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Exploring Art Therapy Techniques in Parent-Child Dyads with Children Who Have Experienced Trauma

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Exploring Art Therapy Techniques in Parent-Child Dyads with Children Who Have

Experienced Trauma

Capstone Thesis

Lesley University

May 5, 2021

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Specialization: Art Therapy

Thesis Instructor: Tamar Hadar, PhD

Abstract

Exposure to trauma during childhood has been shown to have severe long-term consequences. It has been shown that art therapy promotes the reduction of trauma symptoms in children, as it allows them to easily engage in the process of therapy through non-verbal treatment. Involving the caregiver in the treatment process of children was shown to hold significant benefits for children, especially in a setting of parent-child art therapy interventions. In this capstone thesis, I present a case study in which I explored the impact of art therapy interventions performed in a parent-child dyad on the well-being of a child who has experienced trauma. The interventions were performed in family sessions over the course of two weeks in a virtual in-home therapy setting. The case study presents significant benefits of the creative interventions on the child's experienced symptoms, as well as on the parent-child relationship. These preliminary results show a growing need for additional studies on the topic of dyadic art therapy with children who have experienced trauma, in order to improve outcomes in the child's treatment as well as to strengthen the family relationships and the parent's ability to support their child.

Exploring Art Therapy Techniques in Parent-Child Dyads with Children Who Have Experienced Trauma

Introduction

In my thesis, I will examine the use of art therapy techniques in parent-child dyads when working with children who have experienced trauma.

Children survivors of early trauma frequently exhibit impairment in the areas of emotion, behavior regulation, attention, posttraumatic distress, and dissociation. Childhood trauma has profound negative effects on cognitive, social, and emotional development (Dye, 2018). Therefore, it is important to find therapeutic interventions that can best support these children to limit the effects of trauma on their lives.

Art therapy is known to be an effective form of treatment in supporting clients dealing with trauma, and especially children (Woollett, Bandeira, & Hatcher, 2020). Since trauma is usually experienced and expressed through the body, it is often difficult for individuals, especially young children with limited language skills, to verbally process their experience. Speaking about the traumatic event can also be intimidating and overwhelming. Creating art allows a non-verbal, symbolic, non-direct, and non-threatening way for the child to process their trauma (Malchiodi, 2015).

Parent-child art therapy interventions have been shown to hold significant benefits to children's emotional and social wellbeing (Lavey-Khan & Reddick, 2020). In recent years, there is a growing understanding of the importance and benefits of integrating the caregivers into the therapeutic space (Siddaway et al., 2014)

Thus, it appears that the combination of art therapy and parent-child dyad work, can be extremely valuable for children when working through their traumatic history. Child-parent therapeutic approaches have been a long interest of mine, and especially looking into the different ways art can be incorporated into it. Inspired by my work experience with

children of different ages in both of my site placements, I found that working with a child is significantly impacted by the level of cooperation and involvement of the child's caregivers. In addition, the home environment tends to have a great impact on the course of therapy. I believe that in order to achieve the best results while working with a child and to provide them with comprehensive care, a clinician must involve the parent or caregiver. Nowadays, in the times of COVID-19, the parents and caregivers have become a prominent part of the therapeutic process, more than ever before. As therapy is oftentimes done remotely, the caregiver is the one being at home with their child and has the best access to provide them with support and take an active part in their treatment.

In this capstone thesis, I will explore different art therapy techniques in the treatment of parent-child dyads of children who have experienced trauma. I will be exploring these techniques as used with families at my internship site, The Home for Little Wanderers, where I provide remote in-home therapy (IHT) services to children and their families.

In this thesis, I will review the literature around art therapy, dyadic therapy, and trauma-informed care, as well as the use of art therapy with children who have experienced trauma, and with parent-child dyads. My method will integrate the use of art therapy techniques with parent-child dyads when treating children who have experienced trauma. After presenting my method, research approach, and data collection process for my study, I will discuss the study's results, implications, and limitations.

