in their clinical work. This type of study also allowed clinicians to elaborate upon their personal experiences in terms of treatment successes and difficulties. Semi-structured interviews were used to collect data in the interest of conducting a grounded theory analysis of the potential benefits of art therapy in the treatment of cumulative trauma. The openness of a semi-structured interview is essential to qualitative exploration of a topic in that it allows the interview to develop freely toward the concepts that are most important to the participants while remaining unaffected by the preconceptions of the researcher (Rossman & Rallis, 2012). The flexible nature of the semi-structured interview process allows participants to describe personal experiences that have impacted their clinical work and provides the researcher with authentic narratives which are organized in the analysis and coding of data.

Because the topic of cumulative trauma is fairly recent and dominated by quantitative research in the existing literature, qualitative study was warranted in order to gain a deeper and more complex understanding of how professional art therapists have facilitated positive change in traumatized individuals (Creswell, 2013). The information gathered allowed the researcher to develop themes and provided the researcher with an opportunity to “theorize” or “construct robust explanations of actions and interactions” (Rossman & Rallis, p.106, 2012) related to the perspectives of working professionals. The analysis process, informed by a grounded theory approach, allowed the researcher to identify themes related to the mechanisms of change in various art therapy treatments. Grounded theory-informed analysis for this research project culminated in the construction of a basic framework for applying art therapy to the treatment of

cumulative trauma. Creswell (2013) states that grounded theory work is especially useful when a “theory is not available to explain or understand a process” (p.88). This is certainly the case with regard to this research subject, considering the absence of any frameworks for treatment of accumulated trauma in the field of art therapy.

Methods

The methods section includes a list of definitions essential to the understanding of the background and significance of this research project. This section also includes an outline of the design of this particular study, including the participant recruitment procedures and the approach to data collection. A breakdown of the grounded theory data analysis used in this research project is also provided in the methods section.

Definition of Terms

Psychological Trauma: For the purposes of this research project, psychological trauma may be understood as “any event that has a lasting negative effect on the self or psyche” (Shapiro, p. 14, 2004) and causes “intense fear, helplessness, or horror and that overwhelms the normal coping and defense mechanisms” (Solomon & Heide, p. 202, 1999). Psychological trauma occurs when there is a resulting “breakdown in the capacity to regulate internal states” after a specific event or events (Tripp, p. 177, 2007).

Traumatic event: The definition of trauma provided by the Diagnostic and Statistical Manual of Mental Disorders (2000) requires the experience of “actual or threatened death or serious injury; or other threat to one’s physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” (American Psychiatric Association, p. 463, 2000).

Non-traumatic event: For the purposes of this study, events which do not involve “actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (p.463) as outlined by the DSM-IV-TR (American Psychological Association, 2000) will be

referred to as a “non-traumatic” event (Boals & Schuettler, 2009) without regard to its actual psychological impact on any party involved.

Interpersonal Trauma – a traumatic exchange between two parties in which there is an identifiable perpetrator and victim who share a close personal relationship. Interpersonal traumas may elicit feelings of fear, horror, helplessness, or betrayal, and are thought to be markedly more detrimental to overall functioning than other types of trauma. Examples of interpersonal traumas include neglect, physical or sexual assault (Martin, Cromer, DePrince, & Freyd, 2011)

Developmental Trauma Disorder -- Bessel van der Kolk (2005) began publishing his work expanding the definition of complex trauma in an effort to initiate a new diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders. This provisional “Developmental Trauma Disorder” is predicated on the notion that multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults or witnessing domestic violence have consistent and predictable consequences that affect many areas of development and functioning.

Cumulative Trauma – also referenced in the literature as “accumulated trauma,” cumulative trauma refers to the “number of different trauma types (and not the total number of traumatic incidents) experienced” by an individual (Martin, Cromer, DePrince, & Freyd, 2011).

Cumulative Adversity – also referenced in the literature as “accumulated lifetime adversity,” “negative lifetime events” or “lifetime stressors,” cumulative adversity is defined for the purposes of this project as the experience of one or more different types of major stressful events which may or may not fit the DSM-IV TR for psychological trauma (Ansell, Rando, Tuit, Guarnaccia, & Sinha, 2012).

Posttraumatic Stress Disorder (PTSD) -- is a mental disorder characterized by the development of a collection of symptoms following exposure to “an event that involves actual or threatened death or serious injury, or a threat to one’s physical integrity; or witnessing an event that involves death, serious injury, or a threat to the physical integrity of another person, or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” (American Psychiatric Association, p. 463, 2000). The event must elicit feelings of “fear, helplessness, or horror.” The diagnosis of PTSD is warranted when symptoms of reexperiencing the traumatic event, avoidance of stimuli and a persistently hyperaroused state are present in the affected individual (American Psychological Association, 2000).

Subthreshold PTSD – This is also referred to in the literature as “partial” PTSD (Zlotnick, Franklin, & Zimmerman, 2002). An individual is considered to have “subthreshold PTSD” when they are experiencing clinically significant symptoms of Posttraumatic Stress Disorder (including dissociation, avoidance, hypervigilance, hyperarousal, depression and anxiety), but do not fully meet the criteria for a diagnosis of Posttraumatic Stress Disorder as defined in the DSM-IV-TR (Cukor, Wyka, Jayasinghe, & Difede, 2010).

Design of Study

Sampling - Subjects were chosen from a pool of professional art therapists, which included supervisors and clinicians affiliated with Loyola Marymount University’s Marital and Family Therapy program. Three subjects were selected by the faculty sponsor and the researcher based on their availability, willingness to participate, and experience with the treatment of individuals who have experienced cumulative trauma. For the purposes of this research, subjects were all familiar with the use of art therapy as a treatment modality. The small sample size was

appropriate for gaining a complex understanding of each individual clinician's experience with art therapy in the treatment of cumulative trauma.

Gathering of Data

Prior to data collection, the researcher administered a consent form delineating the background and purpose of the research study. Each participant was provided a copy of the outline for the semi-structured interview so that they could familiarize themselves with the topic of the interview. Each semi-structured interview was conducted by the researcher and held at the individual participant's convenience at a mutually accessible location. Each interview was approximately 45-50 minutes long and allowed each of the participants the opportunity to share the nuances of their experience with art therapy and cumulative trauma. Each interview was separately recorded and transcribed by the researcher for data analysis.

Analysis of Data

After each interview was transcribed it was reviewed and edited for accuracy by the researcher. The researcher then began the grounded theory process of *open coding* which organized elements of the transcribed narratives into overarching themes and categories. The researcher identified core phenomena and began axial coding around the most prominent emerging theme. Categories were then connected to each other according to similarities and organized in a visual picture which illustrated how these themes are interrelated. The thematic connections which resulted from this analysis assisted the researcher in constructing a framework for understanding how art therapists have approached the treatment of cumulative trauma and highlighted patterns of efficacy to be considered in the treatment of affected populations.

Results

Presentation of Data

Clinician Interview #1: “Amy”

The interview with Amy was scheduled for a Friday afternoon at 3:00 P.M. in the library of the Marital and Family Therapy and Art Therapy department at Loyola Marymount University. During her second year at Loyola Marymount University, Amy became interested in lifetime trauma and explored the subject in her own research project. As it happens, many of the same citations can be found in both of our literature reviews. When Amy arrived, we took time to introduce ourselves to each other. I learned that Amy practices marital and Family Therapy in an agency near Long Beach, California, which serves families and children who have been identified as in need of extra support to address “emotional disturbances” in members of the family. As we spoke, Amy stated that a great majority of the emotional disturbed individuals who seek treatment at her agency experience difficulty as direct result of the accumulation of trauma. I confided in Amy that I was feeling excited to learn about her experience with the treatment of traumatized children and families, and we officially began the interview.

To begin our conversation, I asked Amy to describe her understanding of the concept of cumulative trauma. This was an important component of our interview, as cumulative trauma is defined in many different ways in the literature. Amy described the experience of cumulative trauma as a “build-up over time” of negative and stressful experiences that are not isolated to client experiences, but something everyone experiences at some point in their life. As Amy put it, “we all get kind of beaten-up on a daily basis” and the extent to which we are allowed to recover from this wear-and-tear seems related to the impact of those negative experiences on our daily lives.

Amy noted that often, recapitulations of traumatic experiences are built in to the family systems she encounters in her work, possibly because caregivers do not have the time or resources to resolve or “work-through” a traumatic experience. Many of the families Amy works with are frequently involved in wider systems like courts, special education school programs, group homes, and foster care systems. Amy stated that these systems are “built on” and around traumatic experiences such as domestic violence, child abuse and neglect and drug use. These experiences are often side-effects of extreme poverty, medical and mental illness and other types of disadvantage. In Amy’s experience, a family’s constant involvement and exposure to the traumatic experience of those in their extended family and social circles may perpetuate the experience of trauma in their own lives. In other words, “trauma begets trauma,” especially with regard to caregivers who are unable to parent as effectively as they would be able to if their own mental health issues had been previously resolved.

Amy then asked me to outline how I was using cumulative trauma in my research study so that she could have an understanding of the type of information I was most interested in. I shared what I had found in the literature with regard to the differences between “little t” traumatic experience and “big T” traumatic experience and explained how I had chosen to define cumulative trauma as accumulation of any combination of types (i.e. two “little ts” and a “big T” versus two “big Ts” and a “little t” traumatic experience). Amy joked that the variability in the combination of different types was reminiscent of a “really bad math word problem in your life.” This seemed to be an apt comparison especially because it is exceedingly difficult to find a workable “solution” to the multifaceted problems of the individual exposed to cumulative trauma.

Amy and I then spoke about the different symptom presentations of cumulatively traumatized individuals. Amy pointed out that depending on risk and resiliency factors and personality type, behaviors often look very different among different individuals (i.e. Oppositional Defiant behaviors, Anxiety and PTSD-like symptoms, or social withdrawal and Depression). Amy clarified the types of individuals that she has worked with at her agency. Among both adults, adolescents and children, exposure to domestic violence, sexual and emotional abuse is frighteningly common in the lives of these clients. Amy mentioned how lack of preparedness to become parents can be hugely detrimental to the well-being of both clients and their caregivers and how the accumulation of trauma can travel across generations for ostensibly very long periods of time.

