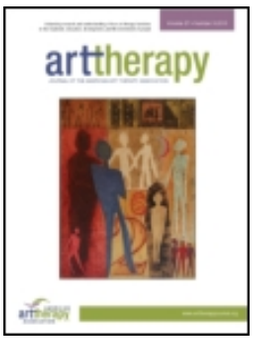

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A Framework for Treating Cumulative Trauma With Art Therapy

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Abstract

Cumulative trauma is relatively undocumented in art therapy practice, although there is growing evidence that art therapy provides distinct benefits for resolving various traumas. This qualitative study proposes an art therapy treatment framework for cumulative trauma derived from semi-structured interviews with three art therapists and artistic representations of their approaches. Key components of practice include attention to the variability of symptom presentation, treatment approach, essential elements of therapy, and the use of art as a treatment modality. Art therapists attune themselves to their clients' subjective levels of distress throughout assessment and the course of treatment.

Introduction

Cumulative trauma is the experience of two or more different types of trauma occurring in one's lifetime (Samuels-Dennis, Ford-Gilboe, Wilk, Avison, & Ray, 2010). As related to complex trauma, which often is constellated from early interpersonal traumatic events that interrupt healthy attachment (Cohen, Mannarino, Kliethermes, & Murray, 2012), cumulative trauma refers in particular to the collective influence of multiple traumatic events. Research confirms the harmful 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, Anckarsäter, Lichtenstein, Nelson, & Gustafsson, 2010).

Trauma is defined by the American Psychiatric Association (2000) as an event during which an individual 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" (p. 463). However, recent research has investigated trauma experiences that do not meet these criteria in order to gain a more complete understanding of why some events elicit symptomology and others do not (Boals & Schuettler, 2009; Cameron, Palm & Folette, 2010; Cvetek, 2008; Meiser-Stedman, Dalgleish, Yule, & Smith, 2012; Mol et al., 2005). Boals and 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.

Cumulative trauma is relatively undocumented in art therapy practice, although there is growing evidence that art therapy provides distinct benefits to individuals who have been traumatized (Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001; Johnson, 1987; Lusebrink, 2004; Pifalo, 2007; Rankin & Taucher, 2003; Talwar, 2007). This article examines approaches used by practicing art therapists who are working with the effects of their clients' cumulative traumas.

Literature Review

Within the field of trauma care, there is a need for greater flexibility in terms of how trauma is defined and treated. Boals and Schuettler (2009) found that posttraumatic stress disorder (PTSD) symptoms could develop in absence of the kind of traumatic event required for a PTSD diagnosis as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). Follette, Polusny, Bechtle, and Naugle (1996) asserted that the objective assessment of the trauma's severity was less significant than its subjective appraisal with respect to dissociative and depressive symptoms. According to Boals and Schuettler (2009), what is most relevant is the intensity of an individual's subjective emotional reaction (i.e., a response of fear, helplessness, or horror); it is "not the nature of the event, but rather the individual's emotional response to an event that is associated with PTSD" (p. 461). This finding is corroborated by recent studies of cumulative trauma (Cameron et al., 2010; Martin, Cromer, DePrince, & Freyd, 2013; Maschi, Morgen, Zgoba, Courtney, & Ristow, 2011). The correlation between perception and symptom development has implications for the impact of emotional stress on overall physical health (Ansell et al., 2012; Martin et al., 2013).

Shapiro and Forrest (2004) defined trauma as "any event that has a lasting negative effect on the self or psyche" (p. 14). However, what constitutes a trauma may depend on its origin. Various life events are categorized as either "traumatic" or "nontraumatic" in the general psychological literature. Stressful and ubiquitous lifetime events, such as exposure to bullying, loss, or experiences of personal failure may fall short of the defining criteria for PTSD (Mol et al., 2005). Shapiro and Forrest (2004) referred to such distressing experiences as "small t" traumas that nonetheless have

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the potential to deeply affect quality of life and warrant clinical attention.