My goal in this study is to offer varied art therapy interventions in a dyadic setting, which had a positive influence on the course of treatment. In addition, I wish to encourage more research in the field of dyadic art therapy and to broaden the knowledge with regard to how dyadic art therapy can assist in supporting children who have experienced trauma.

Background Literature

Trauma

According to the American Psychiatric Association (2013), trauma is described as an emotional response to an adverse event like an accident, exposure to violence, rape, or natural disaster. These experiences may occur during a single event (acute) or as a result of repeated (chronic) exposure. Trauma can result in long-term reactions such as unpredictable emotions, flashbacks, strained relationships, and even physical symptoms (American Psychiatry Association, 2013).

Exposure to childhood trauma can lead to childhood and adult psychopathology, including attention deficit and hyperactive disorder (ADHD), depression, anxiety, and personality disorders (Dye, 2018).

Children survivors of early trauma frequently present with profound negative effects on their cognitive, social, and emotional development, such as impairments in the areas of emotion, behavior regulation, attention, posttraumatic distress, and dissociation (Dye, 2018). Poorly regulated affect is reflected in a number of commonly exhibited behaviors of abuse victims, including aggressiveness against self and others, dissociative behaviors, concentration difficulties, distrust of others, mood swings, and impulsivity. Traumatized children may show rigidly controlled behavior patterns such as inflexible rituals and rigidly controlled eating habits, as well as under-controlled behaviors including aggression, self-injurious behaviors, and frozen avoidance reactions (Price, et al., 2013).

As a result of traumatic stress, a child may experience hypo- and hyperarousal of the central stress response system and the sympathetic nervous system. This can lead to excessive secretions of stress hormones, chronic activation of the fight-or-flight system, and dissociative symptoms. These findings provide evidence that the impact of trauma on the developing brains of children is of serious concern (Garro et.al, 2011). Research shows that critical periods for brain development occur throughout childhood, making childhood trauma

impact the development of brain structures involved in executive functions and adaptive stress responsivity (Bryson et. al., 2017)

Moreover, exposure to trauma during childhood was shown to have severe long-term consequences (Dye, 2018). Histories of childhood trauma are widespread in adolescent and adult psychiatric populations (Price, et al., 2013). Research shows that childhood trauma, specifically in the form of physical, emotional, and sexual abuse, is highly correlated with the need for future psychiatric care and poor mental and physical health throughout the lifespan (Price, et al., 2013). Adults with a history of trauma present a variety of health risks as well, including an increased risk for chronic diseases, such as heart diseases, high blood pressure, and diabetes. Therefore, adults who experienced trauma as children are at a higher risk of physical and psychological challenges that proceed beyond childhood (Dye, 2018). Furthermore, it is estimated that almost 25 percent of the population-attributable risk is due to early adversity (Humphreys et al., 2020).

The severity and type of the trauma experienced also play a role in the long-term outcome. Greater adversity in childhood is associated with more chronic depression in adulthood, more severe depression, and took longer time to reach a remission. Previous meta-analyses examining child maltreatment and depression have found that experiencing any form of maltreatment was associated with more than a two-fold increase in risk for depression in adulthood, and with the development of chronic, or recurrent, depression (Humphreys et al., 2020). Interpersonal violence and victimization have been indicated as risk factors associated with both internalizing (e.g., depression, anxiety) and externalizing (e.g., oppositionality, impulsivity) challenges.

While the experience of one trauma has been shown to disrupt development and cause severe distress, experiencing multiple traumas produces an even greater deficit to the child's well-being and functioning (Liu et al. 2016). Research indicates that youth who have

experienced a variety of trauma types are at a higher risk for psychopathology and alarming behaviors (Price et al., 2013). Complex trauma is defined as multiple forms of interpersonal trauma that occur repeatedly and cumulatively, usually within the child's caregiving system and over a period of time (Liu et al., 2016). It had been found that children with complex trauma experience higher levels of psychological distress and trauma symptoms (Briere et al., 2008).

