SOCIAL WORK, TRAUMA, AND THE ARTS

SUMMER 2019 COURSE ANTHOLOGY

BRYN MAWR COLLEGE'S
GRADUATE SCHOOL OF SOCIAL
WORK AND SOCIAL RESEARCH
Special Topic: Social Work, Trauma, and the Arts

Summer 2019

Course Anthology

Bryn Mawr College

Graduate School of Social Work and Social Research
# Table of Contents

Introduction: Dr. Meagan Corrado … 3

Copyright Statement … 5

Uses for Anthology … 6

Anthology Goals … 7

A Trauma-Informed Intervention for Schizophrenia: Christina Babusci … 8

Arts-Based Intervention/Installation: Outdoor Learning Lab: Nancy Barich … 17

The Power of Music and Creative Writing: Grace R. Capuzzi … 31

Adult Play Therapy: Peter Danzig … 41

Movement Therapy Intervention for Trans and Non-Binary Youth: Mari Flamm … 47

Movement and Music Based Group Activity for Adolescents Experiencing Traumatic Grief: Amanda Frisco … 60

Proposal for Multi-Session Clay Modeling Arts-Based Intervention for Eating Disorder Therapy Treatment and Supportive Programing: Melissa Garfinkel … 71

Providing Music-Based Interventions to Patients with Dementia in a Hospital Setting: Megan Hoskins … 81

Performance Arts Based Intervention in Substance Use Treatment: Adam Ouanes … 87

Aerial Yoga Intervention for Trauma and Loss: C. Louise Profit … 103

Theatre of the Oppressed: Expressive Therapy in Action: Jenna Spitz … 112

The Pizza Box as a Window to the Soul: Elizabeth Tankel … 120

Arts-Based Therapy Group for Urban Youth: Rose Walsh … 128

Choosing Family: A Multifaceted Trauma-Informed Intervention for Transgender Individuals Experiencing Homelessness: Karina Wiener … 142
INTRODUCTION

Dr. Meagan Corrado

In a world of dissention, conflict, abuse, and trauma, it is easy to feel discouraged. Individuals, families, and communities face tremendous obstacles. In addition to the individual adversities people strive to overcome, they also encounter community, cultural, and systemic barriers. But wherever there are stories of trauma, there are also stories of strength and resilience. As social workers assist trauma survivors in processing their experiences, it is important to focus not only on the pain but also on the strength.

The arts are an invaluable tool for social workers seeking to provide strengths-based support to trauma survivors. Creativity provides multiple benefits. Creativity humanizes trauma survivors. It helps them understand who they are and where they want to go. It gives them freedom in places where they feel constrained and oppressed. It gives them a voice in spaces where they feel silenced and marginalized. Creativity—the arts—speak for trauma survivors when they don’t have the language to describe their experiences.

This course, Social Work, Trauma, and the Arts, was designed to teach students how to integrate the arts into work with traumatized individuals, communities, and systems. Using creative engagement and didactic strategies, this class was divided into three phases. In the introductory phase, students learned basic information about (1) the impact of trauma, (2) the
consequences of trauma exposure, (3) the neurobiological implications of traumatization, and (4) best practices and common factors in trauma treatment. In the second phase, students explored the relationship between social work, creativity, and trauma healing. Students critically analyzed (1) the concepts of creativity and destruction, (2) the role of various artistic media in facilitating trauma healing, and (3) the congruity of these arts based practices with social work values. In the third phase, students considered ways to integrate the arts into both clinical and macro contexts. The course culminated with students’ creation of an arts-based proposal to be implemented with an identified population in a social work setting.

This anthology represents students’ efforts toward integrating multiple sources of knowledge and considering creative ways to support trauma survivors in social work settings. Students identified a population of focus and a social work service setting. They presented the theoretical foundation for their concept using course readings, social work values, and relevant literature. They then presented an innovative idea. In sharing these students’ trauma-informed, arts-based proposals, we aspire to (1) motivate other social workers to pursue creative strategies in their work with trauma survivors; (2) assist the greater social work community in developing creative, theoretically sound interventions; (3) develop new and different ways to provide strengths-based support to traumatized individuals, systems, and communities.
COPYRIGHT STATEMENT

Each individual author holds intellectual property rights for their article and concept. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without the prior permission of the author.
USES FOR THIS ANTHOLOGY

As you review the ideas represented in this anthology, it is important to remember that although course readings, social work values, and relevant literature informed the development of students’ interventions, these interventions have not been researched to determine their efficacy. Social workers seeking to use these and other arts-based interventions should use clinical judgment, ethics, best practices, social work values, client preferences, and practice wisdom when intervening with traumatized individuals, systems, and communities.
ANTHOLOGY GOALS

The anthology seeks to achieve the following goals:

- To motivate other social workers to pursue creative strategies in their work with trauma survivors.
- To assist the greater social work community in developing creative, theoretically sound interventions.
- To develop new and different ways to provide strengths-based support to traumatized individuals, systems, and communities.
A Trauma-Informed Intervention for Schizophrenia

Christina Babusci

Many people with schizophrenia are encouraged to ignore their hallucinations and delusions. Medications are aimed at quieting positive symptoms, and psychotherapy often focuses on grounding a client in reality. But for people with schizophrenia, hallucinations are real. The fear that oft accompanies bizarre, well-formed delusions is real. Even during residual periods of the illness, the memories formed during acute psychosis are real. To deny the lived experience of people who have experienced trauma, even if that trauma cannot be perceived by others, is to deny them the chance to recover and grow from their experiences.

**Background and Significance**

Schizophrenia is a serious mental illness that affects one’s ability to think, reason, and interact with others. People with schizophrenia typically experience onset during late adolescence or early adulthood and continue to experience symptoms of schizophrenia throughout their lifespan. With onset occurring during such a critical period of development and transition, people with schizophrenia often suffer serious disruption to their occupational and social functioning. This further compounds their isolation and withdrawal from society and weakens their support systems.
Long-term outcomes for schizophrenia indicate marked, pervasive impairment across contexts. People with a psychotic disorder face a significantly greater risk of penal incarceration when compared to the population as a whole and when compared to people with other mental illnesses (Hawthorne et al., 2012). Of people with schizophrenia, only 53% live independently or with family. The other 47% are either in group homes, hospitalized, incarcerated, or homeless. The economic burden of schizophrenia is the highest of all mental illnesses, with costs totaling about $63 billion per year. Most concerning, people with schizophrenia are 50 times more likely to attempt suicide than the general population. Roughly 10% of people with schizophrenia ultimately die by suicide (“Schizophrenia Facts”, 2010).

The causes of schizophrenia are not fully understood, but most agree that schizophrenia occurs from a combination of factors including a genetic predisposition, environmental factors, and triggering stressors. In the greater population, schizophrenia affects 1 in every 100 people. If a person has a family history of schizophrenia, their risk increases depending on the relation, with an identical twin having the greatest risk at 48%. While schizophrenia is one of the more genetically linked mental illnesses, there is compelling evidence to suggest the importance of other contributory factors. Research has focused on a number of different environmental factors, including the prenatal environment, family environment, and exposure to stressors and trauma. In a study conducted in Finland, adopted children whose biological mother had schizophrenia (typically reported as a 10% risk factor) developed schizophrenia at a rate of 6% when raised in a healthy family environment. That rate increased to 37% when they were raised in a dysfunctional family environment (Tienari et al., 2004).
Trauma and Schizophrenia

The role of trauma as a contributory factor in the development of schizophrenia has become an increasingly important area of research. Childhood abuse and neglect have been linked to the development of many psychological disorders such as depression, anxiety, substance use disorder, and schizophrenia. Read, Perry, Moskowitz, & Connolly (2001) found that childhood trauma creates changes in the brain that have been linked with the development of schizophrenia, blurring the line between genetic and epigenetic factors. In particular, childhood sexual abuse, especially for men, is significantly correlated with the development of schizophrenia in adulthood (Moskowitz, 2011).

The impact of trauma on the development of schizophrenia is not limited to childhood experiences, however. Many people with schizophrenia report a traumatic, triggering event that directly precedes the onset of psychotic symptoms. Additionally, people with schizophrenia are at an increased risk of re-traumatization after diagnosis that may impact the course and outcomes of the illness. Schizophrenia, more so than other psychiatric conditions, often leads to involuntary hospitalization. Many patients report involuntary hospitalization as highly traumatizing. Oftentimes, this is the patient’s first experience with the mental health care system. People with schizophrenia frequently cite a distrust of mental healthcare providers and fear of rehospitalization as reasons for not continuing with care after discharge or when experiencing an increase in symptom presentation.

People with schizophrenia are also more likely to become victims of violent acts. Despite the public perception that people with schizophrenia are inherently violent and likely to commit violent crime (which is not demonstrated by crime statistics or research on schizophrenia), they are actually 14 times more likely to be the victim of a violent crime (Wehring & Carpenter,
Unfortunately, much of the literature on violence and schizophrenia has focused on people with schizophrenia being perpetrators despite consistent evidence to the contrary. This pervasive misconception only further disrupts a person’s reintegration with society when they are most in need of support.

While research supporting the correlational and causal links between trauma and mental health continues to grow, research that has focused on the role of trauma in the development of schizophrenia and other psychotic disorders is much more limited and fairly recent. Moreover, research on the exacerbating effect of trauma on the course and outcome of those already diagnosed with schizophrenia is almost non-existent. The reasons for this discrepancy may be related to a number of issues, including practical difficulties in conducting research with people with schizophrenia (due to incarcerations, homelessness, etc, as previously mentioned). However, of grave concern is the misconception that people with schizophrenia are incapable of providing an accurate recounting of their traumatic experiences, or that people with schizophrenia are not able to benefit from trauma-informed interventions (Schafer & Fischer, 2011).

The trauma associated with schizophrenia is not limited to contributory factors and increased vulnerability after onset. The hallmark features of schizophrenia in and of themselves can be very traumatizing. Auditory hallucinations, which are the most recognizable feature of schizophrenia, are typically persecutory in nature with many people reporting a near constant stream of verbal abuse ranging from derogatory comments to encouragement to harm or kill oneself. The delusions that accompany these hallucinations can be very frightening. In the United States, many people with schizophrenia report knowledge that the government is trying to kill them. People often report that a demonic power has taken control of them. It is important to
note that, diagnostically, a person must have 100% conviction in order to be delusional. These people do not question whether they are in danger; they are convinced that they are.

Current treatment for schizophrenia does not focus on the content of the delusions or hallucinations or the subsequent trauma. Treatment mostly comes in the form of psychoactive medication, which can be highly effective at decreasing the presence of positive symptoms (although not everyone with schizophrenia responds to the current pharmacological treatments that are available and a large number of people continue to experience positive symptoms to a lesser degree). Psychotherapeutic approaches are less common and typically focus on finding a path back to reality, coping with stressors that accompany and/or escalate the illness, and encouraging medication adherence. In fact, treatment for schizophrenia largely advises against engaging or giving weight to hallucinatory or delusional experiences. Schizophrenia has long been viewed as a purely biological brain disorder with little to be gained from non-medical interventions. This runs in sharp contrast to the treatment models for other disorders that may have similar presentations but are considered to be of a distinct etiology. Auditory hallucinations can occur in a variety of contexts from depression, dissociation, PTSD, and anxiety. The content of these hallucinations are often considered to be beneficial in understanding the nature of the illness and formulating an effective treatment plan (Moskowitz, 2011).

**Perception is Reality**

It is vital that we recognize and respect the experiences of people with schizophrenia. This is a population that has long been underserved and whose experiences have been denied. Schizophrenia is often viewed as all or nothing, with no grey area. Once a person passes the threshold of schizophrenia, they are never considered to be well again. Through this lens, it is all too easy to dismiss trauma-informed interventions as futile. Practitioners can become numb to
the reality of their patients’ experiences, and people with schizophrenia can become further disengaged with a society that does not hear them.

Through this intervention, I seek to provide a conduit through which people with schizophrenia can share their experiences with family, friends, and their community. Using a medium with which they feel comfortable, people with schizophrenia will be invited to participate in an exhibition of their stories. By providing a space to be heard without being dismissed, I aspire to encourage a sense of community among people with schizophrenia, a connection to the larger community, and a greater understanding of schizophrenia.

**Population**

People with schizophrenia residing in the greater Philadelphia area will be invited to participate through area agencies that provide services or supports to this population. Participants can be at any stage of treatment (no treatment, outpatient treatment, inpatient treatment) and at any level of functioning. Participants can meet either individually or in a group setting, depending on their comfort level. Guidance at the beginning of the project and support throughout the project will be provided weekly or on an as needed basis.

**Intervention**

Participants will be guided to select an artistic medium through which to share their experience with schizophrenia. For some, this may be through a narrative approach. However, many people with schizophrenia experience positive formal thought disorder with their illness that may impair their ability to communicate verbally. For those who choose not to or are unable to share their experience through words, they will be supported in creating artwork of their experiences through an alternate medium such as painting, sculpting, music, etc. During the creative process, participants will be encouraged to process their experience informally with a
licensed clinician who will oversee the process. If the participant becomes interested in engaging with formal therapy or other treatment, an appropriate referral will be made.

**Exhibition**

Participants can choose to participate in an exhibition of their artwork, either named or anonymously. Participation in the exhibition or attendance at the exhibition will not be required in order to participate in the intervention. Members of the community will be invited to attend to learn more about schizophrenia and the way that it impacts those in the community who live with it. The exhibition aims to facilitate a conversation between people with schizophrenia and people without. It seeks to showcase the immense talent and resilience of this population and humanize their very real experience in an effort to de-stigmatize an illness that has historically been treated with suspicion and disparagement. At the conclusion of the exhibition, the artwork will be published as a collection and provided to all participants. The collection will be available to the public for purchase.

**Future Goals**

Withdrawal, lack of social support, and mistrust of others are all common symptoms of schizophrenia that often lead to increased rates of hospitalization, incarceration, homelessness, and suicide. In opening the door to communication, we may be able to mitigate some of the devastating impacts of schizophrenia. With a purely medical model of schizophrenia, we have taken for granted that these symptoms are an inherent and biological part of the illness and have ignored the impact that the community response to schizophrenia may have on long-term outcomes. In de-stigmatizing schizophrenia, we may increase the acceptability of living with schizophrenia and openly seeking treatment for it.
Creating a collection of artwork that can later be disseminated may be beneficial in combating the feelings of isolation that are so often a characteristic of schizophrenia. Many people with schizophrenia experience marked avolition or asociality that prevents them from connecting with others. Support groups for schizophrenia are extremely rare. A tangible publication that showcases the aptitude of people currently living with schizophrenia as well as the wide variety among people who live with schizophrenia may alone provide better engagement with treatment and reduction of symptoms for those experiencing schizophrenia. Additionally, sales of the publication can further bolster research into schizophrenia which lags behind other disorders in dollars spent per person affected (“Schizophrenia Facts”, 2010).

It will only be through the collaboration of clinicians, the community, and the people living with schizophrenia that we may change the narrative of this disorder for the better. People with schizophrenia are real, their experiences are real, and they deserve to be heard.

References


Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. Psychiatry: Interpersonal and Biological Processes, 64, 319-345

Schafer, I. & Fischer, H.L. (2011). Childhood trauma and psychosis - what is the evidence?

Arts-Based Intervention/Installation: Outdoor Learning Lab

(With Sample Garden Growing Group)

Nancy Barich

Note: The original proposal was developed for the Bryn Mawr College Graduate School of Social Work and Social Research and is therefore written to address Bryn Mawr’s program structure. I have tried to adapt it for use in any social work program, but have kept some of the specific descriptions that apply to Bryn Mawr’s program structure.

Proposal Objective

To develop and sustain an Outdoor Learning Lab at a school of social work to provide students with a space for well-being and a unique, arts-oriented learning environment.

Goals

● To provide a forum for students to create (and to create in) an expressive and supportive environment.

● To provide a forum for students to work through issues that arise during the course of obtaining an MSS/MSW or doctoral degree.

● To provide a model for an arts-related intervention. This involves the planning of the space and eventual use of the space.

● To inspire individuals, communities, and organizations to implement arts-based methods in their own work with trauma survivors.
• To create opportunities for interdisciplinary collaboration and resource sharing.
• To create a space that allows students to focus on their personal well-being while also enhancing the environment of the social work institution.
• To create a safe environment that is open and accessible to all students and faculty.

The Who

• Students & faculty (at the school of social work)
• Students & faculty (at the larger institution within which the school of social work is embedded)
• Greater community

The Why

We are living in a very tumultuous time with a great deal of uncertainty. Many of the social justice issues and concerns studied within the Bryn Mawr College Graduate School of Social Work and Social Research and other similar programs are extremely unsettling. At Bryn Mawr, the nature of the program, limitations of the physical space, and even where the program is situated in relation to the main campus, affect the students’ experience. For many, it is challenging to adequately process and integrate classroom experiences, curriculum, and internship experiences with their own personal histories/narratives. There are several key considerations when reflecting on the education of social work students.

Stress of Social Work Education

Social work students are under an enormous amount of pressure. The combination of school work, internships, and fulfilling the responsibilities of everyday life can strain even the most organized and balanced of students. The depth and breadth of new material, some of which
is deeply disturbing, is introduced to new students in a relatively short period of time. This can add additional tension to an already stressful experience.

**Student History (Trauma)**

Some literature suggests that MSW/MSS students have experienced traumas or adverse childhood experiences (ACEs) themselves which may affect their experience in school and their ability to provide treatment to others. While there are some who question the validity of ACEs research, others suggest that exposure to adverse childhood experiences can have negative implications for social relationships and physical health (Thomas, 2016). Thomas’ (2016) cross-sectional study demonstrated a higher prevalence of adverse childhood experiences for MSW students when compared with other general population groups. Thomas references earlier studies (Black, Jeffreys, & Hartley, 1993; Rompf & Royse, 1994) that suggest social work students might be drawn to the field of social work based on their own early traumas. This research suggests that social work educational institutions need to consider the effects of earlier traumatic experiences on their students.

MacRitchie and Leibowitz (2010) make the case that exposure to the traumatic experiences of their clients can lead social workers to experience secondary traumatic stress. This comes as a result of supporting victims who have experienced the trauma of violent crimes. They cite earlier trauma studies by Munroe et al. (1995) and Solmon (1993), indicating that social workers’ “unacknowledged or unresolved” primary traumas “may intensify and increase symptoms of secondary trauma” (Munroe et al., 1995; Solmon, 1993 as cited in MacRitchie & Liebowitz, 2010, p.155).
Physical Learning Environment

The learning environment, and whether or not the physical space provides the opportunity to access nature and outdoor environments, can impact learning. Flutter (2006) reviews several studies that suggest that the school environment can influence student learning and attitudes. Lippman (2010) suggests that developing a space designed around “green principles” is not enough. He argues that the learning environment should be structured using a responsive design approach. Unfortunately, social work programs are notoriously underfunded. The learning environment often reflects the lack of financial investment. An Outdoor Learning Lab would enhance the social work students’ educational experience.

Multiple Learning Styles & Arts Based Interventions

Social work students have different learning styles. Nevertheless, many social work programs are heavily oriented around a traditional learning model in which the teacher imparts knowledge to the students. The student then explores the concepts and identifies future uses for the information. In Howard Gardner’s, *Frames of Mind: The Theory of Multiple Intelligences*, he proposes 8 different types of intelligence: visual-spatial, linguistic-verbal, interpersonal, intrapersonal, logical-mathematical, musical, bodily-kinesthetic and naturalistic (Gardner, 2006). Some of these intelligences require different styles of teaching in order to facilitate learning. Though some have criticized Gardner’s theories, many educators have developed creative approaches to teaching to address these different learning styles (Cherry, 2019). Social workers have also examined some of these concepts and have developed interventions to address different patient needs. Art, music, dance, creative writing and poetry access different types of intelligence and modes of expression. While faculty and guest lecturers at schools of social work
present on their specialities, they generally do not have access to dedicated, creative space that allows students to fully experience or experiment with these interventions and tools.

**A Summary of The Why**

The pressures students already face in conjunction with social work students’ potential trauma histories and a less than optimal learning environment calls for the need to create new, adjustable learning spaces. Co-creating an inviting, adaptable, and usable space for students and faculty to relax, create, and make meaning would enhance the social work program. It would provide an active laboratory environment in which students and faculty could test out many of the concepts they are exploring in coursework.

**Introduction to the Outdoor Learning Lab**

The development of the learning lab would involve two phases. Phase I, a founding stage, involves developing and creating an outdoor learning and support space for current students and faculty. Phase II, updating and reworking the space, allows future cohorts and faculty to make changes and adapt the space for their needs. The process would be open to students, faculty and anyone else the organizers wanted to include (alumni, community artists, etc.). It would provide the added benefit of integrating aspects of Bryn Mawr’s macro program with programming from the clinical curriculum. The Outdoor Learning Lab would consist of several different intervention/installation sites that could be used in a variety of ways. Installations could include art, dance, gardening, music, poetry, mosaic, etc. There are many added benefits to creating this environment as mentioned in the “goals” section.