In terms of resiliency factors, Amy enumerated the conditions that predispose clients to relative successes, one of which was stability of environment. Another important component of this resiliency was positive reinforcement of the client's natural resources and the power of unconditional positive regard. Amy suggested that the nature of the therapeutic relationship as a safe, consistent container for thoughts and feelings was particularly effective for those who have experienced multiple types of trauma over time. Amy was able to recall one individual in particular who was recently discharged from her program because she had been evaluated as relatively self-sufficient. Although this client was originally identified as "severely emotionally disturbed" and diagnosed with Oppositional Defiant Disorder and Major Depressive Disorder, Amy reported that she is now in a relatively stable home and on-track to graduate from her high school. As Amy spoke about this client, it was clear that they had developed a rich and supportive relationship and that Amy was proud of her former client's remarkable progression through her 3-year course of therapy. Amy admitted that it was a difficult and slow-going

process for this child to open up enough to be able to use the therapy or the art to reflect upon her behavior and her life situation.

At this point, Amy bashfully admitted that she had to jump through hoops and pull strings left and right to keep this client on her caseload for 3 entire years because she felt that it was what the client needed to make use of their therapeutic relationship. Amy and I spoke about the restrictions that are now being imposed upon psychotherapists and the agencies at which they practice in terms of goal-setting and time frame for treatment. It is rare that a psychotherapist at a community mental health agency would be permitted to see one client for such an extended period of time, despite the fact that the stability provided by three years of consistent therapeutic contact was a determining force in her client's success.

At this point, I questioned Amy about her approach to therapy, given the complexities and nuances of an individual case so affected by the accumulation of both "little t" and "big T" types of trauma. In response, Amy shared that her client had rejected many of her initial invitations to engage in conversation about her life and personal circumstances. It appears that Amy's client was practiced at defending against reminders of the many painful experiences in her life. Despite this, eventually their relationship became strong enough for her client to begin to disclose the intimate details of her traumatic life experience. Amy also noted the importance of a humanistic approach with traumatized clients. She stated that it seemed particularly important to respect the client's well-developed defense mechanisms in order to ensure a sense of safety, and that often the most beneficial approach was to consider the client's daily state of being and address her real-world concerns in every session. This helped the client feel that Amy truly cared about her and was willing to be gentle in the process of treatment. Amy stated that

allowing the client to take her time and maintaining authenticity helped her client to gradually become more vulnerable and ready for the deeper processing to occur.

At this point in the interview, the clinician shared that there had been a pivotal point in the client's treatment when her living environment was stable and she allowed herself to be completely vulnerable with the therapist. Although it took over two years in treatment with this particular clinician, the client was finally able to acknowledge the difficult feelings she had been defending against so fiercely. When the client sensed that she could be in safe in her vulnerability, Amy noticed a change in the way her client began to think about herself. It was remarkable to Amy that after two years, her client had finally absorbed some of the positive regard, respect and admiration that had been reflected to her by her therapist throughout treatment. Even after she noticed this change in her client, Amy reiterated that some days the client was capable of delving into deeper psychotherapeutic work, and other days the client became protective once again. Allowing the treatment to flow in this way and following the client through personal therapeutic journey appeared to be a hallmark of Amy's treatment with this particular individual. Amy reflected that navigating the balance between being flexible and creative while also meeting the expectations of one's respective agency can appear daunting. She candidly shared how she worked to meet the regulations of her own agency while also meeting the ever-shifting needs of her client. Using measurable goals and interventions is becoming more prominent in the field of mental health, and it is important for clinicians to find ways to be creative and flexible while meeting the expectations of the agencies in which they work. Amy voiced the importance of transparency in her work with regard to involving the client in goal-setting, particularly because her agency requires therapists to create concrete, measurable goals for treatment.

Amy shared that when creating goals for treatment with her client, she explained them in the context of the experience of “little t” trauma, and spoke at length with her client about how she felt each of those experiences had impacted her ability to cope and communicate with other events in her life. With her traumatic experiences in mind, the client was able to delineate where she felt she wanted to make personal improvements through the therapeutic process. Throughout Amy’s descriptions of her interactions with her client, it became clear that part of the reparative process hinged upon empathic reflections by the therapist, and a genuine sensitivity to the client’s personal needs. As a part of treatment, Amy encouraged her client to practice both relaxation and self-care techniques, both independently and within session. In time, the client began to use the art-making process outside of sessions, and even began engaging in a self-directed art process during which she would alternate hands while drawing to help her achieve a sense of balance. Amy shared her feelings that “little t” and “big T” events exist on a continuum of the client’s overall experience, and that targeting a cognition that is tied to a “little t” is likely also related to some “big T” experience.

Throughout the treatment, Amy provided acceptance and containment in different ways. Whether she provided security to her client through the space in which they worked, through reflecting and reframing, or through the art materials themselves, Amy was careful to be sure that the client’s experience was a safe one. The art appeared to be particularly useful for Amy’s client as a way to triangulate the intensity of the emotions shared in session. The art served Amy’s client as an externalization of powerful and painful themes which might have been too overwhelming for the client to expose as a part of herself. In addition, the routine of using art in every session provided her client with a sense of grounding. In terms of the types of directives that were most effective, Amy recalled one session during which she divided a single page into

four boxes and recorded the feelings she associated with a narrative described by the client. After recording the four most prominent emotions, Amy asked her client to illustrate each of them. This appeared to be helpful for the client as part of a therapeutic dialogue about the identification, expression, and acceptance of her own feelings. In addition, this exercise may have provided a sense of attunement from the therapist that the client had not experienced in the rest of her life. Amy also shared that the art should be used with care and consideration, keeping in mind the associations that might be connected to each of the materials. She stated the importance of selecting materials with the needs of each client in mind, and to tread slowly when individuals are unfamiliar with art-making in general.

Finally, I asked Amy if she had any advice to offer a fellow clinician for treating individuals who have had an experience of cumulative trauma. Amy's advised that clinicians should always be mindful of how the expectations of their respective agencies shape their treatment approach. She encouraged me to consider the needs of the client first and foremost, and to be genuinely attuned to the client's readiness to proceed in treatment. I reflected to Amy that I was taken with the way she spoke about her clients with love and admiration, and asked whether she thought her clients internalized some of that value and positive regard. Amy wholeheartedly agreed, and further suggested that if the therapist's feelings about the client are genuinely felt, they will be absorbed and also felt by the clients themselves.

When we finished the interview, I took some time to process the felt sense of my meeting with Amy through art-making. For my reflective art piece, I chose to use watercolor paint. This choice was informed by the sense of flexibility and fluidity that had been described in Amy's treatment approach. In creating this watercolor painting, I followed the direction that I sensed the water was flowing until a recognizable shape appeared. The colors I chose were warm and

reflective of the genuine human connection I had felt within the interview process. I used colors that I felt communicated the sense of hopefulness Amy had communicated with regard to her client. As I continued to paint, two distinct figures emerged. One appeared to be larger and stronger, while the other figure appeared to be underdeveloped. Gradually, the larger figure became a representative of stability and protection –both elements that Amy had described as essential to her clients' recovery. As I reflected on the ways that my painting was transforming, it occurred to me that the two figures could reflect both the transformation of the client in trauma treatment as well as the importance of the therapeutic connection. It was interesting for me to consider whether the two figures I had drawn were indicative of the process of a single entity, or the connection between two separate entities.

As I continued, I decided to outline some components of the painting with colored pencil and pen. My urge to contain this very fluid painting may reflect the importance of a containing environment during a course of cumulative trauma treatment. At the center of the painting, the smaller figure is represented with a spiky, painful-looking outline which may represent the additive damage sustained from multiple traumas. Although the smaller figure appears to be supported by the larger, more developed figure, the central redness makes the figure appear raw and vulnerable. Lastly, the sweeping lines around both figures, meant to indicate change and transformation, also form the shape of a heart. This part of the image was unintentional, and it may be representative of the great amount of love and positive regard necessary for successful trauma treatment. The artwork described is shown below in figure 1.



Figure 1

Clinician Interview #2: “Marie”

The interview with Marie was scheduled for a Friday afternoon at 12:00 P.M. at her private practice office. Marie has been treating individuals through private practice since her graduation from Loyola Marymount University’s Marital and Family Therapy and Art Therapy program. She sees children and adults of all ages and accepts referrals from many different agencies in Los Angeles County. When I arrived at her office, she invited me to take a seat across from her and closed the door before we began. For a moment, I was able to imagine what it might like to be a patient in her private practice. Her room was warm and comforting. For my first point of inquiry, I asked Marie to share her understanding of cumulative trauma. Marie suggested that cumulative trauma might refer to the occurrence of multiple “acute” and “diffuse” events over the course of a person’s lifetime. She suggested that many traumas in one’s life are “harder to pinpoint” than overtly traumatic events like sexual abuse or neglect, and that the accumulation of these events contribute to the experience of cumulative trauma. I related her example of “diffuse” events to the concept of “little t” occurrences, which is a term used to describe objectively small, but subjectively distressing events which have a significant psychological impact.

At Marie’s invitation, I went on to explain the definition of cumulative trauma as the state of an individual who has experienced more than one “type” of traumatic event (i.e. physical abuse in addition to witnessing to the death of another person). We then discussed the difference between “little t” events and “big T” events in the context of Francine Shapiro’s writings about Eye Movement Desensitization and Reprocessing techniques, which stipulate that any event can be classified as “traumatic” if it had lasting negative psychological effects on the individual involved. We began a conversation about the two criterion introduced in the DSM-IV-TR classification of trauma, first that the event must involve “actual or threatened death or serious

injury,” and second, that the experience must yield an emotional reaction of “fear, helplessness, or horror.” When I asked Marie how she felt about these contrasting definitions of trauma, she stated that in her experience as a clinician, she has seen “big T” and “little T” events “go hand-in-hand.” In Marie’s view, each large or small trauma has the potential to compound and complicate the detrimental psychological effects produced by the other. After a minute of silence as she tried to think of an example of an individual who may have had a big T trauma in the absence of little t experience, she shook her head. With an air of surprise, she admitted that nearly every single individual she could recall from her practice had experienced both “major” and “minor” traumas together. Marie disclosed that the individual she originally had in mind had been acutely sexually abused once by a stranger, but had come from a relatively stable home environment. After some discussion about his case, Marie acknowledged that the individual had also been bullied at school and that this experience may have been impactful enough to qualify as a minor trauma.