From a social perspective, there is growing evidence that chronic exposure to physical or sexual abuse or other types of trauma can result in successive affective inhibition and detachment of emotions, proneness to delinquent and violent behavior, and in the development of psychopathic traits (Hollerbach et al. 2018). Childhood trauma is also associated with violent and criminal behaviors in adulthood and with higher rates of incarceration (Sarchiapone et al., 2009).

Understanding these severe effects of childhood trauma raises the need for effective interventions to assist this vulnerable population and to minimize their potential risks for developing severe symptoms in the future.

A few of the generally agreed methods for treating trauma are trauma-focused psychological therapies, specifically trauma-focused cognitive-behavioral therapy (TF-CBT), and Eye Movement Desensitization and Reprocessing (EMDR). These methods are often recommended as a first-line treatment for posttraumatic stress (Cloitre, 2015). TF-CBT is a manualized, structured, phase-based treatment protocol for children who have experienced traumatic events. It has been reviewed widely among children and adolescents (Allen, 2018; Peters et al., 2021). Eye movement desensitization and reprocessing (EMDR) therapy is a very useful and innovative evidence-based treatment for posttraumatic stress disorder (PTSD), complex trauma, dissociative disorders, and many other conditions (Shapiro, & Brown, 2019).

However, since traumatic experiences are stored and processed in the body, as implicit memories, it is often difficult to address them in verbal and cognitive-based forms of therapy. This can be even more challenging for young children who have limited vocabulary to fully express their emotions. Therefore, using art as a form of expression can be particularly helpful for this population (Malchiodi, 2015).

Art Therapy

According to the American Art Therapy Association (AATA, 2020), art therapy is defined as “an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship” (American Art Therapy Association, 2020).

Art therapy, facilitated by a professional art therapist, is meant to support clients’ treatment goals as well as concerns in the community. Art therapy can be used to improve cognitive and sensorimotor functions, cultivate emotional resilience, promote insight, increase self-esteem and self-awareness, enhance social skills, reduce and resolve conflicts and distress, and advance change (American Art Therapy Association, 2020). Art therapy uses experiential and sensory means to connect with pre-verbal attachment templates and provides opportunities for active participation, imagination, and mind-body connections in addition to the benefits of traditional talk psychotherapy (Lavey-Khan, & Reddick, 2020).

Today there is a significant amount of evidence indicating that art therapy is effective in supporting traumatized patients in various contexts. It has been shown that art therapy promotes the reduction of trauma symptoms in children, as it allows them to easily engage in the process of therapy through non-verbal treatment (Woollett et al., 2020).

It has been proposed that art therapy can assist children exposed to traumatic events to express their emotions and communicate their experiences. This is done through the

engagement of the senses and the body by sensory art materials, the use of symbols to process the traumatic memories, and cognitive reflections of work through the repetitive reframing of product and process (Racco, & Vis, 2015).

According to Pifalo (2002), who integrated data from several case studies documented by art therapists, art was found to be the most appropriate and least stressful way to treat children who have experienced physical and sexual abuse. Pifalo (2002) explains that children are more easily engaged through drawing pictures (either directly or indirectly related to the traumatic event) than through talking about the event. A child may not possess sufficient vocabulary to describe their traumatic experiences, and reliance on verbal or discursive forms of thought or communication may actually seem to be counterproductive to the process of accessing these particular types of traumatic memories. Quite often, verbal descriptions are only approximations of the actual sensory-motor experience because one is attempting to give verbal articulations to a nonverbal form of experience (Pifalo, 2002). An art therapy intervention, however, may provide the means for the type of “psychical binding” necessary to allow the process of healing to begin (Pifalo, 2002). Several studies emphasized the efficacy of art therapy in reducing symptoms of PTSD amongst victims of childhood abuse (Pifalo, 2006). Pifalo (2002, 2006), examined the effectiveness of the integration of art therapy (AT) and cognitive behavioral therapy (CBT) to reduce symptoms associated with posttraumatic stress disorder (PTSD) in children who suffered sexual abuse (Pifalo, 2002; Pifalo, 2006). In a study done with youth victims of childhood sexual abuse, Pifalo (2006), found that a treatment program that used a combination of AT and CBT was able to reduce the children’s PTSD symptoms, as evidenced by better scores on the Briere Trauma Symptom Checklist for Children (TSCC) following the eight-week intervention (Pifalo, 2006).