The experience of multiple types of traumas, such as physical assault in addition to childhood sexual abuse, is thought to have an additive effect on symptom complexity (Cloitre et al., 2009) and severity (Martin et al., 2013). Stress activates neurobiological mechanisms in the neural, endocrine, and immune systems that allow a person to adapt and maintain equilibrium, which is a condition known as allostasis (McEwen & Gianaros, 2008). However, with repeated exposure to stress, the accumulation of "large T" and "small t" traumas over time may overstimulate allostatic systems or cause them to become dysregulated, and accelerate the person toward the precarious tipping point of allostatic load. Allostatic load is a maladaptive response that occurs when the stress of an individual's environment and circumstances overwhelm that individual's capacity to formulate an adaptive response (McEwen & Gianaros, 2008). Examples of behavior changes that result from allostatic load include fatigue, decreased quality of sleep, increased smoking or drinking, and drug abuse. Affected individuals may also be at risk for depression and anxiety (Sprang, Katz, & Cooke, 2009).

Treatments that are specifically geared toward recovery from trauma, whether singular or cumulative, include eye movement desensitization and reprocessing (Cvetek, 2008), bilateral stimulation (McNamee, 2006), and narrative therapy (Wigren, 1994). Trauma-focused cognitive behavioral therapy (TF-CBT) is a widely used approach that proponents claim is effective in reducing the severity of distressing symptoms (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Kleim et al., 2012). Murray, Cohen, and Mannarino (2013) recommended an adaptation of TF-CBT for severely and repeatedly traumatized youth who experience "continuous" trauma from reexposure, while in treatment, to other traumatic events. These authors combined TF-CBT with reinforcement of positive coping skills and strategies for dealing with repeated traumatic exposure. Art therapy also has been combined with TF-CBT to treat sexually abused children (Pifalo, 2007) and traumatized youth (Lyshak-Stelzer, Singer, St. John, & Chemtob, 2007). Lyshak-Stelzer et al. (2007) compared TF-CBT with a trauma-focused art therapy group intervention to treat adolescents who had experienced cumulative trauma. Their findings indicated that, as compared to non–art therapy treatment, trauma-focused art therapy was more effective for treating trauma-related symptomology.

Art therapy involves processes that circumvent neurological barriers to remembering the trauma (Chapman et al., 2001; Gantt & Tinnin, 2007; Hass-Cohen & Findlay, 2009) and accessing trauma-related emotions (Johnson, 1987) and nonverbal memories (Talwar, 2007). Lusebrink (2004) suggested that these unique benefits might be attributed to alternate neuro-pathways that art making follows when accessing traumatic memory. Art therapy may allow a more helpful reconstruction of the experience (Gantt & Tinnin, 2007) and closure to be able to recontextualize and move beyond the event.

Although the use of art therapy to treat different types of trauma is growing, literature on cumulative trauma and art therapy is recent and limited (e.g., Testa & McCarthy, 2004). There appears to be a need for quantitative and qualitative art therapy research to target the effects of cumulative and multiple traumas. This qualitative study explored the thinking, assumptions, and treatment approaches of three clinicians who have had success treating cumulative trauma, in order to extract the most essential components of treatment. Results may inform the development of best practices in this emerging area.

Methods

Participants

Participants were recruited from a pool of registered art therapists affiliated with the clinical art therapy program at Loyola Marymount University in Los Angeles, California. The selection criteria required that participants were currently practicing art therapy and had both knowledge of and experience in treating cumulative trauma. Three clinicians were chosen based on the selection criteria and availability and willingness to share their experiences. Prior to data collection, the study proposal was reviewed and approved by the university's human subjects review board. Each of the volunteer participants received and signed a consent form that delineated the background and purpose of the research study.

Procedures

A small-scale qualitative study was suitable for generating rich, detailed data on how some art therapists are currently addressing the accumulation of trauma with their clients. According to Kapitan (2010), qualitative studies are conducted for the purpose of "understanding a phenomenon rather than testing it" (p. 212). The flexible nature of the semi-structured interviews generated authentic narratives of actual clinical experiences. The interviews were conducted individually and were approximately 45–50 minutes in duration.

All three clinicians first were asked to describe their conceptual understanding of cumulative trauma. In follow-up questions, they described common symptoms that their clients with cumulative trauma presented, approaches to treatment, and their clients' responses to art-making directives. Each clinician was asked to describe a typical course of treatment during which traumas had been successfully resolved, and also a more challenging case example. All interviews were recorded via audio tape.