**The Where**

The outdoor learning lab should be located in an accessible, open location, close to the social work school.
The How

Phase I – Developing & Creating

A. Laying the Groundwork:

This phase of the project requires several interested and committed team members to kick-start the project. They will establish the organizing structure for developing and creating the space, ensuring that the space is accessible for individuals with physical limitations. The founding members of the Outdoor Learning Lab will determine the appropriate model for undertaking this project and create rules around the model. Faculty may want to consider if creating the Lab can be integrated into aspects of their curriculum or programming. The team would also need to consider things like funding, timing, recruiting, layout, and what other members of the school/university and larger community they would like to involve. Additionally, they may want to develop ideas to foster connections and experiences among the staff and the students.

B. Creating the Installations/Interventions:

Beyond creating a supportive environment, the purpose behind the Outdoor Learning Lab is to create a living laboratory for students and faculty to test out the concepts they are learning in the program. Ideally, the lab will include areas for self-care (walking meditation circles, lounging areas, garden boxes) along with installations/interventions for multiple arts-based interventions (dance, art, poetry, music, garden, play spaces) and perhaps even an area set aside for group work. Faculty should consider how they can use the space to integrate it with parts of their curriculum. For example, could the Social Work, Trauma and the Arts Class develop ideas
for the installations? Is there some kind of team building programming that the Multiculturalism Class could do in the space? How might the group therapy class take advantage of the space?

*Note: In order to make sure that the space is useful in the future, it is imperative that aspects of the space are open to change. Thus, while a structure is being created, it is important to make sure that there is room for adaptation as there may be changes to the structure.*

**Phase II – Updating and Reworking**

While it may seem repetitive to include this phase, it is important that this aspect of the project be specifically highlighted. Much of the literature on trauma-focused interventions discusses “meaning making.” In order for this space to be useful for the students and faculty, it needs to “meet them where they are.” To that end, it’s important that systems are established to allow members of the various cohorts to contribute their views on what they want to see in this space. Whether it is done as part of a larger program (i.e. new student orientation) or in smaller settings (i.e. individual classes). It is useful to provide multiple opportunities for students to share their interests and be involved in making the space meaningful for each of them.

**Garden Growing Group: Sample Installation & Use**

*There are multiple ways that the space could potentially be used. This is a sample use for the garden beds.*

On an intuitive level, we know that being connected to nature feels good. Studies have revealed that it can reduce stress and generally improve happiness (Richardson, Cormack, McRobert, & Underhill, 2016). Gardening is a great tool for connecting with nature. It is also a great vehicle for learning because the trials and tribulations of gardening are a lot like life. Success in the garden depends largely on what you do to prepare and how you follow through. But in the garden (and in life), success is not guaranteed, and some things are beyond the
gardener’s control. If the garden has a strong healthy foundation (e.g. good soil), things will grow, but not always. You also need good seeds, light, water, food and a little bit of luck. If you plant the seeds at the right time and water and feed them, the plants should grow. Along the way, you might encounter pests – like insects or weeds. Usually, if you get to them early enough, they can be removed easily. But sometimes, it just doesn’t work out. That’s when you have to start over. I propose starting a weekly garden group for students in the social work program.

The garden would be situated in the Outdoor Learning Laboratory. The garden area and beds would be set up in a thoughtful manner similar to the one described by Cohen and Findlay (2015). Beds can be arranged in a sunny location to create a structure or room. The beds themselves would be sized so that participants can easily reach into all parts of the beds (6’ x 3’). The beds would be spaced in such a way as to give the individual room to move freely (movement can help processing), and also be close enough so that group can occur. Each group member would be provided with their own usable garden plot and a journal. Like all therapeutic processes, we can’t have specific dates or times associated with the steps because so much is dependent upon where the person and the plant is at any given time. Each session would begin with (pun intended) a grounding exercise.

**Step 1: Ground Rules!**

Garden club members will meet to discuss the structure of the group. We will handle housekeeping details. This includes meeting times (1 time a week for an hour), creating and assigning jobs, assigning plots,* and discussing ground rules and questions (e.g. if I see a weed in someone else’s bed, should I pull it? What happens if someone’s plot needs watering?)

*Each person will be assigned their own space. We will also have group spaces. There will be a master journal and calendar. Members take turns recording the events in master journal.
Garden Exercise: Personalize/decorate garden journal and garden name sign.

Materials: Journal and Garden Name Sign.

Homework: Encourage people to research the seeds they’d like to plant for the next meeting.

End: Did you do a journal entry? Participants may want to reflect on their experience. Did the art activity affect their experience? What did they notice about that part of the meeting?

Step II: Research & Preparation

Participants will meet to research which seeds to plant.

Garden Exercise: Prepare the garden space. Organize all tools. Prepare the beds by filling the soil. If there is already soil, rework it and add compost. Assign beds and add personal labels.

End: Did you do a journal entry? Consider creating a journal prompt that addresses what it feels like to touch the soil. We know that touch is related to emotional and cognitive memories, and this exercise might bring up emotions for participants (Cohen & Findlay, 2015).

Step III: Planting

Participants will plant the seeds and finish any other garden organizing that needs to be done.

Garden Exercise: Plant the seeds.

End: Did you do a journal entry?

Step IV: Maintenance & Problem Solving

Participants will meet weekly to work on their individual bed and the group beds. We will problem solve as things come up.*
*We expect things to come up (plants failing, interpersonal issues, etc.), but that’s where the growth will take place.

Garden Exercise: Weeding and tending to the beds.

End: Did you do a journal entry? As the seeds are sprouting and the plants are changing and growing, consider developing prompts that foster examination of the experience. Reflect on the process. Group members can determine if they are comfortable sharing.

Step V: Harvest Party

Depending on what is planted and weather conditions, we will celebrate our success and begin reflecting on our experiences.

Garden Exercise: Celebrating!

End: Did you do a journal entry?

Step V: Putting the Garden to Bed

Depending on the weather, the group participants, and the intensity of work, we will schedule at time to put the garden to sleep. Participants will be at different points in their readiness for the group to end, but we will work to create a thoughtful ending to our growing season. We might consider creating a special ceremony or ritual to help with acceptance and moving on (Mazza, 2001).

Garden Exercise: Reflection.

End: Did you do a journal entry? Participants can create an ending page in the journal and also indicate if they are interested in joining another group in the future.

References


https://doi.org/10.1080/1366879X.2010.522046

https://doi.org/10.1787/5km4g21wpwr1-en


https://repository.brynmawr.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1008&context=facilities_history

Committee on Health Promotion and Protection (CHPP), The Chinese University of Hong Kong (2006) Healthy University and Healthy Units at CUHK: Promotion of Health and Healthy Environment. Accessed at:
http://www.cuhk.edu.hk/uhs/healthpro/healtharticle/healthyunits CUHK.pdf


The Power of Music and Creative Writing

Grace R. Capuzzi

The Power of Music

Davis (2010) states that “music can be creative, and expressive use of music can be a powerful therapeutic intervention with individuals who have experienced trauma” (p.125). Music is an effective arts-based intervention that can provide reparative experiences for trauma survivors and can be a catalyst for growth. Creativity is a process that allows individuals, communities, and systems to recognize that their traumatic experiences may have destroyed their view of themselves and others; however, they have a new opportunity to transform that pain into something beautiful (Kasso, 2019).

What is Trauma?

Courtois (2014) defines trauma as “any event or experience (including witnessing) that is physically and/or psychologically overwhelming to the exposed individual” (p.5). Herman (2015) suggests that “traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning” (p.33). While there are multiple definitions of trauma, the controversy surrounding the “correct” definition of trauma is counterproductive in my opinion and not conducive for trauma healing. I believe one can choose various definitions of trauma. Trauma is subjective and should be defined by the individual, systems, or communities
who experience trauma. As social work clinicians, we should allow our clients to define their own traumatic experiences, rather than defining it for them.

**Trauma Symptoms**

Trauma survivors may be experiencing a variety of physical, psychological, and emotional symptoms. Trauma symptoms can include intrusive flashbacks of the traumatic event, avoidance, cognitive mood changes, and distorted thoughts. Understanding that trauma symptoms will not look identical for all trauma survivors, we must be aware of the various ways in which trauma can be conveyed. There are multiple layers that directly and indirectly impact an individual’s behavior. The person-in-environment perspective suggests that an individual is influenced by their environment (Corrado, 2018). Considering the person-in-environment perspective, Wakefield (1996), highlights the importance of viewing individuals in the context of their environment, which allows for greater empathy on behalf of the clinician. Some clinicians are trained to look for symptoms and are quick to provide an individual with a pathologizing diagnosis. Trauma symptoms are often overlooked and misdiagnosed. It is crucial to be aware of the long-term adverse effects that diagnoses can have on clients. Consequently, being attuned to trauma symptoms and taking a holistic approach is necessary when helping trauma survivors.

**Therapeutic Relationship**

Trauma often consists of experiences where victims feel powerless. Trauma survivors may have difficulty trusting others because they have been betrayed in the past. Therefore, developing a therapeutic relationship between trauma survivors and clinicians is essential in trauma healing. Modalities such as music-based interventions are a powerful technique that can strengthen one’s therapeutic relationship, build trust, and provide support for clients on their journey towards healing and safety.
Music-Based Interventions

Music can empower trauma survivors who may have felt powerless in the past; however, music-based interventions are not limited to the trauma population (Hanson-Abromeit, 2015). Music-based interventions can be utilized throughout various stages in one’s life (Hausig, 2019). According to Aalbers et al. (2017), music therapy can also reduce symptoms of depression and anxiety and increase one’s productivity in employment and relationships.

Additionally, literature suggests that “music can calm neural activity in the brain, which may lead to reductions in anxiety, and that it may help to restore effective functioning in the immune system partly via the actions of the amygdala and hypothalamus” (Stuckey & Nobel, 2010, p. 255). Prolonged stress has been shown to have detrimental effects on one’s brain and can result in structural changes in the brain. Thus, music-based interventions’ efficacy in reducing stress and anxiety may positively impact one’s brain, particularly for survivors of trauma (Bloom & Farragher, 2013).

Music-based interventions offer a variety of opportunities for self-expression and creativity (Hohmann, Bradt, Stegemann, & Koelsch, 2017). A systematic review conducted by Koelsch (2017) suggests that music-based interventions resulted in positive mood changes for participants. The majority of participants included in this systematic analysis reported reduced anxiety and anger and an increase in acceptance and joy (Hohmann, Bradt, Stegemann, & Koelsch, 2017).

Creative Writing and Language

Creative writing “gives clients the freedom to use language in a way that best captures their thoughts, feelings, and experiences” (Corrado, 2019). Creative writing can temporarily
allow trauma survivors to remove themselves from present challenges they may be experiencing. Desmond et al. (2015) suggest that art and writing can aid in the healing process for trauma survivors and empower clients to express their thoughts, feelings, and emotions creatively. Often, trauma survivors are expected to verbalize their traumatic experiences in chronological order. This can be overwhelming for trauma survivors as they frequently remember their story in fragments. Language is one of our primary modes of communication. Words are important in the process of self-reflection, meaning-making, and mastery (Corrado, 2019).

Everyone has a story to tell, and as social work clinicians, we should help clients authentically find their voice to share their story, rather than interpreting their story for them. Preventing a client from interpreting their own narrative may result in the client feeling powerless, rather than feeling empowered. An intervention that has been highly effective in helping trauma survivors tell their story is Storiez. Dr. Meagan Corrado is the founder of Storiez, which is “a nine-step trauma narrative intervention focused on helping inner-city youth tell their stories” (Corrado, 2015). Dr. Corrado’s Storiez intervention (2015) can be applied to multiple populations, such as people with substance use disorders.

**Substance Use and Trauma**

Exposure to substances and abuse are risk factors that can contribute to an individual’s drug addiction. Traumatic events can make one more susceptible to substance use. After conducting research, I found limited research about trauma-informed creative writing and music-based interventions utilized in inpatient substance use treatment facilities. However, studies reveal that creative writing and music-based interventions are effective for trauma healing (Corrado, 2015; Hanson-Abromeit, 2015). Therefore, I propose a music-based concept, *Healing through Music*, to inspire trauma survivors who are suffering from substance use disorder.
Healing through Music Intervention

- I used Storiez (Corrado, 2015) as my foundational intervention.
- I developed a plan for how to revise Storiez for my client population using music as the main “story style.”
- Healing through Music is an arts-based intervention that combines music and creative writing modalities.
- It allows clients to determine how they choose to share their story of pain and resiliency.
- Healing through Music is a therapeutic resource to help trauma survivors and those suffering from substance use disorder creatively express their narrative in a safe environment.
- The goal of Healing through Music is to provide clients with a creative outlet that they can utilize throughout the trauma healing process. A client can use music in a way that empowers them and allows them to see that their story does not have to end with an overdose.

Setting and Target Population

- Inpatient treatment facilities treating those suffering with substance use disorder.

Duration

- Short-term and long-term inpatient treatment stay.
- 13-15 sessions.
- 60-minute sessions.
  - Trauma work should not consume the entire 60-minute session.
○ The clinician should provide adequate time for the client to process their traumatic experiences and stabilize the client physically and emotionally before the end of the session until equilibrium is reached.

**Why Healing through Music is Beneficial**

- The *Healing through Music* intervention aligns with the National Association of Social Workers Code of Ethics (NASW, 2017).
- *Healing through Music* uses a strengths-based perspective which focuses on empowerment and sources of resiliency.
- It is a creative method that allows clients to express their thoughts, feelings, and emotions.
- Processing one’s narrative should not be re-traumatizing. *Healing Through Music* is a less abrasive approach for trauma survivors so that they do not become flooded with emotions in the process of telling their story.

**Is Healing through Music Appropriate for your Client?**

- The therapeutic rapport between the clinician and the client is important before introducing *Healing through Music*.
- Create a safe and supportive environment. Use your clinical judgment to determine whether your client feels mentally and physically safe and supported to work on your trauma narrative.
- Safety and stability are the keys to a successful intervention.
- If you and your client have an established therapeutic rapport, then proceed by explaining the arts-based intervention *Healing through Music*. 
If the client and the clinician determine that *Healing through Music* is an appropriate intervention for the client’s recovery, then proceed. If not, stop and explore other interventions that may be more fitting for your client.

**Healing Through Music Implementation**

**Session 1: Is This Space SAFE?**

- Developing a safe place may look different for each client. For example, a client may feel safe with the door open or sitting near the door to reaffirm that they are safe and can leave at their own will. Another client may focus on the aesthetics of a clinician’s office such as pictures, quotes, chairs, etc.
- Regardless of how safety is achieved, it is an essential component for trauma healing.

**Session 2-3:**

1. Allow the client to *choose a song*, play the song, and eliminate censoring their music selection. Let the client authentically choose a song that speaks to them.
2. While the client is listening to music or sitting in silence, ask the client to creatively express past experiences in their life.
   - Clients can also use a thematic narrative approach (i.e. writing about incarceration or recovery).
3. The **goal** is to have a balanced proportion of positive and negative events so that the client does not become overwhelmed.
4. **Before the client begins writing:**
   - Inform your client that they have the freedom to write words, complete sentences, poems, raps, lyrics, etc. The client may also choose to have the
clinician type their past experiences. The clinician should not embellish the client’s narrative and write exactly what the client expresses.

- Emphasize that grammar is not important. How the client chooses to express their past experiences is their choice.
- Trauma survivors may have fragmented memories and struggle to put past events in chronological order.

5. Always leave enough time for processing and questions.

Sessions 4-7: Discussion

- Discuss each experience, and help the client process their thoughts, feeling and emotions.
- Reflect on the client’s past experiences: pain, strength, barriers, hope, etc.

Session 8-12: Incorporating Music

- Let the client express their narrative with a music medium of their choosing.
  - Example: music videos, singing, rapping, writing a song, or altering the lyrics to a song.
  - Collaboration with the inpatient Music Therapist can be arranged as well.

Remember to practice within your scope of expertise.

Session 13-15: Performance

- Each client will be given the option to record their performance onto a compact disc (CD) or flash drive, so that when they discharge from treatment, they will have a memory to remind them of their ability to overcome adversity, despite their traumatic experiences.

Strengths

It is crucial to support our clients in their healing process. Arts-based interventions are such a powerful tool, but there is often lack support to fund these interventions. It is essential that
we advocate for all artistic mediums and that we do not become complacent in allowing arts-based interventions, such as music and creative writing, to continue to be undervalued and discredited. Music is an effective arts-based intervention that can provide reparative experiences for trauma survivors and can be a catalyst for growth.

**Limitations**

There continues to be an ongoing debate regarding the efficacy of arts-based interventions. However, the lack of funding for arts-based interventions is typically not taken into consideration. Another barrier to an arts-based approach is the apprehensiveness of the client in expressing their story creatively. Clients can be resistant to making mistakes and failing. However, it is crucial to reassure the client that the goal for any arts-based intervention is the process rather than the product.

**References**


Herman, J. (2015). *Trauma and recovery: the aftermath of violence- from domestic abuse to political terror*. New York: Basic Books.


Adult Play Therapy

Peter Danzig

Introduction

Artists, dancers, movers and makers have extensively explored somatic work. The ideas of liminal space, open exploration, and impulsivity are encouraged and if nothing else, required for artistic exploration and the pursuit of truth. Anne Bogart, the creator of the Viewpoints method states, “We are debris arrangers. Equipped with what we have inherited, we try to make a life, make a living and make art. We are assemblers. We forge received parts into meaningful compositions. This state of affairs is our plight and our destiny, but it also offers the opportunity to find meaning as well as to find communion with others” (Bogart, 2014, p. 75). In considering theatrical training practices for performers, I am drawn to the ideas of ‘debris assemblers’ and this idea in relation to trauma informed practice. Through Bogart’s training practices, artists take hardships, plight, and pain and construct a process that may not lead to a concrete deliverable. But the process does lead to vulnerability and the expression of truth.

Considering this paradigm, I’d like to consider Whitehouse’s notion of the psychophysical reaction of our bodies to trauma and the development over time. Whitehouse illustrates that “two things about physical movement are striking. One is that movement is non-verbal and yet it communicates—that is says something. The body does not, I would almost say cannot lie” (Whitehouse, 1999, p. 42). Reflection on Bogart’s notion that we find debris in our lives and use
movement create a sense of truth and Whitehouse’s idea that the body holds truths we don’t dare speak leads one to consider a question. Why don’t we provide more support for people to engage in imaginative practices? Why don’t we incorporate adult play in trauma therapy? Trauma-informed work spans a multitude of applications, ensuring that we can meet people where they are, however, there is a misconception that movement, play and imagination are for dreamers and artists and that therapy must consist of revisiting trauma, pain and fragmentation to “fix” the person. What would happen if we considered Bogart’s movement language in Viewpoints and created opportunities for clients to engage in meaningful work without expectations? From a trauma-informed lens, we can look at our clients as devisers of their own narratives—playwrights—even if they don’t always end the process with a finished product.

**Adult Play and Imagination**

In the Western landscape, we view adult play—attending the movies, traveling, axe-throwing, pottery making classes and yoga retreats—as being related to privilege and financial stability. However, those at the highest risk for trauma often don’t have access to these notions of play. For them, living day to day is considered a triumph. I believe we have done a disservice to the American population in our attitudes toward play. We have relegated play to the financially stable, but play, creativity, and internal growth should be available to all people. Our culture has also restricted our views of creative movement. What if we thought about the idea of play differently in our culture, encouraging it in our streets, our homes, our state facilities, our managed care systems, and our government. What would happen if we gave adults permission to play and express themselves? Could we mitigate some of the emotional dysregulation our clients feel and provide them with alternative ways to communicate?
“What is play?” you might ask. We face the same difficulty defining play as we do when defining trauma, integration, stability, and vulnerability. Nevertheless, it is important for our clients to have the space to play. In their play, we gain insight into their character, traumas, and the fragmentation and dissociation they may experience. Through play they may find a language rooted in truth. While we can’t change our Western culture immediately, as a profession of helpers, we can make space for play and imagination in our offices and on our therapy couches.

Theoretical Models of Support

Presently, I’d like to explore the idea of somatic work in conjunction with adult play, considering not one intervention, but a clinic model that employs various activities that live in the realm of play. I hypothesize that this would allow clients to have a different experience in the therapy environment and encourage different means of communication. This model would facilitate exploration but allow for a multitude of somatic responses that might assist in the development of a trauma-informed play environment. Our images of ourselves are shaped by moment patterns. Bernstein (1993) states, “This movement education provided not only sensations of power and control but actually increased body strength.” “According to Schilder (1950), body image is shaped through movement and for the survivor, healthy movement experiences contribute to reshaping negative body images” (Levy, 2014, p. 53). While this indication of movement patterns and emotional regulation is promising, I must ask, what constitutes our ideals of movement in trauma work? Just as we are shaping the definition of trauma, might we also reshape the definition of movement as well? Does the stroke of a hand with a paintbrush count as movement? What about axe-throwing facilities? Line dancing or even pole dancing? Human anatomy and movement is broad and the person-in-environment perspective just as much so. I’d like to propose a clinical intervention that uses both conventional
and creative therapeutic activities to support people in navigating their emotions, relationships, and traumatic experiences.

