The Arts in Psychotherapy 54 (2017) 128–135

Contents lists available at ScienceDirect

The Arts in Psychotherapy

Research Article

Creative arts in psychotherapy treatment protocol for children after trauma

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ARTICLE INFO

Article history:
Received 9 October 2016
Received in revised form 23 April 2017
Accepted 23 April 2017
Available online 6 May 2017

Keywords:
Child trauma
Creative arts therapy
Treatment protocol
PTSD
Group intervention

ABSTRACT

In this article we introduce a Creative Arts in Psychotherapy (CAP) treatment protocol for children who have been traumatized, aiming to enhance their psychological wellbeing and strengthening positive development. The protocol combines principles of group dynamics and multimodal arts activities in order to facilitate healing through the three stages of the trauma recovery model; creating a safe space, telling the trauma story, and preparing the children to return to the community. The programme takes place over a period of ten 90-minute sessions. The CAP therapeutic process is designed to be run in groups of six to eight participants in the age between 8 to 12 years. The described protocol aims to bring more uniformity in the management of child trauma in multicultural and under-resourced communities. It can be carried out by any qualified health care professional, where clients are seeking help and relief.

Introduction

Sibu[1] *is a 12-year old black South African boy, residing in Johannesburg, with his parents and two siblings in a two-room shack. Sibu's family is Christian and their home language is isiZulu. His parents are both unemployed and depend on a child support grant. Two years ago, when Sibu was 10 years old, he was sexually abused. One evening on his way home from soccer practise he was stopped by four strange men, tied up, taken into the park and raped. Soon after this event, Sibu reported excessive fear to walk on the street, and expressed feeling angry about what happened. His parents observed that he withdrew. After conclusion of a forensic assessment, Sibu was referred for therapy.*

There are children like Sibu all over the world who are exposed to traumatic experiences that leave them stressed, anxious, or worried. Some of them may develop disturbances afterwards, in particular posttraumatic stress disorder (PTSD). According to DSM-5, the core symptoms of PTSD include re-experiencing, avoidance, negative alterations in cognitions and mood, and trauma-related alterations in arousal and reactivity (APA, 2013). With appropriate support and help many children may also show a positive change as a result of the struggle with trauma, which can be reflected in a measure of posttraumatic growth (PTG; Tedeschi & Calhoun, 2004). PTG includes a greater appreciation and new possibilities for one's life, more meaningful interpersonal relationships, increased sense of personal strength and spiritual development (Tedeschi & Calhoun, 2004). Programs and approaches designed for treatment after trauma and enhancing positive development mostly focus on verbal disclosure, like cognitive behavioural therapy, through which behaviours, emotions and thought processes are challenged and transformed (Beck & Haigh, 2014). For some trauma victims, verbal disclosure works well, yet there are specific populations and age groups, such as young children and refugees who do not speak the same language as the therapist, where other means of expression may work more effectively because they incorporate non-verbal forms of processing that can avoid language barriers and may be more culturally sensitive and appropriate (Beauregard, 2014; Malchiodi, 2015; Quinlan, Schweitzer, Khawaja, & Griffin, 2016). There is a strong need for evidence-based treatment that demonstrates that non-verbal and embodied practices, such as

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http://dx.doi.org/10.1016/j.aip.2017.04.013
0197-4556/

those of the creative arts, can be successful in the treatment of trauma clients (Slayton, D'Archer, & Kaplan, 2010; Van Westrhenen & Fritz, 2014).

The Creative Arts in Psychotherapy (CAP) programme discussed in this paper was developed and implemented in South Africa, a country with extreme high rates of interpersonal violence and abuse. Interpersonal violence in South Africa is mentioned as the leading risk factor for injury related death, and exceeds four and a half times the global figures (Seedat, van Niekerk, Jewkes, Suffla & Ratele, 2009). Violence against children frequently takes place in the form of beatings, sexual violence including rape and also emotional violence and neglect (Seedat et al., 2009). South African figures on child sexual abuse are the highest worldwide, for both boys (60.9%) and girls (43.7%) (Pereda, Guilera, Forns & Gómez-Benito, 2009). Exposure to single traumatic events is common, but exposure to multiple traumas is even more frequently reported (Williams et al., 2007). Moreover, about 10 million children in South Africa are living in extreme poverty (Hall & Sambu, 2014), and are at increased risk of exposure to chronic physical neglect, domestic and community violence, abandonment, and alcoholic parents (Optimus Study, 2016). This type of chronic exposure to adversity may lead to insecure childhoods and developmental trauma, and complex emotional and behavioural problems as a result (Van der Kolk, 2005). Poverty and inequality are key contributors to the violent and insecure climate, but also the lack of prevention and intervention fuels the continuation of the intergenerational cycle of violence (Seedat et al., 2009). Psychological services for victims of violence, specifically for abused children, therefore need to be strengthened.

