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Creative Therapies with Adults

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Historical Background

The creative arts therapies are the intentional use by a trained therapist of art, music, dance/movement, drama, and poetry in psychotherapy, counseling, special education, or rehabilitation. Creative arts therapies, as professions, began during the 1940s, when a number of psychotherapists and artists began collaborating in the treatment of severely disturbed clients. Since many severely disturbed patients were unable to utilize the highly verbal modality of psychoanalysis, nonverbal forms of communication seemed to hold much promise. Creative arts therapies were nurtured in a few long-term psychiatric hospitals such as St. Elizabeth's in Washington, D.C., the Menninger Clinic in Topeka, Kansas, and Chestnut Lodge in Rockville, Maryland, and by psychiatrists such as Jacob Moreno, who had introduced action-oriented techniques into psychotherapy in the 1930s. In addition, creative arts therapies

were utilized as forms of relaxation/activities therapy for returning World War II veterans. The music therapy association formed in 1950. During the 1960s, the general atmosphere of social consciousness, the Vietnam War, and the dearth of jobs in the artistic field brought a number of artists into the health field. By the late 1960s, the field of creative arts therapies was developing rapidly and establishing university-based graduate programs. The dance therapy association was formed in 1966, the art therapy association in 1969, and the drama and poetry therapy associations in 1979. By this time, the creative arts therapies had diversified their interests well beyond psychoanalysis into behavior therapy, special education, and humanistic approaches. These associations are now constituent members of the National Coalition of Arts Therapy Associations (NCATA). There are approximately 15,000 trained creative arts therapists in the United States, and several thousand in other parts of the world. Creative arts therapists are trained in specialized university programs, usually a 2-year master's degree (music therapists may receive training at the bachelor's or master's degree level). Several PhD programs also exist. Scholarship from the faculties of over 100 universities is regularly reported in the eight professional journals in the field.

THEORETICAL CONTEXT

Initially, the creative arts therapies were justified by psychoanalytic concepts such as projection, externalization, and abreaction, or less convincingly, by assumptions of the value of artistic expression. More recently, however, it has become evident that the creative art therapies owe their effectiveness to the same therapeutic elements contained in cognitive-behavioral treatments. Thus, while specific creative arts therapy treatments for trauma have not yet been sufficiently tested, many of the major components of creative arts therapy treatments have received a great deal of empirical support.

Imaginal exposure is perhaps the most important therapeutic element in trauma treatment. All forms of creative arts therapy treatment of trauma utilize imaginal exposure, in that the trauma scene is represented in the artwork, dramatic role-play, poetry, or music. Halfway between in vivo and in vitro exposure, the client not only imagines the trauma scene, but represents it in physical or constructional behavior. The concretization of the traumatic imagery may be especially helpful in overcoming the client's avoidant tendencies. J. L. Moreno's psychodrama demonstrated the power of such imaginal exposure in the 1940's and 1950's, and stimulated renewed interest among psychologists in studying imagery (Singer, 2005; Utay & Miller, 2000; Weis et al., 2003). Guided imagery became an important element in early flooding procedures for PTSD (Keane, Fairbank, Caddell, & Zimmering, 1989), and continues to be used in a

variety of methods in cognitive-behavioral therapy (Krakow et al., 2001) as well as the creative arts therapies (Blake & Bishop, 1994; Orth, 2004).Foa,Doron, Yadin (2004) suggests that the clients should be engaged in the traumatic story whilst retelling it in the imaginal exposure. They describe three positions of clients engagements Under engager, a client that is emotionally remote from his story , Over engaged , a client that is too close to his story and can't really tell the story with out sobbing. This concept of the right distance from one's own experience is described by Landy (1986) in his dramatherapy model. He suggest that the best place for both the therapist and the client to be is in what he called esthetic distancing where the client can experience the story but not be overwhelmed by it. The other two positions are over distancing (somewhat like under engager) and under distancing (like over engager). Lahad (2006) suggests that the imaginal exposure is very much connected to what he calls "transcendence into fantastic reality" in fact he claims that the Imaginal Exposure is an as-if space (fantastic reality) because the event is not really happening. By recounting the story as-if it is happening now and at the same time knowing it is not, Lahad suggest it allows all Ifs (meaning wishes and aspirations) to happen in the impossible event. They can see things they did not notice, they can light up areas and darkened others etc, and thus change the experience itself.

Studies of the activation of the limbic system and the hippocampus by traumatic

memories (Liberzon et al., 1999) may indicate to the potential of the arts therapies. These studies found more activity in the amygdala and less in the medial prefrontal cortex (MPC) in PTSD than controls during challenging stimuli. Symptom-severity was positively correlated with amygdala activity & inversely correlated with MPC activity in PTSD cases (Shin et al., 2004).

The limbic memory is not linguistic but sensual (colors, light, sensation, sight, smell etc) .The art form therapies and its products are also non-verbal in their essence and thus can be helpful in retrieving the memory as it is embedded in the reptile brain.