However, despite the common use of expressive and art therapy with children who have experienced trauma, it is often offered for the child and does not usually include the caregiver as a routine practice.

Dyadic Therapy

The literature on infant-parent psychotherapy reveals the significance of vital, adequate, and responsive parenting for children's development (Hosea, 2006; Baradon, 2002). Hosea, (2006) and Baradon (2002) argued for the value of infant-parent approaches for creating a safe, holding, and non-judgemental environment, that promotes secure attachment and good communication. Hosea (2006), examined mothers and children who painted together, and used a video camera to record and document their experiences. The study showed that the joint artmaking had a positive effect on the mother-child relationship (Hosea, 2006).

Multiple studies demonstrated the efficacy of involving the caregiver in the treatment process of children (Bratton et al., 2005; LeBlanc & Ritchie, 1999). Dyadic Developmental Psychotherapy is a family therapy treatment based on Attachment Theory, which has been shown to be effective to help families with a variety of difficulties, including complex trauma (Becker-Weidman & Hughes, 2008).

Although much of the treatment of childhood trauma today utilizes trauma-informed expressive therapies, play therapy, and sensory-based interventions (Ryan et al., 2017), more research is needed in order to determine the effects of such techniques when used with the parent in a dyadic therapy setting.

Dyadic Art Therapy

Research has shown that parent-child art therapy interventions hold significant benefits to children, supporting their physical, social and emotional development, and to their relationship with their primary caregiver, as well as increasing the caregiver's overall mental health and self-esteem (Lavey-Khan & Reddick, 2020). A meta-analysis of Dowell and Ogles

(2010) comprising 48 studies reported that child-parent or family treatment was significantly better than individual child treatment (Dowell, & Ogles, 2010)

The work with children and parents in art therapy is prevalent in the field. A survey of 878 British art therapists found that 60% of them found benefits in working with children and their caregivers together and did so occasionally as part of their treatment (Buck et al., 2012).

According to Lavey-Khan, & Reddick (2020), dyadic art therapy groups are specifically designed to integrate art therapy, as well as other therapeutic aspects such as child development theories and attachment theory. Studies show that these parent-child art therapy groups hold benefits for both the child and parent. Art making in the group provides a space where parents and children can work together and provides opportunities for parents to find pleasure in interacting with their babies and children (Hosea, 2006). Dyadic therapy provides support for parents and children with challenges in attunement, behavior management, and psychosocial and developmental issues. In addition, Armstrong and Howatson (2015), for example, found that the group provides a sense of empowerment for parents. In their study, which examined the parents' self-report before and after the 12-week art therapy dyad group intervention, they found an improvement in parents' perceived ability to think about their infant and to interpret how they may feel or what they may need. Participating in dyadic art therapy has been shown to improve the parent-child relationship, parental sensitivity, and to improve parental mental health and self-esteem (Lavey-Khan, & Reddick, 2020).

Despite all these known benefits to the use of art or dyadic therapy with children and caregivers, there is limited research featuring art therapy child-parent dyads, specifically for treating trauma in children. This study was designed to address this gap.

I believe that the combined benefits of art therapy and dyadic therapy can be a powerful intervention that can assist children to process their trauma and allow the parent to

better support them in the process. I believe this can be particularly beneficial in cases where the trauma was a part of the child's home experience, such as abuse or neglect, and the parent/caregiver is given the opportunity to be involved in the treatment and support their child. In these cases, given the ability to establish safety in the home and in the therapeutic setting, the dyadic component can assist in improving the communication in the home environment and strengthening the parent's ability to support their child. This can promote the healing process of the child as well as the family system as a whole.