Mental health interventions in South Africa today are conducted by both traditional practitioners such as diviners, herbalists and faith healers, and professionals trained in Western health care services focusing on evidence based practices valued and in use in Western society (Campbell-Hall et al., 2010). Western oriented health care services in South Africa often fail to incorporate the cultural roots and traditions of the African population in therapy, and in combination with the poor public healthcare infrastructure in South Africa, this negatively effects the accessibility and effectiveness of trauma interventions. Creative arts practise, however, can incorporate cultural traditions such as dancing, storytelling, visual depiction, and music, and therefore may be an effective tool in psychotherapy (for instance Bandawe, 2005; Glaveanu, 2010; Harris, 2009).

Creative arts therapy is an umbrella term covering the creative modalities of visual art, dance, drama, creative writing and music. This form of therapy integrates art practices with principles of psychotherapy and counselling (Malchiodi, 2015). Creative treatments are supposed to help externalize thoughts in a safe space (Cassidy, Turnbull, & Gumley, 2014; Malchiodi, 2015), stimulate sensory processing of traumatic memories stored in the body (Harris, 2009; Ho, 2015; Koch, Kunz, Lykou & Cruz, 2014; Levine, 2010), provide a sense of containment for difficult feelings and emotions (Skeffington & Browne, 2014), and in this way offer the possibility of helping children to heal from the debilitating effects of abuse and violence (Malchiodi, 2015; Pretorius & Pfeifer, 2010). Additionally, creative activities may offer children opportunities and expressions through which they can explore alternative ways of responding to life experiences (Camic, 2008; Vermetten, Kleber, & Van der Hart, 2012, p. 582).

In this paper, we introduce a therapeutic process called the Creative Arts in Psychotherapy (CAP) treatment, and describe a protocol that incorporates creative arts methods for treating trauma in children, aimed at enhancing children's psychological wellbeing and strengthening positive development. The CAP treatment was developed by the authors in response to the need for a semi-structured, low-resource, and culturally sensitive programme that can be implemented in the underprivileged communities and poor areas of South Africa. Evaluation of the programme is still ongoing, therefore this paper mainly focuses on describing the treatment characteristics and therapeutic processes, and we present some initial responses in the form of a case example as well as quotations obtained from interviews with the social workers facilitating the programme.

Rationale for Creative Arts in Psychotherapy (CAP) treatment

To provide a rationale for using creative arts within psychotherapy for child trauma victims, we propose a combination of three processes that can help in the facilitation of an improved psychological wellbeing and the development of relevant coping skills. The processes used in CAP include the benefits of group dynamics, empowerment through arts, and following a sequential approach to treatment. These processes will be discussed further below.

Benefits of group dynamics

> *"If you find empathy from your fellow members, then you feel like a person once again."*

Many traumatic experiences involve interpersonal violence (e.g. rape, physical assault, domestic violence, emotional neglect, and torture) resulting in broken trust and suspicion towards relationships (Aspelmeier, Elliott, & Smith, 2007; Wright, Crawford, & Del Castillo, 2009). Group therapy can provide an opportunity to regain trust in others by modelling healthy relationship structures and rebuilding social techniques and connections (Betancourt et al., 2010; Herman, 1992; Killian & Brakarsh, 2004; Yalom & Leszcz, 2008). Traumatic experiences often result in feelings of alienation, loneliness and self-blame, and connecting with others within a safe space can help the children realize that they are not alone in their experiences and help reduce their sense of alienation (Gallo-Lopez, 2000; Killian & Brakarsh, 2004; Yalom & Leszcz, 2008). Moreover, perceived social support has been related to a better recovery process and thus could be a helpful focus during treatment (Cluver, Fincham, & Seedat, 2009).