**Adult Play Therapy Model**

**Clinical Interventions**

- Talk therapy
- Movement/somatic release therapy
- Creative art therapy
- Music therapy
- Drama therapy

**Somatic Experiences**

- Axe throwing
- Circus silks
- Tumbling
- Viewpoints and Laban theatre exercises
- Found object soundscapes
- Breaking room (room to break plates, tear things, let out aggression)
- Fight choreography

**Physical Experiences**

- Personal training
- Bodyweight group fitness classes

**Clinical Service Providers**

- Social Workers (LCSW), therapists, psychologists
- Certified Art Therapists (music, drama, visual art, dance, etc.)
• Non-Clinical Service Providers
• Masters-level artists
• Certified Personal Trainer
• Life coaches
• Certified nutritionists
• Certified stage combatant

Potential Challenges for Implementation

• Funding approval for a creative, multi-modal approach
• The need for buy-in and financial support from managed care
• Presents a new, counter-cultural approach to adult play and movement
• Interdisciplinary approaches can create additional opportunities but may also create potential areas for conflict

References


Cook, J. M., Biyanova, T., & Coyne, J. C. (2009). Barriers to adoption of new treatments: an internet study of practicing community psychotherapists. Administration and policy in


Movement Therapy Intervention for Trans and Non-Binary Youth

Mari Flamm

Youth who do not identify within the man/woman gender binary (those who identify as transgender/gender non-binary/gender fluid/etc), are at greater risk of experiencing trauma stemming from their identity than the general population. Many of these individuals feel a disconnect from themselves because their gender identity does not match the binary into which society assigned them, augmenting the disconnect already felt from this same community. The following proposal will address the multitude of traumas faced by trans and/or non-binary people. It will then describe the ways that the responses to this trauma might be mitigated through group therapy that utilizes dance and movement as well as mentorship.

Target Population: Trans Youth

This intervention will focus on adolescents who identify outside the male/female gender binary or who are questioning their gender identity. Keo-Meier and Ehrensaft (2018) define gender identity as “one’s innermost concept of self as boy or girl or both or neither” (p. 6). Gender identity is separate from an individual’s gender assigned at birth. Those who do not identify with their gender assigned at birth may refer to themselves in a variety of ways including “gender non-binary,” “gender nonconforming,” “transgender” or “trans,” “gender fluid,” or “queer” (Keo-Meier & Ehrensaft, 2018). From here forward, this proposal will refer to the
community in question as “trans and/or non-binary,” but this does not limit the target population of this intervention.

**Trauma in the Trans Community**

Studies of different sample sizes found that anywhere from 40 – 60% of transgender participants had experienced violence, either in their communities or in their homes (Mizock & Lewis, 2008). The prevalence of transphobia is seen in the availability (or lack thereof) of bathrooms for trans and/or non-binary people, the ban of trans people from the military, the inaccessibility of the medical system and the murder of trans people (primarily trans women of color). The trauma faced by trans and/or non-binary people is multifaceted and culminates in what Courtois (2014) calls “complex trauma.” The layers of trauma faced by trans and/or non-binary people are best understood using Courtois’s organization of trauma, including interpersonal trauma, secondary trauma, institutional trauma and identity trauma.

**Interpersonal Trauma**

Interpersonal trauma is deliberately perpetrated by one or more people (Courtois, 2014). Courtois (2014) notes in her description that “when committed by a stranger, this type of trauma is most likely a one-time occurrence” (p. 8). For trans and/or non-binary people, however, the victimization by strangers is not a one-time occurrence. The interpersonal trauma can be both overt, as the United States has seen in the murder of so many trans women of color, or covert, in what Richmond, Burnes & Carroll (2012) call “insidious trauma” (p. 47). Examples of insidious trauma include microaggressions such as misgendering, the use of binary ID markers on documentation, and the inability to find a bathroom that matches one’s gender identity. While insidious trauma may not seem traumatic in the moment, its repetitive and demeaning nature can lead to symptoms similar to that of PTSD (Richmond, Burnes & Carroll, 2012).
A subset of interpersonal trauma is what Courtois calls “attachment trauma.” Attachment trauma is “interpersonal trauma that occurs in relationships where there is primary dependency or a close personal bond, such as a parent-child relationship” (Courtois, 2014, p. 9). The issues facing trans and/or non-binary people are not just in their community. Many trans and/or non-binary people face the misunderstanding and rejection of transphobic families, leading to the trans and/or non-binary child’s feelings of isolation, confusion, and abandonment. The transphobia of the child’s family could lead to emotional and physical abuse perpetrated against the child in their home (Mizock & Lewis, 2008).

**Secondary Trauma**

Courtois (2014) explains that secondary trauma occurs “when a person or an institution that should provide help does not and/or does additional damage” (p. 10). Trans and/or non-binary individuals face trauma not only moving through their everyday life, but quite often in access to healthcare, which should be accessible to all people. Mascis (2011) points out that trans and/or non-binary individuals must placate the medical system and “facilitate access to treatment by satisfying the anxieties of providers” (p. 202). Instead of the system working for them, trans and/or non-binary people must alter their own sense of self, or diminish their own sense of self, to gain access to care.

Similarly, trans and/or non-binary people may lose jobs because of their gender identity (Mizock & Lewis, 2008). They may lose access to structures that should otherwise support them because of their gender identity; for example, shelters, that are organized into binary (man/woman) living arrangements (Mizock, 2008). These kinds of trauma lead to an even deeper sense of isolation. If a person is rejected from their social circle, losing access to the resources afforded to cisgender people only compounds their isolation and helplessness.
Institutional Trauma

Institutional trauma is a lack of support or protection on an institutional level (Courtois, 2014). In the past four years, the United States has been systematically traumatizing trans people. In two major examples, the Trump administration banned trans people from serving in the military, and healthcare policies have shown legal loopholes discriminating against trans and/or non-binary people (Richmond, Burnes, & Carroll, 2012). Navigating a system actively working against them only adds to the stress already felt by members of the trans community. Moreover, it minimizes the control these individuals feel they have over their own lives.

Identity Trauma

Identity trauma is defined as when “the individual’s inherent (and mostly unchangeable) characteristics such as gender, race, ethnicity, and sexual identity or orientation, are the cause of ongoing discrimination, mistreatment and violence” (Courtois, 2014, p. 11). Each of the traumas above boil down to identity trauma. Identity trauma becomes particularly pervasive when trans and/or non-binary people begin to internalize the negative experiences they face. Some trans people, due to the influence of society, experience “internalized transphobia” in which they take on the transphobic views of society and turn them inward (Mizock & Lewis, 2008, p. 343). One coping mechanism particularly prevalent amongst trans communities is self-harm. One study of 515 trans people found that 32% had attempted suicide, and in another study of 176 trans people 30.1% had attempted suicide. Sixty seven percent of them did so because of their gender identity (Mizock & Lewis, 2008). Substance abuse and unsafe sexual behaviors are also particularly prevalent in this population. These may be ways to cope with the persistent trauma (Richmond, Burnes, & Carroll, 2012).
Complex Trauma

The multiple kinds of trauma faced by the trans community indicate that many trans people are experiencing complex trauma. Additionally, these traumas could also be augmented by trauma of the individual’s gender identity. If these individuals, particularly youth, are experiencing trauma and are also isolated from family and community, they are unable to process this trauma with others. The impact of the traumas will intensify, leading to coping mechanisms that might ultimately cause additional exposure to trauma, for example unsafe sex or substance abuse.

Goals of the Intervention

The goal of this intervention is not only to allow trans and/or non-binary youth to process their trauma but also to work towards what Keo-Meier and Ehrensaft (2018) call “gender health.” Gender health is defined as “the opportunity for a child to live in the gender that feels most real and/or comfortable for the child and the ability for children to express gender without experiencing restriction, criticism, or ostracism” (Keo-Meier & Ehrensaft, 2018, p. 13). The intervention will offer a safe space for the adolescents to explore their gender identity through movement and discussion.

This intervention will also allow for the creation of community between group members, an important way to help the youth reconnect to others after their trauma (Herman, 2015). This is especially important for trans and/or non-binary youth who feel disconnected from society or who have experienced attachment trauma. By exploring their gender alongside others who are doing the same, group members can bond. Additionally, the group connection will decrease the possibility of further traumatic victimization for the youth as they integrate into society (Masci,
The group cohesion formed in the sessions becomes a protective factor for these young people.

Incorporating transgender and non-binary adults into the group practice each week will create models for the youth, in which the adults in this group become mentors. The relationships created with these adults may help to repair unhealthy attachment styles formed during the child’s exploration of their gender identity. If the adolescent was shunned by their parent, the trans and/or non-binary adults in the session demonstrate that supportive adults do exist. These adults might also act as representatives of a future for adolescents unsure of their future as transgender adults. Seeing successful and happy trans and/or non-binary adults helps them understand that happiness is possible in their own skin (Mizock & Lewis, 2008). These adults may also act as a resource for adolescents looking for safe doctors, questions about medical transitions, and specific issues affecting trans and non-binary people.

**Timeline**

This program will last approximately 3 months. Sessions will occur 1 time per week for approximately 1.75 hours. Each session will utilize the following framework:

- 30 minutes: The adult trans/non-binary individuals will meet with the adolescents. This section of the session will allow the youth to talk to their adult “mentors,” hear about their lives and ask any questions they might have.

- 30 minutes: In the following portion, the adults will leave. This will be the time when the adolescents focus on group work with the therapist.

- 30-45 minutes: The final section will focus on processing the movement piece and closing the session so that the adolescents will not leave feeling dysregulated.
Proposal

Pre-Requisites

- Approximately 5-8 youth should be involved in each group, and the number of adults involved in each group should not exceed the number of adolescents present.
- The space in which the groups are taking place must be accessible for trans people – including the accessibility of gender-neutral bathrooms (Mizock & Lewis, 2008). The space should also be safe for a trans person to access.
- All staff – including any support staff in the facility – should be trained not to assume pronouns by the way a person looks.
- Each session must also affirm all of the trans and non-binary people involved in the session (Mizock & Lewis, 2008). Every time individuals enter the space, they should write their preferred pronouns on a name tag. This is particularly important for youth and adults who are gender fluid and use different pronouns during different sessions.

Sessions 1-5

In these sessions, the adolescents will learn basic choreography from various dance styles and cultures. This will allow the youth to master the movements and begin to explore how they might manipulate the movements to match their own individual styles. In these sessions, therapists might bring costumes or props that further allow youth to explore themselves within the movement. Therapists might bring in various types of music, perhaps suggested by the adolescents, to which they can dance.

These sessions will establish safety within the group, arguably the most important step in trauma work (Herman, 2015). In order for the youth to eventually express themselves in their own movement, they will access what it’s like to move their bodies, a particularly important step
because of the disconnect between their body and gender identity. Because everyone in the group will be doing the same movements, this choreography will also increase the sense of group cohesion, further making the space safe for future expression.

These sessions will also allow for mastery on the part of participants. Harris (2009) explains that “facilitating mastery over the phrasing of a movement sequence, for example, may be the prerequisite to gaining control over impulsive behaviors or recurrent anxieties or fears” (p. 99). Feeling as though they can control the movement will lead these adolescents to understand that they can regain control of their lives, something taken away from them by the trauma they have experienced. Herman (2015) explains that, “establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment” (p. 160).

Group conversation in these sections should be around the movement itself. The therapist can ask the adolescents how it feels to move their bodies. The therapist may ask if there is any part of moving their bodies that is uncomfortable, where they feel a disconnect with their bodies, when they had fun, or what they did not enjoy.

Sessions 6-10

These sessions will focus on the use of improvisation (Bernstein, 1995). In these sessions, the children will begin to create their own movement. The sessions will utilize the following themes:

- **Session 6:** How did you feel growing up? What does your relationship with your family look like?
- **Session 7:** What did it feel like to start questioning who society said you are?
- **Session 8:** What does embarrassment look like?
- **Session 9:** What is an important moment in your life?
- **Session 10:** How does the world see you? How do you see you?
The session themes are the questions that should be asked as the adolescents begin to create movement. However, as Bernstein (1995) explains, “movement is a bridge to content-laden themes” (p. 46). The movement and conversation may not stop at the questions noted here. Group participants, as the therapist takes note of their movements and asks questions, may reveal certain themes that should be expanded upon in discussion or in further movement. The therapist should follow where this conversation leads, as they would in verbal group therapy.

These sessions focus on bringing unresolved, and maybe unconscious, memories to the surface to help reintegrate them into the person’s narrative. Before the person can reconstruct their story, they need to take inventory of the fragmented pieces of their story created by the trauma (Herman, 2015). In these sessions, the adolescents should be encouraged to explore parts of their story that they may otherwise have been unaware of or hesitant to bring up in talk therapy.

Conversation in these stages should be detailed, so that the therapist is not assuming anything about the adolescent or their story (Herman, 2015). Also important in this session is the adolescents’ reconnection with their emotions. Courtois (2014) notes that feelings are the “conscious experience of emotions” (p. 24). Using movement, the adolescents in this group will be able to recover emotions that have been otherwise suppressed or avoided (Courtois, 2014). These survivors will be able to integrate these emotions such that they do not lead to unhealthy coping mechanisms or shame.

Session 11

● **How did you get to be who you are today?**

As Herman (2015) explains, after safety is established, the survivor can relate the story of their trauma. This session will focus on the youth creating a narrative of their trauma through
movement. In this session, the therapist should ask the participants to think back on the past weeks reflecting on movements that were significant to them as they explored themes in their own lives and how these might be incorporated into the movement piece they create. The adolescents can decide if they would like to add music to their piece.

As the adolescent works through their movement piece, they begin to take control of their story. Instead of becoming something constricted and intrusive, it becomes a testimony to their life and their resilience (Herman, 2015). By taking control of their narrative, the adolescents may become less emotionally affected by the trauma they have experienced. The fragmented parts may begin to create a more cohesive narrative.

This session can culminate with youth (who feel comfortable doing so) teaching the other group members their movement pieces. Not only does this give the trauma survivor a sense of control over their environment, it creates a sense of understanding between the group members. When the trauma survivor sees their movement performed by others and experiences their movement (and their story) alongside others, the movement creates a deep connection between these individuals. Trauma, and in particular identity trauma, destroys a person’s relationship with their community, and performing a piece of movement that they created alongside their peers emphasizes the fact that other people have the capacity to understand them.

Session 12

- **Where are you going next?**

  This session will ask each group member to create a brief movement that represents their goal for the future. The group will combine each of these movements to create one full piece of choreography making up the totality of the group’s hopes for the future. The final conversation
of this session should look forward. The therapist should ask what the goals of the adolescents are for the future and what they are looking forward to as they transition out of the group.

Trauma can create a sense of hopelessness in survivors, particularly those whose trauma is so completely intertwined with their identity. The goal of this session is to minimize the effects of that hopelessness. Because the adolescents have worked through the creation of their narrative and the feelings surrounding their narrative, a new self that includes these integrated feelings and memories needs to be created (Herman, 2015). Herman (2015) explains that “empowerment and reconnection are the core experiences of recovery” (p. 197). By creating movement as a group, the adolescents are not only looking to the future, but know they have support in the present and that they are not alone.

**Limitations**

Those who are hiding their gender identity from parents or not sharing their gender identity with their parents may be unable to attend this group if they need a ride from them. Offering this intervention in a space like a school may be the best option to combat that scenario, though schools may be a place of victimization for some trans youth. There is also the chance that individuals will not attend all sessions. Unfortunately, this is a risk that one takes with group therapy. The best option is to emphasize the importance of attending all meetings. Additionally, starting with the choreography-based groups may entice the youth to return because they are enjoying themselves. Ideally, after the first five sessions, connections will begin to form in the group, encouraging participants to continue to attend.

**Conclusion**

“Living in a body that misrepresents one’s gender makes caring for that body or feeling safe in that body enormously challenging” (Mascis, 2011, p. 202). Trans and/or non-binary
people face a constant bombardment of interpersonal and identity trauma as they move through the world. However, the resilience of trans people – the way that they continue to show up for themselves – and the fact that they are unapologetically themselves is the mark of an incredibly strong person. While the proposal above works to help support this community, the strengths these individuals already possess cannot be underscored enough.

References


Herman, J. (2015). *Trauma and recovery: the aftermath of violence- from domestic abuse to political terror*. New York: Basic Books.


Movement and Music Based Group Activity for Adolescents Experiencing Traumatic Grief

Amanda Frisco

**Introduction and Background**

After the death of a loved one, an adolescent may experience “healthy grieving” known as uncomplicated grief. This includes reactions such as “intense sadness,” pulling away from friends/family, lack of sleep, and interest in normal activities (Mannarino & Cohen, 2011, p. 23). The youth is able to process their grief by accomplishing the tasks of grieving, which experts have identified as essential in order to achieve reconciliation. Reconciliation occurs when one “integrate[s] the new reality of moving forward in life without” their deceased loved one (Cohen, Mannarino, Greenberg, Padlo & Shipley, 2002, p. 309). The tasks of grieving as described by Wolfelt (1996) and Worden (1996) include acceptance of the loss, “fully [experiencing] the pain of the loss,” “adjust[ing] to an environment and self-identify[ing] without the deceased,” and “finding meaning in the deceased’s death” (as cited in Cohen et al., 2002, p 309-10).

In order to accomplish the tasks of grieving, a youth needs to be able to sustain thoughts or tolerate reminders of their loved one (Cohen et al., 2002). Youth who experience traumatic grief are stuck and unable to move forward. Because their trauma symptoms inhibit their ability to sustain thoughts about their loved one, they are unable to integrate their feelings about the traumatic death. Cohen, Mannarino and Deblinger (2017) define “childhood traumatic grief as the development of significant trauma symptoms following the death of a parent, sibling, or other
important attachment figure that interfere with typical grief responses, leading to co-occurring trauma and maladaptive grief responses” (p. 7). The death of a loved one can be objectively traumatic (i.e. homicide, suicide, violence, car accident, or drug overdose), or it can be subjectively traumatic if “the child’s response to the death involved intense fear, horror, or helplessness” (Cohen et al., 2002, p. 316).

**Current Practices of Treating Childhood Traumatic Grief**

Cohen and Mannarino (2004) discuss the development of a treatment intervention for youth with childhood traumatic grief (CTG). This treatment model, Cognitive Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG), was developed after the realization that treating children with CTG must address their trauma symptoms before focusing on grief interventions (Cohen & Mannarino, 2004). A study conducted by Cohen, Mannarino and Knudsen (2004) showed that the introduction of the trauma interventions before engagement in the grief interventions improved the youth’s adaptive functioning, reduced their PTSD symptoms, and improved their CTG symptoms.

Although there are limited studies about creative group interventions for youth experiencing traumatic grief in the literature, Edgar-Bailey and Kress (2010) propose various creative interventions to use with youth with traumatic grief. These interventions are theoretically based on the use of CBT to treat CTG and include writing, drama/role-play, drawing, and painting. These creative techniques primarily focus on addressing the grief components of CTG. This proposal focuses on the trauma symptoms experienced by children with CTG as suggested by Cohen and Mannarino (2004). As observed from the various studies done with youth experiencing traumatic grief, it appears that a youth needs to process their trauma and resolve their trauma symptoms before grief therapy work.
**Introduction of Movement and Music Based Activity**

The activity proposed in this paper will focus specifically on adolescents who have experienced the traumatic death of a parent, caregiver or sibling. The activity is music and movement-based to facilitate the trauma processing component of their treatment. This activity can be incorporated into pre-existing hospital support groups for adolescents.

The goals of this activity are to assist adolescents in identifying their emotions, gaining affective expression and regulation skills, decreasing their sense of isolation, and processing their trauma. Ultimately, the long-term goal is for the adolescent to process their trauma in order to reduce their PTSD. This will allow them to move forward in their grieving process. This proposed activity is founded on the concepts from the CBT-CTG treatment model and addresses trauma-driven emotions as a preparatory step to completing a trauma narrative and engaging in grief processing.

**Theoretical Foundation**

The trauma and PTSD symptoms adolescents with childhood traumatic grief (CTG) experience include re-experiencing, avoidance, hyperarousal, emotional and behavioral dysregulation, and learning difficulties (Cohen and Mannarino, 2011). The youth’s trauma symptoms are triggered by trauma reminders. They are also triggered by “loss and change” reminders. Trauma reminders are “any people, places, things, conversations, activities, objects, situations, thoughts, memories, sounds, smells, or internal sensations that the child associates with the traumatic event” (Cohen et al., 2017, p. 8). Loss reminders are any of the triggers that the child associates with their deceased loved one. Change reminders are any of the triggers that they associate with life changes after the traumatic death, such as moving to a new neighborhood or a change in their caregiver (Pynoos, 1992, as cited in Mannarino & Cohen, 2011).
When someone experiences a traumatic event, their survival instincts become activated. The left hemisphere of the brain, which is responsible for language, is inhibited. Perryman, Blisard, and Moss (2019) explain that “[they] may be overwhelmed with emotion and thus operating predominantly from their right hemisphere. They frequently struggle to assign words to describe these implicit memories and feelings...” (p. 84). As a result, they experience fragmented memories, and they are unable to assign meaning to the traumatic experience.

Cohen et al. (2017) report that “fearful memories are also encoded in the brain differently than those from nontraumatic memories. Some children will subsequently experience the same…fear reactions…” experienced at the time of the trauma when they are reminded of the trauma and/or loss (p. 9). When a survivor re-experiences the trauma in the form of a flashback, their body responds as if the trauma is happening all over again (Courtois, 2014). The survivor experiences hyperarousal symptoms and extreme stress in response to their brain’s activated limbic system. This happens even though the individual is not presently in danger. The individual may also experience emotional dysregulation resulting from their unprocessed emotions. Courtois (2014) defines emotional dysregulation as “the inability to express emotions in modulated ways” (p. 25).

