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Creative Expressive Arts Therapy for Children with PTSD Symptoms caused by Sexual Abuse in South Africa: A Pilot study.

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Abstract

Child sexual abuse (CSA) and related Post traumatic Stress (PTSD) are considered to be highly prevalent in South Africa. One potential mediating factor in the onset and PTSD prognosis has been identified in previous research in the form of coping strategies. In search of an accessible therapy for the multi- lingual and cultural population for children in South Africa, Creative Expressive Arts therapy (CEAT) is explored in a pilot study. The participants in the therapy and waiting list group were 8-12 years old and from the Gauteng Province, South Africa. CEAT did not decrease PTSD symptoms significantly. Coping could not be identified as a mediating factor, nor was coping associated with higher symptom levels. This study suffered from attrition and translation problems, decreasing the outcome validity and reliability. Further research is needed to validate CEAT as a potential therapy to treat children with PTSD symptoms, with more awareness for cultural and socio-economical background.

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Introduction

Child sexual abuse (CSA) is considered to be a major problem in South Africa (Jewkes & Abrahams, 2002; Jewkes, Penn-Kekana & Rose-Junius, 2005). Although there is uncertainty about the factual prevalence, ranging from the relatively conservative figures of the department of public health (1998) (9.7% in children from age 15-19) to much higher prevalence rates found by Pereda, Guilera, Forns and Gómez-Benito (2009) (60.9% for boys and 43.7% for girls), South Africa ranks amongst the countries with the highest CSA figures. This is why South Africa is also named “the rape capital of the world” by Human Rights Watch (1995).

The prevalence discrepancy suggests that there are important issues concerning child sexual abuse that need to be addressed to get a better appreciation of the complexity of the problem. First of all, the definition of child sexual abuse seems unambiguous, but this is not the case. Until 1999 only coercive penile penetration of a vagina was recognized as a sexual abuse by South African law (Jewkes & Abrahams, 2002). Also, males often feel that they have the right to act out their manliness, so they do not see their actions as form of abuse (Jewkes et al, 2005). Furthermore, apart from very small children (below the age of 6), there seems to be a perception that girl victims often provoke the abuse by their behaviour or clothing. These views are often shared by family, police and even the victim, putting extra shame and guilt on the victim and family. Another consequence of this is that the family of the victim does not press charges, or that the police will not prosecute (Jewkes et al., 2005).

The consequences of abuse can be severe. Not only are victims at risk of getting physical complications like HIV or unwanted pregnancies, there is also evidence that psychological disorders are linked to CSA such as depression, anxiety disorders, substance abuse and post traumatic stress disorder (Estes & Tidwell, 2002; Hall, Mathews & Pearce, 2002; Johnson, 2004). One study found that CSA is the strongest predictor for developing post-traumatic stress disorder (PTSD) in South African children, accounting for 25% of the psycho trauma cases (Seedat, Nyamai, Njenga, Vythilingum & Stein, 2004). Given the high incidence of CSA, and the relatively high chance for victims to develop PTSD, it is important to have effective forms of therapy available. This pilot study aims to explore the use of creative and expressive arts therapy as a potential effective and accessible form of therapy in South Africa.

Theoretical framework of PTSD

PTSD, as defined in the DSM-IV-TR (APA, 2000), is characterized by intrusive re-experiences and avoidance. Multiple theories have been proposed to explain how severe stressful events can lead to PTSD (Brewin & Holmes, 2003), but for the purpose of this study two will be highlighted: the neuroscience perspective and cognitive theory.

The neuroscientific approach to psychology is relatively young and tries to explain psychological phenomena by looking at the way the brain functions on a neurological level (Brewin, 2001). Research in the area of trauma has mainly focused on traumatic memories. Harris (2009) hypothesizes that during a traumatic event activity decreases in the left hemisphere of the brain, where the language and declarative memory is located, causing a decline in verbal processing. This hypothesis seems to be supported by research findings which show that traumatic memories are stored in the right hemisphere of the brain and are nonverbal (Glaser, 2000; Klorer, 2008 in Harris, 2009). Harris (2009) and Klorer (2005) also found that traumatic memories are fragmented and encoded as visual images and somatic sensations without translation into narratives. This makes the traumatic memories feel intense without understanding them. Conway and Pleydell-Pearce (2000) explain fading of traumatic memories as an automatic process, which is accomplished by integrating the traumatic event in the autobiographical memory. According to Conway and Pleydell-Pearce (2000), the integration process is disturbed when someone is experiencing post-traumatic stress.

The cognitive theory states that fundamental assumptions about oneself and their world are shattered by the traumatic event (i.e. the world does not feel safe anymore or life does not feel worth it anymore) (Brewin & Holmes, 2003; Janoff-Bulman, 1992). According to the cognitive theory, people suffering from PTSD display cognitive distortions in the way they appraise situations, labeling certain stressors as overly negative or threatening (Ehlers & Clark, 2000). In an effort to reduce the anxiety that follows the negative appraisal, people try to avoid triggering situations and suppress the negative thoughts. To recover, the traumatic event should be assimilated and integrated into the existing fundamental assumptions, by making meaning of the traumatic event (Horowitz, 1986 in Brewin & Holmes, 2003).

The role of coping in PTSD

Though incidence rates of PTSD are high under sexually abused children, not every child experiences the same amount of problems after the event. Therefore it is important to look at possible influencing factors in the onset and the persistence of PTSD. One established influence is coping. Whenever a situation is appraised as being threatening, coping strategies are applied to decrease the emotional and cognitive stress. (Rademaker, 2012)

Coping strategies have been the subject of numerous studies researching the nature of coping, the phenomenology of coping and whether there are functional and dysfunctional forms of coping in different situations. This has resulted in a multitude of different coping definitions and constructs. Still, research has shown that the right form of coping in the right situation can have a protecting effect on physical and mental problems (Hill & Kennedy, 2002; Schou, Ekeberg & Ruland, 2005; Thorne, Andrews & Nordstokke, 2013). Agaibi and Wilson (2005) showed that persons relying on active problem solving coping strategies were found to be more resilient to developing PTSD symptoms. Conversely, certain types of coping increase the risk of psychological problems. Avoidant and thought suppression coping strategies in particular have been linked to a unfavorable prognosis with PTSD. There is evidence that attempts to suppress unwanted thoughts are very likely to fail, and will even cause intrusive thoughts to return more strongly (Wenzlaff & Wegner, 2000). The relationship between greater avoidance and higher symptom levels has also been confirmed in a number of studies on assault and motor vehicle accident victims (Dunmore, Clark & Ehlers, 1999; Steil & Ehlers, 2000). Both avoidance and thought suppression are also related to a slower recovery from PTSD (Dunmore, Clark & Ehlers, 2001; Ehlers et al., 1998).