Cognitive restructuring is another very important therapeutic factor in trauma treatment. Psychologists in the 1950's demonstrated the effectiveness of role-playing in attitude change (Hovland, Janis, & Kelley, 1953), so much so that role-playing has been integrated into most forms of education and many types of psychological intervention (McMullin, 1986). Role-playing (and its relative, *covert modeling*) have not surprisingly become standard elements in many forms of trauma treatment (e.g., Foa & Rothbaum, 1998). Playing out scenes, switching roles, and replaying more health-promoting options can be a very effective means of changing or challenging a person's view of a situation. "Role playing is a way to learn new behaviors and words for old ways of doing things….the

repeated practice of a behavior reduces anxiety and makes it more likely that a new behavior will be used." (Foa & Rothbaum, 1998, p. 217).

Cognitive interventions, including identification of distorted cognitions, cognitive reprocessing, and reframing, are essential components of the creative arts therapies. The aim is to impact the client's narrative of their traumatic experience, often termed *restorying*: the use of journaling, writing, and storytelling are common narrative techniques used in the creative arts therapies (Lahad, 2000; Rose, 1999). Producing the trauma narrative is a component of many cognitive-behavioral forms of intervention (Cohen, Mannarino, & Deblinger, 2006; Rynearson, 2001).

Stress/anxiety management skills are also important elements of effective trauma treatment, especially relaxation techniques. These techniques were integrated into behavioral treatment for anxiety disorders in the 1960's, and have been utilized in trauma treatments, particularly as Stress Inoculation Training (Meichenbaum, 1974). Techniques such as progressive muscle relaxation (Bernstein & Borkovec, 1973) and deep breathing are standard elements in most forms of creative arts therapy for trauma (Dayton, 1997; Levy, 1995; Riley, 1997).

Resilience enhancement techniques are more recently receiving greater attention (Bonanno, 2005). Here the creative arts therapies can presumably make an important contribution, since most studies of resilience point to the

importance of creativity, humor, flexibility, and activity, all of which are incorporated into creative arts therapy methods (Lahad, 1999,2000; Raynor, 2002). Creative activity is increasingly being recommended for traumatized clients (Bloom, 1997). Creative arts therapies may improve PTSD clients' self-esteem, hope, and prosocial behavior, and reduce feelings of shame and guilt, through the association of traumatic material to adaptive and aesthetic modes of expression.

Effective therapeutic interventions at the social level include *testimony, public education, and de-stigmatization*, which can often be enhanced through creative forms. For example, theatre troupes of trauma victims, exhibitions of victim's artworks, and public readings of victim poetry serve to educate the public about trauma, de-stigmatize the condition of PTSD, and offer an avenue for re-integration into society for the victims themselves (Jones, 1997; Losi, Reisner, & Salvatici, 2003; Mapp & Koch, 2004; Meyer-Weitz & Sliep, 2005; Park-Fuller, 2000; Sithamparanathan, 2003).

In summary, the effectiveness of the creative arts therapies will most likely be shown to be due to their use of the empirically-supported therapeutic factors of imaginal exposure, cognitive/narrative restructuring, stress management skills, and resilience enhancement methods.

Unique Contribution of the Creative Arts Therapies

The potential advantage of utilizing a creative arts therapy procedure is most likely based on the nonverbal (behavioral) aspects of the artistic modalities. First, the symbolic media of the arts may provide more complete access to implicit (as opposed to explicit) memory systems, as well as visual–kinesthetic schemas (Johnson, 1987; van der Kolk, 1994). It seems possible that certain aspects of traumatic experience and associated distorted schemas are stored in these non-lexical forms. By providing a wider range of stimuli (visual, sonic, tactile, and kinesthetic), the creative arts therapies may increase the vividness of imaginal exposure. By providing concretized forms of representation (visual, written, enacted), the creative arts therapies may help decrease avoidance. Both of these effects should lead to greater habituation of the client's fear response. The behavioral nature of the creative arts therapies may also support or enhance cognitive restructuring strategies. All of these potential effects appear to be especially helpful with clients with dissociative tendencies (Altman, 2000; Kluft, 1992; Mills, 1995). "Like other victims of childhood trauma, DID [dissociative identity disorder] patients are often uniquely responsive to nonverbal approaches. Art therapy, occupational therapy, sand tray therapy, movement therapy, other play therapy derivatives, and recreational therapy are reported as helpful toward achieving treatment goals, including integration." (ISSD, 1997, p.

6).

Second, the claim that creative arts therapies are especially helpful to traumatized, inexpressive persons has been supported by the concept of alexithymia, about which much has been written in the trauma field (Krystal, 1988). The inability to put feelings into words appears to be relatively common in patients with posttraumatic stress disorder (Krystal, Giller, & Cicchetti, 1986). Presumably, clients who are unable to find words to express their experience may find the nonverbal/behavioral forms of the creative arts a more welcoming means of expression (Lev-Wiesel, 1998). There is ample evidence that this is a reason why creative arts therapies have been especially useful with children [See Chapter X, Creative Arts Therapies with Children].