In order to cope with the pain associated with intrusive emotional memories, the youth may avoid triggers. If avoidance is not possible, as is often the case when a youth experiences loss and change reminders, the youth may numb themselves emotionally and isolate themselves from peers and other family members (Mannarino & Cohen, 2011). Bloom (2010) explains that when the triggered emotions are so intense, the body experiences dissociation to cope with the “physiological and emotional hyperarousal” (p. 202). Avoidance and dissociation result in the youth being unable to attend to grief tasks, because they cannot thoughts of their deceased loved
one. Cohen et al. (2017) emphasize that youth who utilize avoidance to cope with intrusive distressing emotions don’t grieve since they “may be so detached from their feelings” (p. 25). The proposed movement and music-based activity will assist youth in safely identifying, holding, and expressing their trauma-driven emotions. The activity helps youth express themselves creatively, since they may be unable to verbalize their emotions. As Van Der Kolk (2014) writes, “Traumatic events are almost impossible to put into words” (p. 233). The use of movement and music as an outlet to express emotions will support youth in improving their affective expression skills.

**Why Music and Movement**

This activity is specifically designed for adolescents. Music provides teens with an outlet to express themselves. Self-expression is needed in order for them to process emotions associated with the traumatic death so that they can begin the grieving process. Austin (2007) reflects on a music therapy group with teens in foster care, stating that “the structure inherent in music can offer stability to adolescents who have an unstable psychic structure, and can provide them with a strong, resilient container for intense affects” (p. 94). Austin (2007) adds that the music a teen chooses will “reflect and validate the inner and outer worlds” of the teen (p. 94).

The use of movement allows adolescents to embody emotions that they may be avoiding. Goggin (2018) writes that in the therapeutic setting, movement can foster the processing and expression of one’s emotions. Mirroring, a dance/movement therapy technique, will be used with this movement-based intervention to foster a sense of connection amongst the teens in the group. “Mirroring… is a way to enhance emotional resonance between a therapist and patient, and sometimes is used between patients in group therapy to promote group cohesion (Mills & Daniluk, 2002, as cited in McGarry & Russo, 2011, p. 180). Van der Kolk (2014) speaks to the
benefit of mirroring exercises with youth, stating that mirroring helps them connect physiologically with their peers, and allows them to feel “truly heard and seen” (p. 81). Mills & Daniluk stated that women survivors who received group dance therapy “reported having enhanced emotional awareness through movement, and a sense of emotional connection with others through mirroring their emotional movements” (Mills & Daniluk, 2002, as cited in McGarry & Russo, 2011, p. 182).

Youth’s understanding of their sense of self and the world around them changes after they’ve experienced a traumatic event (Cohen et al., 2017). Participating in a group of peers with similar experiences while engaging in the creative arts, provides adolescents with reparative experiences. In connecting with other members of the group, youth can reduce their feelings of isolation.

**Proposed Activity Elements and Process**

This activity should be incorporated into pre-existing support groups of 5-7 adolescents. They should be between 14-16 years old and receive services at a children’s grief center. The proposed activities should only be implemented after group cohesion and rules have been secured to ensure the safety of the group members.

**First Session**

The session will begin with a grounding activity so that youth can get in tune with their body and prepare for the movement-based activity. Next, the facilitator will introduce the activity and explain the use of movement/dance and music to help them express things they aren’t able to articulate with words. This explanation will help them feel in control, so that they fully understand what they are about to participate in.
The group will be directed to stand in a circle. Participants will be asked to think about how they feel on the inside when they think about their loved one’s death. This can include feelings they keep hidden from others. The facilitator can also ask them to think about where they feel the emotion in their body. As Van Der Kolk (2014) explains, there are connections between the body and the brain. We feel emotions viscerally in the body. The group will be asked to think of a movement that symbolizes their concealed emotions. This will help the youth connect with their internal emotions and physical feelings by identifying them and expressing them externally. The facilitator will ask each group member to perform their movement one by one. After each individual expresses their movement, the rest of the group will be asked to mirror their peer’s movement briefly. At the end of this process, the group will be asked to share what their movement meant to them and name an emotion they are experiencing. It is important to note that not every member has to share. The group will end with another grounding activity to ensure each member’s emotional safety.

Second or Third Session

This session will begin with another grounding activity. Then the group will be asked to stand in a circle, and reflect on the movement they shared during the prior session. Each member will then be asked to think about what they show others and express externally when thinking about their loved one’s death. The group will be given the option of either writing a poem or lyrics to describe these emotions or choosing a song that connects to their outward expressions of grief. Although this is a small choice, Austin (2007) supports this method and explains that providing clients with choices gives them a sense of control and “[is] therefore therapeutic in that [it] provide[s] opportunities for clients to assert themselves...and become active participants in creating their own safe environment” (p. 98).
This may take one session to complete, or the group may need two sessions. For any members who have written a poem or lyrics, the facilitator will help them record their poem electronically. Once each member has either written a poem or chosen a song, members will be asked to share it with the group. The facilitator will guide them in a discussion about the shared songs and lyrics/poems and how they feel that they connect to their external emotions. This session will end with a grounding activity of the group’s choice, to avoid members from becoming flooded after discussing potentially painful emotions.

**Third or Fourth Session**

The final session of this activity will provide the youth with an opportunity to integrate their internal emotions (their created movement) with their external emotions (their song or poem) surrounding the traumatic death of their loved one. After a grounding activity, the group will be asked to “perform” their created movement while the song or recorded poem/lyrics plays in the background. This will symbolize the conflicting emotions they may feel, those that they internalize, and those that they express outwardly. The therapist will facilitate discussion about youth’s emotions and the regulation skills they can use in an attempt to make meaning of, and process, their conflicting emotions surrounding the traumatic death. This activity will end with a grounding activity to bring them back into the present.

**Considerations and Limitations**

It is assumed that group members will be attending individual therapy to acquire coping skills to deal with the emotions that will arise during this activity. Additionally, safety needs to be set in the group in order for members to be able to express themselves without becoming flooded by emotions. Courtois (2014) emphasizes the need for an “environment of safety with a focus on containment and healthy coping skills” which help them stay grounded in the present.
This safety can be achieved within the group through the building of trust. Movement and music act as a container and safe holding environment, since it allows them to “maintain a protective distance from [their] own personal experience” (Edgar-Bailey & Kress, 2010, p. 162). Safety can also be achieved by maintaining the social work perspective of meeting clients where they are in the moment; if a member is resistant or if they seem to not be taking the activity seriously, it’s important to realize this could be a necessary coping skill.

A possible limitation in doing this type of group activity with adolescents is that hearing other teens’ traumatic experiences may potentially be a trigger for them (Cohen & Mannarino, 2004). Coping skills gained during individual treatment as well as the grounding activities in the group, can alleviate this. However, listening to other teens who have a similar experience can also serve a therapeutic purpose and reduce the sense of isolation that is common for traumatized adolescents to feel.

**Sustainability**

As stated above, this proposed activity is only one activity of many in their treatment process. This activity sets the stage for adolescents to work through their trauma so that their trauma symptoms are reduced, and they are able to move forward in their grief therapy. It is suggested that the group continue to use these creative techniques if the participants respond positively to the use of movement and music to express emotions and process traumatic experiences.

**References**

Bloom, S. (2010). Bridging the black hole of trauma: the evolutionary significance of the arts. 
_Psychotherapy and Politics International_, 8, 198-212.


doi:http://dx.doi.org.proxy.brynmawr.edu/10.1177/0143034311400827

Courtois, C. (2014) _It’s not you, it’s what happened to you_. Longboat Key: Telemachus.


https://doi.org/10.1080/15401383.2010.485090


Herman, J. (2015). *Trauma and recovery: the aftermath of violence- from domestic abuse to political terror.* New York: Basic Books.


Proposal for Multi-Session Clay Modeling Arts-Based Intervention for Eating Disorder Therapy

Treatment and Supportive Programing

Melissa Garfinkel

Executive Summary

The intervention proposed is a week-long arts-based therapy program designed for populations seeking treatment for eating disorders. The program is suitable for both individual one-on-one therapy and group therapeutic settings. The program does require a trained mental health professional with an existing therapeutic alliance with the client they intend to implement this intervention with. The program can also be used with various budget limitations and can be altered when taking into account any client physical disabilities.

The intervention involves the use of clay to create a narrative timeline through a series of three, separate non-human animal sculptures. The first sculpture is meant to represent the client’s view of their past/childhood self, the second sculpture represents the client’s current view of themselves specifically in their present treatment context, and the last sculpture is the client’s projection of their future self. The use of non-human animals is intentional to challenge clients to think about themselves in a body, but to provide them with some emotional distance.

The intervention is an arts-based therapy intervention in order to target the nonverbal, deep seated emotions and memories of trauma within clients. Clay was specifically chosen as a medium due to its physical, grounding nature. Clay encourages clients who may be very out of
touch with their bodies to reconnect with their bodies in healthy ways. Clay is malleable enough to encourage clients to engage in both creative and destructive impulses simultaneously.

**Theoretical Support**

Eating disorder (ED) treatment is a multifaceted process that takes many forms. Eating disorders themselves come in many different forms and yet share many underlying characteristics such as emotional regulation difficulties, feelings of loss of control, and body dysmorphia. The intervention detailed further in this paper is intended primarily for people in eating disorder treatment who also have trauma histories. Child sexual abuse, as well as other forms of abuse and neglect, have close ties to eating disorder behaviors (Brewerton, 2007). Additionally, according to Brewerton (2007), trauma and PTSD symptoms must be expressly and satisfactorily addressed in order to facilitate full recovery from the ED and all associated comorbidity. As eating disorders offer a form of control and bodily self-harm, they can be a very compelling coping mechanism for bodily and interpersonal trauma (Courtois, 2014). They may also function similarly to drug and alcohol addiction in terms of the eating disorder behaviors offering a form of dissociation or escape from painful emotions. Dissociation is one of the main coping mechanisms trauma survivors use as it allows them to escape from the constraints of reality and, in doing so, tolerate irreconcilable conflicts (Bloom, 2010).

Keeping in mind clients’ potential trauma histories and eating disorder behaviors, an arts-based therapy intervention was chosen to help clients tap into the less verbal parts of the brain and memory. Trauma strips the individual of feelings of safety and belonging in their environment. The brain, in an attempt to cope with that altered reality, codes the traumatic events differently within the mind and nervous system. There is a frozen, wordless quality to traumatic memories (Herman, 2015). The nonverbal and visceral aspects of trauma largely stem from how
the different hemispheres of the brain interpret and store information, specifically in how the right hemisphere stores trauma. The right hemisphere tends to remember episodically and implicitly, whereas the left specializes in autobiographical memory and acquired knowledge. The right hemisphere does not interpret experiences or nonverbal aspects of a trauma (Fisher, 2017). As such, the trauma is often unable to be fully rectified in the mind of the survivor, particularly in the verbal, concrete way that is so often expected by Western society.

Moreover, the earlier the trauma happened, the more difficulty the brain has in linking all of the pieces together, leaving the individual fragmented to some degree. As Fisher (2017) notes, “Without a clear chronological record of what happened but vulnerable to the uninvited activation of trauma-related feeling and body memories, individuals are left with a legacy of symptoms and reactions with no context that identifies them as memory” (p. 20). This repeated stimulation of the trauma often results in repetitive intrusions into the survivor’s life that arrest the course of normal development and functioning. Those intrusions include flashbacks, anxiety, panic, traumatic dreams, social isolation, and aggression (Herman, 2015). Consequently, the individual has to live with an internalized reality that feels divorced from their current lived reality. They have no clear sense of how to rectify or even express those competing certainties.

However, creative arts interventions offer a way for individuals to engage their right hemisphere and less verbal parts of their brain. Creative arts, for its mimetic expression, allows people to re-enact or represent events and feelings in their life that they might not be able to put into words or that is better expressed nonverbally (Bloom, 2011). Additionally, the ability to be creative is inherent in all humans at all points in life. As Winnicott (2005) writes, “Creativity in and of itself, beyond being necessary for authentic art, is present when anyone looks in a healthy way at anything or does anything deliberately.” It not only allows for people to express themselves in
ways beyond language, but it is also an accessible way for individuals to enact control and purpose over the present reality.

Another treatment element that gives clients a sense of control and cohesion is creating and expressing a trauma narrative. The intervention detailed is a clay-based interpretation of a generalized trauma or eating disorder recovery narrative. It is necessary to some degree in trauma healing to make sense of traumatic memories and subsequent feelings (Courtois, 2014). Clients need to make sense of their past realities in relation to their current lived experience and sense of self. Narrative expressions of trauma show up repeatedly throughout different cultures and historical time periods. Cultural rites, rituals, collective storytelling, interpretive dance, and the creation of visual works of art are all examples of past and continuing mediums that humans have used and continue to use to express experiences with others in their community and within themselves (Harris, 2009). Traditional Western psychological practices also emphasize storytelling, but they fall short by forcing clients to tell their stories verbally and immediately in a coherent, linear way. The very nature of the human brain’s storage of traumatic memories undermines verbalization, to the point where verbal expression can be completely out of reach for many trauma survivors. Linear storytelling and narrative performance through clay sculptures is one way for clients to dig into their understanding about their sense of self and their traumatic experiences even if words are inaccessible.

**Intervention Goals**

- To outline an adaptable, cost-effective, arts-based intervention to use with current models of eating disorder treatment.
● To create a sustainable, arts-based intervention that can be applied to a multitude of therapeutic settings and treatment programs, including individual therapy and group treatment.

● To present an arts-based therapeutic intervention that is accessible for clients of different identity intersections and can be adapted for clients with different physical abilities.

● To encourage trauma healing and reintegration through creative expression and nonverbal story telling.

**Target Population**

● Individuals of all ages, identities, and ability levels in the process of eating disorder recovery.

● Individual clients in one-on-one therapeutic settings.

● Participants in group therapy settings for eating disorder treatment (inpatient, intensive outpatient therapy, outpatient group therapy, community run organizations such as Overeaters Anonymous (OA), etc.).

**Program Narrative**

The intervention challenges participants in eating disorder recovery programs/therapy to create three animal clay sculptures. The first sculpture is meant to represent the client’s view of their past/childhood self. The second sculpture is meant to represent the client’s view of their current self, particularly within the context of treatment. The final sculpture is intended to represent how the client views their future self. Due to the target population commonly suffering from issues of body dysmorphia and other related issues, the sculptures are very intentionally meant to be non-human animals. Animals can be extremely diverse or even fictionally inspired, but they still have physical bodies that have to be molded purposefully.
Clay modeling was chosen specifically as the artistic medium due to its grounding nature and amount of physical engagement involved to use the medium. Too much physical engagement, particularly physical engagement that might induce self-consciousness over the body, would likely not be accessible to many clients dealing with eating disorders. However, it is possible that an activity that shows clients that they can create powerful art through a specific, generally non-emotionally charged part of their body like their hands can be empowering. Clay can be a powerful way to help people express difficult or conflicting feelings through tactile involvement at a somatic level. Clay also facilitates cathartic release and reveals unconscious materials and symbols that cannot be expressed through words (Stuckey & Nobel, 2010). Touch is one of the first and most basic forms of communication that humans learn and is consequently linked to many memories—both conscious and unconscious within the individual. Clay gives a sense of agency and control through tactile communication. The individual has the opportunity to make a concrete thing out of clay, which is symbolic of one’s inner world. It is a physical act of transforming the pain into meaningful expression (Sholt & Tavron, 2006). Moreover, the clay itself is grounding and soothing. The act of molding and touching can help keep the client’s mind centered on the here and now as much as possible to ensure safety.

The materials needed for the intervention can be altered based off of agency budgetary needs. The materials that are completely necessary are modeling clay (which can take many forms such as non-firing, oil-based, wax, etc.), sculpting tools, and clean up/protective materials. Other suggested materials include paints and textured pieces to add in. The intervention can also be altered for the different physical abilities of each client. The type of clay should be chosen carefully. Multiple types should be offered in order to be accessible for people of varying
dexterity levels. For people who cannot sculpt with their hands, they can still potentially sculpt with other parts of their body or with the assistance of the therapist/group leader.

After all three sculptures of the series are completed, the group and/or individual therapist should support the client in debriefing. Clients are encouraged to name the pieces they created, explain what they experienced while creating each piece, and describe how it feels to look at the completed series. It is the role of the therapist to provide a safe environment for clients to put words to their experiences and describe their story through their art in as much detail as possible. The sculpting activity is meant to facilitate verbal, linear storytelling. As storytelling and rectifying past events in a comprehensible way is vital to trauma processing (Talwar, 2007), the debrief is necessary to help clients reintegrate their fragmented experiences and emotions.

**Timeline**

The project is intended to take seven days—two full days to create each of the three sculptures and the seventh day for debriefing and presenting the sculpture narrative. Two days should be dedicated to creating each sculpture because it provides time for paints to dry overnight and for modifications to be made the following day. For practicality reasons, the project can be scaled back to three to four days in length, but it is not ideal. From a therapeutic standpoint, a second day allows participants the chance to more objectively observe their previous day’s work. It is vital for participants have time to evaluate their creations, battle with their inner critics, and grapple with their inner urges to either hide or destroy their sculptures. As Safan-Gerard (2018) writes, “At a certain stage during creative work destruction becomes as necessary as the ensuing reconstruction and control of its elements” (p. 3). Destruction is part of the creative process, and participants deserve the chance to critically interact with their creations. Destruction and pain are part of the participant’s story and history. Exploring destruction in a
safe and supported environment can encourage a sense of agency in the participant. After such destruction and anguish, a leap of faith and an internal desire for expression move the artist to engage in a renewed effort to create something of value again (Safan-Gerard, 2018). The back and forth of destruction and creation, the rebirth as a result, can model healthy and safe interaction with internal feelings and conflicts.

The intervention could be extended to be longer than one week, but that is not suggested unless there is a strong enough therapeutic alliance to support a prolonged dive into the feelings this activity may bring up. While participants are encouraged to fully and emotionally interact with their creations, giving too much time to each task might allow for too much self-criticism over artistic skills. Additionally, this activity is intended to be just one exercise to include in the contest of a pre-existing treatment regimen. It is intended to encourage an individual to briefly connect in some way with some of their more buried, fragmented, and nonverbal memories of trauma. That connection is designed to be brief in order to not radically shake up an individual’s sense of self more than can be supported by their current therapeutic alliance.

In that sense, the role of the social worker or art therapist is critical in creating a safe environment for the individual. In accordance with the Sanctuary Model, a therapeutic relationship serves the additional purpose of providing and modeling healthy, professional relationship patterns that are inherently healing (Bloom, 2013). Moreover, the act of participating in any therapeutic intervention has the possibility of creating emotional distress. An arts-based intervention is no exception to this. It is necessary, therefore, that whoever is leading the group or individual session is able to ground the participants and bring them back to relative emotional equilibrium before the end of the session. The purpose of this intervention is not to cause sustained distress or emotional upheaval beyond the session limits.
Evaluation of Risks

The main risk of the intervention is emotional distress within participants. The activity is designed to express distressing thoughts, traumatic memories, bodily hate, mourning for the past, and fears over the future. With all of those emotions being brought forward, it is possible that participants may experience more emotional distress between sessions than they are able to handle. It is imperative that participants are taught and practice grounding techniques and coping strategies. It is also necessary that regular methods of coping not be taken away in favor of performing these exercises. Additionally, to minimize risk, clients should not work on their art projects outside of the supervision and support with their therapist.

The last of the three sculptures will challenge clients while ideally encouraging future thinking and instilling a sense of hope. The debriefing/presentation session may be difficult for clients because of their need to connect their experiences with words and expose personal experiences to their therapist and/or group. However, it is also intended to give clients a sense of closure, instill a sense of pride as a result of finishing a narrative, and provide a physical takeaway. Ideally, these positive aspects serve as a mitigating factor when weighing the risks associated with this intervention.

References


https://doi.org/10.1080/10640260701454311


Providing Music-Based Interventions to Patients with Dementia in a Hospital Setting

Megan Hoskins

**Background/Important Facts About Dementia**

Alzheimer’s Disease is the 6th leading cause of death in the United States. 5.8 million Americans are living with Alzheimer’s, and by 2050, this number is projected to rise to nearly 14 million. In 2019, Alzheimer’s and other dementias will cost the nation $290 billion. By 2050, these costs could rise as high as $1.1 trillion (Alzheimer's Association, n.d.).

Dementia changes a person’s life drastically, creating challenges with memory, communication, visual perception, reasoning, and focus. It also impacts the lives of family members and caregivers. Unfortunately, the needs of people with dementia are frequently unrecognized. Too often, behavioral disturbances in a person with dementia result in unwarranted medication in an effort to calm or stop the behavior altogether. Rather than attempt to halt behavioral disturbances with psychotropic medication, an effort should be made toward use of creative methods including music-based interventions.