Creative arts activities may enrich group interaction and group dynamics, as they serve as a medium of communication through which support and exchange between group members can be reinforced (Malchiodi, 1998). Dance/movement can be a particularly helpful way to address relational issues, because moving in a shared space and embodied self-expressions witnessed by others stimulate group interaction (e.g. Ho, 2015). For instance, mirroring activities (where one person or the entire group follow the spontaneous movements initiated by an individual) are used to establish a sense of connection and understanding between two people. In visual art (such as drawing and painting), representations of a situation or emotions can be projected onto a surface outside the person, and images can be used to communicate concepts or feelings that can then be shared with one another, even those one might not know too well (e.g. Skeffington & Browne, 2014). Music in group settings can provide an opportunity to enhance the ability to communicate and build relationships with others through simultaneous interaction, listening and paying attention to others (e.g. Bensimon, Amir & Wolf, 2008). Drama can offer a multisensory way to establish relationships by using both physical, kinaesthetic, auditory, and visual abilities of expression (e.g. Cassidy et al., 2014). For instance, through role play and mirroring a child can try out different roles and situations while playing at being someone else.

Empowerment through arts

"Kids can be healed more thoroughly if they have been given a platform to show their talents"

Traumatic stress reactions are responses to an overwhelming experience that can result in difficulties in verbal expression (Perry, 2009). Therefore, arts can be used as an adjunct in trauma therapy, facilitating the expression of emotions and experiences. The body provides a pre-reflexive way of communication and interaction with the world: "The senses are the vehicles through which our histories are recorded. Consequently, memory is not exclusively verbal, nor is it restricted to the domain of the brain." (Knill, Barba & Fuchs, 1995, p. 45). Although evidence is limited, a number of researchers hypothesized that during the traumatic event, activity decreases in the left hemisphere of the brain, where the language and declarative memory is located, thereby diminishing verbal processing of the way it is stored in the brain (Glaser, 2000; Harris, 2009; Klorer, 2005; Lanius et al., 2004). Alastair (2002) also found decreased activity in Broca's area in patients with PTSD, supporting the challenge of verbal expression after trauma. Siegel (2017) describes that trauma can impair integration of implicit memory, including perceptions, emotions and bodily sensations associated with the traumatic event, resulting in intrusion of those memories without experiencing it as something from the past. Integration into explicit memory is then an important part of resolving these memory intrusions, which can be achieved through for instance writing (Siegel, 2017) and drawing (Malchiodi, 2015). On a physiological level, Levine (2010) describes PTSD as a result of dysregulation of the 'flight or fight' response in the autonomic nervous system. In line with this theory, somatic, sensory and bodily expression and integration is needed for healing (see Lamers-Winkelman, 1997; Siegel, 2017; Van der Kolk, 2014).

The ability to act or have any sense of agency during a traumatic occurrence is exactly what is missing for trauma victims. This is emphasized in theoretical and conceptual perspectives stressing the need for control, mastery or self-efficacy (Bonanno, 2004; Kleber & Brom, 2003). By using arts in the therapeutic process, the opportunity is offered to the client to move out of the thinking mind, or stuck mode, into a realm where they can actually have an impact on what is happening, through the use of manipulable materials, by transforming an image into something else, or by employing symbolism as a kind of protective barrier against the actuality of what happened. Through physical activities such as dancing and drama, the child has an opportunity to re-orient and re-gain control over his or her own body, something that is especially important after sexual and physical abuse (Ho, 2015; Koch et al., 2014; Lamers-Winkelman, 1997). Incorporating physical activities relates to the way in which young children learn and communicate, using movement rather than language (Lamers-Winkelman, 1997). Although creative arts within psychotherapy do not avoid verbal expression, it helps verbalization through initial non-linguistic communication modes and sensory expression (Malchiodi, 2003). Where children seem unable to express certain aspects of their trauma verbally, these experiences can be explored through arts activities. The experience of being able to release and share this difficult material can be very empowering for a child. Each of the art disciplines works in its own particular way towards promoting awareness and growth. For instance, the creation of art can mediate reflection and personal exploration (Malchiodi, 2015; Skeffington & Browne, 2014), dance allows for experiencing emotions through physical expression (Ho, 2015; Koch et al., 2014), music can have a soothing capacity and reduce psychological stress (Jiang, Rickson & Jiang, 2016; Malchiodi, 2015), and drama offers control and choice, and establishes safety (Cassidy et al., 2014). Through the careful and sensitive selection of different artistic modalities, the therapeutic session can be shaped.