Immediately following each interview, I created a response in art (Fish, 2012) to document, reflect on, and distill information about the clinician's perspective, approaches and strategies, and treatment considerations discussed. This artwork served to preserve the ambiance of my interaction with the clinician and yielded data that could be triangulated for analysis with the clinician's verbal descriptions.

Art can be used in data analysis to deepen understandings and to facilitate conceptualization of information (Kapitan, 2010).

Data analysis combined open and axial coding, augmented by my art responses to the interviews. Open coding is a process in which all elements of the data record (transcripted interviews and response artwork) are organized into overarching themes and categories. During axial coding, these categories were connected vertically (within the transcripts and corresponding artwork) and horizontally (between and across all transcipts and artwork). As a result, the categories could be ordered according to the most prominent emerging themes. The analysis helped to isolate the specific elements of treatment that the clinicians found to be helpful in resolving cumulative trauma.

Themes were extrapolated from the art by noting formal elements (e.g., figure size and placement, line quality, color selection, etc.) and choice of material. For example, the watercolor media and undulating lines seen in Figure 1 generated the codes *flexibility* and *fluidity*. The central figure, depicted as resting against the support of the larger figure who extends a curving arm of protection, represents the fractured state of the traumatized individual. This configuration produced the themes of *security* and *containment*. The central warm yellow reflects an *attuned therapeutic presence,* which is also seen in Figure 2. Several of the shapes in Figures 2 and 3 are outlined or otherwise made clearly distinct. The structured materials of pen, marker, and collage resulted in codes for *containment, structure,* and supported interview data describing *phase-oriented treatment*. The heart shapes depicted in both Figure 2 and Figure 3 connected to the attributes of the participating therapists. These were coded as *love* and *unconditional positive regard*.

From the data analysis described above, I was able to discover key similarities among the participants' experiences as clinicians treating cumulative trauma. Four major themes emerged that the art therapists found most helpful to consider for their clients' resolution of cumulative truama: (a) symptom presentation, (b) treatment approach, (c) essential elements of therapy, and (d) the use of art as a treatment modality.

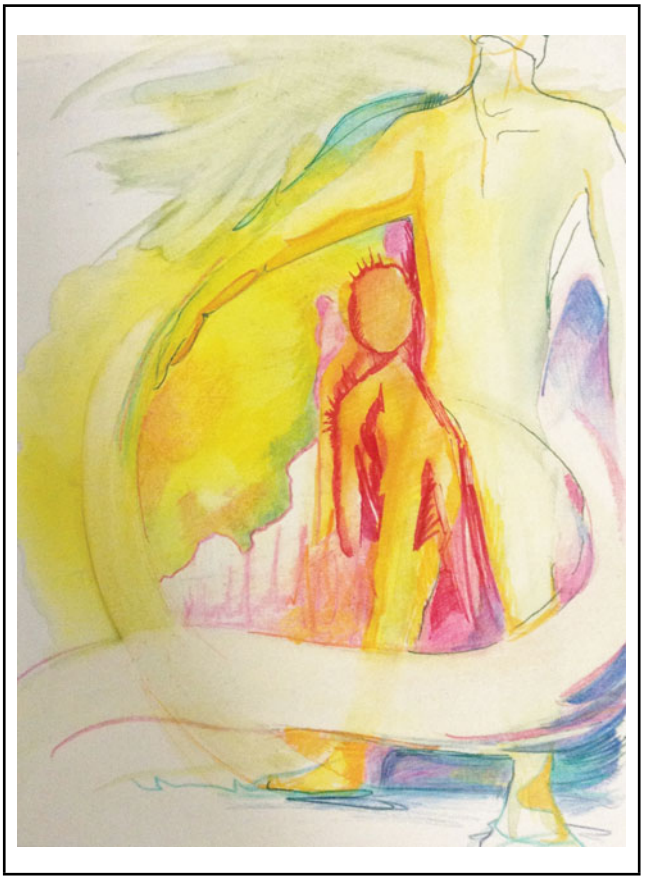

Figure 1 Researcher's Response to Interview A (Color figure available online)

Results

Symptom Presentation

All three of the practitioners emphasized that the symptom profile of a person who has experienced cumulative trauma is typically complex and can be misleading upon initial presentation. Many individuals with cumulative trauma seek mental health treatment for symptoms of depression, anxiety, substance abuse, and relationship difficulties. In children cumulative trauma often manifests as behavioral problems. It is not uncommon for these children to exhibit symptoms of oppositional defiant disorder, conduct disorder, depression, or attention-deficit hyperactivity disorder. At times, the client's symptoms do not meet full criteria for any one disorder.