TECHNIQUES

Given the numerous formats and models in the creative arts therapies, it is a difficult task to describe them in a comprehensive manner. Nevertheless, we can outline some general principles. Generally, a typical session, whether with an individual, family, or group, begins with discussion about how clients are doing and what problems or concerns they have been facing. Then, instead of exploring these issues in continued verbal discussion, the therapist guides the client(s) into the use of a particular art medium, such as painting, movement, role playing, or

listening to or creating poetry or music, as a means of working on the presenting problem. Often, the therapist leads the client in warm-up or relaxation exercises in order to help prepare for the work and/or focus on the issue (i.e., *stress management*). For example, in art therapy, the client may be asked to draw or scribble randomly on a sheet of paper; in dance/movement therapy, the client may be guided through slow breathing exercises, stretching, or even running around the room; in music therapy, a client listens to music, sings a familiar song, or makes random noises on an instrument; or in poetry therapy, the client might write spontaneously for 5 minutes or listen to a poem. These activities typically open up and relax the client, and indicate to the therapist the client's mood or level of anxiety regarding the presenting issue.

The creative arts therapist attempts to understand the client's behavior in terms of the particular art medium: for example, the art therapist attends to the expressive qualities of different colors, lines, forms, patterns, and arrangements; the dance/movement therapist assesses the meaning of different movement patterns and qualities, rhythms, energy flow, articulation of body parts, and use of space; the poetry therapist attends to word choice, images, or metaphors selected; and the music therapist attends to the rhythm, harmony, pitch, timbre, and meter of the client's musical productions. Cultural and social contexts are always taken into account in these observations. Each discipline has developed

assessment procedures that give the therapist information about different clients with different diagnoses.

The main part of the session is spent participating in the arts medium. Sometimes the therapist participates with the client or group; at other times, he or she acts as a facilitator of the client's expressive activity. In psychodrama, the director rarely participates. In treatment models specifically designed for psychological trauma, the traumatic memories are worked on directly (i.e., *imaginal exposure*); for example, when a man is having trouble with memories of physical abuse by his father, the drama therapist takes on the role of his father, and they role-play the scene. At other times, the client draws, sings, or improvises, and issues linked to the trauma are addressed by the therapist as they emerge. For example, the art therapist may ask the client to draw a picture of her home before the abuse began, or a picture of her feelings of anger, or her perception of her own body. The music therapist may help the client to produce an improvised song concerning the impact of the rape on her life. The client in poetry therapy may write and then read a poem written as a letter to a buddy who died in Vietnam. In each of these activities, in addition to the client's manifest thoughts that arise about the subject, it is believed that the presence of the rhythms, melodies, colors, and actions of the arts media enhances the possibility that new aspects of the situation will emerge. These sensory prompts

may allow a more vivid recalling of the trauma scene. The therapist may leave it up to the client to make observations about how he or she is feeling and what the artwork means. At other times, the therapist may facilitate the client's exploration and questions about the poem, artwork, or song. Usually the therapist will attempt to direct the client toward more healthy views of his traumatic experience (i.e., *cognitive restructuring*), by encouraging them to represent in the art medium a more hopeful or accurate perspective, or the articulation of a more integrated narrative (i.e., *re-storying*). The concretization of the client's issues in the art form tends to serve as a distancing tool, allowing the client to reflect on his or her own behavior in real-life situations. In time, some therapists point out possible underlying meanings or clarify vague, undeveloped meanings or themes evident in the client's artwork. In institutions, the course of therapy is determined by the client's length of stay. In outpatient situations or in private practice, creative arts therapy may be brief, such as 6–8 weeks, when a particular problem can be focused on readily, or it can be a long-term commitment of 6 months to several years. While many creative arts therapists are familiar with several arts media, each therapist generally specializes in one or two. In most cases, the selection of the particular medium is based on the client's preference. However, in institutions where creative arts therapists work in teams, more sophisticated assessments have been developed that help the team select

the best modality for the client. For example, in working with people with PTSD, such as Vietnam veterans or sexually abused women, art is often used to help elicit the visual aspect of the repressed images. Drama and poetry are often used in the later stages of therapy, when the client has become aware of the traumas and wishes to rejoin the world through testimonial or public education formats (Johnson, 1987).

METHOD OF COLLECTING DATA

The material gathered for this chapter was derived from an extensive review of existing literature on the creative arts therapies (including PILOTS and PsycLIT databases), as well as reports from two previous International Society for Traumatic Stress Studies (ISTSS) Task Forces on Curriculum.

LITERATURE REVIEW

The creative arts therapies have been used both to target specific PTSD symptoms and to address other, associated conditions and functional problems (Carey, 2006; Thomas, 2005). Exposure-based components address re-experiencing and avoidance symptoms, and relaxation and distraction-based components target hyperarousal symptoms. Group interaction components aim to improve interpersonal relationships, communication skills, and work

functioning. Creativity/performance-based components aim to increase resilience and reduce shame caused by victimization. The multifaceted aspects of creative arts therapy treatment lend themselves to broadly defined treatment goals. Thus, Cruz and Essen (1994) note that many adult survivors of childhood trauma can benefit from the inclusion of arts therapies into their overall psychotherapy treatment program.