A sequential approach

"Overall I can say the children moved from the point of being a victim to survivors."

The general outline for the CAP treatment is based on the trauma treatment model that was formulated by Judith Herman (Herman, 1992; see also Mooren & Stöfsel, 2014), and inspired by the modification of this model proposed by Malchiodi (2015) for use in an art and play group therapy protocol for children from violent homes. The model includes three phases: 1) establishing safety, 2) the trauma story, and 3) restoration of internal connection between traumatized individuals and their communities.

The first phase of trauma treatment includes establishing safety and stabilisation. Feelings of safety are crucial after a traumatic event, when assumptions of safety are violated. If children are feeling insecure and unsafe in the group, the children will not be able to disclose what happened or express how they feel, and thus benefit from the therapeutic process. The second phase of treatment involves activities that encourage the children to share their traumatic experiences in order to make sense of what happened and obtain a degree of control over the experience. By sharing the story, the aim is that the children regain their ability to experience and enjoy life whilst containing their traumatic memories within a particular space. The third and final phase of the trauma recovery model includes restoration of the connection between traumatized individuals and their communities. It focuses on preparing the children to go back to their normal lives, using specific activities that help increase self-esteem and coping strategies, and to regard the traumatic experience as a chapter in their life's story. Although there is also criticism on the methodological limitations of studies supporting the need for phase-based treatment (De Jongh et al., 2016), it is regularly used in the treatment of patients with disorders caused by abuse and sexual violence and has been found effective among adult victims (Cloitre et al., 2010).

CAP treatment outline

The CAP treatment can be facilitated by any health care professional qualified to facilitate group therapy, and with an in-depth understanding of both traumatic stress and using creative arts in group therapy. The CAP treatment outline is presented below, and includes the target group, timing of the intervention, the therapeutic goals, the planning of the CAP treatment, and a description of all ten sessions.

Target group

This treatment is aimed for children in the age of 8 to 12 years who have experienced a traumatic event. Traumatic exposure may include sexual abuse or assault, physical abuse or assault, emotional abuse, neglect, serious accident, domestic violence, community violence, school violence, or interpersonal violence. Children that display distress after experiencing such a traumatic event can join the programme.

Timing

The treatment can start any time between 1 month and 2 years after the traumatic event took place. When the child enters the trauma clinic and symptoms of distress are noticed, the child will be referred to therapy by intake workers or social workers, as well as by psychologists after a short screening.

Therapeutic goals

Within the proposed sequential approach, the following goals can be considered when implementing the CAP treatment per trauma treatment phase:

- Phase 1 (creating a safe space): An increased knowledge of the emotional effect of abuse
- Phase 2 (the trauma story): An improvement in identification and communication of emotions and a reduction in posttraumatic stress symptoms
- Phase 3 (returning to the community): An improvement in inter- and intrapersonal skills and resilience to cope with future crises and an increase in posttraumatic growth

Planning the CAP treatment

It is recommended that a group consists of six to eight participants. The programme is designed to meet ten 90-minute sessions (Table 1). When planning the start of a new group, the facilitator must carefully select the participants based on the type of trauma, the severity of the trauma reactions and developmental level of the children. The sessions are structured and activities are directive in order to establish safety and containment, and to help the children move through all phases of the protocol successfully. Every session starts with a ten-minute check-in, has a ten-minute break halfway, and ends with a check-out. In between, 60 minutes are divided for two different activities before and after the break.

Whilst adhering to the structured outline of the CAP protocol, the facilitator at all times should rely on their professional judgement and be flexible to adjust to arising needs. When planning the treatment, in principle, everyone meeting inclusion criteria is eligible to participate. Yet, a contraindication for joining the group for instance would be if a child is too aggressive or violent, due to the potential harm to others and disruption this may cause. In this case, an individual treatment may be a preferred approach. Also, it is possible that after completing the ten sessions of the CAP protocol, some children have remaining problems that could be addressed in follow-up treatment. One challenge of the group setting is that the individual children may move through the phases at a different pace and with different preferences of expression. At times, the facilitator could offer different modes of expression to meet a certain therapeutic goal, as long as the overall sequence of phased goals is followed.