Treatment Approach

Among the treatment approaches for cumulative trauma, the participants most commonly used trauma-focused cognitive behavioral therapy (TF-CBT). The interviewees highlighted a number of components within TF-CBT that they found to be particularly effective with their clients, including psychoeducation, relaxation techniques, and the gradual development of a trauma narrative. Among these, attention to the client's trauma narrative was seen as especially important in resolving or recovering from traumatic experiences. This finding supports the use of art therapy treatment protocols for trauma described in the literature (Chapman et al., 2001; Gantt & Tinnin, 2007) that emphasize the construction of a trauma narrative.

In addition to TF-CBT, all three participants supported the use of a humanistic, client-centered approach. In particular they asserted that appropriate pacing and building self-awareness of the client's resources or strengths help inform a natural ebb and flow of treatment. For example, when a client experienced increased instability elsewhere in life, the therapist adjusted the pacing, in recognition that it might be inappropriate to delve into deeper work. Client involvement in goal setting also was mentioned as a means for increasing the client's sense of self-efficacy and self-esteem.

Figure 2 Researcher's Response to Interview B (Color figure available online)

Figure 3 Researcher's Response to Interview C (Color figure available online)

Essential Elements of Successful Treatment

Themes that emerged from the data analysis identified what the clinicians felt were essential for successful treatment with this population. First, *unconditional positive regard* for the client was seen as crucial, given that traumatized people generally are in need of emotional support. Specific to people who have experienced cumulative trauma are the needs for connection, guidance, validation of personal strengths, and recognition of their individual potential. It is vital for a therapist to model self-acceptance, positive coping, open communication, and self-love. This finding supports Hass-Cohen and Findlay's (2009) emphasis on the role that attachment plays in the perception of physical and emotional pain, and suggests that sensitivity and attunement by the therapist is a powerful reparative force.

Second, the clinicians stressed that *consistency* is essential to successful treatment. Developing a routine or sharing the treatment plan with a client may promote a sense of safety. Stability outside of the therapeutic environment will likely fluctuate during treatment; therefore, maintenance of an *authentic, healing connection* with the therapist was acknowledged as important in order to help increase the client's internal stability. This connection between client and therapist strengthens as the clinician begins to normalize difficult emotions such as shame and guilt. Acceptance of uncomfortable feelings may help clients recognize the significance of their experiences. Finally, all three participants asserted that *goal setting* was essential. Art therapists must continually assess a client's readiness to continue working with traumatic experiences and to create realistic and appropriate goals for moving forward.

Uses of Art Therapy

The art therapists interviewed for this study were committed to using the creative process to help clients concretize their knowledge, coping skills, and resources, and to reinforce an understanding of art techniques introduced in session. Clients may come to view their artwork as an extension of their sense of self. Creating a respectful space for the artwork may in turn enhance self-worth (Hass-Cohen & Findlay, 2009). The clinicians also valued art making as more accurately reflecting the client's inner emotional process with minimal distortion. They found that the use of art in session often diffused tension because it allowed the client to remove the focus from the self. As a result clients learn to exert control over the intensity of their trauma-focused work

in a way that appropriately meets their needs. Highly structured art materials, such as collage images, altered books, or boxes were seen as effective in reinforcing feelings of control.