Next, I asked Marie to describe any patterns she had noticed among clients who had experienced cumulative trauma. Marie asked for clarification as to whether she should describe common presenting problems or patterns of behavior in the context of therapy. I assured her of my curiosity regarding all patterns among this population. To begin, Marie described a heightened level of “guardedness” and issues of trust, especially at the beginning phase of therapy when it is important to establish rapport. She stated that it is often easier for clinicians to see how mistrust is related to major traumatic events, especially those which involve betrayal by another individual such as sexual abuse or neglect, but she also stated that the damage from smaller traumas distributed throughout a lifetime can be more insidious. Marie suggested that the impact of smaller traumas is often harder to target in treatment because their significance is

predicated on subjective appraisal by the affected individual. According to this clinician, small traumas may also affect the way a client approaches the therapeutic relationship, because small traumas are often interpersonal in nature. Marie shared that the defensiveness she has witnessed in treating individuals with TF-CBT will sometimes prevent an individual from becoming fully engaged in the process of recovery. Defensiveness can be especially impactful with respect to the art process. Often, individuals who have experienced traumas feel vulnerable and exposed when asked to make art in session.

Intrigued by Marie's discussion about how small traumas may complicate treatment, I asked if she had any individuals in mind who were in treatment for an accumulation of different types of "small t" events. Initially, Marie seemed stumped by this and gave the question a great deal of thought before outlining a case in which the individual had only accumulated multiple minor traumas. Marie shared that this particular client had difficulties related to internalizing negative events and relating them to her self-worth. Marie described the treatment as a reflective, in-depth exploration of the various small traumatic events that had caused the client to begin regularly blaming herself for the actions of others. After Marie described the client's behavior in detail, she suggested that because small t events are often not acute, identifiable occasions, they can be hard to identify and are often subconsciously internalized as a defective part of the self.

With regard to patterns in symptom presentation of individuals who have experienced cumulative trauma, Marie stated that when there has been a "big T" event, she often notices conflicting patterns of avoidance and re-experiencing, both of which are common in Post-Traumatic Stress Disorder (PTSD). Marie shared that there is often a sense of "powerlessness" and "agitation" with regard to avoidance and re-experiencing. She stated that clients will often express profound confusion at their own irritability and sense of internal conflict. Marie stated

the importance of psycho-education in acknowledging and normalizing an individual's struggle with re-experiencing and avoidance. I then asked Marie if she ever came across a client whose symptoms did not meet full criteria for PTSD, to which she answered that if she looks closely, full criteria can often be met. Marie went on to add that she believes people can be "triggered" by exposure to a situation reminiscent of a "small t" event in their lives. She shared that explaining the concept of "triggers" works for those affected by major and minor traumas alike. Marie explained being "triggered" as being temporarily compromised and "locked away" from one's insight, patience and positive coping skills. Marie shared that getting people to recognize triggers and what it means to be triggered can assist individuals in moving through treatment successfully, regardless of the type of trauma experienced. I asked Marie if she had seen any individuals who had depression or anxiety in the absence of avoidance and re-experiencing. Marie assured me that most of the time if there has been a trauma the complete symptom profile for PTSD is usually present, although it sometimes takes some "digging around" before the client discloses certain types of re-experiencing, such as recurring nightmares about the traumatic event.

For the next segment of our interview, I asked Marie about any risk factors that may predispose an individual to having more or less symptoms as a result of the traumatic events that were experienced. Marie hesitated to make a generalization about risk factors, but she was able to state that there may be a difference between clients of high or low socioeconomic status with regard to intensity of symptoms. This observation may be related to the amount of financial or familial stressors that affect an individual's perception of the traumatic event and the availability of resources to help them effectively cope. I then transitioned into a question about risk factors with regard to possible "sticking points" in the treatment. I asked Marie if she noticed patterns in

individuals who are able to integrate traumatic events successfully and patterns among those who have more difficulty completing this treatment goal. Marie responded emphatically that the common denominator in successful integration appears to be secure attachment, and especially parental support through the treatment. She stated that one of the reasons why she is sure to include parents in TF-CBT is that the unconditional love and support of a parent makes an incredible difference in treatment outcome. Recognizing that for some, parental support may not be a viable option, Marie reflected about an adult client of hers who is working through addiction. She speculated that the Alcoholics Anonymous community has given her support and helped her to have faith in her own ability to heal, and that it seems very important to have a primary support group when working through a traumatic experience. Marie also related the primary support group of an individual as a step toward generalization of the gains made in therapy.

Next, I invited Marie to share a case vignette that she considered to be successful and to discuss any resiliency factors that may have been at work during treatment. She described a 14-year old client who had been sexually abused by her mother's romantic partner. The client had also been exposed to domestic violence at a young age and came into treatment because she began experimenting with illicit substances in an effort to control her symptoms. To further complicate the matter, Marie believes that there were multiple minor traumas experienced within the process of moving out of the home, the involvement of the Department of Child and Family Services, and feeling that she had destroyed her family by disclosing the sexual abuse. Marie described the client's mother as "quite-attuned" and that treatment involved art-making and TF-CBT in concert. The client used art-making and writing to construct a narrative of her trauma, which her mother listened to carefully as part of the treatment protocol. Marie noted that the

client's mother would also "hold" her, when she was distressed, both in session and at home, and appeared to be very patient and understanding in helping her daughter with recovery.

The pivotal point in this course of therapy, according to Marie, occurred within the module of creating, reading and re-reading the narrative. She said that this was a great help to her client in being able to "take the power away" from the traumatic event. Another inspiring moment that Marie described occurred when the client was at the beach with friends outside of session. The client returned to Marie's office and shared that while she was at the beach, she had realized, "there are so much bigger things than this. There is so much more in the world than this, and I am so much more than this." Marie explained that this client's ability to make positive meaning out of her experience signaled that the memory of the trauma had become exponentially less impactful. The client was able to integrate the trauma into her narrative in such a way that she began realizing the importance of offering support and understanding to other traumatized individuals. Marie described this as an ideal movement through TF-CBT with appropriate parental support, culminating in positive meaning-making and integration. Marie then added that the client left treatment for a time after her course of TF-CBT was finished, but then returned to work through more "little t" events that were able to surface once the larger traumas had been appropriately worked through.

I then asked Marie if she worked exclusively through TF-CBT when treating traumatized clients and she stated that it was her "go-to" plan. She also stated that art-making aligns nicely with the various components of TF-CBT, especially with the creation of the narrative. She stated that using words is important in creating the narrative, but that artwork adds an important layer of sensory experience as well. I asked Marie to describe any successful or unsuccessful art interventions she had used within TF-CBT. Marie responded that using the art materials to create

personalized scales was particularly useful for clients so that they could participate in recognizing the intensity of their emotional and physiological responses throughout treatment. Additionally, the artwork appears useful for creating a representation of the client's "safe space" that they may retreat to when they are overwhelmed or triggered. Marie also shared a specific directive which involved writing coping strategies on sheets of paper and storing them inside of a tissue box where the client can retrieve them when he or she feels triggered. After some thought, Marie added that she enjoys one particular directive designed to help the client identify feelings in the body by providing an outline of a human form and pieces of tissue paper. Marie explained that the client can recognize where intense emotions are felt somatically and gain awareness of the specific physical sensations they experience when they are triggered. I then questioned Marie about any materials that she would use or choose to avoid with individuals who have experienced cumulative trauma. After some thought, Marie said that she would lean toward highly structured and containing materials, especially during the narrative portion of TF-CBT. The only exception to this would be if the individual had difficulty expressing emotion in general. In this case, Marie would use looser materials to psycho-educate the client about the link between art and emotional expression in an attempt to help the individual "open-up."

At this point in the interview, I became curious about Marie's relationship with her clients. I invited her to share her personal interactional style, and describe how "gentle" she felt she needed to be when treating those with the experience of multiple traumas. Marie shared that during introductory sessions, it was important for her to be professional, knowledgeable, and warm with her clients. She stated that at the beginning of TF-CBT, providing psycho-education, making efforts to normalize the client's experience, and instilling a sense of hope are of utmost importance. Marie added that joining was also important, and that she will work with the clients

to prepare a list of helpful distractions before treatment begins so that if they are triggered, they can turn their attention to an activity that the client enjoys. Marie used the examples of playing “Uno,” watching funny YouTube videos or creating non-Trauma related stories with her clients to redirect their attention. Marie also noted the importance of a sense of humor, and the importance of being a continuous source of reassurance and affirmation for her clients. At times, Marie has acted as a “coach” when her clients are in need of an encouraging “push,” especially during the narrative portion of TF-CBT. Marie finds it helpful to “take control” of the session more with traumatized clients because they are in a “compromised” state when trying to navigate through the myriad of ways their trauma has affected them. I reflected upon what Marie had said and suggested that perhaps taking control provided a sense of containment and safety that served to counteract the unpredictable and dangerous nature of the traumatic event. Marie wholeheartedly agreed, and added that the most effective way to handle the internal chaos experienced by traumatized individuals seemed to be helping them regain a sense of power and control.

I began the final portion of my interview with Marie by asking if she had any advice to offer a fellow clinician regarding the treatment of those who have experienced multiple major and minor traumas. I admitted that as a young therapist, the concept of treating not just one, but many traumas in a single individual seemed daunting, and that I wondered what her recommendations were in terms of how to approach the complexity involved in cumulative trauma. Marie answered that it was most important to target the traumatic experience that had the largest impact on the individual’s life. She stated that the meanings people make of their lives are subjective, and so it is important to uncover the most prominent and painful experience first. Marie suggested that the effects of targeting the most traumatic event often generalize out to

lesser traumas in an individual's life experience. She also noted that "small t" events may require a different type of treatment, because lesser traumas may be easier to repress and avoid than large, acute events. Marie and I discussed the possibility of guilt becoming a factor in avoiding treatment for a "small t" event, because they may seem objectively unremarkable. She suggested that the first step in treating a "small t" event would be to help the client recognize and accept the impact of what transpired, regardless of its objective importance. Marie advocated for the importance of the cognitive restructuring module of TF-CBT, and speculated that if the restructuring was implemented successfully, practiced by the client, and continually reinforced, it would have an effect on related cognitions about "little t" events. In Marie's experience, many unhelpful cognitions that develop in response to various "little t" and "big T" events in an individual's life are related, and so it stands to reason that the resolution of one incorrect cognition might impact others.