Session breakdown

Phase 1: Creating a safe space

> *"I think that was a reality check for most of them to really understand that we are not here just to play, but to receive help and healing for what happened... And they were able to tell stories and relate to it. That is where they started to connect."*

Session 1: Introduction

The aim of the first session is for children to get to know each other and to start creating trust and a safe space. It is also important to establish group rules; this can be done in a collaborative brainstorm resulting in the creation of a poster. The role of the facilitators is to suggest any important rules that are not being mentioned. Drumming as music activity can provide children with the opportunity to learn each other's names, increase a sense of togetherness and practise listening skills (Bensimon et al., 2008). In this exercise, everyone initially follows an easy rhythm. After a while, children take turns calling out their names, along with a chosen gesture or expression, after which the whole group repeats the name and the gesture. Drumming can draw a group together and it is an easy and fun activity that can motivate participation and allow for the expression of energy. As children follow the actions and names called out by others, they learn to listen and connect with one another. Furthermore, as each child hears the group reflecting their own name and gesture back to them it offers them a sense of belonging and validation. Another activity that can serve as an introduction is using an object blanket. All children bring a meaningful or special object to the first session. They take turns telling the story of the object as they place it on the blanket presenting themselves to the group. When everyone has shared their story/object, they can look at the scene they have created on the blanket and anyone can choose to place their object somewhere else on the blanket, to refer to how they relate to the other objects/stories. These examples of activities are appropriate for a first session, as they do not require well-developed artistic or technical skills and are therefore non-threatening. At the same time, they all focus on group collaboration and connection.

Session 2: Psycho-education

The aims of the second session include psycho-education, identifying and normalizing feelings, practicing relaxation, and opening-up communication. A bibliotherapy activity that is recommended is the reading of a story called 'A terrible thing happened' (Holmes, 2000), in which a racoon saw the most terrible thing happen and started having negative feelings until he went for therapy. Reading the story will allow the children to identify with a non-threatening character and engage in conversation to open up communication. Another activity that can be practised is scribbling to music, in which children listen to different types of recorded music and draw a series of scribbled lines on paper. Afterwards children can talk about what they created, and start exploring experiences, emotions and thoughts.

Session 3: Safe space

The goals of the third session are to enhance feelings of safety and self-control, and to practise self-soothing techniques. An activity that can be done to create a safe space includes a visualisation exercise, in which the children close their eyes and create an image in their minds of a space that feels safe and comfortable. Subsequently, a discussion can be held about different kinds of symbols such as personal and cultural symbols. The children are asked to think of a symbol that has got the power to protect them at bad times. They will be encouraged to find personal symbols specifically, and then helped to place their symbols within a cultural or global context. They then create this symbol in an arts activity. Another activity that can be done is mirrored dancing, in which one child will take the lead and the other children need to copy everything this child does, at the same pace just like he or she is a mirror. This can be done in pairs, or alternatively with the entire group. If the group struggles to stay together or to dance, a large sheet can be used; every child has to hold one side and move the sheet when it is their turn. This exercise aims to increase connection between group members, and when children's movements are mirrored they feel validated and affirmed.

Phase 2: The trauma story

> *"Everyone was given a platform ... I was glad that Zandile[1] was the one who first wanted to go. She had given the others an access to feel comfortable, and the others also came and then they were able to share, all of them."*

Table 1
Creative arts therapy programme session phase, themes and goals.

Phase	Session		
	#	Theme	Goal
Creating a safe space	1	Introduction	Getting to know each other, creating trust and a safe space, setting group rules
	2	Psycho-education	Normalizing feelings, opening-up communication, practicing relaxation
	3	Safe space	Enhancing feelings of safety and self-control, practicing self-soothing and mindfulness
The trauma story	4	Emotion identification	Identifying and validating feelings, improving emotion vocabulary
	5	Emotion regulation	Understanding emotion regulation, and powerful and powerless emotions
	6	The trauma story	Providing transformation through disclosure, giving the trauma a voice and place
Returning to community	7	Strength finder	Emphasizing strengths and reminding of favorite things as coping strategy
	8	Community support	Emphasizing group connection and support networks
	9	Meaning making	Reflection on learning and emphasizing growth
	10	Goodbye	Saying goodbye to the group, leaving them with hope and positive memories

Session 4: Emotion identification

The aim of the fourth session is to identify and validate feelings and improve emotional vocabulary. A music activity that can be done to help identifying feelings is to play different pieces of music and discuss what emotions they evoke. An addition to this is for one group member to express the feelings they relate to the music using musical instruments or facial or bodily expressions and for the group to guess what emotion they are expressing. A drama activity conducted in this session is called emotional drama, in which the children write a boring dialogue without any emotions followed by each actor choosing an emotion to act out their part of the script. The rest of the group is then required to guess the emotions. This exercise will aid identification of emotions and the development of emotional vocabulary.