Method

My method focused on exploring common art therapy techniques employed with one family I work with at my internship site (The Home for Little Wanderers, Safe at Home program), upon which I based my case study.

Participant

The case my research was based on is the case of Ruby (alias). Ruby is a white/LatinX 15-year-old non-binary identifying teen, residing in the Boston area in Massachusetts. At birth, Ruby was assigned as female and had a different name, and that is the way they were introduced to the in-home therapy (IHT) team at the beginning of treatment. Shortly after treatment had begun, Ruby came out to their mother, Shelly (alias), declaring that they want to start using they/them pronouns and change their name to Ruby. Ruby currently lives at home with their mother and mother's fiancé. Ruby is a very talented artist and studies at a well-known art school. They also enjoy music (especially Kpop), and drama. Ruby has a strong sense of humor, is communicative, and seems to be open to engaging with their therapy team. Ruby has a diagnosis of Major Depressive Disorder and takes Prozac sporadically. They were in therapy before, but according to Shelly, were not very much involved in treatment and although appearing very cooperative and communicative, they never truly opened up. Ruby has a tendency to self-isolate,

communicating mostly with online friends with whom they never met. They often struggle to remain engaged in school due to their depression and lack of motivation. Ruby's mother, Shelly, is in recovery from years of struggling with an addiction, which led to the Department of Children and Families (DCF) involvement for the neglect of Ruby. One of the goals of treatment was to work on repairing their relationship after the past neglect Ruby experienced by their mother, which they never openly spoke about.

The family's initial treatment goals included:

1. *To decrease depressive symptoms and improve emotion management for Ruby-* The IHT team will work with Ruby on increasing distress tolerance skills and maintaining safety by creating a safety plan, exploring, and further developing current or past distress tolerance skills, and learning and developing new distress tolerance skills. The team will also support Ruby in identifying triggers for emotional dysregulation, utilizing expressive techniques to work with them on increasing their ability to express emotions, in understanding their needs from others in moments of dysregulation, and in developing language to express their emotions and needs to others.
2. *To improve family communication-* IHT team will support the family in identifying what preferred communication looks like for them and facilitate conversation with family around moments where they noticed and were able to practice preferred communication happening. IHT team will also support the family in noticing what gets in the way of preferred communication happening and create a space in session to explore understanding and managing her emotional responses in their communication with each other. IHT team will utilize expressive therapy techniques to support Ruby and Shelly in their communication with each other and allow them to reflect on difficult moments. The team will also support the family in facilitating a conversation about their past and Ruby's past trauma following their neglect by their mother. IHT team will support Shelly

in better understanding and accepting Ruby's gender identity, which will include psychoeducation about gender non-binary identity, and supporting Ruby and Shelly in their communication around this topic.

I performed the parent-child art therapy interventions with Ruby and Shelly over the course of two weeks, including one family session per week, in addition to the regular individual or parent sessions. Due to the COVID-19 pandemic, all sessions and artistic interventions were performed remotely, via Zoom. I made adjustments to the activities to make sure they were suitable for the clients' home and art materials supply. In addition, I made sure that all art activities utilize accessible and safe art materials. The specific art therapy activities were determined according to the specific family's needs at the time the intervention took place and took into account Ruby's age, the family relationship, the type of trauma Ruby had experienced, their symptoms (in Ruby's case, their depression symptoms in addition to their trauma reactions), the child and caregiver's level of openness level to therapy and to art, as well as cultural considerations.