For her final advice for the treatment of trauma, Marie offered what she believes to be the pillars of successful treatment: installation of hope, and expression of love. Marie clarified that by "love" she means unconditional positive regard, and total acceptance of the person who comes into treatment. In her practice, Marie shows "love" to her clients through unwavering support, encouragement, and affirmation of their value as a unique and resilient human being. This "love" enables the client to become completely vulnerable with Marie, a leap of faith which she feels is a pivotal force in the healing process. Before leaving her office, I thanked Marie for her time and support of my research project.

Later in the day, while listening to an audio recording of our interview, I created a piece of artwork (Figure 2) to help me reflect upon the information that I had collected. The work was created from collage material and includes a large, cracked heart as the central image, with three

figures facing each other below the central heart. Through a methodical process of cutting, pasting, and outlining, two larger humanoid figures emerged. One figure appears to be transparent with the exception of a layered paper heart, which I pasted over the figure's chest. This figure was created to represent the therapist. In this work, the therapist is facing a larger, shadowy figure behind the small orange person on the staircase. The orange figure and the black figure are both facing the therapist. This contact between the three figures seems to represent the attunement of the therapist to the client as they present during treatment as well as attunement to a deeper, inner-self, represented by the orange figure. The orange figure is seated at the top of a staircase, which is meant to represent progression through each module of TF-CBT.

Recognizing the need to contain these elements of my artwork, I used a photo of dried flowers and warm, comfortable-looking images to surround the central heart. It is possible that the inclusion of symbols of comfort reflected Marie's gentle and comforting approach to the treatment of traumas. The importance she places on safety and containment is reflected in the many outlines that frame the central figure. Despite my efforts to contain the broken heart pictured below (figure 2), the white oil-based marker I was using overflowed and dripped towards the bottom of the page. This phenomenon provided an interesting metaphor for the importance of patience and acceptance of the client's readiness to proceed with treatment. Additionally, there is a red, sharp-looking outline surrounding a portion of the black client figure. Upon reflection, it occurred to me that this bright red line was a representation of both the client's vulnerability and his exposure of pain, both of which are difficult and necessary for complete resolution and reintegration of traumas. To finish the picture, I placed a quote from the interview on the bottom right corner of the page, and imagined what it might be like for a client

to hear the words from Marie during treatment. The words read, “You have a capable guide. Everything is going to be OK.”



Figure 2

Clinician Interview #3: "Jenna"

My interview with Jenna was scheduled for a Friday afternoon at 1:00 P.M. Because Jenna had recently relocated to the Pacific Northwest, our interview was conducted via Skype, an internet video chat program. After some difficulty connecting with each other, her face finally appeared on the screen. Jenna supervised my first practicum at Loyola Marymount University, so when we finally connected we spent some time catching up with each other. I learned that Jenna is working with both children and adolescents at an addiction treatment center. After some casual discussion, our interview officially began.

My first question for Jenna was to describe her understanding of the term "cumulative trauma." Jenna conceptualizes "cumulative trauma" in terms of medical trauma because her first placement was at a medical hospital. In the medical context, "cumulative trauma" is a physical condition which results from placing additional stress or damage on a part of the body that has already been injured. In this case, the original wound either becomes larger, or simply does not heal. Jenna stated that she believes the term is directly translatable to the field of mental health if one simply replaces physical injury with an emotional wound. She went on to say that life stressors and events, including triggers, can prevent a person's psychological wounds from healing completely and often worsen the damage done by the original trauma. Jenna provided an example of a person tripping and damaging an already sprained ankle, and related it to the experience of an individual with a history of abuse becoming somehow involved with another abusive person. I explained to Jenna that her conceptualization of the concept seemed to be perfectly aligned with what I discovered in my research, and added that a number of journal articles stipulated that for an individual to experience "cumulative trauma," he or she must experience more than one type of traumatic event. Jenna was interested in why the researchers chose to define "cumulative trauma" as the experience of more than one type of traumatic event.

We speculated that two occurrences of the same type of trauma might relate so closely to each other that treatment for one of the events could possibly generalize out to impact the other. In contrast, it is likely that two very different types of trauma, such as an experience of sexual abuse and natural disaster, would each require individual attention to be adequately resolved. Jenna was very curious about the concept of cumulative trauma, and said that when she considered the clients at her agency, most of them had experienced more than one traumatic event during their lifetimes. Jenna and I reflected for a moment upon how surprisingly common the experience of cumulative trauma seems to be.

I invited Jenna to describe her familiarity with Francine Shapiro's conceptualization of "little t" and "big T" trauma. Jenna responded that she was indeed familiar with EMDR and with Shapiro's definitions of major and minor trauma. She laughed and said that she found it to be an amusing coincidence that we both focused on cumulative trauma for our research projects, since we had bonded so easily when we first met. Although her research does not use the term "cumulative trauma" outright, it was focused on the ramifications of childhood trauma as manifested in adult clients. Jenna shared that she openly discusses the concept of "small t" and "large T" events with her current clients as part of assessment and psycho-education. She assesses for "small t" experiences in her clientele by asking them to describe "anything in your life that is significant to the point that it has impacted you negatively in any way." Usually, her clients will deny the experience, possibly because society in general has not yet recognized the power of "little t" events. It may be that clients remain unaware of these experiences because they do not understand that it is possible to be severely impacted by them. Many "little t" experiences include events that seem inconsequential in comparison to the kinds of "big T" traumas that tend to attract media attention. Jenna stated that many of her clients discover the

impact of “little t” events during a course of treatment, despite having denied their presence when they were questioned during assessment. Jenna and I discussed the potential for a “little t” event to be extremely damaging, depending on how the event was subjectively perceived and internalized.

For the next portion of the interview, I invited Jenna to describe any patterns between individuals in treatment who meet criteria for the experience of cumulative trauma. First, Jenna informed me that she has worked mostly with children and adolescents. She shared that in her experience, children and adolescents who are referred for treatment rarely know that they have experienced any trauma whatsoever. In fact, the presenting problems and diagnoses that she most often encounters include acting-out behaviors, Attention-Deficit Hyperactivity Disorder, Oppositional-Defiant Disorder, Conduct Disorder, and symptoms of Anxiety and Depression. Jenna added emphatically that Post-Traumatic Stress-Disorder is almost never the presenting diagnosis. Instead, children are most often referred because they have been labeled as a “bad kid” by parents and teachers alike. Jenna shared with me that she has recently been reading about the neurobiological mechanisms involved when a traumatized child becomes “activated,” and has come to understand that PTSD can look more like ADHD in children because the functionality of the prefrontal cortex, the part of the brain responsible for impulse control, is markedly impaired.

Jenna also stated that every single individual that she is currently treating in the addiction program has experienced at least one significant traumatic event. As it happens, use and abuse of substances is a remarkably effective method of coping with difficult emotions because it allows the individual to numb and completely avoid the difficult feelings associated with a trauma. Jenna admitted that the co-morbidity between trauma and substance abuse is “huge.” Jenna

reflected on a group that she is running in the treatment center, wherein all of the adolescents have stated that they used substances to “numb the pain.” When the substances are removed and the clients can no longer self-medicate, they are forced to confront the memories that they have been actively avoiding, and the results can prove to be disastrous.

With regard to risk and resiliency factors, Jenna sees a marked difference in the existing support systems of those who successfully maintain sobriety and those that relapse. The most resilient individuals Jenna has treated have had consistent, stable, and involved caregivers. Those who she considers to be “at-risk” for relapse have parents who are largely absent. Jenna stated that even an individual with one consistent and supportive adult in his or her life is far more likely to achieve complete recovery than an individual with no parental support. Most of the clients referred to Jenna’s agency have been intercepted by probation officers, and involvement in the court system is often a traumatic experience in and of itself. Jenna works in acute inpatient, outpatient, and residential treatment and she sees a consistent pattern of involvement with the legal system across all of three forms of care. I asked Jenna about gang involvement in the individuals at her agency, thinking that those without familial support may seek relationships elsewhere. Jenna shared that gang involvement is exceedingly common in the adolescents in her treatment center. As we were discussing this, Jenna remembered a client who denied any history of trauma, but when questioned further, disclosed that his brother had been shot and killed. To this client, violence was such a common occurrence that the death of his brother seemed unremarkable. This anecdote suggests that the accumulation of trauma permeates the lives of the disadvantaged.

I then inquired about Jenna’s approach to the treatment of cumulative trauma, given her experience with individuals who appear to be at a high risk for this condition. When Jenna was in

Los Angeles, her treatment approach was dictated by the amount of funding received by her agency. For this reason, she used evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Jenna spoke very highly of this method and said that she has had remarkable success using TF-CBT with traumatized clients. Jenna has also used the “Seeking Safety” method when treating substance abuse. In her current work, Jenna uses Dialectical Behavior Therapy (DBT), mindfulness practices, and TF-CBT. According to Jenna, it is important to treat the substance abuse and replace the individual’s coping strategies with healthy alternatives before delving into any trauma-focused work. Mindfulness and relaxation techniques as a component of TF-CBT appear to be particularly helpful, as these coping skills can be used outside of the therapy sessions and maintained for years after termination. Jenna added that individuals who have experienced cumulative trauma, particularly children, seem to respond well to structure. Jenna admitted that she initially resisted highly-structured treatment methods, but she has come to realize that there is ample room for flexibility within each of the modalities she has used. Art therapy also seems to fit nicely into many of the treatment models, and serves to add a special dynamic to the treatment of cumulative trauma.

At this point in the interview, Jenna recalled a case wherein she was “pushed” to use TF-CBT with a client who was not mentally stable enough to tolerate trauma-focused work. As a result, the client experienced a psychotic break. Jenna took a valuable lesson from the experience, and emphasized the importance of making safety an absolute priority when trauma is involved. She has used this awareness to help others at her agency understand the delicate and complicated nature of working with trauma. There appears to be a danger of pushing a client to talk about their trauma too soon, especially with clinicians who are new to the field. I took the opportunity to ask Jenna to describe another instance when treatment of accumulated trauma was

not successful. Jenna shared that a few of her clients were unable to completely integrate their trauma narratives because of the absence of their parents. One of the most powerful modules of TF-CBT appears to be the act of reading the narrative to a stable, supportive family member. Jenna recalled a heartbreaking instance of this, and described a 6-year old client who completed his narrative and was ready to present it to his mother. As it turned out, the mother never arrived at the scheduled time and her son was left alone with no one to bear witness to his painful trauma story. Jenna believes that this experience was perceived as abandonment and may have actually re-traumatized the client. It was incredible to hear how a single action or inaction on the part of a parent has the potential to “undo” many months of painstaking work. Because of this experience, Jenna tries her best to assess the stability of the family system and the reliability of the parents before designing a treatment plan. Ideally, parental involvement may provide the client with an intra-familial continuation of care. When working with trauma-focused treatment, Jenna describes parental involvement as “essential.”