Session 5: Emotion regulation

The aim of session five is to understand emotion regulation, and the difference between feelings of being powerful or powerless. An arts activity that can be done to help with development of self-concepts is making or decorating masks, to illustrate the concept of distinguishing between the inside (only noticeable for yourself) and the outside (how do others see you). A drama exercise can start by visualising a time the child felt powerless or helpless, and to think of what shapes or positions the body had, how did it feel in your body, and how did your body move. Then the visualisation moves to a time in which the child felt powerful and able to act as they wished. If the child cannot locate a memory of ever feeling powerful the children can act like animals, for instance a powerless animal such as a mouse, and a powerful animal such as a lion. What moves would their bodies do/make? How would they stand? What would be around them? What would it feel like? Music can be paired with this activity as well as sound, for example a powerful sound versus a timid sound.

Session 6: The trauma story

This session aims to provide opportunities for transformation through disclosure of every trauma story, and to give the traumatic experience a voice and place. Support is very important in this phase of treatment, and the facilitator provides a modelling role for how to be supportive to the other group members. The main activity will be around facilitating change of the sensory experience relating to the trauma, by drawing a picture about their experience. Containment in this session is crucial, to ensure that the children do not leave the therapy space feeling distressed. This can be done for instance by engaging in another drawing that connects children to their resources, inner as well as outer, or to do a relaxation exercise blowing bubbles combined with saying words of hope, so that children leave with reminders of what is positive in their lives despite trauma they have faced.

Phase 3: Returning to the community

> *"We went with the music and they were given a platform to all come with their rhythms . . .how do you feel to connect yourself with an existing rhythm. . . and the biggest thing was to show them that, you know what, despite what happened, you can still connect with others in life."*

Session 7: Strength finder

The aim of session seven is to emphasize strengths and remind the children of their favourite things that they can use as a coping strategy. A drama activity that can be done is for instance the hero's play, in which the group is going to create their own story about a hero and then act it out. The framework of the hero's journey can be introduced to the children as an example of the story. Stage 1: Hero is in a comfortable place but feels bored/tired/is forced out, and then receives a call to move on (someone asks for help, has a dream, or has to move away from danger). Stage 2: The hero begins the journey, usually feeling powerful, content, excited/able to do what needs to be done. Stage 3: The hero meets a threat – some conflict or barrier/difficult situation/stressor that needs to be conquered – either by fighting the threat/running away/by surrendering to it or making friends with it. Stage 4: The hero triumphs over the threat and receives gifts (learnings, wisdom) that can then be taken back home. Stage 5: The hero returns home with his/her gifts (Campbell, 1949). At the end a reflection exercise can emphasize the strengths that the hero has, and how that can relate to the children's own strengths in their lives. A second activity that can be done is listening to or singing the song of the sound of music 'my favourite things' linked to personal attributes. The children can create a collection of their favourite things, making them from clay or drawing them on paper.

Session 8: Community support

The aim of session eight is to emphasize group connection and support networks. Emphasizing group connection can be done via a music group. The group is divided into two. The one group together sets a consistent base pattern, like a slow drumbeat, over which the other group makes sounds with their mouths or instruments, one after the other, finding their voice in the group. After this, the roles are switched and the second group supports the expression of the first group. Various sounds and/or songs can be experimented with. Depending on the groups' response, facilitators may need to take a strong role in directing rhythms or offering sounds. Another activity to emphasize support networks is by drawing hands on a paper, decorating them and writing names of people in every finger that can help the child in times of emergency. Individual drawings can be pasted on a large paper to make a community collage, emphasizing the community of safety and support they have established. The children can also rearrange the collage items

in relation to how they feel connected to each one, as they did in the beginning session with the story blankets.