The two creative interventions used were:

1. *Drawing each other with the non-dominant hand*- Ruby and Shelly were asked to have paper and a pen or pencil for this activity. Then, they were instructed to use their non-dominant hand to draw each other. This activity is meant to create an enjoyable space, reduce anxiety around art activities, foster positive experiences in the home, and promote positive communication.
2. *Exploring different perspectives*- for this activity, each family member was asked to bring an object that is meaningful to them. They were also requested to have a piece of paper and a writing utensil for each (pencil, pen, marker). They were asked to place them together on the table and take a seat each in a different corner of the table. Then, each family member was asked to draw the items from their

own perspective. Following the artmaking, the family members compared the drawings, and a discussion was held about different perspectives which are each true to the person from their own perspective, and how different perspectives manifest in the family's life.

Research Approach and Data Collection

To collect the data, I used a journal where I carefully documented my sessions with the family and the art therapy intervention. In the journal, I documented the sessions in which the intervention occurred in detail. I focused on the client's reaction to the intervention, the communication between the child and their parent/caregiver before, during, and after the activity, and their reflections after the activity. I also documented their use of skills and ideas learned during the intervention in sessions that follow, and any changes that occurred in their communication.

Throughout my research, I made sure to receive ongoing supervision and consults with my thesis instructor. I made sure to consider my biases surrounding the case and identify elements that might impact my objectivity, such as the family's cultural background, history, as well as Ruby's gender identity. To assist me in performing a more objective analysis of the data, I determined clear markers for identifying improvement, based on the client's therapeutic goals and objectives also described in their treatment plan. For Ruby, these include: more frequent positive moods, based on their self-report, mother's report, and observed affect during sessions; a decrease in depressive symptoms such as anhedonia, self-isolation, lack of self-care, and suicidal ideation; an increase in their school involvement and assignment completion; increased motivation to meet with friends; a decrease in conflicts in the home, measured by conflict frequency and severity; increase in motivation to participate in treatment, indicated by a decrease in the number of missed sessions/ no-shows.

I also consulted with other peer clinicians at my internship site, primarily with my co-clinician on the case, to get another view on Ruby's progress and response to the intervention. In order to process the sessions further, I also created response art to reflect on the work with this family, explore their reactions to the interventions, monitor their progress and continue to set goals for future sessions.

Results

In the first session, upon starting the session, Ruby was asleep in their bedroom. Shelly woke them up and they were still visibly drowsy. The team started by engaging Ruby and Shelly in a creative activity. Ruby and Shelly were instructed to use their non-dominant hand to draw each other. The purpose on this activity was to reduce anxiety, create a positive space to begin the family session on a positive note, and help Ruby feel more awake and energetic. Both RR and SM were engaged and cooperative with the activity, laughing and fully interacting with each other. They both appeared to truly enjoy this experience and the session was joyful and full of humor. Following the activity, RR was completely awake and engaged in the session.

The rest of the family session involved setting ground rules that are important for RR and SM during the family sessions. Ruby and Shelly each shared rules that they felt are important for them in order for the family sessions to be productive and positive (speaking calmly without yelling or storming out, requesting and taking a break if needed, etc.). Both were able to name things that are important for them in their communication, and their goals for the family session. IHT team also discussed with RR and SM their similarities and differences. During the session, RR and SM were very playful and close with each other, and the session was full of humor.

For the second session, IHT team facilitated a creative activity of perspective taking. Ruby and Shelly were instructed to bring an object that is meaningful to them. They each

brought an object, and the items were placed in a pile in the middle as they all sat on different sides of the table. Each family member was asked to draw the items (and background) as they view them from their own perspective. The artmaking was followed by a discussion, during which IHT team explored with the family the differences between their drawings and related it to real life differences in perspectives which can be different and create conflict. An immediate example occurred as Ruby used swearwords as a joke, and Shelly reacted to it as if they were getting upset. With the IHT team's support, the family members were able to recognize that multiple perspectives could exist and be true at the same time. Ruby became uncomfortable when discussing their reaction and being misunderstood by Shelly. IHT team named the uncomfortable feelings that can arise during a family session and conflict and normalized them as a part of the therapeutic process. The team later suggested to Ruby to finish the session by telling the team about KPop to help Ruby regulate, which seemed to be helpful.