On the specific subject of child abuse, previous research has shown that coping has a mediating effect on the onset of trauma symptoms (Shapiro & Levendosky, 1999). Again, it has also been found that children who rely on avoidant strategies have more behavioral problems and experience more psychological symptoms (Tremblay, Hebert & Piche, 1999).

In an attempt to decrease the large number of different definitions for coping styles, Skinner, Edge, Altman, and Sherwood (2003) proposed a hierarchical coping classification structure. One of the best fitting hierarchical coping models found was a model proposed by Ayers, Sandler, West, and Roosa (1996), distinguishing four coping strategies: active coping, distraction strategy, avoidance strategy and support seeking strategy. De Boo and Wicherts (2007) later divided active coping further into problem focused and direct emotion focused coping for an even more detailed fit. This five-factor model will be the coping model used in this pilot study.

Treatment issues when dealing with the multilingual population in South Africa

As South Africa has eleven official languages and several distinctive cultural backgrounds, language barriers are likely to influence therapy in many cases. Although words are usually the strongest way to communicate among humans, sometimes words cannot describe the amount and complexity of feelings we experience (Harris, 2009), especially if the client needs to express in a language other than their mother tongue.

This potential wording problem is a significant concern of therapists. The strategic use of words is one of the main tools in a psychologist's arsenal. It is common for South Africans to speak more than one language, but most psychological treatments require high language finesse. For instance, cognitive behavioral therapy, which is recognized as preferred therapy for PTSD (National Institute of Clinical Excellence, 2005), consists for a large part of challenging and restructuring beliefs and appraisal of situations and relies on questioning techniques and redefining negative thoughts (van Minnen, 2012). The skill of linguistic nuancing is therefore very important for the therapy to be effective, but cannot be guaranteed if the therapist and client cannot communicate on a high level.

The apparent benefit of Creative Expressive Arts Therapy

Given the problems described above, it seems desirable to extend the therapist's arsenal with therapy forms that rely on mostly non-verbal communication. One potentially viable option is art therapy. Art therapy gives an opportunity to explore the issues surrounding a traumatic event in a less threatening, nonverbal way. It circumvents a potential language barrier as much as possible, but still allows

integrating the traumatic event in the autobiographical memory. It also allows the victim to explore their traumatic experience with some distance and control over disclosure (Backos & Pagon, 1999). According to Malchiodi (2008), making and reflecting on art will increase awareness, improve cognitive abilities and increased resilience to stress and traumatic experiences.

Creative Expressive Arts Therapy (in short CEAT) is a combined form of different disciplines of art therapy used for self-expression and reflection by art, but it avoids verbalization and uses non-linguistic communication and expression (Harris, 2009; Malchiodi, 2003). The therapy is composed of different forms of art combined with psychotherapy: it incorporates visual arts, dance, music, drama, and creative writing (Malchiodi, 2003). The CEAT protocol also includes specific drawing exercises and questions to help children illustrate their traumatic experiences, so children can reframe their emotions and negative thoughts (Malchiodi 2003). An important aspect of CEAT is that it provides the children with a safe place to express their feelings, so they can feel safe and valued. This should reduce the symptoms of post-traumatic stress. Also, the CEAT will focus on community support, which helps the child to see their world/community as a safe environment again.

Critical view on scientific support of CEAT

Research supporting art therapy is growing (Camic, 2008; Carolan, 2001; Gilroy, 2006; Slayton, D'Archer & Kaplan, 2010; Waller, 2006). There are, however, some serious issues to be addressed. First of all, there is a serious lack of research using control groups or randomization (Lyshak-Stelzer, Singer, Patricia & Chemtob, 2007; Slayton et al., 2010). Most studies are qualitative designs, pretest/posttest comparisons without control group or anecdotal case material to demonstrate treatment outcomes. Secondly, standardized reporting is often poor, and give only vague descriptions of the treatment interventions, which makes it difficult or impossible to determine the study procedures (Slayton et al., 2010). These problems seriously compromise the certainty of conclusions about the effectiveness of art therapy. Finally, most research has been conducted in Western societies, and can therefore not automatically be implemented in South Africa. Only one published art therapy intervention study has been done in South Africa.

This study by Pretorius and Pfeifer (2010) focused on girls only, and found positive results regarding anxiety and depression when implementing a group based art therapy intervention for sexually abused girls from 8 to 11 years old.

Aims of this research and research questions

In search of an appropriate therapy for (sexually) abused children in South Africa and to contribute to a greater knowledge about art therapy, the treatment efficacy of creative expressive arts therapy as an intervention for traumatized children in South Africa will be explored. The present study contributes to the field in three important ways. First, it considers a less-studied but in terms of PTSD-prevalence highly relevant context, South Africa. Second, by using a control group it uses a more rigorous research design than previous studies to assess the effectiveness of the therapy. Third, in an attempt to identify (one of) the possible mechanisms through which CEAT might achieve its effect, the study investigates if coping functions mediate between the intervention and the treatment outcome. The following research questions have been formulated:

1. What is the effect of a creative expressive arts therapy intervention for traumatized children in South Africa on post-traumatic stress reactions?

Hypothesis 1: Children who joined the CEAT intervention will experience less post-traumatic stress symptoms after the therapy than before therapy.

Hypothesis 2: The post-traumatic stress symptoms will decrease more in the treated children group compared to the waiting list (control) group, when looked at the difference between pre and post measurements.

2. Does coping affect the way children experience post-traumatic stress prior to the intervention?

Hypothesis 3: Children who predominantly use distraction and avoidant coping strategies will experience more post-traumatic stress related problems compared to children who predominantly use problem focused coping, positive cognitive restructuring or support seeking strategies.

3. Is the effect of CEAT on post-traumatic stress symptoms mediated by coping style?

Hypothesis 4: It is expected that coping is a partial mediator on CEAT

Method

Participants

The participants in this study were selected from the client pool of *The Teddy Bear Clinic* (TTBC), a nonprofit clinic specialized in child abuse based in Gauteng.

The inclusion/exclusion criteria for the participants in this study are:

- The child must have experienced sexual abuse one or more times;
- The child must experience symptoms of distress or functional impairment as defined in the DSM-IV-TR (APA, 2000).
- The child must be 8 to 12 years old during the period between pretest and post-test.
- The last sexual abuse must not have occurred longer than 2 years ago
- The child must not have cognitive impairments
- The child must not have received therapy for sexual abuse prior to this study

37 children have been identified and approached to take part in the study. Of these children 9 children in total completed the therapy and 4 children from the waiting list group completed the post measurements (see fig. 1 for more details). Due to logistical challenges, only two children in the control group were actually assigned to the control group in advance. The other two children in the control group were children who did not show up for therapy, but did show up for the post-test. The mean age of the completer participants was 10,78 ($SD= 1,48$) for the therapy group and 10,00 ($SD=1,63$) for the control group. The gender distribution for the completer participants was 77,8% female in the therapy group and 75% female in the control group.