Next, I asked Jenna to describe how she incorporates the art process into trauma-focused treatment modalities. When it comes to DBT or mindfulness practices, Jenna enjoys using a variety of different textures and colors. When leading a client through recognizing physical sensations, sculpting or drawing a representation of their bodies has been particularly useful. Jenna also enjoys using transparencies to encourage the client to portray the different “layers” of emotion they experience while grappling with a traumatic experience. It seems that using the art as a companion to psycho-education can help solidify the patient’s understanding of the mechanisms at work when they become “triggered” by a traumatic event. I asked Jenna to describe her choice of materials in terms of rigidity or fluidity, and what benefits each type of material has to contribute to trauma treatment. She responded that she will often begin with

structured, simple and “non-threatening” materials and very gradually progress to more expressive media. Jenna emphasized the importance of choosing developmentally appropriate materials as well. She also stated that art therapists should have an awareness of materials that may be triggering depending on the nature of the trauma, and that every intervention should be designed thoughtfully. Collage images, found objects and boxes often feel very safe for clients, especially those who are unfamiliar with art-making in general. Jenna has also used art in the narrative module of TF-CBT by inviting clients to create puppets and re-enact the various traumatic events in addition to writing it out in words. Art can be especially powerful if the client experienced a trauma before they were capable of verbal expression. The impact of a traumatic event is often felt so deeply that the experience is entirely beyond words.

I encouraged Jenna to describe any intervention that proved to be particularly successful in the treatment of trauma. She recalled the treatment of a 5-year old boy who had been sexually abused, and had such markedly impaired speech that she could not understand him most of the time. Jenna described how they developed a form of communication that was largely non-verbal, and consisted of pointing, making noises, gesturing, creating art and playing with puppets. The simple act of attuning to his needs and “meeting him where he was” in a humanistic fashion appeared to be the most reparative intervention in this case.

As our time drew to an end, I invited Jenna to engage in a discussion about how she felt art therapy was uniquely suited to treating cumulative trauma. Jenna laughed and exclaimed that art therapy was overall “better for treating everything!” Her passion for her work became clear as she began to elaborate. In Jenna’s experience, art has been able to access traumatic experience in a fuller, deeper way that she believes cannot be achieved through talk therapy alone. The sensory experience of organizing and creating external objects to reflect an internal experience is so

impactful for many reasons. Art creates an external and tangible record of personal experience, and has the power to reflect the unconscious very clearly. Art seems to allow for a different point of access than verbal communication, and for this reason it may create more lasting change.

Jenna shared an anecdote about an older man who was initially hesitant about making art in session. During one of their first meetings, he created a collage with an image of a man riding a motorcycle with a woman who was clinging to him tightly. The artwork was put away until two months later when rapport was stronger. Jenna and her client were discussing what he wanted the most out of life, and the man disclosed that he felt that he needed a person in his life that truly trusted him to keep them safe. Remembering the image from earlier in treatment, Jenna brought out his artwork. When the man looked at the art before him, he was moved to tears. This was a beautiful illustration of the power of the art in reflecting our deepest unconscious needs. Jenna noted the value of art as a direct channel to our unconscious.

Finally, I questioned Jenna about any advice or “words of wisdom” she had to offer a fellow art therapist regarding the treatment of cumulative trauma. Jenna answered that it is incredibly important to participate in personal psychotherapy, especially if one has a history of trauma themselves. There exists a great potential for intense countertransference when working with cumulative trauma, and it is our ethical responsibility to attend to our own needs so that we are healthy enough to assist others. Jenna also highlighted the importance of patience in working with a cumulatively traumatized population. She believes that clinicians must keep an open mind in order to fully attune to their clients. Further, she stated that therapists should always feel “humbled” by the depth of experience of the individuals we treat, and recognize that no two lives are identical. Jenna feels that another important piece of advice is to try to be fully present with every client, and to be willing to meet them where they are. With those words of wisdom, our

interview came to an end. We wished each other luck and Jenna asked that I keep her posted about my findings at the end of the semester.

When I arrived home, I listened to the recording of our interview and reflected upon our discussion of art therapy and cumulative trauma. I made a collage in my personal art journal to solidify my understanding of Jenna's approach to treatment. I began by finding a central image that was bright red. A faint silhouette of a tree was visible in the field of red. I chose to tear the edges of each collage piece, as I imagined that various traumas "tear" at the emotional fabric of the individuals affected by them. I included images that represented both vulnerability and fear in the photograph of an angry crowd and three figures free-falling. I imagined that entering treatment after traumatization would be a frightening "leap of faith."

I recalled how much Jenna seemed to honor the personal struggle of each of her clients, and chose to depict the struggle through the image of a mountain-climber. Almost without thinking, I connected the mountain with a flight of stairs which reflect the steps of TF-CBT. At the summit, I included an image of a forest covered in fog. Remembering the setting of Jenna's work and the importance of the caregiver in bearing witness to a child's trauma narrative, I included part of an image depicting an infant with a thermometer. This image signifies the importance of familial support and care for the traumatized individual, and indicates vulnerability. As I considered the parallel between "medical" cumulative trauma and emotional cumulative trauma, I chose a doctor to represent the therapist. I inserted a broken heart in his hand to illustrate the power of a caring clinician to facilitate healing, even in the most damaged individual. The completed artwork is shown below (figure 3).

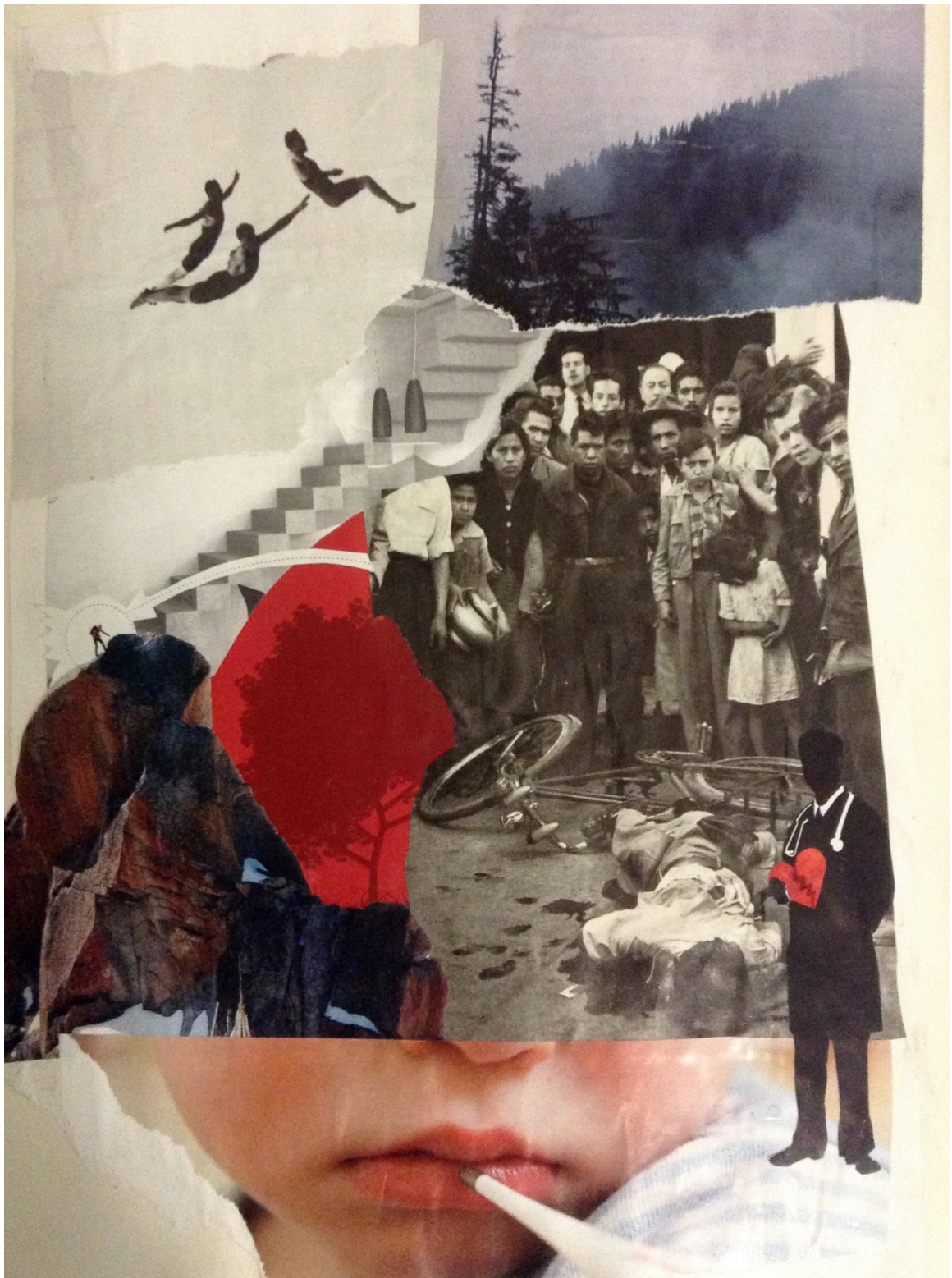


Figure 3

Analysis of Data

The first step in my process of analysis involved listening to each of the clinician interviews and transcribing them. The opportunity to listen to the interviews multiple times from beginning to end allowed me to reflect on the knowledge and experience that had been shared with me through each one of them. After the transcriptions were completed, I delved deeper into the material for the process of axial coding, which involved vertical and then horizontal examination of each of the transcripts. This immersion in the interview texts allowed me to become completely saturated with the information gleaned from the interviews. Due to the saturation of data, themes began to organically emerge during the coding process. It was helpful for me to listen to the audio recordings periodically while coding, as the clinicians each had a particular style and manner of speaking. I made special note of the moments in each interview when the clinician showed great passion or special interest for a particular topic. After a lengthy distillation of the data, it became clear that there were patterns in the way that these clinicians worked with individuals who have experienced cumulative trauma.