The creative arts therapies have been utilized with all types of trauma, though there are no data to indicate whether their efficacy varies according to type of traumatic event, single versus repeated traumatization, or age of traumatization (Cohen & Cox, 1995; Dayton, 1997; Kellerman & Hudgins, 2000; Kluft, 1992; Spring, 1993; Winn, 1994). Clinical experience suggests that the creative arts therapies have been helpful for clients with acute trauma in accessing memories of their trauma or abuse (Steele, 2003). These therapies have been increasingly applied in cross-cultural interventions with survivors of war and torture, and in post man- made disasters (Baker, 2005; Barnes & Peters, 2002; Hardi & Erdos, 1998; Lahad,1999, 2000; van der Velden & Koops, 2005). The creative arts therapies have also aided clients with chronic posttraumatic stress disorder (PTSD) address conditions of demoralization and hopelessness (Dintino & Johnson, 1996; Feldman, Johnson, & Ollayos, 1994; LeLieuvre, 1998).

There is a dearth of experimental research on the creative arts therapies,

due largely to the lack of training of its practitioners in research methodology and the relatively few available doctoral-level programs in the creative arts therapies. Evidence from clinical case studies indicates that improvement has most often been noted in (1) the primary symptoms of PTSD and (2) global clinical improvement. Noted less often are improvements in functional behaviors or clinical service utilization. The mean effect size of dance/movement therapy for core psychiatric symptoms, based on meta-analyses, has been estimated as 0.37 (range =0.15 to 0.54; Cruz & Sabers, 1998). However, no estimates are available with specifically PTSD populations, nor to our knowledge have any meta-analyses been completed on the other creative arts therapy modalities. Most empirical work has been done on assessment, particularly in the discipline of art therapy.

In a review of the empirical literature on graphic indicators of sexual abuse, Trowbridge (1995) found 12 studies that met inclusion criteria. In summarizing the results of this meta-analysis, she wrote, "Presence of the following indicators in children's drawings warrants further investigation: genitalia, hands omitted, fingers omitted, and head only drawn" (p. 492).
We found few empirical studies of the creative arts therapies in the treatment of trauma. Morgan and Johnson (1995) used a single-case experimental (A-B-A) design that demonstrated significant reductions in PTSD symptoms and

frequency of nightmares after an art therapy intervention with four Vietnam veterans. Johnson, Lubin, James, and Hale (1997) found that the creative arts therapies produced higher rates of short-term symptom reduction among Vietnam veterans in an inpatient PTSD program, though the program, as a whole, showed modest therapeutic effects. The art therapy group was found to be most beneficial for the more symptomatic veterans. Similar results were found from another VA inpatient PTSD program (Ragsdale, Cox, Finn, & Eisler, 1996).

Story telling and narrative as healing

Fry and Barker (2002 212) liken therapeutic storytelling with survivors of abuse to resuscitation: 'By encouraging survivors of abuse to stay involved in reminiscence sessions we, as facilitators of the group sessions, were successful in our attempt to reposition the young survivors of abuse among a "community of the living" as opposed to a "community of almost dead" or "barely living" women.'

> The conclusion of their research (ibid. 214-215), The storytelling sessions helped clients meet some psychological needs, such as gaining self-affirmation, preserving and recovering self-esteem, and overcoming constant feelings of self-blame and self-criticism for negative events they had experienced. The story- telling enabled some clients to recognize that indeed, they had powerful stories to tell. The fact that clients were given the opportunity to tell their stories to attentive listeners contributed considerably to their self- confidence, and in several small ways it revealed to them their own strengths and capabilities they had had in the past which they now felt they could regain with some effort. The storytelling enabled several clients to give order to the many chaotic events of their lives… it is reasonable to conclude that the telling of stories answered a deep human need of the survivors of abuse - the need to say "I am here, my life has not been filled with great successes ...but it has not been in vain"…

Boggs and Leptak (1991.) suppose that 'even when life review leads to anxiety or depression, many people ultimately experience great satisfaction and develop a better understanding of and appreciation for their place in society and history'. In concluding

their research on the influence of a theatre performance that engaged issues and dilemmas of senior citizens as a catalyst to study life-review reminiscing, they suggest (ibid. 245):

> Attendance at the play seemed to give focus to the reminiscing. On balance it can be said that the participants have adjusted well to events that were traumatic and view their past decisions and behaviors with understanding and acceptance. Overwhelmingly their focus and their energies are on the present. Recalling the past served as a reminder that the time remaining is limited. Maintaining an intense level of activity through travel, crafts, continuing education, and volunteering was the norm.

Gersie relates (1997 33-34) to the efficacy of storytelling and storymaking as treatment in traumatic and stressed emotional states:

> The capacity to derive meaning from even the most scrambled or incomplete information fails bitterly when a person is shocked, tired, in pain or frightened. In the throngs of emotional unwellbeing, the capacity to make sense of unstoried information is sharply reduced… When we are upset, shocked or in pain, we become preoccupied with our inner world. This inner story is insufficiently checked to see that it actually matches the outer circumstances…Though the circumstances of someone's life may be painful, the capacity to relate a story remains…The willingness to absorb or to convey a story, and thereby to comprehend vital aspects of what is taking place around them, is rarely lost... Moreover, participation in storytelling activities can significantly strengthen a troubled person's ability to make sense of their world.