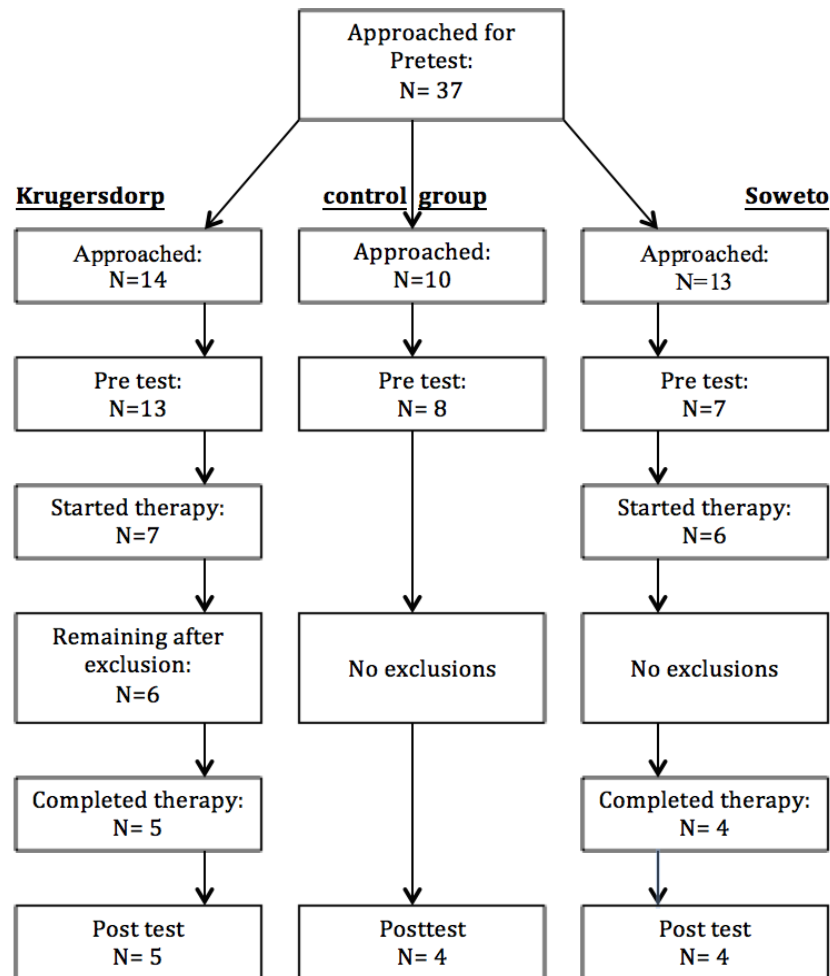


Figure 1. Flowchart of the number of children in the study from the moment of approach until posttest, divided between the two therapy group locations and control group

Questionnaires used

Post-traumatic stress symptoms were measured using the *Young Child PTSD Checklist* (YCPC) (Scheering & Haslett, 2010). The YCPC is a standardized, DSM-IV based questionnaire. It consists of 30 items, divided over 4 subscales measuring 1) re-experiencing 2) avoidance and numbing and 3) increased arousal 4) functional impairment. The items were scored on a Likert scale from 0 to 4 where 0 means hardly ever/none, and 4 means every day (see appendix A for the checklist). Sum scores and cut-off scores are provided, but this questionnaire is not meant to diagnose PTSD, but rather to give an indication if further clinical attention is needed, or if a child is likely to be diagnosed. There are no published studies about the psychometrics of this questionnaire, but the YCPC is based on 20 years of extensive research and has been compared to diagnostic interviews.

The coping strategies were measured with an altered version of the *Children's Coping Strategies Checklist 2nd* revision (CCSC-R2; de Boo & Wichert, 2007). The CCSC-R2 distinguishes between 5 different coping strategies with 15 subscales measured in 64 items. The strategies distinguished are: 1) active 2) distraction 3) avoidant 4) support seeking and 5) direct emotional focused. The items all start with the sentence: WHEN YOU HAD A PROBLEM... followed by a statement such as "You tried to ignore it". The participants are asked to fill in a number from 1 to 5 where 1 means 'do not do this at all' and 5 means 'always do this'. A high total score on a subscale corresponds to a high frequency of using a particular coping strategy. The checklist and former incarnations have been validated in different studies (Ayers et al., 1996; Weyer & Sandler, 1998; Thorne et al., 2013), but to date has not been used in a published study in South Africa. While taking care that the item stayed as close as possible to the original, 8 items were adjusted to be more appropriate for the local South African context. For example: the chance of a child in Soweto owning or using a skateboard is very small. The chance of having access to a football is much greater. Also, father/mother was changed into parent/caregiver because many children grow up in broken homes due to HIV or poverty (see appendix B & C for the questionnaire and the complete list of altered items).

Creative Expressive Art Therapy Protocol

The CEAT protocol used in this study was developed by van Westrhenen, Fritz, lemont and Oosthuizen (see table 1 for the therapy summary and for a more elaborate description of the sessions see Appendix D for the entire protocol). It consists of 10 two hour sessions divided in three phases: 1) establishing safety, 2) telling the trauma story, and 3) restoration of connection between traumatized individuals and their communities. The structure of the sessions is always similar. The therapy starts with a check-in activity, followed by activity 1, which is always related to the theme of the week. After a 10-minute break in the middle of the session, activity 2 is held, also relating to the theme of the week. Finally, a check out is done and a short preview for the following week is provided. The activities were mixed disciplines of the art forms music, drama and drawing. The exercises were purposeful, but allowed for as much freedom as possible to avoid limiting the artistic expression by holding on to too many guidelines.

Table 1 *therapy summary*

Phase	Session number	Session theme	Activity 1	Activity 2
<i>Creating a safe space</i>	1	Introduction	Group rules	This is me
	2	Psycho-education	Brave Bart	Scribble to music
	3	Safe space	Safety symbols	Mirrored dancing
<i>Telling the story</i>	4	Emotion identification	Name the feeling	Emotional drama
	5	Trauma telling	What happened	Bubbles of hope
	6	Emotion regulation	Mask	Powerful/powerless
<i>Return to community</i>	7	Strength finder	Hero's play	My favorite things
	8	Community support	Music group	Helping hands
	9	Meaning making	Past/present/future	Group photo shoot
	10	Goodbye	Memory box	Certificate ceremony

Procedure

The files of the children approached to participate in this study were all identified by the social workers working at the Teddy Bear Clinic for Abused Children. Associated social work students called the parents or caregivers to make appointments, and briefly explained the purpose of the study in the most appropriate language for the parent.

Multiple pretest moments were held, and transport fee was provided to the parents/caregiver in order to get as many participants as possible. A social work student thoroughly explained the therapy and research goals to parent/caregiver in their first language, and informed consent/assent was signed.

Depending on the understanding of the English language, the parent/caregiver and child could fill in the questionnaires themselves or get translations from a social work student. In practice, this meant that almost every person asked for help in translating. Due to time constraints and because there were not enough social work students to help everyone at once, the participants were sometimes divided into small groups per student while filling in the questionnaires.