Communication deficits are a key symptom of dementia which can make it difficult to express and articulate needs. It is important to remember that a person living with dementia was, and still is, a multi-faceted person. Cohen-Mansfield (2005) states that individuals with dementia, “bring a lifelong set of experiences, preferences and habits” (p. 38). These preferences and habits have not changed, so it is important to try to maintain the person’s quality of life.
Cohen-Mansfield (2005) explains, “even when people with dementia articulate their needs and wishes, we tend to believe that these are not ‘true needs” (p. 38). Caregivers tend to believe that because of dementia, people with the disease do not understand their needs anymore. As a result, caregivers become overly cautious. For example, a person with dementia “shouldn’t walk too far” because they could fall, “shouldn’t eat alone” because they could choke, or “shouldn’t go outside” because it is too cold. Improving the lives of people with dementia through non-pharmacological interventions means finding ways to assist them in continuing to fulfill their basic human needs.

One of the core values of social work is to meet a person where they are, and it should be no different in the case of a person living with dementia. Cohen-Mansfield (2005) speaks to the concept of “informed care” and describes it as “a treatment approach that is based on the individual patient in particular, similar to the notion of person-centered care” (p. 37). Patient-centered care can include non-pharmacological interventions to address behavioral problems. Cohen-Mansfield states, “Treatment of the patient’s unstated needs [should] take precedence over pharmacological treatment” (Cohen-Mansfield, 2005, p. 38). Treatment teams should make every attempt to “meet the person where they are” and assess any physical or emotional needs that can be treated with non-pharmacological interventions.

Triggering situations can also play a role in behavioral symptoms. Change can be difficult for anyone, and for a person living with dementia, change can be especially stressful and may increase fear. Common situations that could be triggering for a person living with dementia include changes in a familiar environment or caregiver arrangements, misperceived threats, admission to the hospital, being asked to bathe, or being asked to change clothes (Alzheimer's
Association, n.d.). Unfortunately, all of these triggers occur in the hospital setting, which can make it extremely difficult for the patient to remain calm.

**Proposal**

I would like to propose that hospitals use music on a daily basis with patients who have been diagnosed with dementia. I would initially introduce this intervention to patients receiving care from the hospital at which I am currently employed. This hospital recently began using hospital-provided iPhones at work. We can look up a patient’s chart, message other employees when we need assistance in a room, and contact medical providers if necessary. I propose that these iPhones be given the capability of playing music by downloading an app like Spotify, which allows you to search for different artists, songs, genres, and playlists.

**Goals**

Goals for this proposal include reduced frequency of the use of psychotropic medications for patients with dementia, reduced aggressive outbursts, increased socialization, and improved moods. Psychotropic medications are commonly used with dementia to combat behavioral disturbances with sedation, but according to the Alzheimer’s Association, “antipsychotic medications should not be used to sedate or restrain persons with dementia” (Alzheimer's Association, n.d.). This is detrimental because it robs a person with dementia of what little cognitive abilities they may have, and it limits their ability to communicate and express their needs. In turn, this makes it impossible for caregivers to assess a true underlying need, creating a cycle of sedation with no long-term benefits. The risks of using antipsychotic medications to treat dementia symptoms are so substantial that in 2005, “the FDA issued a black box warning that the use of atypical antipsychotics leads to increased all-cause mortality when used for behavioral disturbances in patients with dementia” (Maust, 2015, p. 439). It is terrifying that...
some medical providers would rather sedate a “difficult” patient than provide simple interventions to improve quality of life without the risks of psychotropic medications.

Socialization is also an important factor in preventing and improving symptoms in patients with dementia. According to the Alzheimer’s Association, “a number of studies indicate that maintaining strong social connections and keeping mentally active as we age might lower the risk of cognitive decline and Alzheimer’s” (Alzheimer's Association, n.d.). Socialization can create feelings of inclusivity, improve brain health, strengthen connections to time, place, and current events, and help to maintain focus. Eisenberger (2012) states, “It is well established that social relationships are important for physical health...Socially connected individuals live longer and show increased resistance to a variety of somatic diseases ranging from heart disease to cancer” (p. 669). Family, friends and community are an extremely important resource and source of support for a person living with dementia. Social connection and “the perception that one is cared for, loved and valued by others” leads to better health outcomes (Eisenberger, 2012, p. 669). Music can help the patients to socialize in settings where they may otherwise feel isolated and disconnected.

**Target Population**

Appropriate patients are those who are “acting out” as well as those who are seemingly calm. The patients who are acting out may be bored, confused, or scared and cannot communicate their feelings or needs effectively. Patients that are seemingly calm are also appropriate as they may also be bored, confused and/or scared on the inside but cannot express these emotions on the outside. It is important to provide music-based interventions for both types of patients.
Music Selection Process

The music selection process will be different depending on the stage of the disease. Patients in the early stages of dementia will be able to choose music on their own, while a patient in late-stage dementia may not. Patients who are seemingly nonverbal and unresponsive will need music picked for them, and it is important to choose wisely in order to provide beneficial effects. The wrong music could evoke a negative response in the patient. Help with music choices could be requested from family members and loved ones.

Ideal Duration & Frequency

Patients with dementia may not have a long attention-span, which makes it crucial to figure out an appropriate duration and frequency for music sessions. A first session may be longer in order to explore different types of music that the patient may enjoy, while later sessions may be shorter and focus solely on the playing of the music. The duration and frequency of the sessions will depend on each and every patient. They could potentially last anywhere from ten minutes to one hour.

Limitations

A potential limitation is cost. Spotify would be preferred over the purchase of individual iPods for patients. The cost of an account on Spotify would be cost-effective while also providing patients with the therapeutic effects of music. While it is a great idea for a nurse or nursing assistant to use music in their work with patients, it is simply unrealistic that an employee could devote up to one hour of their shift playing music and talking to a patient given their additional responsibilities. It could be beneficial to hire a few individuals who could provide this service to patients. These individuals could be certified music therapists or even individuals who are not therapists.
Implication for Future Research

Research on this topic is imperative in order to improve the quality of life for people living with dementia. Simple interventions like this can decrease the costs of healthcare and eliminate the administration of unnecessary medications. As previously stated, in 2019, Alzheimer’s and other dementias will cost the nation $290 billion, and by 2050, these costs could rise as high as $1.1 trillion (Alzheimers Association, n.d.). The cost of dementia, as well as the overwhelming statistic that people living with dementia will almost triple by 2050, is enough to show the importance of non-pharmacological interventions like music.

References


Performance Arts Based Intervention in Substance Use Treatment

Adam Ouanes

Introduction

In many substance abuse treatment facilities, a major component of treatment is telling one’s personal narrative to the rest of one’s treatment group. The belief is that storytelling has the ability to heighten patient’s ability to communicate thoughts and feelings in a clear way and eliminate feelings of isolation. This can lead to the development of imagination to aid in accomplishing life goals (Lynne. Walsh, 2016).

By the time many patients come to treatment for substance abuse, they are often consumed with guilt, shame, regrets over past behaviors and feel alienated from those around them (Humphreys, 2000). Patients often feel as though their past is a heavy, shameful secret to be heavily guarded.

Psychologist Orval Hobart Mowrer discusses the role secrets have in upholding suffering, particularly isolation from one’s community (Mowrer, Vattano, Baxley & Mowrer, 1975). Mowrer et. al (1975) posit that when one shares “secrets” with a community of people with shared experience, one is often met with community acceptance promoting health and personal integrity. They state that by turning the past into a story, one can gain power and reflexivity over experiences and begin to heal from past trauma (Mowrer et. al, 1975). Thus, telling one’s personal narrative is a way to resolve past trauma. This is a crucial part of substance abuse
treatment; a very high percentage of patients are affected by trauma in some way. A study of approximately 1000 individuals in substance abuse treatment showed that 89% of participants reported experiencing trauma prior to seeking treatment (Farley, Golding, Young, Mulligan & Minkoff, 2004).

**Barriers**

There are major barriers for patients who have trauma histories and are expected to share a personal narrative. Fragmentation, dissociation, and loss of language are primary concerns. Fragmentation, a splitting of the self, is a way in which one may compartmentalize overwhelming experiences. Similarly, dissociation is a way of “withdrawing in consciousness from the body, anesthetizing oneself from severe physical or emotional pain” (Emunah, Raucher, & Ramirez-Hernandez, 2014, p.106). These processes help a person to move forward until they are ready to heal, but they make constructing a narrative difficult.

In the case of dissociation, one may feel completely removed or numb in relation to their trauma. Fragmentation leaves survivors feeling as though they are shattered or broken (Corrado, 2019). Not only do trauma survivors feel shattered, but they also have memories that are fragmented. This is because in the face of a stressful experience, the brain releases stress hormones. The HPA axis adapts to the stress through a process known as allostasis. When the allostatic system is overworked, other systems in the brain are in overdrive (McEwen, 1998). The hippocampus (which helps form memories and put experiences into a meaningful context) helps to shut off the stress response. But, if stress is experienced consistently over time, neurons in the hippocampus can be killed, resulting in fragmented memories (McEwen, 1998). Having memories that are not clear or cohesive is a major challenge when trying to piece together a trauma narrative.
Another challenge for trauma survivors seeking to construct a narrative is that trauma results in a loss of language. There is a belief among researchers that traumatic memories are stored in a preverbal/nonverbal part of the brain. Thus, memories are often experienced as amorphous sensations and images as opposed to linear stories (Harris, 2009). It has been hypothesized that upon experiencing a trauma, the hemisphere responsible for language and memory has a decrease in activity, which ultimately undermines verbal processing (Harris, 2009). Thus, it becomes a challenge to contextualize the memories in time and space, and all the while the Broca’s area (an area of the brain that translates experiences into language) is deactivated (Harris, 2009). This process allows the person to move on through the trauma, but ultimately they must figure out a way to deal with the experience at some point in order to heal. Harris (2009) discusses how engaging one’s “imaginative faculties” (p. 101) can help people process unimaginable circumstances. Harris (2009) states that creative arts therapists can help process traumatic experiences through symbols, circumventing challenges like finding the words to process the event.

With these major barriers in mind, I propose a performing arts-based intervention called Shakespeare Performance Therapy (SPT) to help patients undergoing treatment for substance abuse. Patients will create and perform a solo performance using Shakespearean text to express their personal story and share with peers. This allows trauma survivors to find ways to process feelings about experiences that they may not have the language for. This process works with, rather than against, the fragmentation or dissociation processes. SPT uses elements of Self-Revelatory Performance Therapy, Receptive/Expressive/Symbolic Therapy, as well as narrative building techniques from the Storiez Intervention.
Background on Drama Therapy

SPT employs techniques and evidence from the field of Drama Therapy. There is a body of research that points to the advantages of theatrical imagination in trauma healing (Sajnani, 2014). The concept of Fantastic Reality, a tenant of drama therapy, is a way of creating a safe space for a patient to process a traumatic event from a safe distance within the confines of an imaginary world. It is a way to make room for dissociation and fragmented experiences (ie. when a trauma survivor detaches from reality temporarily to be able to cope), meeting the patient where they are. The use of a theatrical approach with trauma allows flexibility and range in cognitive distance from the experience which can give patients the ability to move from “cathartic emotional release to highly observant and reflective states towards experience” (Sajnani, 2014, p. 17). Additionally, “in terms of memory theory, engaging clients in theatrical ways can allow for the transition of traumatic information initially coded in visual, embodied forms to verbally accessible memory systems allowing the client to find words for experiences” (Sajnani, 2014, p. 17).

SPT Goals

SPT gives the patient a sense of control and agency over their life through constructing their own story and making artistic choices in how to convey their message. It provides distance from the traumatic events to allow self-discovery and a safe outlet for expression. It also helps patients identify emotions. SPT fosters a sense of community. During group sharing, patients see similarities between their experiences and feel seen and heard. Most importantly, this intervention allows the patient to process traumatic memories and become integrated by taking ownership of feelings and constructing a more cohesive self-story.
**SPT Overview**

Patients will be given the option to artistically construct their trauma narrative by working closely with a therapist who has a working knowledge of trauma theory and acting techniques. Like all interventions, this is not for everyone and should be used if the therapist feels the patient would be receptive and gain positive results from this work. Patients who participate will tell their own narrative using Shakespeare Performance Therapy (SPT). SPT is very similar to Renee Emunah’s Self-Revelatory Performance (Self-rev) Intervention. Self-rev is a form of drama therapy that culminates in a solo performance. This performance will take place with the patient’s treatment cohort. There will also be the option to invite friends and family to the performance.

The primary purpose of SPT, like Self-rev, is on raising emotional awareness within the performer along with the audience. SPT also focuses on healing the traumatic wounds addressed in the piece through creative expression (Emunah, 2014). Although the content of each performance will clearly be individualized, there will be common emotional themes in each story that will connect every piece together leading to a sense of universality among patients who perform. This aids clients in building community with one another and eliminates feelings of isolation; patients will be able to see the similarities they share with one another through the emotions that come up in each piece. Creating the Self-rev has been shown to “accelerate self-discovery, expand perspective, catalyze change, and deepen healing” through the power of unique expression (Emunah, 2014, p. 94).

Many patients who are seeking treatment for substance abuse are struggling with intense emotional pain connected to trauma. While it is important to remind patients that the past is unchangeable, self-rev provides them with the opportunity to feel emotions associated with
trauma, many of which have been, “suppressed, denied, or channeled in self-destructive ways” (Emunah, 2014, p. 98). Just as in self-rev work, the focus is not on reliving the trauma. This intervention is more concerned with looking at current emotions that the patient is struggling with that are connected to past traumas and communicating those emotions with others. This may include expressions of grief, fury, sorrow, or even moments of joy. What is of paramount importance is the processing and coming to terms with feelings that are associated with the past (Emunah, 2014). Therefore, when constructing the narrative, patients will be able to process emotions about the trauma rather than giving a play by play with gory details.

What makes SPT unique from Self-rev is the use of pre-written text. In introducing text to the client, elements of Nicolas Mazza’s Receptive/Expressive/Symbolic (RES) model of poetry therapy are used. The use of written text fills in the major gaps left by Self-rev and accomplishes two goals. First, this creates what is known as aesthetic distance. Aesthetic distance “involves portraying emotionally charged material through the use of dramatic distancing. Distancing aids in re-establishing equilibrium between thoughts and feelings” (Emunah, 2014, p. 108). Where one may typically get overwhelmed in discussing the trauma, the use of text can act as a protective barrier that still communicates the essence of the event. The use of text like Shakespeare creates more aesthetic distance, allowing the patient to ease into the process.

The second goal achieved in using pre-written text is that it solves the problem many trauma survivors encounter with not having the language to express the trauma. This is the major flaw in Self-rev work. Self-rev assumes that patients will be able to easily come up with their own language to discuss the trauma. In being able to read and identify someone else’s words
about a similar feeling or event, the goal of expression is achieved, and the language can be provided as a starting point.

**Why Shakespeare?**

The reasons for using Shakespeare may seem puzzling, but there are several strong motives for this specific choice in language. Shakespeare’s words are intimidating at first. However, Shakespeare can be understood by anyone. His plays were written for the masses. Admittedly, it does take a little extra work for most people to comprehend what he was saying. Tackling his text can be a consuming task, but having a distraction is useful for patients who are looking for new ways to fill up their time. But the work with the text is more than a distraction. The exercise of translating the words into modern English can further the patient’s ability to process their own emotions. The process allows the patient to identify connections between their experiences and the experiences of the characters within the context of theatrical performance. Someone who may have been initially afraid of this Shakespearean language can translate the text into their own words, leading to an immense sense of self confidence and achievement.

Ultimately, the lives of Shakespeare’s characters are remarkably similar to those of individuals who have survived traumatic experiences, especially those in substance abuse treatment. Their lives are dramatic, over the top, and filled with extreme, heightened emotions. Although Shakespeare’s narratives were written 500 years ago, the issues he addresses are modern and universal. Shakespeare talks about sex, violence, passion, betrayal, loss, anger, grief, joy, freedom, and fear. He described traumatic experiences before we used the word “traumatic.” Shakespeare wrote a scene or a monologue for just about every pivotal moment one can have. Patients might not know what it’s like to lose a title like “king,” but they all have questioned their identity when losing something that they once thought defined them, like drugs or partying.
Shakespeare’s text provides a perfect amount of aesthetic distance to enable meaningful growth and processing.

This unique use of language has proven effective in helping prison inmates heal from past traumas. Dr. Jonathan Shailor founded a theater program at Racine Correctional Institution where he gave inmates the opportunity to explore their past experiences and heal from trauma while studying the characters. In his production of King Lear, an inmate who played Cordelia explained:

I can use putting the costume on as an excuse to show emotion, Lear's abandonment of Cordelia reminds me of my mother saying she should have had an abortion. This lets me vent out my frustration. It lets me vent out my sadness. I've never actually done that. It feels safer. I am Cordelia in so many ways, and in being her I’m learning more about me. (Shailor, 2008, p. 638)

Shailor (2008) explains that using Shakespeare’s language, he is able to help inmates heal and move through difficult emotions. In using theatrical text, inmates are able to find:

An increased sense of dignity, discipline, creativity, self efficacy, and develop community and deep empathy for one another…it also provides a safe space to explore emotions, alone with self-awareness and insight into oneself. Inmates are able to reflect on and critique patterns of perceiving, thinking, feeling, acting, and responding. (Shailor, 2008, p. 634)

The same goals that are achieved by prison inmates can also be accomplished with substance abuse patients struggling with trauma.
How Will it Work? A Step by Step Guide

To begin, patients will be shown an example SPT performance using these theatrical techniques. Patients who express interest in this form of storytelling will work closely with the therapist, who should have knowledge of trauma theory as well as extensive theater training. Patients will meet with the therapist regularly for 60-90 minute sessions, building a strong therapeutic bond based on trust and honesty.

In the first session, patients will give a brief personal history to the therapist in an initial assessment. This will be considered a brainstorming session. When specific traumatic events are mentioned, the therapist will ask the patient to title the events. The therapist will provide a workbook in which the patient will write down the titles. This workbook will function as an acting journal as well. Patients are encouraged to decorate it and make it their own. The purpose of this assessment phase is for the patient to identify ten to twelve major life events that they would like to delve further into. It is essential to create balance in the story as well as in the sessions. Therefore, positive experiences are necessary as well. When discussing specific traumatic moments in this session, it is important to be brief in order to prevent the patient from emotional flooding. The therapist should be mindful not to overwhelm the patient in the discussion of multiple traumas. The therapist should remind the patient that details will be focused on later. This brainstorming session is fairly similar to instructions from Dr. Corrado’s Storiez Intervention (2019).

In the following sessions, the therapist will ask the patient to choose one or two selected moments from the initial meeting to revisit. The therapist will ask the client questions about the experiences, specifically focusing on the current emotions related to the experience. The therapist will offer alternative ways for clients to express themselves such as asking if there is a
song that comes to mind when thinking about the event. The therapist can also invite the patient to draw the experience in their acting journal. This is a way of honoring the difficulty patients may feel in using language to describe events. The use of visual art can help reduce anxiety and gives the patient a place to process memories outside of themselves. This helps to reduce dissociation (Johnson-Buda, 2019). The therapist will ask the patient questions throughout the process and check in with the client to determine if there is an accurate understanding between the two.

In the next week, Shakespearean texts will be introduced to the patient following Mazza’s Receptive/Expressive/Symbolic (RES) model of poetry therapy (Mazza, 2001). Mazza’s work with poetry therapy is helpful because it allows the patient to externalize problems. The re-telling of the story can also give the patient a sense of empowerment by promoting the patient’s ability to make choices around the story (Mazza, 2001).

Following Mazza’s model, the therapist will introduce the text into therapy in connection with the issues and traumas the patient may be facing. The therapist will choose a text that connects to one of the experiences named in the initial session. The first step is to make sure that the patient feels a connection between the text and their real life experience. The patient and therapist can discuss the text in depth. It may need to be translated with the help of the therapist. Before decoding the words verbatim, the patient will identify a general idea or feeling they experience when reviewing the text. The therapist can ask questions like, “How do the sounds in the text feel?” and “What feelings do you get from the text before we dive into the meaning?” By analyzing and decoding the text, the patient is, in effect, talking about their own experiences with aesthetic distance. In SPT, the patient can go deep into the emotional work by studying the character that is speaking the text in the context of the play that the text comes from. Reflective
questions that go deeper into the text may include: How is the character like you? How is he/she different? What is the character’s world like? How would the character act today? How is this experience related to your own? Therapist and patient will work in this way until every titled moment is covered. The therapist and patient will alternate each week between processing moments through art and then introducing text to the moment processed the following week.

In the next phase of the adapted Mazza model, the patient and therapist work closely together on performance-based techniques. This can include role play between therapist and patient with the therapist performing important roles in the story. Other techniques may include improvising the moments that happen before and after the text, creating backstory, or performing the monologue in plain English. Additionally, the therapist will aid the patient in breaking down the monologue into dramatic beats. This means breaking down the monologue into smaller individual thoughts and coming up with actions or intentions for each section that is spoken. In doing all of this work, the patient delves deep into their personal interpretation of the text, which allows the patient to process their experiences from an aesthetic distance.

In the beginning, each piece of text will exist as a fragment and may not be processed chronologically. In this way, the therapist can honor the patient’s fragmentation if their own narrative is not yet cohesive or clear. Patients who struggle with dissociation are also able to go through the dramatic motions of a moment without becoming numb or withdrawing (Emunah, 2014). This gives patients the opportunity to express where they are in the moment. The use of dramatic text creates distance, making it safer to explore possible emotional reactions.