Gersie's (1997 34) description of the intricacy in uttering traumatic memories resembles the aforementioned findings of research conducted by Laub (1992b, 1998), Laub and Auerhahn (1993), Van der Kolk (1995, 2001), van der Kolk, Hopper and Osterman (2001) and others:

> When the conditions of a person's daily life are dehumanizing - due to persistent poverty, violence or great lonesomeness - an eerie silence falls. At first this silence is filled with the clamour of protest. However, when the situation continues unalleviated, and the risk of merely expressing the wish for a new situation remains great, meaningful words grow to dwell beyond the reach of expression. Only the eyes continue to speak the story of the endured experience in a precisely encoded glance.

Grinberger(2006) studied the therapeutic qualities of the process of re-narrating life stories with holocaust survivors she concludes her research In conclusion, the findings of this research provide support for the notion that storytelling as well as guided life-review are more appropriate modes of therapy for clients enduring traumatic memories even many years

after the actual traumatic occurrence. Moreover, this research offers new perspectives and additional methods of employment to be implanted in the therapeutic process of writing: exercising various literary genres, invoking the imagination, being audience to your own drama as well as exploration, enlargement and transformation of the client's role system and roles repertoire.

Most of the evidence of efficacy is derived from clinical reports and case studies. The creative arts therapies have been cited as helpful in the reduction of alexithymia (Duey, 1991; James & Johnson, 1996;), increase in emotional control (Cohen, Barnes, & Rankin, 1995; Slotoroff, 1994), improvement in interpersonal relationships (Stember, 1978), decrease in dissociation and anxiety (Austin, 1996; Duey, 1991; Greenberg & van der Kolk, 1989; Jacobson, 1994; Riley, 1996), decrease in nightmares and sleep problems (Daniels & McGuire, 1998; Hernandez-Ruiz, 2005; Morgan & Johnson, 1995), improved body image (Simonds, 1992), and reduction of depression (Clendenon-Wallen, 1991). In the nomenclature used for this guideline, all of these reports would be coded as Level D or E in terms of support.

Specialized Methods Targeting PTSD

A number of creative arts therapy methods have been specifically designed to target PTSD symptoms and trauma-related pathology. Though none of these approaches have been empirically tested in random control studies, each

has shown promise as an effective technique for trauma symptomatology. Barry Cohen and his colleagues have developed a method of art therapy that carefully guides the client through increasing levels of exposure to traumatic imagery (Cohen, Barnes, & Rankin, 1995; Cohen & Mills, 1999; Cox & Cohen, 2005). Helen Bonny and her colleagues have developed a method called Guided Imagery and Music that has been successfully used with traumatized populations (Blake & Bishop, 1994; Schulberg, 1997). In this approach, the client recalls their traumatic experience while specifically selected music is playing. Kay Adams has developed a form of Journal Therapy in which the client's trauma narrative is developed and then restructured through a creative writing process (Adams, 1997). Mooli has designed the 6-Part Story Method, a creative narrative technique that helps clients achieve successful coping responses (Lahad, 1992). This method has been widely applied in community stress prevention settings, disaster relief, as well as psychotherapy (Lahad,1999, 2000).

Mooli Lahad (2006) developed an integrative method called SE FR CBT combining aspects from Somatic Experiencing (Levine) PE (Foa) and his method called Fantastic reality (Lahad 2005). This protocol is using therapeutic cards (Ayalon 2003) to create a safe space as an anchor of safety when the traumatic memories are too hard to endure. From the set of cards the client is encouraged to select 6 that helps her to re-narrate her trauma . Just like in Prolonged

Exposure this part is repeated several times. Control over unbearable memories achieved through the Fantastic Reality method by asking the client to take out of her story a card or two that she wish not to be there and then to re narrate the story again.At the end of the process the client is encouraged to introduce two cards she would have liked to have had with her in the incident that would have helped her but would change the outcome. Role palying and enactments of some parts of the traumatic memory is introduced too. Thus with what Lahad calls fantastic reality, empowerment and wishes are introduced into the traumatic story .Kate Hudgins has designed the Therapeutic Spiral method of psychodrama that applies various methods of affect containment, cognitive restructuring, and testimony (Hudgins, 1998; 2002). The approach has been applied with refugees and disaster victims as well as psychotherapy clients. David Johnson and his colleagues have applied a drama therapy technique called Developmental Transformations to numerous trauma populations (Dintino & Johnson, 1996; Johnson, 1999; Landers, 2002; James & Johnson, 1996). Using improvisational role playing, the client is gradually guided through a recalling of their traumatic experience and then encouraged to transform it playfully into more health-promoting forms.

Known Risks and Side Effects

There are no known risks or side effects specific to the creative arts

therapies when used by appropriately educated and trained therapists. Occasionally, as in most forms of trauma treatment, clients may become overwhelmed when accessing traumatic material too quickly or too intensively, though these reactions can often be prevented through specific structuring techniques within the session (Carey, 2006; Cohen, 2006).

SUMMARY

Despite relatively wide use and application, the efficacy of the creative arts therapies has not been established through empirical research. Creative arts therapy professionals claim that these treatment modalities may be useful as either primary or adjunctive interventions (Johnson, 1987). There is clinical consensus that the use of the creative arts may be helpful as an adjunct to the treatment of PTSD under the following conditions: (1) The arts therapy is conducted by a practitioner educated and trained in that approach; (2) the therapy is conducted with the permission of the client; and (3) the therapy is conducted in conjunction with other ongoing treatments and therapists. The exact source of therapeutic benefits of the creative arts therapies in the treatment of PTSD has not been identified, but is likely to be a combination of generic psychological processes (such as imaginal exposure, cognitive restructuring, stress management, resilience enhancement, and testimony) and specific

contributions of nonverbal and creative elements. There is currently insufficient evidence to differentiate the impact of the creative arts therapies on PTSD, co-morbid disorders, or associated disruptive symptoms.