Chapman et al. (2001) observed the benefits of treatment flexibility based on the understanding that the client's personal meaning of a traumatic event holds significance. The clinicians in this study agreed that the development of therapeutic rapport is particularly important so that clients feel a strong sense of safety during treatment and feel motivated to continue. It also is imperative for the art therapist to match a client's emotional readiness to the types of materials used in art therapy and to be mindful when navigating the wide spectrum of art media. In their experience some art materials could be inappropriate and trigger stress responses. Particularly for clients who are not formally trained in art, the act of creating also may cause stress or increased feelings of vulnerability. Nevertheless, the fluidity of the creative process was seen as an integral part of cumulative trauma treatment, with each client bringing a unique set of experiences to the therapeutic relationship. The clinicians strongly encouraged consideration of the needs of each particular client when developing a treatment plan.

Discussion and Recommendations

A conceptual framework for art therapy treatment of cumulative trauma (Figure 4) can be proposed from qualitative data of how the three art therapists in this study are practicing with this population, to be elaborated and tested with future research. One key finding is that art therapists attune themselves to their clients' subjective levels of distress throughout assessment and the course of treatment, and most especially before initiating an exploration of what the client identifies is the most impactful trauma. This approach, corroborated in the research literature, acknowledges that it is individuals' subjective experience of trauma that dictates their emotional response, symptom severity, and symptom presentation (Dulin & Passmore, 2010; Kleim et al., 2012; Martin et al., 2013; Rankin & Taucher, 2003; Suliman et al., 2009). However, given the multifaceted nature of trauma and variability of subjective experience, any treatment framework should leave room for flexibility; a prescriptive approach that is not continuously attuned and sensitive to each client's needs could prove to be counterproductive or harmful.

The art therapists in this study used trauma-focused cognitive behavior therapy to resolve the first trauma presented and then to continue treatment of each traumatic event in descending order of subjective distress. Regardless of whether the most distressing event is "large T" or "small t" in nature, initial treatment should be dedicated to the therapeutic alliance. A supportive relationship (represented by the thick line in Figure 4) is essential for effective treatment and allows the individual to feel safe when reprocessing each traumatic event (Tripp, 2007). Before discussing any trauma, clinicians should provide psychoeducation, introduce relaxation techniques, and engage the client in safety planning. Treatment length will vary based on the individual needs of each client.

When using TF-CBT, clinicians should adhere to treatment progression as outlined in the literature (Deblinger et al., 2011; Murray et al., 2013). In this study the use of TF-CBT in conjunction with art therapy (Lyshak-Stelzer et al., 2007; Pifalo, 2007) was unanimously supported by the clinicians. This approach offers interventions that alternate between fluid expression and greater structure and containment. There are many ways that art can help facilitate this balance; however, clinicians need to be mindful of the distinct properties of art materials in this regard.

Phase-oriented treatment with traumatized clients provides helpful direction both for the client and the therapist, as well as an efficient avenue for the treatment of complex issues (Rankin & Taucher, 2003). As identified in this study's conceptual framework, the objectives of each phase of treatment are closely aligned with TF-CBT and other published art therapy–based trauma protocols (Chapman et al., 2001; Gantt & Tinnin, 2007; Lyshek-Stelzer et al., 2007; Rankin & Taucher, 2003). For traumatic experiences that cause less subjective distress, art therapists may gradually transition from TF-CBT into another approach, provided it will complete the sequence of preparation, containment, narration, and integration described as follows.

Preparation Phase: Installation of Hope

According to participant data and validated by the research literature, the preparation phase is essential in helping clients gain a sense of optimism about their capacity to complete treatment successfully. The therapist should invite questions about art therapy, discuss any fears or expectations associated with the treatment of trauma, and provide psychoeducation that supports the client's sense of control and competence (Gantt & Tinnin, 2007; Pifalo, 2007). If the client has already completed a cycle of TF-CBT, a reflective art directive may help consolidate cognitive gains before moving forward. It is appropriate to revisit this stage after addressing each trauma in order to guarantee ample opportunity for the client to voice concerns and express feelings about his or her therapy.

Many clients are unable to access feeling states due to avoidance of traumatic memory, despite the fact that it is important to do so (Gantt & Tinnin, 2007; Pifalo, 2007; Talwar, 2007). According to Chapman et al. (2001), validation of emotions associated with the traumatic experience is an important factor in recovery. Art making may encourage the flow of emotion; psychoeducation may help people identify the normal range of human feelings and life events that affect humans deeply, despite how large or small they appear to be (Shapiro & Forrest, 2004; Suliman et al., 2009).