The therapy was carried out by two social workers from TTBC, who were specially trained for this study. One social worker was assigned to each therapy group. The planning of the ten sessions was flexible around the children's availability.

One child in the Krugersdorp therapy group had to be excluded from the therapy (see fig. 1) because it was only found out during the therapy that this child had sexually abused 3 other group members prior to the therapy sessions. This child was referred to another therapy.

The posttests were done directly after the last therapy session, in the same manner as the pretest, with social worker students to translate the questionnaires.

Design and analyses

This pilot study is best classified as a quasi-experimental design. All the analyses were done using SPSS v. 22 for Macintosh (IBM corp, 2013).

The first hypothesis (*Children who joined the CEAT intervention will experience less posttraumatic stress symptoms after the therapy than before therapy*) was tested with a two-sided paired sample t-test with alpha .05.

The second hypothesis (*The posttraumatic stress symptoms will decrease more in the treated children group compared to the waiting list group when looked at the difference between pre en post measurements.*) was tested using an independent t-test analysis between control group and therapy group, and alpha .05.

The third hypothesis (*Children who predominantly use distraction and avoidant coping strategies will experience more posttraumatic stress related problems compared to children who predominantly use problem focused coping, positive cognitive restructuring or support seeking strategy*) was tested using a linear multiple regression model, and alpha .05.

The fourth hypothesis (*coping is a partial mediator on CEAT*), a casual-steps mediation analyses as proposed by Baron and Kenny (1986) was performed for all five separate coping strategies (Figure 2). All coping strategies are separate theoretical constructs and expected to have a different impact on treatment outcome.

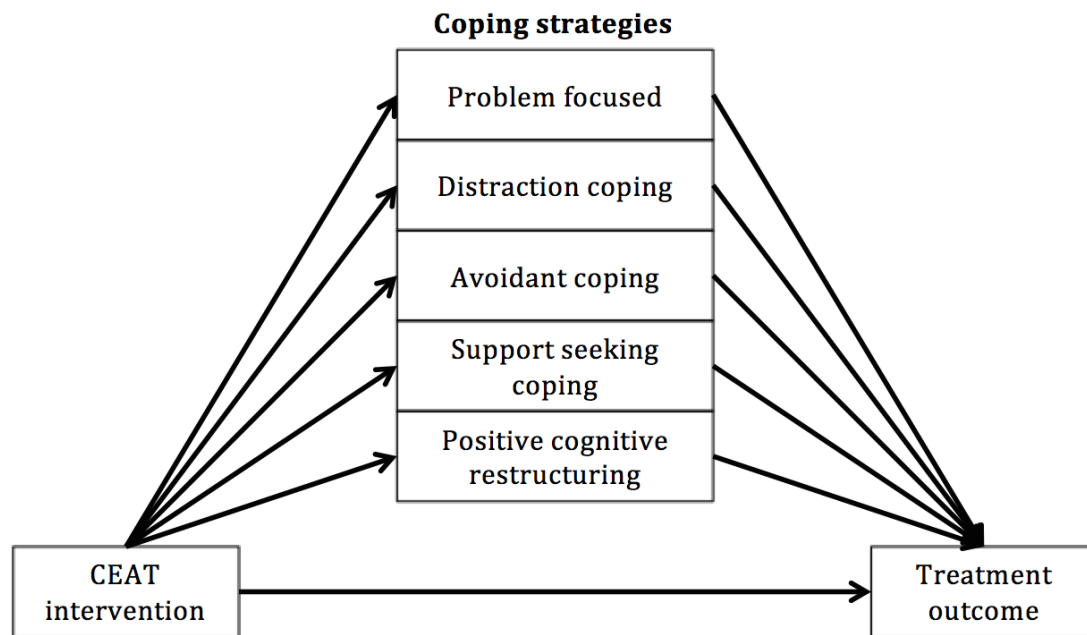


Figure 2. Mediation model

Results

Firstly, some general statistics of the collected data is provided in the form of coping and symptoms descriptives. After initial analyses, one participant from the control group was deemed an outlier and was excluded from the analyses. The results will be presented per research question.

Coping descriptives

The mean and standard deviations for the different coping strategies can be found in table 2. There are no significant differences between groups in coping style use at pre and post measurements. Interestingly, coping scores increased overall on most scales. However, no significant differences within the control group were found when pre- and post-tests were compared, and only distraction coping increased significantly in the therapy group ($t(8) = 0.922$, $p = .02$), while still not being significantly more pronounced than other coping strategies in the therapy group.

Table 2 Pre/post test Mean (M) and Standard Deviation (SD) for Problem Focused coping (PF), Distraction Coping (DC), Avoidant Coping (AC), Support Seeking (SS) and Positive Cognitive Restructuring (PCR)

			Coping style				
			PF	DC	AC	SS	PCR
Therapy Group	<i>Pre test</i>	<i>M</i>	3.26	2.49	3.03	3.31	2.96
		<i>SD</i>	0.90	0.69	0.49	0.78	0.93
	<i>Post test</i>	<i>M</i>	3.57	3.41	3.02	3.76	3.17
		<i>SD</i>	0.63	1.03	0.61	0.63	0.54
Control Group	<i>Pre test</i>	<i>M</i>	1.94	2.57	2.72	2.26	1.83
		<i>SD</i>	1.14	1.29	1.22	1.02	1.01
	<i>Post test</i>	<i>M</i>	2.25	3.20	3.33	2.76	3.08
		<i>SD</i>	0.58	0.53	0.90	0.89	0.36

Symptom descriptives

The mean and standard deviation for the different scales of the YCPC can be found in table 3. At pre test, the level of functional impairment is significantly higher ($t(10) = -2.710$, $p = .02$) for the control group compared to the therapy group. In table 4 the distribution of participants between the cut off scores can be seen. In the therapy group the majority of the children (55.6 %) presented sub clinical symptom levels, and only one child (representing 11.1%) reported enough symptoms for a probable diagnosis at pre test.

At the post-test measurements two children reported enough symptoms for a probable diagnosis in the therapy group. In the control group the distribution stayed the same, although it has to be noted that this data does not show if participants shifted between cut off points.