Recommendations

1. The recognition, justification, and further development of the creative arts therapies in the treatment of psychological trauma will be most fully encouraged by more sophisticated empirical inquiries using control groups and randomized assignment.

2. Creative arts therapy treatments designed as specific treatments for PTSD will presumably have heightened therapeutic effects over nonspecific creative arts therapy approaches. The further design, development, and testing of such treatments is recommended.

3. Greater attention to the possible contraindications (e.g., types of clients, types of symptoms, stages of treatment) is needed.

REFERENCES

Adams, K. (1997). The way of the journal. Denver, CO: Sidran Press.

Altman, K. (2000). Psychodramatic treatment of dissociative identity disorder. In P. Kellerman & K. Hudgins (Eds.), Psychodrama with trauma survivors. London: Jessica Kingsley.

Austin, D. (1996). The role of improvised music in adult psychodynamic music therapy. Music Therapy, 14, 35–41.

Ayalon, A. (2003) Using Therapeutic Cards For Dealing With Conflict, Stress and Trauma , *26th Annual International School Psychology Colloquium* Mental Health and Education: Students, Teachers and Parents July 28th ---- August 1st, 2003 Hangzhou, China

Baker, B. (2006). Art speaks in healing survivors of war: The use of art therapy in treating trauma survivors. Journal of Aggression, Maltreatment, and Trauma, 12, 183-198.

Barnes, H., & Peters, D. (2002). Translating trauma: Using arts therapies with survivors of violence. South African Theatre Journal, 16, 157-183.

Bernstein, D., & Borkovec, T. (1973). Progressive muscle relaxation training. New York: Research Press.

Blake, R., & Bishop, S. (1994). The Bonny Method of Guided Imagery and Music in the treatment of posttraumatic stress disorder with adults in the psychiatric setting. Music Therapy Perspectives, 12, 125–129.

Bloom, S. (1997). Creating sanctuary. New York: Routledge.

Bonanno, G. (2005). Resilience in the face of potential trauma. Current Directions in Psychological Science, 14, 135-138.

Carey, L. (2006). Expressive and creative arts methods for trauma survivors. London: Jessica Kingsley.

Clendenon-Wallen, J. (1991). The use of music therapy to influence the self-confidence of adolescents who are sexually abused. Music Therapy Perspectives, 9, 17–31.

Cohen, B. (1996). Art and the dissociative person. In L. K. Michelson & W. J. Ray (Eds.),Handbook of dissociation: Theoretical, empirical, and clinical perspectives (pp. 131–149). New York: Plenum Press.

Cohen, B., Barnes, M., & Rankin, A. (1995). Managing traumatic stress through art. Lutherville, MD: Sidran Press.

Cohen, B., & Cox, C. (1995). Telling without talking: Art as a window into the world of multiple personality. New York: Norton.

Cohen, B., & Mills, A. (1999). Skin/paper/bark: Body image, trauma, and the Diagnostic Drawing Series. In J. Goodwin & R. Attias (Eds.), Splintered reflections: Images of the body in trauma, pp. 203-221. New York: Basic Books.

Cohen, J., Mannarino, A., & Deblinger, E. (2006). Treating trauma and traumatic

grief in children and adolescents. New York: Guilford Press.

Cox, C., & Cohen, B. (2005). The unique role of art making in the treatment of dissociative identity disorder. Psychiatric Annals, 35, 685-694.

Cruz, F., & Essen, L. (1994). Adult survivors of childhood emotional, physical, and sexual abuse. Northvale, NJ: Jason Aronson.

Cruz, R., & Sabers, D. (1998). Dance/movement therapy is more effective than previously reported. Arts in Psychotherapy, 25, 101–104.

Daniels, L., & McGuire, T. (1998). Dreamcatchers: Healing traumatic nightmares using group dreamwork, sandplay, and other techniques of intervention. Group, 22, 205-227.

Dayton, T. (1997). Heartwounds: The impact of unresolved trauma and grief on relationships. Deerfield Beach, FL: Health Communication.

Dintino, C., & Johnson, D. (1996). Playing with the perpetrator: Gender dynamics in developmental drama therapy. In S. Jennings (Ed.), Drama therapy: Theory and practice (Vol. 3, pp. 205–220). London: Routledge.

Duey, C. J. (1991). Group music therapy for women with multiple personalities. In K. E. Bruscia (Ed.), Case studies in music therapy. Phoenixville, PA: Barcelona.

Feldman, S., Johnson, D., & Ollayos, M. (1994). The use of writing in the treatment of PTSD. In J. Sommer & M. Williams (Eds.), The handbook of

post-traumatic therapy (pp. 366–385). Westport, CT: Greenwood.

Foa, E., & Rothbaum, B. (1998). Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. New York: Guilford.