1) Symptom Presentation

One of the questions posed to interviewees in this research involved an exploration of the common symptom presentation of individuals exposed to multiple different types of traumatic events. All interviewees agreed that the symptom presentation of cumulatively traumatized individuals is often complex and, at times, misleading. Many individuals who have experienced cumulative trauma seek mental health treatment for symptoms of depression or anxiety disorders. Only rarely do individuals with cumulative trauma seek treatment for Post-Traumatic Stress disorder. According to the clinicians in this study, symptoms of post-traumatic stress are often discovered during a course of treatment directed at resolution of symptoms of depression,

anxiety, and relationship difficulties. It is also common to discover that individuals in treatment for substance abuse have had multiple types of trauma in their lives, and first began using substances as an attempt to “numb” the emotional pain and intrusive memories associated with the various traumas they have experienced. In children, cumulative trauma often manifests as behavioral problems at school and home. It is not uncommon for children who have had cumulative traumas to present with symptoms of oppositional defiant disorder, conduct disorder, depression or Attention-Deficit Hyperactivity disorder (ADHD). Depending on the nature of the trauma and when it occurred, it can affect children at a cognitive level to the extent that they develop learning disabilities or speech delay. At times, an individual’s symptoms are mixed and do not meet full criteria for any one disorder. Some agencies have applied the term, “severely emotionally disturbed” to individuals who have overlapping presentations of symptoms related to the build-up of trauma.

Cumulatively traumatized individuals also experience symptoms related to how they see they themselves and how they see the world. Many individuals who have been traumatized conclude that the world is generally unsafe or that people are inherently bad, and experience difficulty trusting others. This is an especially important factor to consider for therapists, as establishing rapport may take longer with individuals who have difficulty allowing themselves to be vulnerable. Therapy can appear threatening to an individual who is very guarded, and the vulnerability of creating artwork in session may amplify the patient’s discomfort at the onset of treatment. This may manifest as a lack of engagement or seeming disinterest in the treatment process. Some individuals may consciously or unconsciously lock themselves away from feeling states in an act of self-preservation. These patterns of behavior appear to be related to avoidance of stimuli which is a hallmark of Post-Traumatic Stress Disorder.

In addition, individuals who have experienced cumulative trauma often minimize their traumatic experiences or blame themselves for their reactions to traumatic events. This is particularly common in the event of “little t” events. Clients often experience difficulty acknowledging that an objectively small event may have impacted their lives greatly. Even after they are able to acknowledge the effects of “little t” events, the individual may feel a sense of guilt or shame. Cumulatively traumatized individuals often feel powerless or out of control, which may translate to low self-esteem and a lack of self-worth.

2) Treatment Approaches

The clinicians interviewed in this study reported a number of approaches that have proven to be successful in treatment of cumulative trauma. A number of evidence-based models were suggested for the treatment of cumulative trauma, including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and the “Seeking Safety” approach. The most commonly used approach with cumulative trauma appears to be Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). The clinicians highlighted a number of components within the TF-CBT model that proved to be particularly effective with cumulatively traumatized individuals, including psycho-education, relaxation techniques, and the trauma narrative. Among these components, the trauma narrative was found to be uniquely effective in resolving traumatic experiences, particularly when it is shared with a member of the client’s primary support system. Creating and sharing the narrative with members of the client’s support system appears to be an integral task related to positive meaning-making and generalization of gains made in the therapeutic process. The trauma narrative is ideally shared with a parent or caregiver. This element of TF-CBT appears to have a special purpose and is designed to assist the client with positive reintegration of the traumatic

events into his or her personal narrative and identity. The clinicians noted that when a child is in treatment for cumulative trauma, it appears to be essential that his or her parents or caregivers are involved and supportive throughout treatment and not only during the narrative sharing process.

Interestingly, in addition to trauma-focused treatment approaches, the interviewees unanimously supported the use of humanistic, client-centered approaches as well. Each clinician stated the importance of appropriate pacing and an awareness of the client's current stressors and coping strategies, as these factors serve to inform the natural ebb and flow of the treatment process. If a client is vulnerable because of increased instability in his or her life, it may be inappropriate to delve into deeper work until the client finds a more stable form of outside support. It may also be useful for the client to participate in goal-setting so that the tasks of therapy appear more manageable. Because cumulative trauma often causes a sense of overwhelm, it is important for clients to be invited to take control of their individual treatment and be granted a sense of control over the process. Client involvement in goal-setting may also increase the client's sense of self-efficacy and personal value.

3) Essential Elements of Successful Treatment

One of the hallmarks of successful treatment of cumulative trauma appears to be maintenance of unconditional positive regard for the client. Traumatized individuals are often emotionally compromised and find themselves in need of a great deal of emotional support. Among the specific needs of those who have experienced cumulative trauma are the need for genuine human connection, guidance and continuing reassurance of personal strengths and individual potential. A client who has experienced cumulative trauma will likely also benefit from appropriate mirroring and modeling by a qualified, supportive individual. Mirroring a

client's difficult emotions around various traumatic experiences helps to instill hope and communicates unconditional acceptance of all feeling states. It is vital for a therapist to model self-acceptance, positive coping strategies, effective and open communication, and self-love. In addition, showing confidence and faith in one's abilities as a therapist may help the traumatized individual feel secure and safe as they are guided through treatment.

With regard to the treatment itself, it appears essential to foster a sense of consistency and stability within the therapeutic environment. Developing a routine or sharing the treatment plan with a client may help them feel safe enough to be vulnerable with the therapist. Although consistency and stability outside of the therapeutic environment are predictors of successful treatment, those who experience cumulative trauma often also have unstable support systems. Maintaining consistency within the therapeutic space may mitigate some of the detrimental effects of instability in other areas of the client's life. A large part of helping the client achieve inner stability involves making a genuine connection with them as a fellow human being. Making a healing connection with the client involves fostering authenticity in the relationship and remaining completely present and attuned at all points during therapy. In order to maintain connectivity, it is imperative that the therapist encourage the expression of all feelings. The connection between client and therapist will prove to be especially powerful as the therapist begins to normalize the difficult emotions that accompany traumatic experience, such as shame and guilt. Acknowledgement of these difficult feelings may help clients to recognize the impact of all their traumatic experiences, large t and small t events alike. The connection made between client and therapist may serve to facilitate future acceptance and reintegration during treatment.

Another factor which contributes to successful resolution of cumulative trauma is the therapist's constant assessment of the client's environment. A therapist must remain attuned to

the client's needs at all times and be able to identify a client's emotional readiness for treatment. Therapists must remain sensitive to the appropriateness of pacing and the involvement of parental support in therapy. It is also important to assess for developmental appropriateness of each intervention. A therapist working with cumulative trauma must be realistic about a client's needs and actual resources.

A number of the predictors for successful trauma treatment must be addressed outside of the therapeutic space. A number of the interviewees in this study mentioned the importance of personal reflection, exploring moments in therapy when a therapist becomes "triggered" and one's ability to recognize and utilize countertransference response. In order to ensure competence and emotional stability on the part of the clinician, personal therapy is recommended. Self-care strategies should be appropriately modeled and used to ensure that a therapist is healthy enough to be completely present in every session. The health and competency of the therapist is a determining force in the success of therapy.

4) The Use of Art Therapy

The process of art-making can be an effective tool for solidifying the progress made throughout the therapeutic process. When the creative process is employed to concretize one's knowledge of coping skills and tools for relaxation, the client may feel more secure in their understanding of the various techniques introduced in session. The client may come to view his or her artwork as an extension of the self, and creating a respectful space for attention to the artwork may enhance a client's feelings of self-worth. The art may also benefit therapy as it serves to reflect an individual's inner emotional process without distortion. As an external object, the art may be revisited at any point during therapy. Another benefit of using artwork in session is that it may diffuse some of the tension in the room by allowing the client to remove the focus

from the self and focus on the artwork as needed. In this way, a client may learn that they have control over the intensity of the trauma-focused work in a way that appropriately meets his or her specific needs.

When used appropriately, the art process may help to fulfill the need for containment and stability in trauma-focused therapy. Routine use of art interventions may instill a sense of containment and stability for traumatized individuals. The predictability of making art in every session can be seen as a grounding force in the treatment of trauma, as clients with a trauma history tend to respond well to structure. The art therapist may find it beneficial to create scales with the client so that he or she can learn to control their discomfort within therapy. Other ways to use the art to reinforce feelings of containment include the use of highly structured materials such as collage image, altered books or boxes.

The clinicians in this study agree that it is imperative to pay special attention to the range of art materials used and take steps to match a client's emotional readiness to the types of materials used in art therapy. It is recommended to use structured materials during the trauma narrative in order to provide safety. For example, markers and pencils tend to create a greater sense of containment than clay or paint. Art therapists involved in the treatment of cumulative trauma should be mindful when navigating the wide spectrum of materials available for use, as inappropriate material selection may trigger the client or result in regressive behaviors.

The act of making art, particularly for those who are not formally trained as artists, may cause clients to feel vulnerable and exposed. For individuals who have experiences cumulative trauma, finding themselves in a state of vulnerability may be very uncomfortable or triggering. The development of therapeutic rapport in art therapy is particularly important so that clients may feel safe enough to allow themselves to be vulnerable.

Findings

Examination of the research data resulted in the development of a semi-structured framework for Art Therapy Treatment of Cumulative Trauma (figure 4.1) which describes how an art therapist might approach treatment with an individual who has experienced multiple different types of trauma in his or her life. The visual model begins with Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) adapted for use with art therapy. Art-making may enhance the process of TF-CBT by solidifying important concepts introduced in the psycho-education stage, helping to concretize a client's understanding of relaxation and mindfulness techniques, and supporting the development of therapeutic rapport (Pifalo, 2007). According to this model, treatment of cumulative trauma should focus on each traumatic event in descending order of subjective distress until all traumas have been successfully integrated.