Table 3 Pre/post test Mean (M) and Standard Deviation (SD) for Re-experiencing (RE), Avoidance & Numbing (AN), Increased Arousal (IA), Functional Impairment (FI) and Total score (TOTAL)

			Symptom subscale				
			RE	AN	IA	FI	TOTAL
Therapy Group	<i>Pre test</i>	<i>M</i>	3.00	4.89	4.11	2.11	15.56
		<i>SD</i>	3.50	3.95	5.18	2.71	15.49
	<i>Post test</i>	<i>M</i>	3.00	5.55	3.11	2.44	14.67
		<i>SD</i>	3.08	5.54	2.57	4.75	11.99
Control Group	<i>Pre test</i>	<i>M</i>	5.33	4.00	5.33	7.33	19.00
		<i>SD</i>	2.08	3.00	3.21	3.51	10.54
	<i>Post test</i>	<i>M</i>	5.33	4.00	5.33	2.33	20.00
		<i>SD</i>	6.65	1.73	5.77	3.21	3.21

Table 4 Pre/post test frequency (N) and percentage (%) distribution of the therapy group and control group per cut off score and YCPC subscales Re-experiencing (RE), Avoidance and Numbing (AN), Increased Arousal (IA), Functional Impairment (FI) and the Total score (TO)

		Sub clinical Cut off		Clinical attention Cut off		Probable diagnosis Cut off	
		<i>Pre test</i> N (%)	<i>Post test</i> N (%)	<i>Pre test</i> N (%)	<i>Post test</i> N (%)	<i>Pre test</i> N (%)	<i>Post test</i> N (%)
Therapy Group	<i>RE</i>	6 (66.7)	5 (55.6)	2 (22.2)	3 (33.3)	1 (11.1)	1 (11.1)
	<i>AN</i>	1 (11.1)	3 (33.3)	3 (33.3)	0 (0)	5 (55.5)	6 (66.6)
	<i>IA</i>	5 (55.6)	5 (55.6)	3 (33.3)	4 (44.4)	1 (11.1)	0 (0)
	<i>FI</i>	5 (55.6)	5 (55.6)	2 (22.2)	0 (0)	2 (22.2)	2 (22.2)
	<i>TO</i>	5 (55.6)	4 (44.4)	3 (33.3)	3 (33.3)	1 (11.1)	2 (22.2)
Control Group	<i>RE</i>	1 (33.3)	2 (66.6)	1 (33.3)	0 (0)	1 (33.3)	1 (33.3)
	<i>AN</i>	1 (33.3)	0 (0)	0 (0)	1 (33.3)	2 (66.7)	2 (66.6)
	<i>IA</i>	1 (33.3)	2 (66.7)	2 (66.7)	0 (0)	0 (0)	1 (33.3)
	<i>FI</i>	0 (0)	2 (66.7)	0 (0)	0 (0)	3 (100)	1 (33.3)
	<i>TO</i>	1 (33.3)	1 (33.3)	1 (33.3)	1 (33.3)	1 (33.3)	1 (33.3)

What is the effect of a creative expressive arts therapy intervention for traumatized children in South Africa on posttraumatic stress reactions?

A paired-samples t-test was conducted to compare symptom levels prior and after therapy in the therapy group (M= .89, SD = 12.70). It was expected that symptom levels in the treatment group would decrease. However, no significant decrease was found ($t(8) = .21, p = .839$).

An independent samples t-test was conducted to compare the pre/post test difference in PTSD symptoms between the waiting list group ($M = 1.00$, $SD = 9.54$) and treatment group ($M = -.89$, $SD = 12.70$). The expectation was that symptom levels would decrease more in the therapy group compared to the waiting list group. No significant difference was found ($t(10) = -0.233$, $p = .820$).

Does coping affect the way children experience posttraumatic stress prior to the intervention?

It was expected that Children who predominantly use distraction and avoidant coping strategies would experience more PTSD symptoms compared to children who predominantly use problem focused coping, positive cognitive restructuring or support seeking strategies. A linear multiple regression model proposed to evaluate how well the five coping styles predicted PTSD symptom levels. However, results from this analysis are not meaningful. Multicollinearity was detected between coping styles: 7 out of 10 correlations are strong to very strong (see table 5). A further negative indication for finding meaningful results with a linear regression model is the fact that the Variance Inflation factors (table 6) for three of the coping styles were above the most generally accepted rule of thumb of 10 (O'Brien, 2007).

Table 5 *Correlations between coping*

	1	2	3	4	5
1. Problem focused coping					
2. Distraction coping	.184				
3. Avoidant coping	.599*	.726**			
4. Support seeking	.955**	.397	.754**		
5. Positive cognitive restructuring	.959**	.105	.496*	.865**	

* $p < .05$

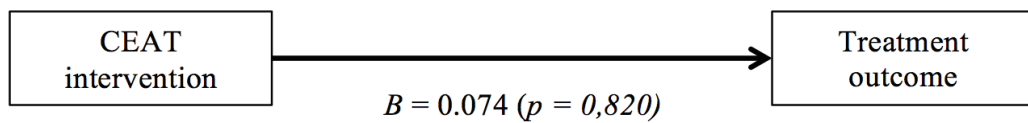
** $p < .01$

Table 6 *Variance Inflation Factor (VIF) for the 5 coping styles*

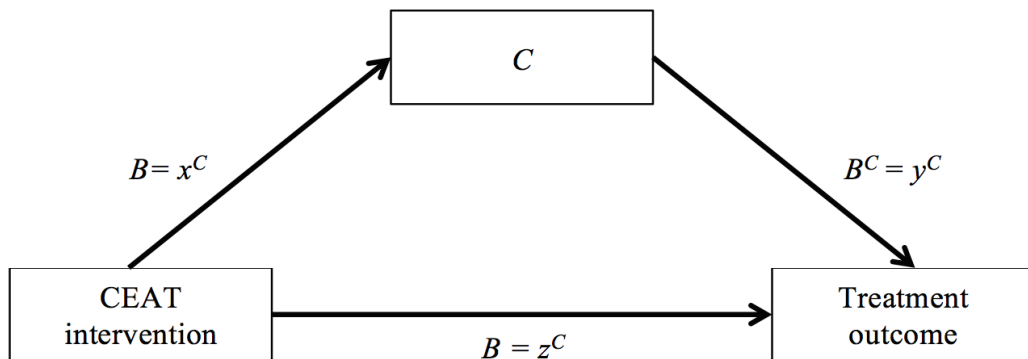
	Problem focused	Distraction focused	Avoidant coping	Support seeking	Positive cognitive restructuring
VIF	100,925	3,515	4,949	52,980	23,041

Is the effect of CEAT on posttraumatic stress symptoms mediated by coping style?

It was expected that coping strategies are a partial mediator on creative expressive arts therapy. Against expectations, no (partial) mediation has been found for any of the coping strategies. Figure 3 shows the casual steps mediation model: pathway *a*) shows the first step, or direct pathway. As shown earlier, the found data suggests the CEAT intervention had no significant effect on treatment outcome. The mediation model *b*) shows each step per coping style (*C*). If one fills in the corresponding value of the variable found in table 7, one can see all the Beta values per step in the mediation model.



a) direct pathway with Beta (B) and significance (p)



b) Mediation model

Figure 3. Casual steps mediation model

C = coping strategy

B = Beta

x, *y*, *z* = beta values for given *C* in Table X

Table 7 Beta values (*B*) for the mediation model per coping strategy (*C*) in figure X

Coping style (<i>C</i>)	$B = x^C$	$B = y^C$	$B = z^C$
Problem focused coping	-.712*	-.050	.038
Distraction coping	-.105	.043	.078
Avoidant coping	.215	-.103	.096
Support seeking	-.568	-.232	-.058
Positive cognitive restructuring	-.078	-.409	-.042

*significant at $p < .01$

Discussion

None of the hypotheses were confirmed in this study: there was no significant advantage found for children completing the creative expressive arts therapy, and coping was not confirmed as a (partial) mediator, nor as a predictor for PTSD symptoms.