Greenberg, M., & van der Kolk, B. (1989). Retrieval and integration with the "painting cure." In B. van der Kolk (Ed.), Psychological trauma (pp. 191–216). Washington, DC: American Psychiatric Press.

Hagood, M. (1994). Diagnosis or dilemma: Drawings of sexually abused children. Art Therapy: Journal of the American Art Therapy Association, 11(1), 37–42.

Hardi, L., & Erdos, E. (1998). Nonverbal therapy of traumatized war victims. Torture, 8, 82-85.

Hernandez-Ruiz, E. (2005). Effect of music therapy on anxiety levels and sleep patterns of abused women in shelters. Journal of Music Therapy, 42,

Hovland, C., Janis, I., & Kelley, H. (1953). Communication and persuasion. New York: Basic Books.

Hudgins, K. (1998). Experiential psychodrama with sexual trauma. In L. Greenberg, J. Watson, & G. Lietaer (Eds.), Handbook of experiential psychotherapy. New York: Guilford Press.

Hudgins, K. (2002). Experiential treatment for PTSD: The therapeutic spiral model. New York: Springer.

International Society for the Study of Dissociation. (1997). Treatment guidelines. Washington, DC: ISSD Publications.

Jacobson, M. (1994). Abreacting and assimilating traumatic, dissociated memories of MPD patients through art therapy. Art Therapy: Journal of the American Art Therapy Association, 11(1), 4–52.

James, M., & Johnson, D. (1996). Drama therapy for the treatment of affective expression in post-traumatic stress disorder. In D. Nathanson (Ed.), Knowing feeling: Affect, script, and psychotherapy (pp. 303–326). New York: Norton.

Johnson, D. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. Arts in Psychotherapy, 14, 7–14.

Johnson, D., Lubin, H., Hale, K., & James, M. (1997). Single session effects of treatment components within a specialized inpatient posttraumatic stress disorder program. Journal of Traumatic Stress, 10, 377–390.

Johnson, D. (1999). Refining the developmental paradigm in the creative arts therapies. In D. Johnson, Essays in the creative arts therapies: Imaging the birth of a profession, pp. 161-181. Springfield, IL: Charles Thomas.

Jones, J. (1997). Art therapy with a community of survivors. Art Therapy, 14, 89-94.

Keane, T., Fairbank, J., Caddell, J., & Zimmering, R. (1989). Implosive (flooding)

therapy reduces symptoms of PTSD in Vietnam combat veterans. Behavior Therapy, 20, 245-260.

Kellerman, P., & Hudgins, K. (2000). Psychodrama with trauma survivors: Acting out your pain. London: Jessica Kingsley.

Kluft, E. (Ed.). (1992). Expressive and functional therapies in the treatment of multiple personality disorder. Springfield, IL: C. C. Thomas.

Krakow, B., Hollifield, M., Schrader, R., Koss, M., Tandberg, D., Lauriello, J., et al. (2001). A randomized controlled study of imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder. Journal of the American Medical Association, 286, 537-545.

Krystal, H. (1988). Integration and self-healing: Affect, trauma, alexithymia. Hillsdale, NJ: Analytic Press.

Krystal, J., Giller, E., & Cicchetti, D. (1986). Assessment of alexithymia in post-traumatic stress disorder and somatic illness: Introduction of a reliable measure. Psychosomatic Medicine, 48, 84–94.

Lahad, M. (1992). Storymaking in assessment methods for coping with stress. In S. Jennings (Ed.), Dramatherapy: Theory and practice II, pp. 150-163. London: Routledge.

Lahad, M. (1999). The use of drama therapy with crisis intervention groups, following mass evacuation. *The Arts in Psychotherapy*, *26*(1), 27-33.

Lahad, M. (2000). Darkness over the abyss: Supervising crisis intervention teams following disaster. Traumatology, 6, 273-293.

Landers, F. (2002). Dismantling violent forms of masculinity through developmental transformations. The Arts in Psychotherapy, 29, 19-30.

Landy, R. (1986) **Drama Therapy: Concepts and Practices**, Springfield, IL, U.S.A. Charles C Thomas

LeLieuvre, R. (1998). "Goodnight Saigon:" Music, fiction, poetry, and film in readjustment counseling. Professional Psychology: Research and Practice, 29, 74-78.

Lev-Wiesel, R. (1998). Use of a drawing technique to encourage verbalization in adult survivor of sexual abuse. The Arts in Psychotherapy, 25, 257-262.

Levy, F. (Ed.). (with J. Fried & F. Leventhal). (1995). Dance and other expressive art therapies: When words are not enough. New York and London: Routledge.

Liberzon I, Taylor SF, Amdur R, Jung TD, Chamberlain KR, Minoshima S, **et al** (**1999**): Brain activation in **PTSD** in response to trauma-related stimuli. *Biol Psychiatry* 45:817–826.

Losi, N., Reisner, S., & Salvatici, S. (2002). Psychosocial and trauma response in war-torn societies: supporting traumatized communities through arts and theatre. Geneva: International Organization for Migration.

Mapp, I., & Koch, D. (2004). Creation of a group mural to promote healing

following a mass trauma. In N. Webb (Ed.), Mass trauma and violence: Helping families and children cope, pp. 100-119. New York: Guilford.