Session 9: Meaning making

Session nine aims to facilitate reflection on learning and acknowledgement of growth. It is also a preparation for saying goodbye in the next session. In order to reflect, the children can for instance fold a paper in three and make a collage about their past, their present, and their future. This collage will summarize where they came from, how they are feeling now, and where they see themselves in future, reminding them of different chapters to their life's story. Alternatively, they can fold the paper in four and reflect on the four seasons of life in a collage. Children can also be asked to name the things that touched them the most in the sessions; which images or stories (their own or from others) or activities will they remember or what stood out the most for them. Have them incorporate those images/things into their collages. Collages can be presented to the rest of the group. In order to make a memory and to enhance group cohesion, another activity is to create a booklet where every person in the group writes or draws an encouraging message to the recipient. This can serve as a reminder of their connections and peer support.

Session 10: Goodbye

The tenth and final session of the creative arts in psychotherapy treatment aims to facilitate saying goodbye, as well as leaving the children with hope and positive memories. A certificate ceremony can be held, in which the children are praised for their participation, courage and one or two special skills of each child are emphasized. Another closing activity can be to make and/or decorate a memory box in which children can place one or two central ideas they are going to take from the group. The box can contain the art works from the children they made during the ten sessions, and the gifts they received from their group members in session nine.

Case description

This article started with the case of the 12-year old boy Sibu who was a victim of rape. He attended the Creative Arts in Psychotherapy (CAP) programme in Johannesburg, South Africa.[2] In therapy, Sibu appeared to be a mild mannered willing participant. In the beginning (phase 1), Sibu was easily distracted, he did not make much eye contact and did not interact much with the other children. He responded well to physical expressive activities, particularly drumming, where he became very enthusiastic and energized. With other activities such as drawing or reading the story of 'a terrible thing happened' (bibliotherapy), he was more restless and struggled to concentrate. Towards session three it became apparent that Sibu started feeling more comfortable in the group, as he actively approached other children; he smiled at his peers, made eye-contact and asked questions.

During phase 2, Sibu struggled at first to express his emotions. Taking into consideration Sibu's background and developmental level, he was unable to adequately verbalize his emotions surrounding the trauma, and showed limited vocabulary. This was for instance indicated by him using the word 'happy' most of the times when asked about his feelings. After session 6 he said: 'I feel happy because we told stories'. After drumming in session 7 he said: 'I feel happy because I like this song. It makes me feel better at angry times'. Observation notes from session 5 reported that 'he expressed himself during the drumming activity by enthusiastically taking the lead while making drum-beats'. The creative arts activities could accommodate a limited vocabulary and language barriers, providing a safe space and wide variety of tools for nonverbal expression.

During session 6, where the children were asked to share their trauma story, Sibu was less engaged and appeared distracted and distressed. Initially, he isolated himself from the group while working with art materials. He seemed frustrated, reflected by an unhappy expression on his face and an impatient attitude. The situation escalated when Sibu threw scissors. During the trauma storytelling, Sibu did not show clear emotions, but he listened carefully to the stories of the other children. As soon as the facilitator changed the activity into a more physical engagement using drums and dancing, Sibu's body language and mannerisms changed. He was more at ease with himself and could regulate his emotions better. The drums provided an opportunity to explore and express his feelings in an appropriate manner.

Towards the end of the therapy (phase 3), Sibu expressed more feelings without being prompted, indicating that he became more comfortable with the creative arts therapy process as well as having more trust in his peers. When reflecting on their future wishes, Sibu was proudly holding his painting in the air and told the group: 'I want to learn, I want to help people, to finish school and to be a soccer player'. During the final session, he concluded: "I'm happy because we were drawing, telling stories and talked about our feelings. And we were learning things we didn't know."

Discussion

Treating abused children in a culturally diverse setting is a challenging endeavor, especially in a country where abuse and violence are omnipresent experiences. Yet, it is essential that children who have been victimized, living in a setting further complicated by poverty and unemployment, receive sufficient and high quality health care. In this paper, we have proposed the creative arts in psychotherapy (CAP) treatment that can be offered to these children after experiencing a traumatic event. We expect that his protocol will fit the developmental needs of children, so they can express themselves in nonverbal, nonthreatening and playful ways. The treatment protocol strives to bring more uniformity in the management of child trauma in multicultural and under-resourced communities by combining a semi-structured trauma protocol with creative arts therapy principles. Positive aspects of the protocol include its careful and detailed programme, consideration for the specific characteristics of the setting in which the children live and its connection with modern developments in trauma therapy. Nevertheless, there are limitations and pitfalls that need to be considered.