The themes which emerged during data analysis are outlined as phases of treatment and intended for use within the model in figure 4.1 to address the subsequent traumatic experiences of the cumulatively traumatized individual. According to the research (Rankin & Taucher, 2003), the use of phase-oriented treatment with traumatized clients is appropriate because it provides structure and direction for both the client and the therapist, and may be a more efficient avenue for the treatment of complex issues. The four essential components of art therapy treatment of cumulative trauma appear in figure 4.2 and include the following: Preparation, Containment, Narration, and Integration. Suggestions for the incorporation of art-making are described within each phase of treatment.

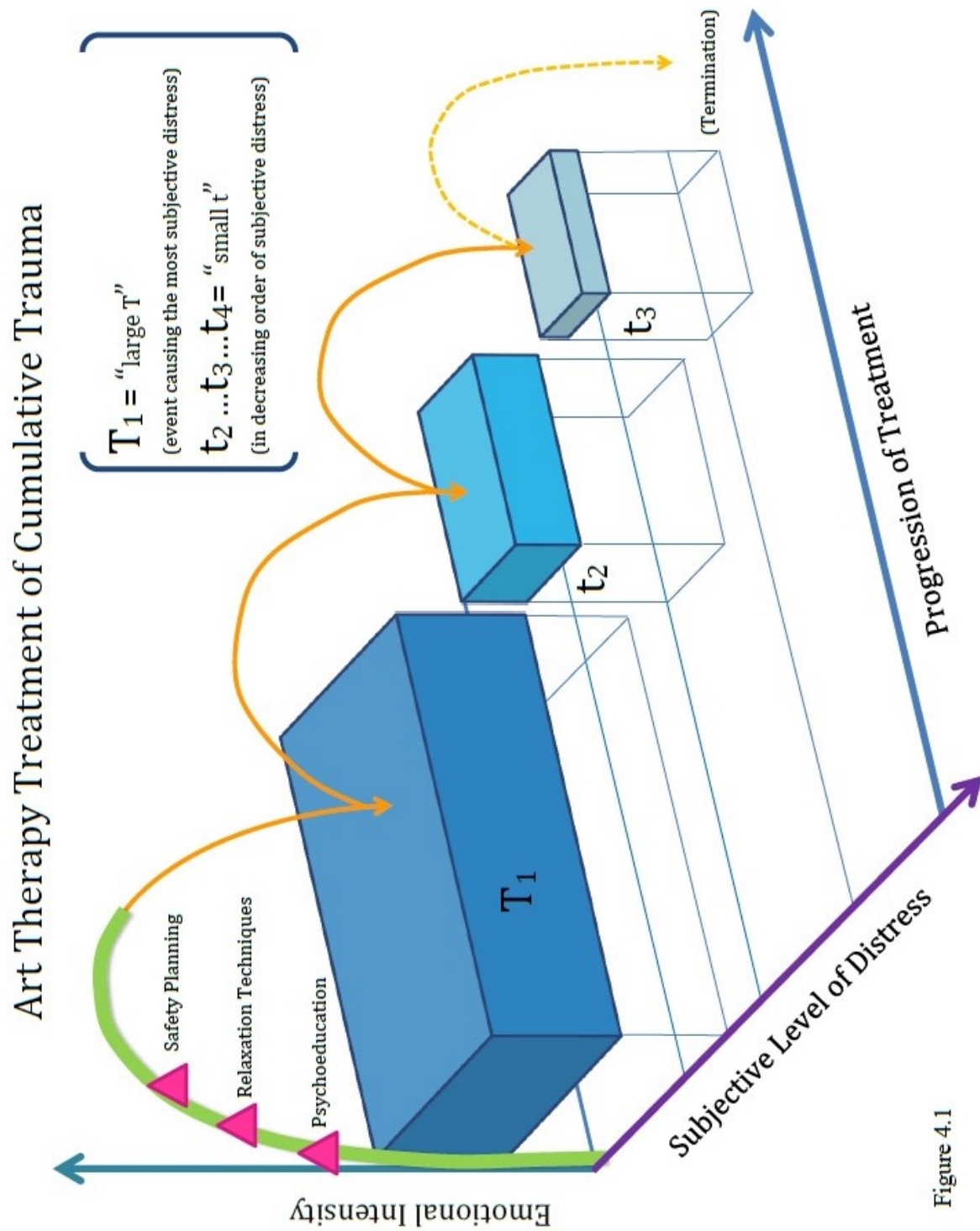


Figure 4.1

A major finding in this research study stipulates that the therapist should remain attuned to client's subjective level of distress throughout assessment and initiate treatment of the most impactful trauma as identified by the client. The clinicians interviewed for this study and a number of independent research studies have acknowledged that it is an individual's subjective experience of trauma that dictates his emotional response and symptom severity, and symptom presentation (Dulin & Passmore, 2010; Kleim et al., 2012; Martin et al., 2011; Rankin & Taucher, 2003; Suliman et al., 2009). Regardless of whether the most distressing event is "large T" or "small t" in nature, the first portion of treatment should focus on establishment of a strong therapeutic alliance. Developing an appropriate and supportive relationship is essential for effective treatment and allows the individual to feel safe when reprocessing each traumatic event (Tripp, 2007). The therapeutic relationship is given special attention in figure 4.1 as depicted by a thick green line.

Before addressing the most distressing event, clinicians should provide psychoeducation, teach relaxation techniques, and engage the client in safety planning in accordance with the triangles illustrated in figure 4.1. In the treatment of cumulative trauma, it is essential for the therapist to help the client achieve a feeling of balance to counteract feelings of inner chaos which are likely to result from traumatic events. Interventions during treatment should alternate between providing space for fluid expression and ensuring structure and containment in order to create the ideal environment for healing. Art therapy can help clinicians to achieve balance between flexibility and structure throughout treatment.

Once a clinician has established a trusting relationship with the client, they should begin introducing the preliminary steps of TF-CBT to work toward resolution of the most prominent trauma as determined by the client. If more than one independent event can be isolated as a

major trauma, TF-CBT may be used more than one time. When using TF-CBT, clinicians should adhere to treatment progression as outlined by the developers of this technique (Deblinger et al., 2011; Murray, Cohen & Mannarino, 2013). The use of TF-CBT in conjunction with art therapy was unanimously supported by clinicians in this research study and has also been supported by recent literature (Pifalo, 2007).

Once the most distressing event is integrated, the therapist may move into another theoretical orientation for treatment of the less distressing traumatic events. The traumatic events addressed after use of TF-CBT may include “little t” experiences. A careful review of the essential elements of successful art therapy treatment as described by each of the clinicians resulted in the development of four pillars for the treatment of cumulative trauma. Each of the four phases of treatment aligns with specific modules of TF-CBT. All phases allow for the introduction of art therapy interventions. Due to the broad and flexible nature of the creative process, the art interventions used may be modified to fit the style and preference of each individual clinician. A clinician working within this framework may select a theory congruent with his or her personal style, provided their orientation of choice allows for inclusion of each of the four phases of treatment, beginning with Preparation and moving through subsequent phases of Containment, Narration, and Integration.



Figure 4.2

Preparation Phase (*Installation of Hope*)

During the first phase of treatment of cumulative trauma, clinicians should focus on building a positive relationship with the client. This process of joining in the therapeutic relationship serves to restore a client's sense of hope and connection, as it is common for traumatized individuals to feel isolated from others (Read-Johnson, 1987). Establishment of rapport is an essential element of successful treatment as it inspires a sense of trust and allows for a state of vulnerability, which is pivotal to the process of healing. Authenticity and attunement to the client's state of being should be introduced in beginning phase and maintained throughout treatment (Buk, 2009).

The preparation phase is essential so that the client begins to gain a sense of optimism about his or her capacity to complete treatment successfully. During the preparation phase, the therapist should invite questions about the process and provide additional psycho-education so that the client feels a sense of control and competence. Psychoeducation is represented by a pink triangle in figure 4.1 and may be addressed in the initial treatment with TF-CBT. It may be important to revisit this stage so that the client has an opportunity to voice any inquiries or concerns about treatment. Additionally, many individuals who have experienced trauma are unable to access feeling states due to extreme conscious and unconscious avoidance of traumatic memory. Despite this, it is important for individuals to be able to access feeling states during trauma treatment (Pifalo, 2007). It may be appropriate to use the art process to encourage the flow of emotion and psychoeducate individuals about the normal range of human feelings.

Art-making can be a helpful contributor to the preparation phase, as it aids in the development of rapport and in delivery of psychoeducation. If the client is unfamiliar with art-making, scribble drawings and experimentation with the art can help the client achieve a sense of

comfort both with the therapist and with the art materials. Guiding the client through exercises to help solidify their understanding of TF-CBT, the concept of cumulative trauma, or common symptoms of trauma may serve to normalize some of their experience and help them to feel safe and hopeful about the process of therapy. In addition, it is important to teach the client that events which are often classified as “little t” can have a lasting negative effect on an individual’s well-being. Every life event has the potential to affect humans deeply, despite how objectively “large” or “small” it appears to be (Shapiro, 2004; Suliman et al., 2009).

Containment Phase (*Introducing Security*)

For the second phase of cumulative trauma treatment, it is essential for the therapist to begin introducing skills that will help the client regulate his or her emotions. When a client remembers a traumatic event they are likely to feel triggered. Emotional dysregulation is a strong possibility. Because feeling dysregulated and out-of-control may feel frightening and overwhelming, it is important for clinicians to help each individual learn how to gain control over physical and emotional reactions to stimuli before revisiting the details of any traumatic event (Deblinger, 2011; Pifalo, 2007). Progressive muscle relaxation, guided imagery exercises and mindful breathing techniques represent a few strategies that may be introduced during this portion of treatment. When a client is engaged in building skills which allow her to have more control over her physical and emotional state of being, she may feel further empowered and more confident about her ability to progress through treatment. Introduction of relaxation techniques is indicated in figure 4.1 by a pink triangle and is an important component of TF-CBT (Deblinger, 2011). The art can be used to communicate coping strategies and help to enhance a client’s understanding of relaxation techniques (Pifalo, 2007). The use of watercolor paints, or soft fabric materials may be incorporated into this phase of treatment. It may also be helpful to create

containment in the artwork by introducing more structured media such as collage images, pencils and markers, and boxes.