McMullin, R. (1986). Handbook of cognitive therapy techniques. New York: Norton.

Meichenbaum, D. (1974). Cognitive behavior modification. Morristown, NJ: General Learning Press.

Meyer-Weitz, A., & Sliep, Y. (2005). The evaluation of Narrative Theatre training: experiences of psychological workers in Burundi. Intervention, 3, 97-111.

Mills, A. (1995). Outpatient art therapy with multiple personality disorder: A survey of current practice. Art Therapy, 12, 253-256.

Morgan, C., & Johnson, D. (1995). Use of a drawing task in the treatment of nightmares in combat-related PTSD. Art Therapy: Journal of the American Art Therapy Association, 12(4), 244–247.

Orth, J., Doorschodt, L, Verburgt, J., & Drozdek, B. (2004). Sounds of trauma: An introduction to methodology in music therapy wit traumatized refugees in clinical and outpatient settings. In J. Wilson & B. Drozdek (Eds.), Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims. New York: Brunner/Routledge.

Park-Fuller, L. (2000). Performing absence: The staged personal narrative as

testimony. Text and Performance Quarterly, 20, 20-42.

Ragsdale, K., Cox, R., Finn, P., & Eisler, R. (1996). Effectiveness of short-term specialized inpatient treatment for war-related posttraumatic stress disorder: A role for adventure-based counseling and psychodrama. Journal of Traumatic Stress, 9, 269-283.

Raynor, C. (2002). The role of play in the recovery process. In W. Zubenko & J. Capozzoli (Eds.), Children and disasters: A practical guide to healing and recovery. New York: Oxford University Press.

Reisner, S. (2002). Staging the unspeakable. In N. Losi, S. Reisner, & S. Salvatici (Eds.), Psychosocial and trauma response in war-torn societies: supporting traumatized communities through arts and theatre, pp. 9-30. Geneva: International Organization for Migration.

Riley, S. (1997). An art psychotherapy stress reduction group for therapists dealing with severely abused client population. Arts in Psychotherapy, 23, 407–416.

Rose, S. (1999). Naming and claiming: The integration of traumatic experience and the reconstruction of self in survivors' stories of sexual abuse. In K. Rogers, S. Leydesdorff, & G. Dawson (Eds.), Trauma and life stories: International perspectives. London: Routledge.

Rynearson, E. (2001). Retelling violent death. Philadelphia: Brunner/Routledge.

Schulberg, C. (1997). An unwanted inheritance: Healing transgenerational trauma of the Nazi Holocaust through the Bonny Method of guided imagery and music. The Arts in Psychotherapy, 24, 323-345.

Shin,L.M.,Orr,S.Carson,M.A.,Rauch,S.L.,Macklin,M.L.,Lasko,N.B., Peters,P.M.,Metzger,L.G.Dougherty,G.D., Cannistraro, P.A., Alpert,N.M.,Fischman, A.J., Pitman, R.K., (2004) Regional Cerebral Blood Flow in the Amygdala and Medial Prefrontal Cortex During Traumatic Imagery in Male and Female Vietnam Veterans With PTSD *Arch Gen Psychiatry*. 2004;61:168-176.

Simonds, S. (1992). Sexual abuse and body image: Approaches and implications for treatment. Arts in Psychotherapy, 19, 289–294.

Singer, J. (2005). Imagery in psychotherapy. Washington, DC: American Psychological Association.

Sithamparanathan, K. (2003). Interventions and methods of the Theatre Action Group. International Journal of Mental Health, Psychosocial Work, and Counseling in Areas of Armed Conflict, 1, 44-47.

Slotoroff, C. (1994). Drumming technique for assertiveness and anger management in the short term psychiatric setting for adult and adolescent survivors of trauma. Music Therapy Perspectives, 12, 111–116.

Spring, D. (1993). Shattered images: Phenomenological language of sexual

trauma. Chicago: Magnolia Street.

Steele, W. (2003). Using drawing in short-term trauma resolution. In C. Malchiodi (Ed.), Handbook of art therapy, pp. 139-151. New York: Guilford.

Thomas, P. (2005). Dissociation and internal models of protection: Psychotherapy with child abuse survivors. Psychotherapy: Theory, Research, Practice, Training, 42, 20-36.

Trowbridge, M. M. (1995). Graphic indicators of sexual abuse in children's drawings: A review of the literature. Arts in Psychotherapy, 22, 485–494.

Utay, J., & Miller, M. (2000). Journal of Instructional Psychology, 33, 40-43.

Van der Kolk, B. (1994). The body keeps the score. Harvard Review of Psychiatry, 1, 253-265.

Van der Velden, I., & Koops, M. (2005). Structure in word and image: Combining narrative therapy and art therapy in groups of survivors of war. Intervention, 3, 57-64.

Weis, J., Smucker, M., & Dresser, J. (2003). Imagery: Its history and use in the treatment of posttraumatic stress disorder. In A. Sheikh (Ed.), Healing images: The role of imagination in health, pp. 381-395. Amityville, NY: Baywood.

Winn, L. (1994). Posttraumatic stress disorder and dramatherapy: Treatment and

risk reduction. London: Jessica Kingsley.