Containment Phase: Introducing Security

In the second phase of cumulative trauma treatment it is essential for the art therapist to introduce or reinforce skills that will help the client regulate emotions. When a client

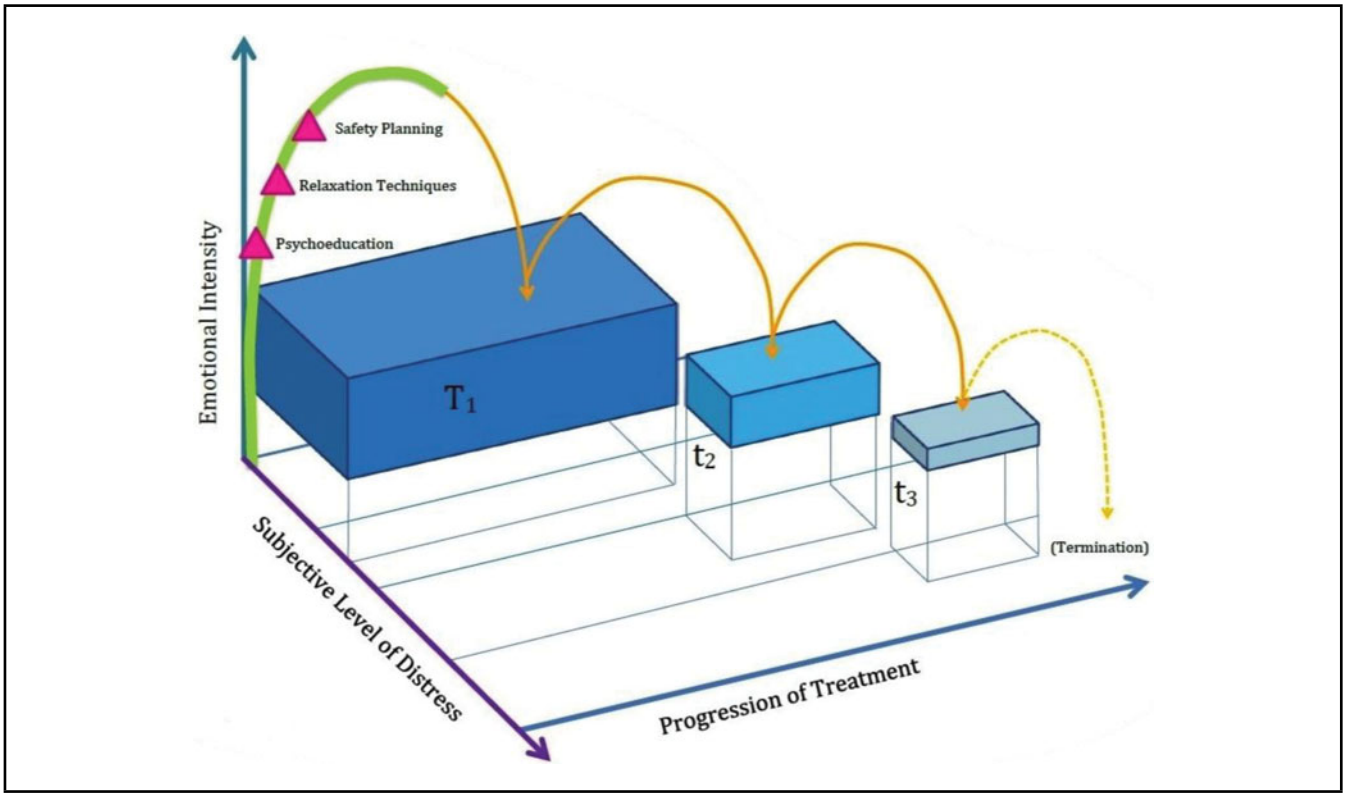

Figure 4 Framework for Art Therapy Treatment of Cumulative Trauma. *Note.* T1 = "large T" event causing more subjective distress; t2, t3 = "small t" events in decreasing order of subjective distress. (Color figure available online)

remembers a traumatic event, emotional dysregulation is a strong possibility. Because feeling out of control is frightening and overwhelming to clients, 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 a trauma (Deblinger et al., 2011; Pifalo, 2007). Progressive muscle relaxation, guided imagery exercises, and mindful breathing techniques are a few of the strategies utilized during this treatment phase. Art may amplify any of the above techniques and also may be helpful for emotional regulation. For example, some art therapists create an art-based intensity scale that clients use to recognize and gain control over their discomfort or identify a pleasurable art activity they can use for relaxation. When clients are engaged in building skills that help them gain control over physical and emotional states, they may feel more empowered and confident about their ability to progress through treatment (Hass-Cohen & Findlay, 2009).