Following the documented sessions, there were some indications of improvement in both Ruby's symptoms and the family communication. Although these cannot be solely attributed to the short two-week dyadic art therapy intervention, some of the direct feedback from Ruby and Shelly following the sessions do show their subjective feeling of progress.

According to Shelly's report, she felt an improvement in the relationships and the communication in the home. She reported more frequent positive communication and reduced conflicts. She attributed these positive changes to the "positive time and experiences" they had together during the family sessions and to having an audience to their interactions, which in her view encouraged them to have more humor and playfulness. She described: "we are both the performer type, so having a chance to have an audience that is attuned and listening created a fun dynamics for us". When asked what makes her feel there is a change in Ruby's behavior at home, she reported "in the past, if I were to go to their

room, she [*Sic*] would be a lot more inpatient with me, tell me to get out and leave them alone. Now she would wait and see what I have to say. She's less emotionally charged and tries to do what I ask most of the time". She also reported that Ruby appears to be self-isolating less and is more open to meeting with friends. At home, they are spending less time in their room and are more willing to spend time with their mother and her fiancé. Ruby self-reported having more energy in the recent weeks, and a positive mood. Their affect was appropriate.

Discussion

Based on the literature, I was hoping to see an improvement in Ruby's trauma symptoms and reactions such as anxiety, depression, isolation, hypervigilance, nightmares, etc., alongside an increase in self-esteem, self-advocacy, and positive mood which can be indicated by self-report, parent report, and corresponding positive affect. Through the use of art therapy techniques with the child-parent dyad, I was expecting to see increased empathy, patience, and increased positive communication between the child and parent/caregiver, with a decrease in conflicts' frequency or severity. With the parent/caregiver I was hoping to see the effects of an increase of self-esteem and sense of capability in caring for their child. I was highly gratified to indeed witness such positive changes in both Ruby's and Shelly's mood and in their communication with each other. According to Shelly's self-report, she felt more empowered as a parent in her relationship with Ruby, a change which she attributed to the family sessions and interventions.

Nevertheless, despite the positive outcomes documented, I was aware of some threats that may impact my anticipated results in this study. First, the COVID-19 pandemic created additional stress to families in our program and their lives. As a result of the pandemic, all work is currently done remotely via telehealth, which created a different dynamic than in-person art therapy. For example, in a Zoom session, the therapist is often unable to see all the

body language and notice subtle changes in the clients' mood and communication. The families' access to reliable internet connection and adequate technology equipment (good-size computer screen, good quality camera) is often limited, especially when working with low-income families. Family members might also struggle in finding a private space where they can feel comfortable to open up, far from other family members present in the home. This can impact the ability to effectively communicate with the therapist without interruptions, and the ability of the therapist to witness the creative process in its entirety.

Furthermore, the family members are in their home settings, and not in an art therapy studio, which might impact their ability and comfort level in using some art materials and techniques (such as materials and techniques that are messy). The family might also not have access to a variety of art materials which will limit the types of creative activities the art therapist can offer to them. All these have limited my ability as an art therapist to provide the quality of care I would have been able to provide families within normative circumstances.

Acknowledging that, I did my best to plan activities that are simple to do at home, require accessible materials, or ones that I could provide the family with. I also tried to limit interruptions by planning in advance and making sure the family has a quiet space and that their technology was working before starting an activity. I also communicated these challenges with the family and got their feedback on what can assist them in feeling more supported through telehealth and try to offer them the kind of support most helpful for them through these unusual times.

Another challenge was that as a result of the pandemic, my internship site has been struggling to supply interns with cases, so at the time of these interventions, I was working with only two families, and only one teen who had a trauma background. This was a major limitation since it meant I did not have a large pool of suitable clients to base my research on.

This meant I did not have the option to choose the ideal clients to fit my research topic and had to make some compromises and base my research on one family only.