Group therapy as an initial treatment is a convenient choice in an impoverished context, due to the fact that more children can be helped simultaneously, saving costs and resources, and the peer-support within the group as a powerful source of healing, especially in a collectivistic culture where the emphasis is on group goals and activities (Triandis, 1995). Group treatment for PTSD is used frequently all over the world. Nevertheless, not much attention has been given to identifying evidence-based group treatments for this disorder, although we have to realize that group clinical trials are complex and expensive to conduct. Based on the existing research, it is unknown whether group therapy for a child with PTSD is reaching similar treatment outcomes compared to individual therapy, and studies including different population groups show that treatment outcomes of (adult) group therapy are ambiguous (Haagen, Smid, Knipscheer, & Kleber, 2015; Manassis et al., 2002; Sloan, Bovin & Schnurr, 2012). It is possible that group treatments also

[2] Information for this case study was derived from different sources: intake interviews, observations, progress notes from the social worker, a post-treatment interview and clinical scales administered pre- and post-treatment.

have negative effects if the group is not managed well, and people are victimized or negative group pressure exists.

Generally, establishing an effective treatment protocol for children after trauma is challenging and there is no consent on what is internationally recognized as evidence-based health care. A critical review by Gillies, Taylor, Gray, O'Brien, and D'Abrew (2012) showed that there is no clear evidence for the relative effectiveness of different psychological interventions for treating PTSD in children. The CAP protocol does not only focus on the traumatic experiences of the children, but rather addresses negative emotions and thoughts associated with the trauma, and aims to build coping skills and strengthen resilience, especially through interpersonal connections. The preferential use of trauma focused treatments (such as trauma-focused cognitive behavioural therapy (TFCBT) and EMDR) has become the centre of a debate among trauma specialists, with many researchers delivering empirical proof of its superiority above non-trauma focused therapies (such as non-trauma-focused CBT and psychodynamic therapy) (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013). Indeed, in general trauma focused therapy has been found to be superior. However, some authors have demonstrated that PTSD psychotherapies can be equally efficacious in promoting recovery through non-treatment specific mechanisms, or placebo (-like) effects, such as treatment expectancies and therapeutic alliance (Wampold et al., 2010).

Another challenge refers to the possibility (or the lack of it) of implementing new treatments in low- and middle income countries and communities. As indicated in previous research, challenges may appear with availability and willingness of health care workers to engage in a 'new' type of treatment, mostly due to a high caseload and relative low numbers of workers trained and supervised in mental health care (Saraceno et al., 2007). A lack of training and continuous supervision of available health care workers is another limitation (Saraceno et al., 2007), and resistance from the community towards foreign interventions can occur (Jordans et al., 2013; Tol et al., 2014). Although this CAP programme tries to address some of these challenges reported in previous studies, for instance by providing additional training and continuous supervision to health care workers joining the programme and by selecting culturally sensitive activities in therapy, we realize implementation of it in low- and middle-income countries is not without resistance. That said, with such a high need for more and effective treatment opportunities for traumatized children specifically in this type of context, it is priority to continue to try and implement, evaluate, and improve evidence-based trauma practices like the CAP programme.

Evaluation of the CAP treatment is still ongoing, and although we received positive responses from the social workers and parents involved in the study, such as illustrated in the case study of Sibu and quotes in this paper, the effectiveness remains to be established. The advantage, however, that we see in introducing the CAP treatment is that it does avail itself to be included in RCT designs due to its structured protocol. This is a new addition in the field of creative therapy, since most creative therapies that take place do not follow a strict protocol, which complicates evaluation (e.g. Schouten, De Niet, Knipscheer, Kleber, & Hutschemaekers, 2014). Further research could clarify treatment efficacy in various cultural settings, whether there is a difference in treatment effectiveness between different types of trauma, and which symptoms are most likely to resolve during treatment.

Acknowledgements

The authors thank Charles Sathekge and Ndumiso Mdaka for their involvement in the pilot study and Maronja de Jongh for her contribution to the case study.

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