When each titled moment has been worked through with text, the therapist and patient will work together in creating a chronological order of the events. After placing things in order,
the patient will dictate how they would like to connect the story. The therapist can act as a scribe by writing the connecting pieces of the story.

Once the full narrative is finished, the patient has the opportunity to perform the solo performance for their group cohort. Patients do not need to memorize words. The performance can be as simple as sitting down in front of the group and reading from their journal. They will also be given the opportunity to invite family or friends if so desired.

**Limitations**

One of the major limitations of this intervention is that many patients may feel uneasy about exploring their past in this unconventional way. They may feel self-conscious, foolish, or simply may not want to do it. Additionally, disclosing sensitive material to the audience through performance may provoke anxiety. The patient may also be hesitant to expose things they feel shame about. Developing trust between the therapist and patient is key to overcoming patients’ resistance. This is the major reason why the process must begin with the therapist modeling the process by sharing parts of their own story. The therapist’s willingness to be vulnerable will hopefully open the patient’s willingness to be vulnerable, too. “Over time, benefits of self-disclosure and the impulse to share one’s truth will typically override the inclination to remain silent” (Emunah, 2014, p. 97).

Another limitation in this intervention is a fear of the language. Although there is ample evidence that shows expression through Shakespeare can be a freeing experience (often allowing participants to wear a sort of mask for expression), it is easy to see how much resistance there may be. This is another reason why the process should begin with an example performance. Dr. Shailor discusses that he used this technique of an example performance when he began his work with prison inmates and found it was surprisingly effective in creating excitement about the
prospect of performing Shakespeare (Shailor, 2008). Tackling intimidating text seems a worthy endeavor, as it can lead to self-efficacy and build confidence.

Another concern with SPT is it relies on the therapist to collect possible texts. This opens up room for misinterpretation from the client. If a moment is misunderstood and the therapist projects incorrect emotions or ideas onto the client, the client may feel disempowered and misunderstood. It is crucial for the patient and therapist to understand one another. It is the therapist’s responsibility to make certain through reflective listening that the correct meanings and feelings are being captured.

Finally, this intervention is limited in scope because few therapists will have the knowledge to apply Shakespeare to each individual patient, and the amount of work it takes to unpack each monologue is time consuming. Realistically, this intervention would only be available to small cohorts.

**Conclusion and Outcomes**

Creating a solo performance that dramatizes the traumatic experiences of patients has several worthy outcomes. In practicing the performance, and continuing to work on the pieces, there is a repeated telling of the trauma which can function somewhat as a softer version of exposure therapy. By retelling the story several times through the use of aesthetic distance, the negative effects of heavy emotions are reduced.

One outcome of this work is the sense of connection built among those who create and perform their pieces together. Patients who have suffered trauma often report feeling disconnected from others. In creating universal stories with shared experiences, patients are able to find a sense of community and feel seen and heard. Having an audience of peers who have gone through similar experiences creates a sense of community for the patient and helps to
eliminate the common feelings of isolation many patients endure. This outcome is achieved because the focus of the material is on the emotional journey rather than on the specific details of events. The community built when patients share these stories with one another helps them overcome fears of judgement and helps to destigmatize the experiences for patients. Many patients who engage in self-rev work have reported results of feeling more connected, understood, and integrated into their communities when sharing their work (Emunah, 2014). There is also a powerful sense of mastery achieved in creating art from a painful experience. Finally, the structuring of a performance is a way for the patient to contextualize and make meaning from the traumatic experience.

In a study of patients who engaged in Self-rev work, one patient described the freedom he felt after his performance stating:

Once I got it out of me, I could do something with it. I had more confidence in myself. I would go around town going over it again and again…externalizing it gave me the chance to gain insight through the distance. I feel a part of now that I have shared my story with others like me. What relief. (Emunah, 2014, p. 106)

Although a fear of public speaking is quite common among individuals, sharing a personal history with the group is very common in substance use treatment. This form of storytelling is a way to provide a safe distance between the patient and the audience while still making the patient feel seen and heard. As mentioned by the prisoner who played Cordelia in Dr. Shailor’s Shakespeare prison program, there is safety in being able to hide behind someone else’s words to express one’s own experiences. In the guise of performance, one can share their truth more openly than they normally would.
This process of theatrical storytelling ultimately helps patients reintegrate confusing traumatic experiences. Patients organize experiences into a story form. The process of digging through text and translating into modern English helps patients to synthesize and create a deep meaning out of confusing or senseless experiences in a meaningful way.

References


https://doi.org/10.1632/pmla.2008.123.3.632
Aerial Yoga Intervention for Trauma and Loss

C. Louise Profit

Introduction

The experience of trauma can overwhelm a person. Trauma assaults the mind, body and emotions, leaving a person feeling that they are living in a body, and/or world, that has become unfamiliar or unknown. Dissociation and fragmentation may cause a trauma survivor to feel disconnected or numb. There is a lack of an integrated sense of self, and the person no longer believes that they are wholly intact and complete.

In traditional psychotherapy, emphasis is placed on processing trauma using the intellect and seeking to find resolution through the mind. In yoga, emphasis is placed on integration of the mind and body, understanding that they cannot be separated. Jung, psychologist and yogi, wrote about the power of somatic psychology, “The separation of psychology from the premise of biology is purely artificial, because the human psyche lives in indissoluble union with the body” (Caplan, 2018). Fostering a strong connection between mind and body makes sense for processing trauma, towards healing and a feeling of a more complete, integrated and embodied self.

Aerial Yoga as an Arts-Based Intervention

Yoga has long recognized the importance of creativity for growth. Aerial yoga offers a unique format wherein the support of a yoga hammock (or yoga silk), makes yoga more
available to persons who may be resistant due to fears of not being physically able to support their own body in yoga poses. The yoga silk enables greater flexibility for therapist and client to explore the concepts of creativity and boundaries, playfulness and safety, and verbal and non-verbal processing of trauma. The yoga silk can make physical yoga poses much less intimidating and more available to every body-type. The yoga silk provides support, a holding environment, and a tool for balance. It also serves as an invitation for the client to tap into their own inner childlike playfulness.

**Ancient Wisdom and Yoga Teachings**

Recovering from trauma requires learning a new way to accept, understand, and exist inside one’s body and mind. This is necessary in order to become unstuck from the impact of the trauma. One of the ancient yogic texts, the *Chandogya Upanishad* gives the following instruction: “Where there is creation, there is progress. Where there is no creation, there is no progress: know the nature of creation” (Mascaro, 1965, p. 32). Yoga, and by extension aerial yoga, teaches us that we are constantly called upon to make internal progress. Inner creativity softens our attachments to our known way of being and connects us with the life force energy that is all around us and within us.

The *Yoga Sutras* are a guide to liberation from the painful confines of the mind. The suffering of trauma is the residual overriding of the mind and heart with thoughts, sounds, images, and sensory experiences that trigger a traumatic response in the body. Yoga calls us to awaken the knowledge of the divine that resides in our hearts to free ourselves from the torment of past and fears. Yoga prompts the individual to focus on the reality of the now. As translated by Devi (2007), “1.2 Yoga is the uniting of consciousness in the heart” (p. 280).
Yoga focuses on drawing one’s attention inward to what is going on in the body and mind and aims to reduce the fluctuations of mind. According to the *Bhagavad Gita* one of the key texts in yoga philosophy, the path of yoga is the path of deliverance from pain and sorrow, “6.23 In this union of Yoga there is a liberty: a deliverance from the oppression of pain” (Mascaro, 1962, p. 33).

**A Strengths-Based Approach**

The sacred texts of yoga claim that the essence of the universe and of ourselves is positive, and our daily, lifelong task is to find our way home to this truth of love, light, and goodness. Our suffering may be our means to access the compassion needed to support others who are suffering. In this way, yoga aligns with the concept of post-traumatic growth - the need to find meaning in our suffering and strength in the face of trauma (Calhoun & Tedeschi, 2014).

**Yoga and Trauma**

Trauma exposure can dysregulate breathing patterns. Recent studies support the use of yoga as a tool to help participants improve emotional self-regulation through a combination of body proprioception, awareness of breathing, body movement, yoga postures, meditation and yoga philosophy (Mocanu, Mohr, Pouyan, Thuillard, & Dan-Glauser, 2018; Van der Kolk, 2014; Gard, Noggle, Park, Vago, & Wilson, 2014; Prathikanti et al., 2017; Patel, Nivethitha, & Mooventhavan, 2018). There is growing interest among psychotherapists about the use of yoga and the incorporation of body movement, breathing exercises, and meditation in helping trauma survivors find relief from suffering (Mocanu et al., 2018). Yoga breathing exercises were used as a part of a 9/11 trauma relief program. These exercises resulted in reduced anxiety, depression, and PTSD symptoms (Gerbarg & Brown, 2005).
Program Description

This specific proposal is for a program developed for women survivors of sexual violence. The range of traumatic experiences and injuries is vast, and what constitutes a trauma for one person is not the same for another. A commonality in many trauma experiences is that it leaves a person battling for their sense of integrated self, suffering from a fear of annihilation, helplessness and loss of control (Herman, 2015; Courtois, 2014).

One of the most prolific causes of trauma for women in America is sexual assault and domestic violence (Herman, 2015). According to the National Sexual Violence Resource Center, 91% of victims of rape are women and 1-in-5 women will be raped at some point in their lifetime. The FBI’s annual crime report from 2017 shows a 20% increase in the number of rapes since 2013. Sexual violence against women is increasing. This program has been designed with the specific needs of women victims of trauma in mind.

For women survivors of sexual assault, their traumatic experience can lead to heightened levels of distress and a broad range of symptoms including: depression, general anxiety, hyperarousal, interpersonal sensitivity, dissociation, anger, suicidality, addictive and/or risky behaviors, substance use disorders, troubled relationships, feelings of worthlessness, despair and repeated victimization (Bloom, 2013; Caplan, 2018; Courtois, 2014; Herman, 2015)

This intervention is organized into ten weekly sessions. Each session takes place for 75 minutes. Groups would include six women experiencing trauma symptoms. Participants will be recruited by mental health clinicians and mental health outpatient clinics. The classes are structured to incorporate yoga breathing exercises, visualization techniques, meditation, sensory and body awareness, motion, balance and physical postures. Clients will be invited to notice their
experiences in the present moment and share verbally in group or non-verbally by journaling at the end of each session.

**Intervention Principles**

1. **Safety**

   In accordance with the best practices for trauma-informed therapeutic treatment as put forth by The Sanctuary Model, the very first concept is safety and how to feel safe in the studio (Bloom, 2013). Instruction will be given on safe use of the yoga silks, including benefits and limitations, so that participants will learn how to use the yoga silk for support. Clients control their own use of the silks and the pace of their practice. One goal is to help clients feel more stable in poses that might otherwise be challenging in a regular yoga class.

2. **Integration**

   Based in gentle movement and breathing exercises, aerial yoga fosters an awareness and connection of mind and body. Under the facilitator’s instruction, clients are guided to pay attention to feedback from their body. What they notice is important. The client is in control of using the yoga silk, pushing further into a stretch or pulling back, or holding a position or inviting movement. The aerial yoga silk helps clients begin to build trust and a more attuned relationship with their body, taking their own needs into account.

3. **Boundaries**

   The yoga silks provide clients with a unique opportunity to test boundaries and explore freedom. Clients can create a soft and supportive cocoon to draw themselves inward and create a protective physical space. In contrast, clients can use the silks to foster openness, perhaps tapping into their inner child while flying/swinging. The silks enable a supported variation of inversion – quite literally taking an upside-down view of the world and themselves. The yoga
silks provide an invitation to experience exhilaration, excitement, joy, protection and motion in
the body at the pace determined by the client.

4. **Touch**

The fabric of the yoga silks prompts an exploration of touch and the feeling of being held in
active support. This can be challenging for clients, and the use of the silks is determined by the
client’s comfort level and individual goals. The yoga silks can be shaken wildly to symbolize
erratic emotions, rushing water or a hurricane. The silks can be used to wrap around the body
and can be pushed away or pulled closer. Clients are invited to notice the sensation of the fabric
against their body and explore thoughts and emotions to facilitate a process towards healing.

5. **Conflict**

Aerial yoga embraces the inherent challenges in facing painful experiences. With gentle and firm
support, and using mindful breathing techniques and body awareness, clients will explore the
conflict in their bodies, minds, and hearts in challenging poses. Staying in a position and learning
to breathe into the challenging pose may help a client non-verbally process a block or trauma in
the body.

**Class Structure**

Each class will include:

- Standing poses
- Supported stretching
- Breathing techniques
- Visualizations
- Verbal and/or non-verbal processing of experience
- Social bonding
**Evaluation**

It will be important to evaluate the progress achieved after each class and the effectiveness of the intervention over time. Assessments will be completed by clients after every class to monitor each client’s experience and gauge the therapist’s empathy and attunement to the client’s needs in class.

**Concepts and Practices for Sustained Benefits**

The long-term impact of this program will be felt by the participants when they apply the knowledge, skills and strategies learned through the program and incorporate practices such as yoga breathing, body proprioception and sensory awareness into their everyday life.

In any therapeutic relationship, it is essential to meet a person where they are. Unquestionably, this is especially important when working with survivors of trauma. Yoga can be intimidating for people who see glossy pictures of yogis in generally impossible poses. Aerial yoga supports every body shape and size. In a group setting, aerial yoga offers a more intimate and personal experience between a client and their yoga silk. The client is less exposed than they might be in a regular yoga class. The use of the yoga silk can provide a cocoon for meditation and a very real sense of being held. The silk can simulate the rocking that a baby may have felt in the womb and reintroduce the opportunity for clients to form attachments with their inner child for self-nurturing, self-protection, and healing.

Yoga silks provide the flexibility to meet a client’s needs in the moment. The concepts learned in the program can be transferred to the client’s living environment through increased awareness of the body’s response to stimuli and the client’s inner ability to modulate emotional reactivity. Aerial yoga can empower trauma survivors to embrace and trust their own bodies and believe in the power of their inner resilience.
References


https://doi.org/10.4324/9781315742908-8


Herman, J. (2015). Trauma and recovery: the aftermath of violence - from domestic abuse to political terror. New York: Basic Books.


National Sexual Violence Resource Center:


The site considered for this trauma intervention is a small alternative progressive school for adolescents in grades seven through twelve. The school’s total enrollment is approximately 100 students with class sizes averaging between seven and fifteen. The school has an advisory program, wherein full-time teachers act as advisors to small groups of students. Each student is assigned to an advisory group upon entering the school and will remain with this group throughout the duration of their education. Advisories meet as a group twice daily for 25 minutes and work to create and meet students’ academic and personal goals.

The school embraces neurodiversity. Thirty percent of students are on the autism spectrum and have specific learning and emotional needs. Secondary school settings can be especially challenging for students with autism because of the complexity of the environment, socially and academically. Students may struggle in learning the different expectations and rules for each class, organizing papers, following directions, and understanding assignments. Students on the autism spectrum have unique learning styles; they are visual learners, so they need the opportunity to see information in order to interpret meaning. They tend to be literal learners, so they need expectations, instructions, and feedback to be explicitly stated.
Additionally, students on the spectrum tend to need consistency, structure, and predictability in their schedule and environment.

**Trauma Perspective in the Progressive Educational Setting**

Students in the alternative school setting often struggle with persistent behavioral, emotional, or mental health challenges that put them at higher risk for interpersonal conflict, substance abuse, or suicidality, among other risk behaviors. Due to the ongoing development of the brain’s prefrontal cortex during adolescence, teenagers approach risk behaviors without a fully developed capacity for impulse control or connecting choices with consequences (Haen & Weil, 2010, p. 40-41). These behaviors are challenging for school faculty and staff to address, and students have been known to end up in crisis situations, inpatient hospitalizations, or rehab programs that take them out of school for weeks to months at a time.

Students might have experiences of rejection, isolation, alienation, or failure in more traditional school settings. Traditional school settings may not accommodate or properly respond to students’ complex needs. Institutional trauma in the education system largely impacts children and adolescents with a higher degree of intellectual or emotional need. For some students, school could be a welcome window of time during which they are free from their parents’ supervision, but for others, it could be an environment that stimulates toxic stress, emotional dysregulation, or feelings of shame or guilt.

Many trauma survivors have difficulty organizing, integrating, and processing their traumatic experiences. The brain’s amygdala (housed within the limbic system) is also more likely to encode negative memories than positive ones during adolescence, which can lead to depressive symptoms and feelings of worthlessness. The limbic system takes over during a traumatic incident and limits the reasoning and organizational capacities of the frontal cortex.
During traumatic events, the brain’s corpus callosum shuts down and cuts communication between the experiential (right hemisphere) and the verbal (left hemisphere) (Haen & Weil, 2010, p. 40-41).

Eighty percent or more of United States citizens have experienced trauma, many during the critical developmental periods of childhood and adolescence (Courtois, 2014, p. 7). Courtois (2014) explains that the effects of trauma are influenced by multiple complex factors, including the individual’s reactions in the moment of the trauma, how their physiology was impacted or disrupted by the trauma, their ability to tolerate or make sense of the experience and the amount or quality of support they receive from family and friends following the trauma (p. 6). Behavioral and emotional challenges during adolescence can stem from traumatic experiences, including experiences of interpersonal trauma, attachment trauma, identity trauma, secondary trauma, and adverse childhood experiences (Courtois, 2014). Adolescents’ health is strongly affected by social factors related to personal qualities, family functioning, and community systems. The student body in this setting is somewhat diverse socio-economically and racially, however, these elements of difference, considering the affluent location of the school and the small number of students on scholarships, can lead lower-income students or students of color to feel alienated among their peers.

Advocating for trauma-informed approaches in group work with adolescents can support and limit risk behaviors among students who suffer with post-traumatic symptoms and relational challenges. Experiential therapies, particularly expressive arts therapies, allow adolescents to be their full, embodied selves with one another and with instructors. Expressive arts “offer a conduit and container for the expression of affect in group therapy,” which support the larger goal of developing resilience in adolescents (Haen & Weil, 2010, p. 38).
Rationale: Theatre of the Oppressed with Adolescents

Hands-on and experiential learning are hallmarks of progressive education. This school’s mission is to produce “self-aware, empathetic, lifelong learners who possess an appreciation for diverse perspectives, their role in society, and their ability to act as agents of change.” The school curriculum emphasizes values of embracing and supporting diversity, equity, inclusion, and social justice. Their commitment to social justice hinges on the belief that it is the whole community’s responsibility to do all they can to eliminate bias and advocate for equity, inclusion, and acceptance of all people with varying identities including (but not limited to) race, ethnicity, religion, gender, gender identity, sexual orientation, socio-economic status, age, national origin, and ability.

The proposed Theatre of the Oppressed (TO) intervention described below is designed for early-to-late adolescents, aged 12-19, with special attention paid to teenagers on the autism spectrum, as well as those who have behavioral or emotional challenges that affect their wellbeing. The goal of the practice is to build self-awareness, mutual awareness, trust, and mutual respect through a series of movement-based, verbal and non-verbal, and interactive exercises that explore the dynamics of power, diversity, equity, and inclusion.

Theatre of the Oppressed: Expressive Therapy in Action

TO was founded during a period of political upheaval and military dictatorship in 1960s Brazil by theater practitioner and chemist Augusto Boal. It was created to resist governmental oppression and corruption during a time when performing or studying theater was outlawed. Inspired by Paolo Friere’s seminal work, *Pedagogy of the Oppressed*, which rejects “traditional” Western education’s “banking model” of filling empty vessels (a.k.a. students) with knowledge,
Theatre of the Oppressed focuses on building critical consciousness among students, educators, and society.

What does oppression look like? As a brief warm-up, a facilitator invites a group of participants to show, silently, with their bodies, what they think of when they hear the word “oppressed.” Some participants’ heads may go down. Some hands go up in the air or clasp behind their heads. Some turn their backs, and some double over themselves. In the context of the United States, oppression often means trauma, victimhood, and powerlessness. The oppressed are those individuals or groups who are socially, culturally, politically, economically, racially, sexually, or in any other way mistreated or silenced. In Theatre of the Oppressed (TO), oppression means recognizing the things in life that are not the way we want them to be. TO offers instructors and students the means to identify difficult events and dynamics with the goal of expressively recreating the world the way they want it to be.

There is no wrong or right way to do anything in Theatre of the Oppressed. There is no right or wrong way to participate. In group settings, students can participate by jumping into the center of the room, engaging in physical gestures, or sitting back and breathing. However each person chooses to participate is just fine. In an individual setting, consent is important. There must also be strong rapport between instructors and students in order to move into this work, considering the potential for dynamics of power or powerlessness to be triggering for trauma survivors.

**TO Principles in Working Toward Trauma Healing**

Theatre of the Oppressed is a practice of creating sustainable, caring communities. It is also a tool for improving communication, collaboration, and group environment. Embodied group practice is supported by a relational model of psychological development. Judith Herman
(2015) identifies social disconnection as a primary source of human suffering that can be healed through “engagement in growth-enhancing relationships” (p. 47). Herman (2015) argues that being in connection with others is “intrinsically satisfying,” and provides a sense of meaning, wellbeing, and worth that keeps us striving for connection (p. 55). Thoughtful preparation and engagement with TO practice can help students with autism maximize their potential and make valuable contributions to activities and discussions in and out of the classroom.