Safety planning is another essential component for introducing security in this phase. The therapist and client should discuss in advance the strategies used if or when treatment intensity becomes overwhelming and develop an action plan. It is important for the client to generate some of the proposed solutions. For example, a client who becomes too upset to continue may choose to redirect attention by drawing an object in the room (Rankin & Taucher, 2003). Hass-Cohen and Findlay (2009) found that when traumatic material becomes too activating, art can help detract the client from the experience in such a way that neurocognitive functioning remains intact.

Narrative Phase: Exposure and Allowance

The narrative phase of treatment is the most emotionally intense and involves guiding the client through specific recollections and descriptions of all thoughts and feelings experienced during the traumatic event. Art may be created to represent feeling states or concrete recollections that contribute to an event-specific narrative, which reintegrates the trauma into the client's life (Chapman et al., 2001). Retelling the trauma and depicting specific events with art provides a sense of control over an event during which the client previously felt helpless. The relaxation and safety skills learned in the previous phase are utilized at different points during the narrative process to move through the memory of the event until its associated emotions are no longer overwhelming (Deblinger et al., 2011; Gantt & Tinnin, 2007; Murray et al., 2013, Pifalo, 2007). For this phase to be beneficial, therapeutic rapport must be strong enough for the client to feel safe in a state of vulnerability.

The neurobiology of art therapy suggests that art making provides a different point of access to traumatic memory (Buk, 2009; Gantt & Tinnin, 2007; Johnson, 1987; Lusebrink, 2004; Rankin & Taucher, 2003; Talwar, 2007; Wigren, 1994). Although verbal memory is stored in the prefrontal cortex, many traumatic memories are nonverbal

and are stored in the visceral response centers of the limbic system. Art therapy may be ideal for preparing individuals for reintegration of trauma by accessing the traumatic memory and allowing it to move upward from the limbic system to the prefrontal cortex where it may be processed verbally (Lusebrink, 2004).

Integration Phase: Healing and Maintenance

Because the art therapist may be the first person to hear the details of the trauma, it is essential to respond with acceptance, compassion, and care (Buk, 2009). Having entered a state of vulnerability with a genuinely supportive and accepting clinician, clients may internalize a sense of loving response and find it easier to make meaning from their traumatic experience. If it is apparent that the therapist values and appreciates the client, the client may gradually absorb and internalize self-worth and love.

When trauma survivors share their stories with another person, they may feel supported rather than isolated, which in turn initiates the process of reuniting with the rest of the world (Johnson, 1987). Art therapists are responsible for reinforcing the gains made in therapy and celebrating with the client successful reconstruction of the trauma narrative. Art can be an effective vehicle for meaning making and reintegration, as it provides an opportunity for physical engagement in the process of transformation and the discovery of metaphor (Pifalo, 2007).

Conclusion

With the danger of allostatic load, cumulative trauma threatens a person's mental and physical health with worsening mental illness, general impairment in daily functioning, increased risk of substance abuse, and predisposition to re-traumatization. Clinicians today recognize the impacts of both traumatic and "small t" events on an individual's ability to cope. In alignment with the framework presented in this study current research suggests that trauma-focused art therapy is an effective approach to treating trauma. However, the lack of specific information about cumulative trauma in the art therapy literature signals an important opportunity to investigate characteristic factors that should be considered when treating this type of trauma. Certainly it can be difficult for art therapists to know where to begin when facing trauma piled upon trauma. The formulization of an evidence-based approach and further study of the cumulative effects of multiple traumas can only aid our efforts to positively impact the lives of those who seek our help.

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