Socio-economic circumstances

Most children in this study come from deprived areas with high unemployment and crime rates. CEAT aims to provide social support, safety and security, but ultimately the children return back to their unsafe environments. It is important that the traumatic events are perceived as a "thing of the past" (Beer & de Roos, 2012). This can be difficult to accomplish when the child is exposed to the same dangers as before. It is usually also recommended to involve close family members in the treatment process (Beer & de Roos, 2012). However, due to apartheid imposed work migration, traditional social bonds and family structures were torn apart, and have never truly been restored (Hunter, 2007; Petersen, Bhana, McKay, 2005). The fact that HIV is rampant and claiming lives in South Africa makes matters even worse. In 2005 reportedly 29 percent of the South African population had HIV, and the double of that amount in informal settlements (Shisana, 2005). As a result, many children do not have a stable social support system to fall back on. Ten sessions, once a week might not be enough to have a lasting impact, and prolonging the session period could be considered in some form of community program.

Another look at appraisal and coping

Distraction coping significantly increased in the therapy group between pre en post measurements, while the trauma symptom levels did not increase significantly. This observation is interesting for two reasons: firstly, CEAT was designed to decrease avoidant coping by improving communication skills and offering a safe place to express. Secondly, it is not consistent with results found by others.

An explanation for the deviation of the results can be found in the goodness-of-fit hypotheses (Zakowski, Hall, Klein & Baum, 2001). According to this hypothesis, the effectiveness of a coping strategy in reducing stress depends on the degree to which it

matches the situation as it is appraised. The appraisal of the locus of control seems to be especially important: controllable stressors may best be dealt with by using coping that is focused on the problem itself (i.e. problem focussed coping), whilst in the face of uncontrollable problems, a more emotion-focused approach may reduce distress more effectively. Applying the hypotheses to this PTSD study means that problem solving strategies would only lead to a lower number of symptoms if the traumatic stressor is appraised as controllable. Yet during CEAT, it is explained that the abuse was not the result of their actions. This might imply to the children that the situation was (and is) uncontrollable. In the last phase of the CEAT protocol there is an exercise emphasizing thinking about favourite things at bad times". This could actually encourage avoidant coping. Dempsey, Stacy and Moely (2000) found that avoidant coping can serve as a protecting buffer for increased arousal. This could explain why children applying avoidant coping strategies did not experience more PTSD symptoms compared to the other strategies.

Looking for theoretical explanations to explain the lack of significant results is important. However, the findings from this study can best be explained from a methodological perspective:

Attrition

One of the most visible problems in this study was attrition. The 37 approached participants all agreed on taking part in this study, yet only 28 showed up for the pre test, and less than half of the children who completed the pretest also completed the posttest. The decline in participants decreases the statistical power and is a threat for internal validity (Dumville, Torgerson & Hewitt, 2006). This means that producing significant and meaningful results is unlikely in this study.

The reasons for dropping out are obscure, because no specific reasons were communicated. Valuable information is lost about the participants, making it difficult in the analysis to control for specific traits. From observations during this study, it seemed that it was not the compliance of the children that was the problem, but rather the caregiver assigned to bring the child. Although transport fee was provided to make therapy as accessible as possible, the barrier to attend might still have been too high. During the pretest stage it was possible to have multiple dates, but during the

therapy stage this was not possible. The consequence was that the caregivers sometimes had to choose between work and bringing their child to therapy.

Validity of used research materials

Children and caregivers alike seemed to struggle with the presented questionnaires. All questionnaires were in English, but the majority of participants did not understand the items. As a consequence, the participants needed help from translators. Direct translation of a questionnaire does not guarantee content equivalence (Brislin, 1970; Cha, Kim & Erlen, 2007). In fact, it proved difficult for the translators to do so, because the appropriate translation did not exist in the native African language. Decentering, translating the item content without preserving the exact direct translation (Cha et al. 2007), was used to make the questionnaires understandable. Although necessary, it does potentially decrease construct validity. One positive argument for translating questionnaires is that participants tend to give more extreme responses on questionnaires when executed in their native language (Harzing, 2006), potentially making it easier to detect differences.

The participants did not only find the language difficult, but also the measuring scales. Both checklists use a five point answering scale, in which the participant is supposed to answer. Both children and adults were unfamiliar with this approach, and proved not intuitive for them to use. Especially the children needed constant reminding of what each number meant.

Furthermore, native South African cultures are considered to be collectivistic (Eaton, Louw, 2000). It is pointed out in literature that item response on questionnaires can be, and often is, biased by culture (Flaskerud, 1988; Lee, Jones, Mineyama, 2002; Harzing, 2006). It was found that social desirable response increases in more collectivist cultures (Harzing, 2006). The sensitive subject matter and the never truly private setting (due to the translator, who also happens to share a similar cultural background) could plausibly enlarge this effect.

Whether social desirable response bias and decentering truly affected the outcome in this study is uncertain but should be considered in further research. It does raise uncertainty whether the YCPC and the CCSC were the right instruments to detect symptoms and coping styles.

Reliability issues

Not only is the validity of the materials questionable, the responses are as well. There was no standardized translation for the used materials. Even though translators were instructed to translate the items content as exact as possible, it was impossible to check if this was carried out successfully because the researchers were unable to understand the spoken language. Because there were multiple pretest moments and multiple translators, it is likely that there was at least some variation in item translation, thus participants answered slightly different questions.

On the spot translation also caused the assessment to take longer than anticipated. This was straining the attention span of the children, causing them to be distracted and bored: The translators noticed that the children sometimes accidentally skipped items, answered them without understanding them and drew patterns on the questionnaires. Most of these problems were solved by immediate attention and motivating skills of the translators, but the reliability of the responses might still have suffered.

Positive notes

It is certainly true that this study suffered from (mostly practical) complications that potentially damaged both the validity and reliability of the results. Most of these, as noted before, are attributable to the social environment. However, this does not mean CEAT and this study approach were fundamentally flawed.

The choice to let local social workers do the therapy sessions proved vital to the therapy and completion of this study. The caregivers still have a great distrust towards Caucasians due to apartheid, and it is highly likely that the no show and drop out rate would have been much higher. Secondly, the social workers were able to tailor the activities most appropriately, because they stem from the same cultural background. Both social workers and caretakers noticed great behavioral progress in some of the treatment group children: they appeared to be less withdrawn, and exhibited less

destructive behavior. There also seemed to be a great sense of group coherence, and children actively supported each other. Though “enjoyment” is not a measure of treatment efficacy, the children voiced on more than one occasion that they enjoyed the ways in which they were allowed to express themselves during the sessions. Given these positive observations (subjective as they may be), it could be that CEAT is effective, but the results were “lost in translation” and further diminished by low statistical power.