Theatre of the Oppressed is a collaborative, shared process between a facilitator and a group/individual. While many TO exercises involve physical touch, when taking a trauma-informed approach to this practice, it is important to request verbal consent as it relates back to touch. Each TO session must involve creating or reviewing community agreements and valuing student participation in setting community expectations. Students are encouraged to go at their own pace and participate to the extent of their own comfort. In this way, the TO facilitator recognizes the challenges of living with trauma and its symptoms and encourages post-traumatic growth. While post-traumatic growth looks different for every individual, TO invites many different forms of verbal and nonverbal expressions of emotion that can help trauma survivors to achieve integration. The post-traumatic healing process depends on building emotional expression skills. Practicing TO with a trained facilitator can help to process and recover from intense emotions.

**Strengths and Limitations of the TO Intervention**

There are many benefits to integrating embodied art practices into behavioral health treatment, particularly as a means to prevent interpersonal conflict, suicide, and substance use. Theatre of the Oppressed has the potential to be a trauma-informed practice for group work with
adolescents who struggle with fragmentation, dissociation, associative absorption, and allostatic load.

Creative arts groups can be particularly effective with adolescents, especially as they navigate the challenges of separating from their caregivers while struggling to develop trusting friendships (Haen & Weil, 2010). TO, which is related to drama therapy, can foster integration in trauma-affected adolescents through self-expression and emotional processing. There are also limitations to the intervention. The effectiveness of Theatre of the Oppressed practice is largely dependent upon the confidence and flexibility of the facilitator. The instructions for exercise are minimal and straightforward. They are, therefore, easy to learn and to implement. It is important, however, to read the room and think carefully about how to sequence exercises, depending on the response from the group.

At the progressive school, “the hidden curriculum” refers to the unwritten rules and codes of social interaction that most people generally know, which becomes increasingly important as students reach middle and high school. These rules are especially challenging for students with autism to grasp because they are not explicitly discussed. Students with this diagnosis may not know how to behave or engage with others in various social contexts. Some elements of TO might be challenging, especially the nonverbal exercises.

A major understanding in TO practice is that every human is capable of seeing the situation and seeing themselves in the situation. For trauma-affected students who are strongly dissociated or fragmented in their sense of self, this might not be a fair assumption to make. Perhaps this can be achieved further down the line in treatment, once the individual’s self-concept has had space and time for repair.
References


Herman, J. (2015). *Trauma and recovery: the aftermath of violence- from domestic abuse to political terror*. New York: Basic Books.
The Pizza Box as a Window to the Soul

Elizabeth Tankel

Introduction

Clients in partial hospitalization programs (PHPs) and residential drug treatment programs attend psychoeducational programming or therapeutic activities for six hours per day. All forms of psycho-ed and therapy complement each other to create a supportive program for personal growth. Art therapy can be part of this comprehensive treatment and support program. Baker (2018) describes the many ways in which art therapy can benefit clients. Art making is soothing and reduces hyper arousal. It is a non-verbal expression of feelings and traumatic events that might be impossible to put into words. It provides a “product” to contain traumatic material and lends the artist a sense of control and distance from traumatic events. The symbolic nature of the activity and product make recall of trauma tolerable. Art making activates parts of the brain that are associated with processing traumatic material. Art making is also fun! It is a pleasurable activity that reduces stress, increases creative engagement, can increase self-esteem, and produces something that can be shared with others.

Teglbjaerg (2011) studied schizophrenic clients and agrees that art-making raises self-esteem. He adds that the biggest benefit is developing a sense of self, which measurably reduces tension from both intrapersonal and interpersonal relationships. Clients who participated in his study developed greater social competence and confidence. Art making in a group setting
increased the cohesion of the group and allowed greater understanding and appreciation of group dynamics. The clients in his study reported that they felt stronger in themselves; they felt more self-confident, and more responsible. They also experienced increased self-understanding and had a noticeable reduction in paranoid symptoms. Teglbjaerg (2011) states that making art allowed clients to better understand their personality styles, which was especially helpful for clients who lacked proficiency in verbal communication.

The results of Teglbjaerg’s 2011 study and intervention were durable. At the one year follow-up, participants continued to report positive outcomes. The most consistently reported result was regarding the clients’ understanding of themselves. Clients felt more competent in relationships, their paranoia decreased, and they were more competent in the skills of daily living. One client said that, through art therapy, they “became a person.”

Nadler (2015) discusses an added benefit of art therapy: it distances the therapist from the client in constructive ways. The non-verbal nature of art-making provides the client with an alternative means of communicating internalized trauma, especially pre-verbal trauma. He states that clients can act-out toward the therapist when they do not possess language that can adequately convey their experience. Art-making accesses non-verbal parts of the brain that are often overwhelmed by linguistic function. Art-making is another way to create and preserve a trauma narrative in its preverbal/nonverbal state.

Durrani (2014) conducted an art therapy intervention with non-verbal children on the autism spectrum. The intervention took place over the course of one year. Durrani (2014) noted significant sensory modulation and an improvement in self-regulation. This lowered the client’s anxiety levels, paving the way for increased attachment to the therapist and the parent. Durrani (2014) hypothesized that this improvement in social functioning would lay the groundwork for
this client’s interpersonal relationships going forward. Durrani (2014) explains that children with sensory dysfunction often block sensory input from the environment as a preemptive defense against unpleasant sensations. Art-making creates sensations that can be controlled by the client. Through these sensations, the client can improve modulation and self-regulation, increasing their capacity for tolerating stimulation in many areas of life.

**Project Goals**

- To provide a forum for self-expression and self-exploration for traumatized clients
- To create a visual record of transformation through the therapeutic process
- To create a platform for discussion about progress and change
- To facilitate integration of current self, public self, and future self
- To access parts of the brain where non-verbal and pre-verbal trauma reside and to process that trauma
- To increase a sense of self
- To create a non-verbal narrative

**Target Population**

- This project is designed for adolescents and adults who are participating in a drug rehabilitation partial hospitalization program (PHP), which is generally five weeks in duration
- It can be used by any population who can use scissors, glue sticks, markers, and crayons

**Materials**

- Clean, unused pizza boxes. These could be donated from local restaurants or obtained from [https://www.webrestaurantstore.com/14-x-14-x-1-3-4-white-corrugated-plain-pizza-bakery-box-bundle/245CB14%20%20%20%20%20WHITE.html](https://www.webrestaurantstore.com/14-x-14-x-1-3-4-white-corrugated-plain-pizza-bakery-box-bundle/245CB14%20%20%20%20%20WHITE.html) and cost $0.30/box
• Crayons and pens
• Discarded magazines and catalogs
• Bling and embellishments from a dollar store or arts and crafts supplier
• A digital camera or cell phone
• Glue sticks and/or hot glue gun
• Scissors
• Large table or work space for participants

**Length of Project**

• One-and-a-half-hour sessions provided on a weekly basis. These weekly sessions would take place for a five week span.

**Daily Schedule of Project Session**

• The therapist will provide the clients with a clean work space and material for the project.

• When the clients gather, the therapist will ask them to view the pizza box as three canvasses for the following content: (1) the outside is how the world sees you; (2) the inside bottom is how you see yourself right now, and (3) the inside top is how you see your best self in the future.

• Clients will have 45 minutes to work on their boxes.

• The remaining 45 minutes will be in a group session to discuss how each person feels the world sees them, how they see themselves, and the ways in which they hope to be transformed.

• Clients will help to put away all materials, and the therapist will make sure that the room is clean.
• The therapist will photograph each project to create a photographic record of change for each client. This photographic record will be shared in an individual session with each client and discussed as part of an exploration of change.

Curriculum

Week One

An exploration of how we feel right now and who we are.

• The therapist will ask clients to consider the blank surface of the inner, bottom part of the box. Who are we? What do we like? What challenges do we face? What resources do we possess? What are our best coping strategies? On whom do we count? What is our best quality? What is our greatest source of enjoyment? What is the most destructive force in our lives? What is our greatest sadness? In the group session we will explore all of these questions for each client.

Week Two

An exploration of how the world sees us.

• Consider the outer surfaces of the box. How do people perceive us? What do we want the world to know about us? Do we think we are perfect? Flawed? Strong? Weak? Bold? Gregarious? Does our outside match our inside? What do I want the world to know about me? The group session will be an excellent forum to see if our perceptions of how the world views us matches up with reality. How does the group see us?

Week Three

An exploration of what we wish to be.

• If we could be anything, what would we be? What do we want to do? What is realistic? How will we make a plan that is workable? What kind of relationships do we want?
Occupations? Housing? In group, clients will share their dreams, hopes and fears for the future.

**Week Four**

*Review and change.*

- After 4 weeks of daily partial hospitalization treatment that lasts six hours per day, how have we changed? We can use this time to alter the record we have created. Do people see us differently? Treat us differently? Is our outside different than it was when we started? What about our insides? Our present selves? Have we discovered new resources, relationships, and strengths? Are we more (or less) resilient than we thought? What about our future selves? Do we want to amend our vision of our future to take into account what we have learned? The group session will include these topics plus the ways in which the group’s perception about each client has been altered.

**Week Five**

*Individual sessions.*

- Each client will meet individually with the therapist for an hour session. The boxes will be explored. The therapist will share the photographic record of the client’s box. The therapist will ask: How did this exercise help you? What changed for you over the course of your 5 weeks of PHP? Do you feel an integrated theme between the three surfaces: Who I am? Who do people think I am? Who do I want to be? Do these match?

**Strengths**

This a project that can be done anywhere with any population that can handle scissors and crayons. This project puts the control of the product on the client. There is ample flexibility for clients to create narratives that speak to their experiences.
Limitations

Use of scissors may not be appropriate with clients who engage in self-harm. This intervention can only be used for people with some amount of small motor control.

Conclusion

What I hope to see through this activity is the expression of a narrative that integrates all aspects of a client’s personal traits and their growth throughout the treatment process. I hope that this activity will create a heightened sense of self and understanding of theory challenges, strengths, and areas for future growth. I am hoping that somewhere in this activity, clients will uncover something positive in their lives upon which they and the therapist can build. Clients can use the images on the box to see where they are emotionally. Is there congruence between the three panels? Between two panels? Were there any surprises? Hopefully, this activity will have accessed emotions and memories that might be difficult to articulate in other ways. This activity should help give clients agency over their narratives. Clients may find satisfaction in creating a work of art that is a record of their inner landscape and their hopes for the future.

An additional benefit of the box is that it can be a file for activities and paperwork accumulated during the treatment program. Many times, clients have an activity in a counseling setting that resonates for them. Their lives are so chaotic at this time that they often misplace these activity sheets. The box would be a storage unit for these items. Plus, when the client takes the box home, they may feel comfortable sharing their perceptions of their current, future, and outside selves with family members and loved ones. The box can be revisited as needed.

References

doi:http://dx.doi.org.proxy.brynmawr.edu/10.1037/a0036974


doi:http://dx.doi.org.proxy.brynmawr.edu/10.1159/000325025
Arts-Based Therapy Group For Urban Youth

Rose Walsh

Introduction

Children everywhere experience traumatic events. Whether it is a one time occurrence or multiple events, these experiences affect them in drastic ways. Trauma physically, mentally, and emotionally destroys children, and sometimes they can never fully heal from it. The best thing they can do is learn how to cope. One mission of social workers is to help children process traumatic events and learn how to continue living--even if the trauma is still occurring. One way to do so is through arts-based interventions, which include drawing, painting, and collaging. Arts-based interventions allow children to use the nonverbal parts of their brain to process and express their feelings and emotions (Talwar, 2007). I am proposing an arts-based therapy group for urban youth in K-8 charter schools. I have experience working as a social work intern at an urban charter school and have witnessed firsthand the ineffectiveness of talk therapy with trauma-affected, urban youth. I believe an eight-week program that meets once a week will teach trauma-affected children new ways to understand and cope with their trauma.

Objectives of the Program

1. Support trauma-affected children as they process their trauma through a non-verbal medium.

2. Teach trauma-affected children ways to cope with stress through art.
3. Inform school staff about how trauma affects children and the importance of arts-based interventions.

**Trauma and Effects**

Trauma can be defined as “. . . any event or experience that is physically and/or psychologically overwhelming to the exposed individual” so much that it alters normal adaptations to life (Courtois, 2014; Herman, 2015). Traumatic events include physical/sexual abuse, experiencing/witnessing domestic violence, incarceration of a parent, living with a parent with a mental diagnosis, homelessness, and the death/loss of a loved one. Trauma can push children’s stress response system, or fight-or-flight, so much that it causes allostatic load (McEwen, 1998).

On top of that, trauma causes fragmentation in the brain, disconnecting the right, nonverbal part (which stores experiential/emotional aspects of experiences), and the left, verbal part (which translates experiences into language) (Fisher, 2017). Trauma-affected children experience even more disconnection between the right and left hemisphere, causing them to struggle even more with communication and comprehension of events (Fisher, 2017; Bremner, 2006). They are unable to put into words what happened to them since they only remember bits and pieces of the events. They may be triggered by certain things without understanding why or what triggered them. Sensory objects, such as sounds, feelings, smells, or even tastes, can trigger a hidden memory within the child and they become hyper-aroused (Talwar, 2007). However, it is hard for the children to know exactly why they are being triggered because the memory is hidden (Talwar, 2007). Children, especially young children, already have difficulty engaging in abstract thinking and understanding, but it is even worse when they have experienced traumatic events (Desmond, Kindsvatter, Stahl, & Smith, 2015).
Children may also engage in externalizing behaviors. The inability to communicate and understand what has happened to them leads children to resort to screaming, kicking, throwing things, and depressed and/or anxious symptoms. One of my clients at the urban charter school was diagnosed as selectively mute, but the social workers understood that it was due to multiple years of sexual and physical abuse.

Not only does trauma destroy certain systems in the body, but trauma also destroys a child’s self esteem and self worth. They feel broken and worthless. They tend to distrust people, especially adults, and have a hard time forming relationships. They may have issues concentrating and completing work, exhibit lack of emotional control, withdraw from social interaction, and have difficulties with peer or adult relationships (Desmond et al., 2015). All of these signs and symptoms can inhibit the child’s academic success. Social workers need to help trauma-affected children process their story using a medium that allows their speechless terror to come to life and also help them cope.

**Arts-based Interventions**

Arts-based interventions allow trauma-affected children to use nonverbal parts of the brain to cope with and process their feelings and emotions. Talk therapy may not be a good outlet for trauma-affected children because they do not have full use of the left hemisphere of their brain, where verbal abilities and full details of specific events live (Desmond et al., 2015; Talwar, 2007; Fisher, 2017). Art, such as drawings, paintings, collages, “. . . can slip by the barrier of ordinary defenses and provide information that has been inaccessible to the [individual]” (Riley, 1999). Art pushes past the child’s built up wall due to trauma and allows the child to tell their story they way they want to (Riley, 1999). Creating art allows the child to access memories and process emotions the way they want to (Talwar, 2007). It is not threatening
or scary because the art is done by the child and interpreted by the child; it is their story and no
one can take that away from them, not even the perpetrators of the trauma (Riley, 1999).

Along with allowing children to process their emotions, arts-based interventions provide
them with a toolbox of coping mechanisms. Art is a different outlet for children when they are
triggered. Instead of throwing chairs, they can draw. Instead of completely withdrawing from
others, they can paint. It gives them a positive outlet for their emotions and feelings when they
cannot control them on their own. Also, it shows children that they can make something
beautiful out of nothing, proving to them that maybe one day they can be beautiful again.

Arts-based interventions have recently become relevant, especially since there is more
understanding of neurobiology. Because these interventions are up-and-coming, there is minimal
research done regarding their effectiveness. Taller (2007) created an art therapy trauma protocol
(ATTP) to assist her clients in accessing nonverbal, traumatic memories. There was no study
completed, but her clients claimed they were able to process speechless traumatic memories and
learn sensory awareness, allowing them to regulate their emotions (Talwar, 2007). Coholic, Eys,
& Lougheed (2011) investigated the effectiveness of a holistic arts-based group program (HAP)
for children in need. Despite the small sample size (n=21) they found that “. . . self-reported
emotional reactivity was reduced over the course of the intervention program” (Coholic, Eys, &
sample size (N=47). They found that the children’s scores on the Piers-Harris Children’s Self
Concept Scale improved. Ziff, Pierce, Johanson, & King (2015) found from teacher and student
self-reports that students built social and emotional expression skills following introduction of
the ArtBreak group intervention. Further studies need to be done to spread awareness of the
effectiveness and usefulness of arts-based interventions. Overall, using them in group therapy will allow trauma-affected children to process their emotions and learn new coping mechanisms.

**Importance of Group Therapy**

Incorporating arts-based interventions in a group setting will allow trauma-affected children to not feel alone (Riley, 1999). Also, participating in a group helps them with peer interactions and interpersonal skills while cooperatively working toward shared goals like learning coping mechanisms and processing feelings through art (Riley, 1999; Coholic & Eys, 2015). The purpose of the group is to participate in the activities together while also processing trauma on their own in their own way. The facilitator can explain the group by telling them the importance of arts-based interventions. It is important to allow the group members to create their own goals together. Group work is empowering and can contribute to resilience due to strength in numbers (Riley, 1999; Coholic & Eys, 2015).

**Population and Setting**

The population I am proposing the arts-based therapy group for are urban youth attending a charter school. There are three reasons why I chose this population:

1. Urban youth experience a wide variety of trauma, especially experiencing and witnessing domestic and community violence.
2. Charter school systems allow for flexibility in the services provided
3. Charter school systems and staff need to be more trauma-informed.

Urban areas house low-income, minority families that experience a wide variety of traumatic events and problems. Urban youth experience many traumatic events within the family, community, and school (Post et al., 2014; Breslau et al., 2004). When compared to rural youth, they are exposed to a higher rate of domestic and community violence, such as gangs,
gun violence, rape, and homicide (Post et al., 2014; Breslau, Wilcox Storr, Lucia & Anthony, 2004). Breslau et al. (2004) found that 82.5% of the 1,698 urban youth in their study experienced one or more traumatic events, the most frequent event being “learning about sudden unexpected death of a close friend/relative” due to homicide or murder (26.1%). In 2012 and 2013, researchers conducted an Adverse Child Experience (ACE) study to see if urban youth experience more ACEs than rural youth (Philadelphia ACE Project, 2019). It was found that “. . . seven in ten adults had experienced one ACE and two in five had experienced four or more” when they were a child living in an urban area (Philadelphia ACE Project, 2019). In the study conducted by Post et al. (2014), it was found that 81% of the 65 participants who lived in urban areas experienced two or more traumatic events. Urban youth experience a lot of traumatic events, and sometimes they do not have the services they need to learn to cope.

Many urban youth attend charter schools. Charter schools are publicly funded schools, run by nonprofit or for-profit entities. Charter schools are not connected to the traditional public school system, so they have the flexibility to create their own systems as long as they reach the performance targets written in their contracts. This flexibility allows charter schools to offer certain services to support their children. Some charter schools, such as the urban charter school I interned at, have one or two social workers that provide individual and group therapy sessions to children who exhibit externalizing behaviors.

Staff at some charter schools pride themselves on being trauma-informed, but sometimes they fall short because the school has to reach certain targets to stay open. Some charter schools follow the “no excuses” policy that focuses on “. . . extended instructional time, data-driven instruction, ongoing professional development, and a highly structured disciplinary system . . .” that create diligent worker-learners who follow strict directions (Golann, 2015). These systems
do not focus on the actual problems the students are facing outside of school. Instead, they focus on creating order and increasing test scores without focusing on the students’ day-to-day experiences at the school (Golann, 2015). I can attest that some staff may not understand the impact trauma has on children. Staff focuses a lot on talk therapy and social-emotional skills, but a traumatized child may not be able to fully comprehend and explain their feelings and emotions. The staff at charter schools should start leaning towards more nonverbal interventions, such as arts-based interventions, in order to help their trauma-affected children.

**Proposal and 8-Week Group Curriculum**

As stated earlier, I am proposing an arts-based therapy group for K-8 graders at an urban charter school. The group should be facilitated by the school counselor or social worker after undergoing a training about the effects of trauma, the purpose of arts-based interventions, and the proposed group curriculum. It is not necessary for the facilitator to be an art therapist as long as they attend the training. The group will meet once a week for eight weeks during school hours. The group will take place for 30-40 minutes. It should include 5-6 students who have experienced trauma. They should be referred to the facilitator by parents, school staff, and/or teachers. The students should be around the same age. Here are a few additional recommendations:

- Find a safe space to hold the group. It should be big enough for 5-6 students to sit down and also create.

- The group is confidential. Make sure to remind the students they cannot talk about what they talk about in group with anyone else.

- Make sure all the students in one group are able to work together. Groups are not for everyone.
• The group is a judgment free zone. No student can judge another student’s artwork or what they are saying.

• Allow students to contribute to the conversation. If they want to talk about their artwork, let them.

• On the first day, create rules that every student must follow: safety, respect, and confidentiality are three important ones.

• Remember that the artwork is not for the facilitator to interpret. Let the students create what they want and allow them to discover things on their own.

The following is a draft of the curriculum for the group. The facilitator is free to adjust the curriculum as needed. There are some suggestions for age groups, but the facilitator can use their judgment. Each week, the facilitator should start with a check-in, asking each student how they are feeling and if they would like to share anything. After that, the facilitator can start the week’s activity. The art should take up most of the time. The prompts are there to guide them, but if they stray, that is totally fine. They are allowed to create their story in any manner they want.