In addition, due to time limitations, the intervention I explored in my research was short-term. I had been priorly working with the family for five months and had already established a relationship with them. The results I saw in my research cannot be solely attributed to the short two-week dyadic art therapy intervention but come as a part of the family's overall treatment and trusting relationship and rapport created with the IHT team.

In order to further explore the therapeutic process and its results, I created response art for each session with the family. Image A is an artistic response to the first session, and to the activity of drawing each other. It is a watercolor painting on 12" x 9" watercolor paper. In the painting I tried to represent both mother (Shelly) and child (Ruby) as they engage in the activity. Although in the session the activity was very "light" in nature and the interaction between Ruby and Shelly was playful and full of humor, I tried to portray the deeper meaning of this activity. In my view, this activity was designed to ease anxiety and to foster a connection between Shelly and Ruby, to allow them to see each other in a different light and connect through looking carefully and observing each other. Since their goals in treatment revolve significantly on their relationship and on better communicating and understanding each other, I find this to be a significant step leading them slowly through the process. The painting portrays the outline of two figures, which are incomplete, and each figure is in the process of drawing the other. I used calm cool colors, one figure is blue and purple, and the other is in brown-red and pink. They were each created using a different color to emphasize the differences between the mother and child and their different needs. The use of a fluid medium such as watercolor allowed me to add to the "incomplete" nature of the figures and to create them to seem more "dream like". The background is also fluid to contribute to this feeling.

Image A



Image B is an artistic response to the second session, and to the activity of drawing objects from different perspectives. It is a watercolor painting on 11" x 8" watercolor paper. In this painting I tried to represent the different perspectives of the two individuals, Ruby and

Shelly. The image contains a parent giraffe and a baby giraffe, each standing across from each other on opposite sides of the page. In the middle there is a shape that can be the number nine or the number six. It is painted with a gradient color going from shades of purple to indigo and blue. Each giraffe in the image perceives and gives meaning to the shape through their perspective, according to their viewing angle. The tall parent giraffe has a speech bubble that says “9!” in the color blue, and that baby giraffe has a speech bubble saying “6!” in purple. They each have an exclamation point, meant to represent how confident each of them is about the accuracy of their perspective. Based on my experience, this often occurs in real-life relationships, where each side is extremely confident about what they view as “the truth” and it is often challenging to view the other person’s perspective and to understand that it might be just as true to them. For this image, I used a childish style and a theme of animals (giraffes) rather than humans, since I believe creating some emotional distance from the figures by using a relatable non-human figure can increase the sense of non-judgment, which can be helpful when trying to identify less effective behaviors.

Image B



The creation of these artistic responses allowed me to further explore the content of each session. It was helpful in assessing what Ruby and Shelly gained from the session and what can be learned from it for future discussion and goal setting.

Recommendations for Future Research

The research about integrating art therapy techniques in parent-child dyadic work with children who have experienced trauma is still limited. I am hoping to see more qualitative and quantitative research in this field that can explore more specific interventions and suggest ways to support this special and sensitive population. Larger scale studies, both long-term interventions and ones including large samples of participants, may provide more

significant data about the effects of such interventions on children and families from different backgrounds and life experiences. Future research, if done once COVID-19 will no longer pose a safety concern, might also be done in-person, where the options for artistic interventions are much more extensive, as well as the therapist's ability to best create a therapeutic relationship with the families and support them.

Conclusion

The fields of expressive therapies and art therapy are relatively new, and the amount of research is still limited. I am hoping to find further evidence of the positive effects of art therapy on supporting families and allow parents to support their child with the processing of a traumatic experience. I feel that art therapy has much to contribute to the field of dyadic therapy and the creative process can provide a powerful path for communication between parents and their children, and foster connection through different ages and life experiences.

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THESIS APPROVAL FORM

**Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Art Therapy, MA**

Student's Name: Yuval Minz

Type of Project: Thesis

**Title: Exploring Art Therapy Techniques in Parent-Child Dyads with Children Who
Have Experienced Trauma**

Date of Graduation: 5/5/2021

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Dr Tamar Hadar, MT-BC