Conclusion and Recommendations

Even though this study does not provide more evidence in favor of using creative expressive arts therapy for treating PTSD, some valuable lessons have been learned: In order to find reliable and valid results the first problem that needs to be addressed is finding cultural sensitive assessment methods for adequately detecting PTSD symptoms and coping strategies. The materials need to be translated appropriately to at least Zulu, Xhosa and Sotho (the three most spoken native South African languages) so that the assessment time is decreased and the validity of the questionnaires maintained. Future studies are also encouraged to develop methodologies that take extra measures to cope with high potential attrition. Given the low socioeconomic status of the targeted treatment group, it would be highly recommendable to do the therapy sessions in a central place like a school, where attendance is likely to be stable to decrease drop out.

It would be premature to conclude that CEAT is ineffective for treating posttraumatic stress, and coping unrelated. The conclusion is that highly controlled experiments are difficult to conduct in a challenging social environment like the one in this study. Even though much care has been taken during fieldwork, the significance and meaningfulness of the results could be compromised by the drawbacks mentioned. However, positive effects of CEAT have been observed by therapists and caregivers. Therefore, more research needs to be conducted to gain more and stronger evidence for the efficacy of Creative Expressive Arts Therapy.

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Appendix A

See the attached PDF file for the YCPC

Appendix B

(item number) *Original item* → *replacement item*

(3) You went bicycle riding. → you went playing outside

(5) You asked *your mother/father* for help in figuring out what to do → you asked your *caregiver/parents* to help you

(16) You told adults (*other than your [mother/father]*) what you wanted them to do.
→ You told adults (*other than your caregivers/parents*) what you wanted them to do.

(24) You told yourself that it *would* be OK. → you told yourself that it *will* be ok.

(30) You went skateboarding etc. → You went out to play football

(36) Read a book or magazine. → You did something fun. Like a hobby

(43) You talked to another adult, other than your [mother/father], who could help you solve the problem. → You talked to another adult, other than your caregiver/parent, to could help you solve the problem.

(52) . You did something like video games or a hobby. → You played games on your phone.

Appendix C

CHILDREN'S COPING STRATEGIES CHECKLIST-R2:

Sometimes kids have problems or feel upset about things. When this happens, they may do different things to solve the problem or to make themselves feel better.

Below is a list of things kids may do when faced with a problem. For each item, select the response that best describes how often you usually do the behavior when you have a problem. There are no right or wrong answers, just indicate how often you usually do each thing in order to solve the problem or to make yourself feel better.

RESPONSES:

(1) Never (2) Sometimes (3) Often (4) Most of the time (5) Always

WHEN YOU HAD A PROBLEM . . .

- ___ 1. You thought about what you could do before you did something.
- ___ 2. You told yourself that you could handle this problem.
- ___ 3. You went playing
- ___ 4. You daydreamed that everything was ok.
- ___ 5. You asked your parent/caregiver to help you.

WHEN YOU HAD A PROBLEM . . .

- ___ 6. You did something to make things better.
- ___ 7. You sought the help of God.
- ___ 8. You told yourself that things would get better.
- ___ 9. You tried to ignore it.
- ___ 10. You told your parent/caregiver how you felt about the problem.

RESPONSES:

(1) Never (2) Sometimes (3) Often (4) Most of the time (5) Always

WHEN YOU HAD A PROBLEM . . .

- ___ 11. You thought about why it happened.
- ___ 12. You tried to notice or think about only the good things in life
- ___ 13. You listened to music.
- ___ 14. You told adults (other than your parents/caregivers) what you wanted them to do.
- ___ 15. Tell myself it will be over in a short time.

WHEN YOU HAD A PROBLEM . . .

- ___ 16. Talk about how I am feeling with some adult who is not in my family.
- ___ 17. You told yourself you have taken care of things like this before.
- ___ 18. You put your trust in God.
- ___ 19. You play sports
- ___ 20. You talked about your feelings to an adult other than your parents/caregivers.

WHEN YOU HAD A PROBLEM . . .

- ___ 21. You imagined how you'd like things to be.
- ___ 22. You told your caregiver how you would like to solve the problem.
- ___ 23. You tried to make things better by changing what you did.
- ___ 24. You told yourself that it will be OK.
- ___ 25. You went for a walk.

RESPONSES:

(1) Never (2) Sometimes (3) Often (4) Most of the time (5) Always

WHEN YOU HAD A PROBLEM . . .

- ___ 26. You tried to put it out of your mind.
- ___ 27. You told your friends about what made you feel the way you did.
- ___ 28. You tried to understand it better by thinking more about it.
- ___ 29. You reminded yourself that you are better of than a lot of other kids.
- ___ 30. You went out to play soccer

WHEN YOU HAD A PROBLEM . . .

- ___ 31. You tried to stay away from things that made you feel upset.
- ___ 32. You talked with friends about what you would like to happen.
- ___ 33. You tried to find comfort in your religion.
- ___ 34. You thought about which things are best to do to handle the problem.
- ___ 35. You told yourself you could handle whatever happens.

WHEN YOU HAD A PROBLEM . . .

- ___ 36. You did something fun like a hobby.
- ___ 37. You wished that bad things wouldn't happen.
- ___ 38. You told your parent/caretaker how you felt.
- ___ 39. You did something to solve the problem.
- ___ 40. You told yourself that in the long run, things would work out for the best.

RESPONSES:

(1) Never (2) Sometimes (3) Often (4) Most of the time (5) Always

WHEN YOU HAD A PROBLEM . . .

- ___ 41. You did some exercise.
- ___ 42. You didn't think about it.
- ___ 43. You talked to another adult, other than your parent/caregiver, to
could help you solve the problem.
- ___ 44. You thought about what you could learn from the problem.
- ___ 45. You reminded yourself that overall things are pretty good for
you.

WHEN YOU HAD A PROBLEM . . .

- ___ 46. You watched TV.
- ___ 47. You avoided the people who made you feel bad.
- ___ 48. You told an adult, other than your caregiver, how you felt.
- ___ 49. You thought about what you needed to know so you could solve
the problem.
- ___ 50. You reminded yourself that you knew what to do.

WHEN YOU HAD A PROBLEM . . .

- ___ 51. You prayed more than usual.
- ___ 52. You played games on your phone.
- ___ 53. You wished things were better
- ___ 54. You figured out what you could do by talking with one of your
friends.
- ___ 55. You did something in order to get the most you could out of the
situation.

RESPONSES:

(1) Never (2) Sometimes (3) Often (4) Most of the time (5) Always

WHEN YOU HAD A PROBLEM . . .