**Week 1: Introduction**

• Go around the circle saying name, grade, and favorite animal

• Talk about arts-based interventions

• Free art (Cohen et al., 1988; Talwar, 2007)
  
  ○ Lay out a variety of materials (colored pencils, markers, crayons, etc) on a table in the middle, and give each student a piece of paper. Tell them to draw whatever they want. The paper can be positioned in any direction, and they can use
whatever materials they want. They are free to get up from their seat and exchange materials.

○ The freedom of this activity allows for the students to see that this group is all about them. They get to choose how to tell their story. The freedom to choose their materials allows them to create their own artistic flow.

**Week 2: Me**

- Paint a picture of you.
  
  ○ Give each student a big piece of paper. Lay out painting materials in the middle. Allow the students to exchange materials as needed.
  
  ○ Let the students paint how they view themselves. There are no right or wrong answers.

**Week 3: Family**

- Paint a picture of your family.
  
  ○ Give each student a big piece of paper. Lay out painting materials in the middle. Allow the students to exchange materials as needed.
  
  ○ However they view their family is how they can paint them. Again, no right or wrong answers.

**Week 4: Relationships**

- Define negative vs. positive relationships.

- Draw a picture of your favorite person.
  
  ○ Give a piece of paper. Lay out colored pencils, markers, crayons, pencils, and pens.

**Week 5: Emotions**
What are emotions?

Give each student three big outlines of a person. Tell them to color in the body how much and where they feel happy (green), sad (blue), and angry (red) when they are at home, in class, and doing something they like to do (K-2)

Give each student three big pieces of paper. Draw what they think they look like when they’re happy, sad, and mad (3-8)

**Week 6: Impulsivity**

- Define impulse/impulsivity.
- Give each student a coloring page. Allow them to pick their choice of drawing material. Tell them to color the page as best as they can.
- Give each student a blank piece of paper. Tell them to scribble whatever they want.
- Ask them to compare their experience. Talk about impulse control.
- Take a picture of each student for next week’s activity.

**Week 7: Self esteem**

- Define self esteem collage:
  - Bring the pictures taken the previous week. Each student will glue pictures onto a big piece of paper. The photos should be in the middle of the paper. Bring in a bunch of magazines and newspapers. Allow the students to cut words, phrases, or pictures from the magazines that remind them of themselves. Let them glue them on the paper however they want.

**Week 8: Conclusion**

- Ask each student to name one thing they learned.
- Conduct an art project of your choice. Something fun.
Each week touches upon a topic that trauma-affected children should explore in their own way. The freedom of each activity allows them to interpret the prompt however they want. There are no right or wrong answers. It is important for the facilitator to remember to never interpret what the student is drawing. You do not want to take away opportunities from the students to make their own discoveries.

In addition to the eight week group, the facilitator should create opportunities for the school staff and administration to learn about trauma and arts-based interventions. They should hold a seminar to explain how trauma affects children and why arts-based interventions are effective.

**Limitations**

The eight-week arts-based therapy group is an excellent idea for urban youth at charter schools, but there may be some limitations that could inhibit implementation. Creating a training for the group facilitators could take a lot of time and effort. Also, some school counselors or social workers may not be willing to attend a training. They also might not be willing to facilitate a group because it can be hard and time consuming. Although charter school systems allow for flexibility, some schools may not be as willing to implement this program due to time limitations and academic work. They may believe that the group will take away from the children’s academics. The school also might not want to provide financial support for the materials. Also, implementing a seminar to talk about trauma and arts-based interventions may be hard for the facilitator because some school staff may not want to participate.

Although there are limitations, it is important to remember that urban youth struggle with trauma every day. Without effective interventions and coping mechanisms to help them heal, they are unable to focus on academics. They are more focused on surviving the trauma.
Conclusion

Trauma is everywhere. It affects children in drastic ways, inhibiting their academic, social, and emotional lives. In order to help children in schools, I am proposing an eight-week arts-based therapy group that focuses on letting students process their trauma and learning new coping mechanisms through various art activities. The interventions will not fully heal them, but it will allow children to grow and keep living. There are some limitations to implementing this program, but it is important to remember that children are struggling whether we see it or not. A social worker’s duty is to help these children the best way we can. A great place to start is with arts-based interventions. Healing from trauma is a process, but children have the opportunity to survive due to resilience and neuro-plasticity.

References


Herman, J. (2015). *Trauma and recovery: the aftermath of violence- from domestic abuse to political terror*. New York: Basic Books.


Choosing Family: A Multifaceted Trauma-Informed Intervention for Transgender Individuals Experiencing Homelessness

Karina Wiener

Introduction

It is well documented that transgender individuals “experience more frequent and more severe incidents of traumatic events throughout their life” than cisgender individuals, including sexual minority individuals who identify as cisgender (Burnes, Dexter, Richmond, Singh, & Cherrington, 2016, p. 75). Shipherd et al. (2011) interviewed 97 transgender people and found that only two had not been exposed to potentially traumatic events. All but a handful had experienced multiple traumatic events, and 42% believed the trauma to be related to their transgender status. Common traumatic experiences among transgender individuals include childhood sexual and physical abuse, social rejection, systemic discrimination, legal barriers, and other minority-based oppression (Burnes et al., 2016). In this paper, I will first examine the effects of rejection from the family of origin and consequent homelessness on the mental health of transgender individuals. I will then build on existing research of resiliency among transgender individuals to design “Choosing Family,” a multifaceted trauma-informed housing intervention to facilitate a safe space to engage in creative trauma healing.

Effects of Rejection
A 2015 online survey of over 27,000 transgender adults over the age of 18 found that half of the respondents who were “out” to their families had experienced some form of rejection from their family of origin, their spouse or partner, and/or their children because of their transgender identity (James et al., 2016). Rejection in this survey takes the form of “relationships ending, family violence, being kicked out of the house, not being allowed to wear clothes matching their gender identity, and being sent to a professional to stop them from being transgender” (James et al., 2016, p. 70). Those who had been rejected were twice as likely to experience homelessness, twice as likely to engage in sex work, and 16% more likely to have attempted suicide than those who had not been rejected.

**Homelessness**

Running away or being kicked out of the home because of one’s sexual orientation or gender identity is the most prevalent cause of homelessness among LGBT youth. While only 0.3% of the US population identifies as transgender, 4% of homeless youth identify as transgender, and 90% of transgender youth (age 12-18) experiencing homelessness have experienced family rejection based on sexual orientation or gender identity (Choi, Wilson, Shelton, & Gates, 2015). Although less than 1% of the US population is homeless, the National Center for Transgender Equality found that 30% of transgender adults have been homeless at some point in their lifetime, with 12% of them attributing their homelessness to antitransgender bias (James et al., 2016). Of those who experienced homelessness, only 10% sought shelter—many did not seek shelter because they feared being mistreated. This seems warranted, as 70% of transgender adults encountered a negative shelter experience based on their gender identity, whether that meant being forced out, forced to present as the wrong gender to avoid being forced out, verbally harassed, physically attacked, or sexually assaulted. Adult and youth shelters are
typically gendered, and transgender individuals are often forced to stay in shelters that align with their sex assigned at birth rather than their gender. Although transgender people gained protections in homeless services under the 2012 “Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity” or “Equal Access Rule,” those protections are at risk of being undermined by policies that would allow shelters to consider an individual’s sex in determining accommodation (Jan, 2019).

**Suicide**

In a recent study by the American Academy of Pediatrics, 14% of the 120,617 adolescents (age 11-19) of all genders surveyed had attempted suicide (Toomey, Syvertsen, & Shramko, 2018). Transgender male adolescents reported the highest rate (50.8%) followed by gender nonconforming adolescents (41.8%), transgender female adolescents (29.9%), adolescents questioning their gender identity (27.9%), female adolescents (17.6%), and male adolescents (9.8%), with increased risk for any group who did not identify as heterosexual. This trend carries into adulthood, in which 41% of transgender adults had attempted suicide as compared to 10-20% of lesbian, gay, and bisexual adults and only 4.6% of the overall US population (Haas, Rodgers, & Herman, 2014; James et al., 2016). Rates of suicide attempts were elevated (65%) among those “experiencing rejection, disruption, or abuse by family members or close friends because of antitransgender bias” (p. 12), but most elevated (69%) among those who “became homeless due to antitransgender bias” (Haas et al., 2014, p. 11).

**Theoretical Orientation**

Transgender individuals who have been rejected from their families and have experienced homelessness are most likely victims of complex trauma. Ford and Courtois (2009) define complex trauma as “extreme forms of traumatic stressors due to their nature and timing.
In addition to being life-threatening, physically violating, terrifying, or horrifying, these experiences are typically chronic rather than one-timed or limited, and they compromise the individual’s personality development and basic trust in primary relationships” (p. 13). While it is important to keep in mind that not all transgender individuals attribute their trauma to their transgender identity and could attribute it to other intersectional identities or impersonal causes, the likelihood that they have experienced trauma is extremely high and needs to be addressed in all areas of treatment. The following sections present the theoretical and research-informed basis for the “Choosing Family” intervention.

**Language**

For transgender survivors whose physical and emotional safety is violated on a daily basis, safety can begin to be established by “consistent and appropriate use of the name and pronoun with which each person identifies as well as gender-neutral bathrooms” (Mascis, 2011, p. 205). While research suggests that the practitioner ask the client for their preferred pronouns (Mascis, 2011; Weir & Piquette, 2018), I believe it is safer and more respectful for the provider to offer up their own pronouns upon introduction. This invites the client to do the same when they are ready, but does not pressure them if they are not. Additionally, asking for one’s “preferred” pronoun implies that their gender is a choice rather than a part of their true identity. I would introduce my name and pronouns. If the client does not provide pronouns in response, staff can refer to them using the gender neutral “they/them”. However, they/them pronouns should not be used if the client does provide alternative pronouns. Pronouns used by the client should be mirrored by all staff and clinicians.
The Therapeutic Relationship

Establishing safety in the therapeutic relationship is an important step in creating a space in which the trauma survivor can work to regain the ability to trust others. Therapists should be trained in principles of cultural competence and cultural humility as it relates to transgender individuals. Additionally, Mascis (2011) insightfully notes the physical power imbalance between transgender clients and care providers in that transgender people have “historically been required to establish themselves as stable and deserving in order to gain access to care” even if that means putting oneself in a vulnerable and risky position (p. 205). This power imbalance needs to be immediately and explicitly dismantled by the provider through clear explanation that access to treatment is unconditional.

Trauma-Informed TransAffirmative Care

Much of the research on supporting transgender individuals speaks of the importance of employing “transgender-affirmative counseling” (Singh, Hays, & Watson, 2011), “transaffirmative practices” (Schnebelt, 2015), or having a “transpositive therapeutic stance” which “positively values, affirms, supports, encourages and empowers transgender clients” (Richmond, Burnes, & Caroll, 2012). This conceptualization is very similar to the principles of Trauma-Informed-Care (TIC) which Courtois (2014) describes as an approach to treatment that recognizes that most people have experienced trauma. This approach advocates that providers approach clients “from a position of respect for them as individuals—for their survivor skills, adaptations, personal strengths, and resilience—incorporating a problem solving and skill building approach that emphasizes client control and empowerment” (Courtois, 2014, p. 78). Some steps that a shelter could take in implementing transpositive TIC would be providing gender-neutral or transgender-specific materials and forms, hiring transgender employees, and
encouraging peer leadership to provide role models and opportunities for growth (Weir & Piquette, 2018).

Resiliency

Resiliency is defined by Luthar & Cicchetti (2000) as one’s capacity to cope with adversity. In order to be trauma-informed and transpositive, we need to understand the resiliency our clients already possess. In addition to skill building, resiliency can be used to “disrupt both societal and internalized transphobia, despite the pervasive discrimination” transgender clients will continue to face in their daily realities (Singh et al., 2011, p. 25). A study by Grossman et al. (2011) found that higher self-esteem, increased sense of personal mastery, and greater perceived social support predicted positive mental health outcomes among transgender youth. Similarly, common themes in a qualitative study by Singh et al. (2011) in which transgender individuals were asked to describe the meaning of their lived experiences of resilience, were “(a) evolving a self-generated definition of self, (b) embracing self-worth, (c) awareness of oppression, (d) connection with a supportive community, and (e) cultivating hope for the future” (p. 23).

Community

Research shows that transgender youth who have familial support have better mental health outcomes than their peers who do not (Ehrensaft, 2012), and that people experiencing oppression benefit from positive relationships with their community (Mascis, 2011). Underrepresentation of transgender identities in mainstream culture can lead to internalized oppression and distorted views of reality. Being a part of a community of transgendered individuals is important for building a sense of self and belonging that strengthens the resilience needed to combat internalized oppression and improve reality testing. Community is an important source of safety “which can allow an individual to modify defensive and avoidant
coping strategies into ones that provide a sense of control over emotional and cognitive processes, which ultimately decreases self-directed violence. Such a process undermines the learned strategies from childhood/adolescence, which once were adaptive, but are no longer needed when safety and stability are present” (Bess & Stabb, 2009, p. 81). Identifying shared experiences within a community can help address feelings of isolation and fear and can also be a setting for individuals to help one another manage difficult relationships outside of the community (Bess & Stabb, 2009).

**True Gender Self Therapy**

Individuals who have experienced complex trauma typically present with a fragmented sense of identity. This is especially true for transgender individuals who have lived some or most of their lives as a gender that they do not identify with. Ehrensaft (2012) proposes the “true gender self model” (p. 339) that is based off of Winnicott’s conception of the true/false self dichotomy. Winnicott identifies the true self as “the authentic core of one’s personality,” in contrast to the false self which is the “part of the personality that accommodates to the demands of outer reality and functions to shield the true self from annihilation” (Ehrensaft, 2012, p. 340). Ehrensaft maps these principles onto gender to describe a true/false gender self. In this theory, the false gender self plays a very important role in protecting the survival of the true gender self. Therefore, the goal of true gender self therapy is to build resilience and explore one’s authentic gender identity. Simultaneously, the false gender self is brought into conscious control to protect the true gender self as a result of social constraints. There is a focus on ego-building and externalization that is consistent with Mascis’ (2012) approach to recreating a client’s narrative. The narrative is built from the context of oppression and transphobia as it exists in the external world, rather than a problem that exists within the client.
Fisher’s (2017) conceptualization of fragmentation is similar to that of Ehrensaft in that she recognizes its adaptive quality and the role that disowned parts of the self can play in survival. Fisher proposes that traumatized individuals can work towards integrating their fragmented parts by giving “meaning and dignity” (p. 26) to each part. She calls for reclaiming the parts of ourselves that we have disowned, “extending to them a helping hand, welcoming them ‘home’ at long last, creating safety for them, and making them feel wanted, needed, and valued” (Fisher, 2017, p. 21).

**Creativity**

Traumatic experiences trigger the limbic system’s fight, flight, or freeze response and simultaneously “inhibit cortical activity, including inhibition of expressive language centers in the left brain” (Fisher, 2017, p. 51). When trying to recall traumatic events, this part of the brain is still cut off, and clients are unable to express intense emotions verbally or sequentially. This leaves subjects in what Harris (2009) describes as a state of speechless terror. While most trauma theory agrees that recreating one’s trauma narrative is an integral part of regaining a sense of control, trust in oneself, a sense of self and reality, and eventually integration, it is often traumatizing or just not possible for survivors to verbalize their narrative. Creative methods can be used to access the trauma that cannot be accessed through language. Art allows clients to experiment with their public and private self-image and can support them towards self-actualization and integration (Schnebelt, 2015). Various forms of creative therapy have been shown to be successful in helping transgender individuals with self-expression and identity formation (Pelton-Sweet & Sherry, 2008).
**Intervention Inspiration**

The “Choosing Family” intervention is inspired by the television series *Pose* which depicts the underground queer ballroom culture of New York City in the 1980s. The show centers around LGBTQ adolescents and adults who have been rejected from their families of origin but join surrogate families or “Houses” within the queer community who may or may not live together. Typically, one or two people will take on leadership roles and designate themselves as “House Mother(s)” and/or “House Father(s),” while the rest of the residents identify as their “Children.” Houses operate as families, providing emotional and financial support for one another and creating their own house rules and expectations. House membership and structure is fluid. Houses compete against other Houses in regularly held underground “Balls.” Each member of the family has their own strength, whether that is vogueing (moving in a way that mimics the way models pose on a runway), dancing, sewing, or any other talents that contribute to the House’s overall presentation at the Ball. There is an emphasis on the ability to “pass” for straight or cis, and presentations are scored by a panel of judges on a scale of 1-10 where 6 is the minimum score. The Ball scene emerged as a safe space for queer people to gather as a community at a time when they were not welcome in any other spaces. “Choosing Family” is a multifaceted trauma-informed housing intervention for transgender individuals who are experiencing homelessness due to rejection from their family of origin. It adopts *Pose’s* depiction of queer ballroom culture as a model for facilitating a safe space for trauma healing.

**“Choosing Family” Intervention**

**The Ballroom**

The Ballroom would be a central meeting space where residential staff and counselor offices are located. In order to provide a level of physical and emotional safety for residents, staff
will introduce themselves with their name and pronoun and have that information openly displayed in their offices. Staff will immediately make residents aware of the gender-neutral bathrooms on site, of which there will be at least two single-occupancy options. Transgender, as well as lesbian, gay, and bisexual, identities will be heavily represented among staff members, and all staff will be trained in principles of cultural competency and humility as well as navigating trans-specific resources, especially those related to transition services. There will be at least one staff member on site at The Ballroom all times.

**Houses**

In addition to The Ballroom, there will be a series of residences (either individual houses or floors of an apartment building) where residents will live as Families. Similar to the Houses in *Pose*, members of a House will take on familial roles of House Mother, House Father, or Child and will adopt a collective last name that the House is also named after (for example: a client named Jessica residing in the House of Abundance would then refer to themself as Jessica Abundance). Families will create their own House Rules and Expectations and update them as necessary. Although residents will be placed into Houses, they are free to move between Families as they desire. House fluidity encourages agency and choice over one’s family and physical space and shifts one’s understanding of family from static to fluid.

Houses will engage in family therapy on a weekly basis. The role of this therapy is two-fold: first, it will serve as a safe space for conflict resolution, mediation, and any other processes that need to be included to ensure House members aren’t re-traumatizing one another or themselves. Second, House members will creatively examine their current roles within their chosen families and compare those to the roles that they or their parents held in their families of origin. Engaging in family therapy as a House allows for individuals to identify shared
experiences which serves to combat isolation while improving self-esteem and reality checking. Residents will be encouraged to recognize both strengths and weaknesses in their families of origin and strive to help one another in building on familial strengths in the House. This process will aid in trauma integration as residents will be able to give meaning and appreciation to their family of origin while embracing their new, chosen family. This path towards integration will simultaneously serve to counteract rejection experienced by residents’ families of origin.

**Balls**

In addition to weekly family therapy, Houses will congregate at The Ballroom for monthly Balls. As in *Pose*, Balls are opportunities for Houses to present themselves to other Houses and demonstrate their skills. Unlike the Balls in *Pose*, the goal of these Balls will not be to “pass,” but instead to embrace one’s authentic self, whatever that may mean to the individual. This provides individuals with the opportunity to demonstrate mastery of a skill, to feel pride and part of a group, to experience the visibility of their identity in the community, and to creatively explore one’s individuality in a safe group context.

**Creative True Gender Self Therapy**

Residents will engage in individual therapy with a counselor at The Ballroom on a weekly basis in order to work on building their trauma narratives. Building a safe, trauma-informed therapeutic relationship is of utmost importance. Once the relationship has been established, counselors will guide residents through an activity similar to what Pelton-Sweet & Sherry (2008) describe as “Inside Me, Outside Me” in which the client makes two representations of the self, using whatever creative medium they choose. However, this exercise will be called “True Gender Self, False Gender Self” in accordance with Ehrensaft’s (2012) theory of gender selves. Residents will be encouraged to focus on the strengths of both selves.
Next, residents will work with the therapist to create a gender narrative through self-portraiture, again using whatever creative medium they choose. The goal of this will be to re-define one’s narrative, working to externalize internalized feelings of guilt and shame, to strengthen one’s sense of self and identity, and to make meaning of the past and pave way for the future.

**Limitations**

One of the largest limitations in working with transgender individuals is the limited amount of data available, limiting the ability to implement research-informed practices. Much of the research on transgender identities is heavily lacking and often grouped together with sexual minorities. While this intervention is heavily research-informed, there is very little research specific to housing models or art interventions for transgender individuals.

Another possible limitation is the responsibility that this intervention puts on individuals to avoid re-traumatizing one another through family roles. Traumatized individuals have a high potential for passing traumatic behavior along to those around them, especially when they have not yet engaged in trauma treatment. The intense immersion of this intervention into a somewhat isolated environment runs the risk of flooding residents, as family situations can trigger prior trauma. An integral part of this intervention is to build the therapeutic relationship early on so that the individual has support within the system.

The biggest limitation to this specific intervention is funding; there is hardly any money available for transgender-specific housing, let alone interventions. Especially in our current political climate, efforts seem to be on erasing transgender identities rather than protecting and empowering them. Though resources may be more limited than ever, there is simultaneously a greater need than ever for this strengths-based intervention.
References