Another essential component of introducing security is development of safety planning. The client should be involved in a conversation with the therapist about what will happen when the intensity of treatment becomes too great for a client to continue. The client and therapist will join in a process of planning for what will happen if this occurs. It is important for the client to generate some of these solutions themselves. For example, when a client becomes too upset to continue, they may choose to redirect their attention by listening to music, playing a card game, doing a physical exercise in session, or making a drawing of an item in the room (Rankin & Taucher, 2003). It has been suggested that when material becomes too overwhelming for a client, the art can play a helpful role in allowing the individual to dissociate from the experience in such a way that his neurocognitive functioning remains intact (Read-Johnson, 1987). Therapists and clients may develop a special “safe” sculpture or painting that is comforting which they may revisit when treatment becomes intense. The client and therapist may also create “safety cards” which outline practical steps that the client may take to regain control after feeling triggered. This may be an important step in helping the client learn to generalize the coping tools gained in the therapeutic space to his outside environment.

Narrative Phase (*Exposure and Allowance*)

The narrative phase of treatment is the most emotionally intense phase of treatment, and involves guiding the client through specific recollections and descriptions of all thoughts and feelings experienced during the traumatic event. The relaxation and safety skills learned in phase II will be utilized at different points during the narrative process in order to help the client move through the memory of the event until the emotions associated the trauma are no longer

overwhelming (Deblinger, 2011; Murray, Cohen & Mannarino, 2013, Pifalo, 2007). In order for this phase to be beneficial to the client, therapeutic rapport must be strong enough that the client feels safe in vulnerability. The safety of the therapeutic relationship helps in allowing the client to experience any emotions and thoughts associated with the event. Many traumatized individuals feel guilt and shame about their traumatic experience, and the containment provided by the therapist, the art, and the therapeutic space can assure individuals that all of their feelings about the event are valid and acceptable (Buk, 2009).

The client will be completely exposed during the narrative process, and it is vital that the clinician responds with appropriate presence and attunement at all times. Art may be used in conjunction with verbal descriptions of trauma, although the use of art in this phase should be made safe and non-threatening to counteract the overwhelming emotions that will surface during the narrative. In the narrative phase, use of structured art materials and small, containing paper. According to current research, the use of art-making may allow for a different point of access to traumatic memory (Buk, 2009; Lusebrink, 2004; Rankin & Taucher, 2007; Read-Johnson, 1987; Wigren, 1994). As verbal memory is stored in the prefrontal cortex, many traumatic memories are nonverbal, and stored in the visceral response centers of the limbic system. Because traumatic memory and art-making are both nonverbal experiences, there is a potential benefit of art in allowing access to memory stored in the non-verbal brain. It has been suggested that the use of art therapy may be ideal for preparing individuals for re-integration of trauma by allowing the traumatic memory to “move upward” from the limbic system to the prefrontal cortex where it may be processed verbally (Lusebrink, 2004). Current studies indicate that certain evidence based-techniques benefit from integration with art-making because the creative process engages

both hemispheres of the brain. For this reason, art may have a special role to play in the creation of the trauma narrative (Tripp, 2007).

Once the client is able to recount the details of her trauma without becoming dysregulated, therapeutic re-processing of some of the thoughts and feelings that were developed during the traumatic event is appropriate (Pifalo, 2007). Whether the event is “large T” or “small t” in nature, it is likely that the client developed some negative and unhelpful cognitions in response to the trauma. Methodically restructuring these cognitions to be more helpful and optimistic will help to prepare the client for reintegration of the event into his or her life story. The use of art during reprocessing may be particularly useful to help solidify concepts and present helpful metaphors to the client (Pifalo, 2007). It is important to remember that developing the narrative, restructuring cognitions and reprocessing the event will take longer for some individuals. Clinicians should be patient and attuned to each client’s specific ability to move forward in the process of treatment.

Integration Phase (*Healing and Maintenance*)

The clinician is the first “loving witness” to the client’s emotional pain (Buk, 2009). After the client has entered a state of vulnerability with a genuinely supportive, accepting, and loving clinician, they may internalize that loving response and may find it easier to make positive meaning out of their traumatic experience. If it is apparent that the therapist values and appreciates his or her client, the client may gradually absorb and internalize those feelings of self-worth and love. In addition, the literature states that when a trauma survivor is able to share their story with another, it helps them to feel support instead of isolation and initiates their process of reuniting with the rest of the world (Read-Johnson, 1987). The clinician has a

responsibility to reinforce all gains made in therapy and offer wholehearted congratulations for successful completion of the narration phase of treatment.

If it is possible, the second “loving witness” to the client’s traumatic experience should be a parent or other member of the client’s support system. It is essential that the second “loving witness” is involved in a parallel treatment process as indicated in TF-CBT so that they are able to tolerate the narrative themselves (Murray, Cohen & Mannarino, 2013). The involvement of a client’s familial support system has been shown to be positive predictor of success in the treatment of trauma. A client with a history of cumulative trauma who perceives that they have helpful support available to them is also more likely to succeed in treatment (Schumm, Briggs-Phillips & Hobfoll, 2006). Acceptance of the trauma and the traumatized individual by an immediate family member may facilitate maintenance of the client’s emotional health. A client with consistent and appropriate emotional support is far more likely to maintain the gains made in trauma treatment than an individual with no external support.

The last step in the integration phase is meaning-making, which involves the client’s process of allocating new meaning to the trauma’s impact on his or her life. The feelings of safety, competency, and control involved in previous phases of treatment may guide the client in finding different ways to view what the traumatic event means to them personally. The client may also develop more positive descriptors of the self, such as identifying oneself as “strong” or “resilient” for overcoming their traumatic event. The development of such descriptors can aid in reintegration of the trauma and facilitate one’s ability to recover (Morgan & Janoff-Bulman, 1994). The art can provide an effective vehicle for meaning making, as it provides an opportunity for physical engagement in the process of transformation and the discovery of metaphor (Pifalo, 2007). The therapist should encourage the client to explore feelings about

successful completion of the narration phase, and gently guide the client in reframing their experience of the traumatic event to include their personal hard work and the resulting recovery.

Conclusion

The proposition that the impact of multiple types of trauma over time is additive is relatively new to the psychology literature in general. The great majority of literature with regard to cumulative trauma has been published within five years of this research study. There have been no studies to date addressing protocols for the treatment of cumulative trauma, specifically, although the need for development of a working model has been stated in the research (Schumm, Briggs-Phillips & Hobfoll, 2006). The singular article explicitly addressing cumulative trauma in the art therapy literature is population-specific and does not discuss treatment techniques in detail (Testa & McCarthy, 2011). For these reasons, the model introduced in this study is both emergent and innovative, and may have groundbreaking implications for the use of art therapy in the treatment of cumulative trauma.

With regard to attending to the client's subjective level of distress, there exists a need for research addressing the art therapy treatment of "traumas" which fail to meet A2 criterion in the DSM IV-TR which stipulates that a trauma must be a "life-threatening" event. Further study should be designed to explore the impact of such "little t" traumas, and can be understood in context of "allostatic load," a state of emotional overwhelm which occurs when the stress of an individual's personal circumstance surpasses his or her ability for adaptive coping. A state of allostatic load creates specific neurocognitive changes in the brain which can manifest as mental illness, including symptoms of depression, anxiety, relationship difficulties or behavioral problems, including substance abuse (Sprang, Katz & Cooke, 2009).

The development of a model for the treatment of cumulative trauma is particularly relevant due to the fact that the majority of individuals exposed to trauma will experience more than one type over the course of their lives (Cloitre et al., 2009). Moreover, a recent review of the general literature with regard to trauma treatment revealed an article that was published

during the course of this research endeavor which outlines a modified form of TF-CBT to be used with youth who experience “continuous” trauma. This article is particularly relevant because those who are impacted by the cumulative build-up of traumatic events are often subjected to re-exposure and further traumatization (Murray, Cohen & Mannarino, 2013). This researcher highly recommends further qualitative or mixed-method study to formally evaluate the effectiveness of this particular model in the art therapy treatment of individuals with a history of cumulative trauma.

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Appendix B

Semi-Structured Interview Outline

Q1: Describe your current understanding of cumulative trauma.

Q2: Describe any notable patterns you have perceived in clients with a history of multiple types of “small t” events versus “large T” events.

Q3: In your experience, what similarities have you observed between clients with regard to behavior, symptom presentation, and potential diagnoses?

Q4: What have you observed with regard to potential risk and resiliency factors in this population?

Q5: Consider a specific case in your clinical work involving cumulative trauma. Describe your treatment approach with each individual, including any goals and interventions.

Q6: How has Art Therapy been uniquely beneficial to the treatment of this population?

Q7: As a clinician, what advice would you offer a fellow professional with regard to treatment of individuals with a history of cumulative trauma?

Thank you for your participation in this research endeavor! Your time and contributions are greatly appreciated.

Appendix B

Informed Consent Form

AN EXPLORATION OF ART THERAPY AS A TREATMENT FOR CUMULATIVE TRAUMA

Purpose: This research serves to examine the use of art therapy in the treatment of individuals affected by cumulative lifetime traumas. Recent publications in the psychology literature suggest that the accumulation of traumatic events in one's life has a profound and uniquely detrimental effect on an individual's mental health and physical well-being. The use of art therapy in the treatment of trauma has been covered extensively in the general psychology literature, but there remains a relative paucity of information in the art therapy literature regarding the use of art therapy in the treatment of cumulative trauma, specifically.

Your Participation: Participation consists of a semi-structured interview lasting approximately 30-45 minutes. This interview will be audio taped. There may also be additional follow-up or clarification through email, unless the participant is unable to respond to follow-up messages.

Benefits and Risks: The potential benefit to the subjects includes an opportunity for a deeper exploration of the concepts of cumulative trauma and art therapy. To minimize any risk or inconvenience to the subjects, the PI will interview each of the subjects in accordance with his/her availability. The PI will ensure the confidentiality of all subjects involved, obtain full consent from subjects, and provide a detailed explanation of the research purpose and procedures. The subjects will be provided a copy of the interview questions. There are no foreseeable risks involved in participating in the study.

Confidentiality: The PI will ensure the confidentiality of all subjects involved, obtain full consent from subjects, and provide subjects with a detailed explanation of the research purpose and procedures. Participation is voluntary and the subjects have the right to terminate the interview at any time. A summary of the results will be available to participants upon request.

By signing below, I acknowledge that I have read and understand the above information. I am aware that I can discontinue my participation in the study at any time.

Print name _____

Signature _____ Date _____

Signature of Primary Investigator _____ Date _____

Primary Investigator: Kristina M. Naff

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