___56. You told yourself that it would work itself out.

___57. You just forgot about it.

___58. You talked with your brother or sister about it.

___59. You tried to figure out why things like this happen.

___60. You reminded yourself about all the things you have going for you

WHEN YOU HAD A PROBLEM . . .

___61. You talked with your friends about your feelings.

___62. You avoided it by going to your room.

___63. You went for a run.

___64. You talked to your brother or sister about how to make things better.

Creative Expressive Arts Therapy Intervention Protocol for Traumatized Children

Nadine van Westrhenen, Elzette Fritz, Suzan Lemont, Helen Oosthuizen

In collaboration with:

The Teddy Bear Clinic, Utrecht University and the University of Johannesburg

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Child trauma

Creative Expressive Arts Therapy Intervention Protocol

The protocol described here has been developed to provide a short intervention for traumatized children aiming to enhance their psychological wellbeing and strengthening positive development. It aims to bring more uniformity in the management of child trauma in under resourced communities, and can be carried out by any qualified and trained health care professional while patients are seeking for help and relief.

1 APPROACH

The approach in this protocol uses creative expressive arts therapy, which is based on scientific evidence, combining knowledge of art with principles of psychotherapy and counselling (Malchiodi, McNiff, Rogers). Research demonstrates the efficiency of such an approach in working with traumatized children and is mainly based on five different principles:

- a) From a *neuroscience* perspective, traumatic memories seem to be fragmented and encoded as visual images and somatic sensations without translation into narratives
- b) According to the *psychoanalytic* perspective, traumatic memories are repressed memories stored in the unconscious and are not verbally accessible
- c) The traumatic *stress theory* supports a need for integration of the body and mind in therapy
- d) From a *social-cultural perspective*, the individual development is constructed through interaction with adults and peers, cultural beliefs and attitudes, plus cultural practices such as artistic and ritual play.
- e) From a *developmental* point of view, children have difficulties verbalizing and rationalizing experiences and emotions, they enjoy play and feel more comfortable expressing emotions in a less direct manner.

2 DEFINITIONS

Creative expressive arts therapy (here after referred to as CEAT) is an umbrella term covering the creative modalities of visual art, dance, drama, creative writing and music. CEAT integrates art practices, origins and applications, and the experience of art-making with principles of psychotherapy and counselling. Creative activity in itself does not necessarily lead to positive resolution, the goal of CEAT is to facilitate expression within a safe framework. This helps children explore feelings and experiences but without reinforcing traumatic memories, providing an opportunity for transformation (Malchiodi, 2008).

<i>Post-Traumatic Stress Disorder (PTSD) DSM-V (APA, 2013):</i>

Criterion A: stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): (1 required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (1 required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (2 required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (2 required)

1. Irritable or aggressive behavior.
2. Self-destructive or reckless behavior.
3. Hyper vigilance.
4. Exaggerated startle response.
5. Problems in concentration.
6. Sleep disturbance.

Criterion F: duration

Persistence of symptoms (in Criteria B, C, D and E) for more than one month.

Criterion G: functional significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion

Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

1. Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
2. Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

Specify if: With delayed expression.

Full diagnosis is not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

3 TARGET GROUP

This intervention is aimed for children between the ages of 8 and 12 years who have experienced a traumatic event and show symptoms of distress or functional impairment as stipulated in the DSM-V. When incorporated in an evaluation study, criteria of inclusion must be strictly applied and the child must be diagnosed with PTSD. At times where no evaluation is taking place, children that display distress after experiencing a traumatic event in line with Criterion A of the DSM-V may join the programme without meeting the strict PTSD diagnosis.

4 TIMING FOR STARTING THERAPY

This therapeutic approach is not aiming to heal deeply-rooted trauma, but focuses more on providing some relief and stronger coping mechanisms. The therapy can therefore be started any time between 1 month and 2 years after the traumatic event took place. Mostly, when the child enters the clinic and symptoms of distress are noticed, the child can be referred to the therapy. It is recommended not to start within a month after the event in order to not disrupt the natural processing of the event. Children can be referred by intake workers or social workers, as well as by psychologists after a short screening of the situation.

5 GOALS OF THE THERAPY INTERVENTION

The optimal goal should be to promote resilience, aiming to strengthen the children's coping strategies and offer a safe space for children to express their emotions concerning the trauma.

More specifically, the following goals are expected to be met at completion of the therapy:

1. An increased knowledge of the emotional and physical effect of abuse
2. A reduction in stress-related or posttraumatic symptoms
3. An increase in posttraumatic growth
4. An improvement in identification of emotions
5. An improvement in communication of feelings with peers and adults
6. An increased sense of social support from other group members and the therapist
7. An improvement in personal skills and resilience to cope with future crisis

The goals per session will be outlined hereunder.

6 PLANNING THE GROUP THERAPY

This group therapy is for traumatized children. The group consists of six to eight participants and is designed to meet ten 2-hour sessions. Group members should be of the same gender if possible and the same developmental level. Also, the nature of the traumatic event and the severity of traumatic reactions need to be considered carefully when putting a group together. It is important to establish a safe space for all group members to make them feel comfortable with each other to find common support.

Informed consent must be provided by the parents or caregivers before the group starts, and also informed assent can be obtained from the children. It is important to get a commitment in writing from the parents or caregivers that the children will attend weekly group sessions for the whole period of 10 weeks. An information session can be held before the first group starts to explain the process, collect the signed forms and to give a brief summary of what the intervention is about. Any questions or concerns from the parents or caregivers can be addressed immediately.

The following list represents items that are required or recommended for the therapy sessions:

- Tables and comfortable chairs
- Pillows and floor mats for relaxation activities
- Art materials:
 - o Paper (*good quality white and coloured drawing paper*), flipchart paper, 1 large paper for group collage
 - o Drawing tools (*graphite pencils, pens, coloured pencils, pencil sharpener, crayons, felt markers, coloured chalks, oil pastels, paint*),
 - o Clay
 - o Clothing protectors (old shirts, aprons)
 - o Handy-wipes for cleaning hands,
 - o Magazines for collages
 - o Decorative materials (stickers, ribbons)
 - o Glue or photo stickers
 - o Hairspray (to keep an image from smudging; only use in a well-vented area)
 - o Water
- Kitchen timer
- Mood cards
- Variety of musical instruments
- Music player and recorded music variety (Mp3, phone, laptop, something to play songs from during breaks) including the song 'my favourite things'
- An assortment of cuddly/stuffed toys, puppets & dolls of appropriate materials and representing a variety of preferences
- Snacks for breaks and stickers or tokens as treats
- Specific materials for 1 session only:
 - o Book Brave Bart
 - o Bubble blowers
 - o Plain masks

- Photo camera
- Medium boxes
- Certificates

7 GENERAL PROGRAMME OUTLINE

The general outline for intervention is based on the trauma recovery model that was introduced by Judith Herman (1992). It includes three phases 1) establishing safety, 2) telling the trauma story, and 3) restoration of connection between traumatized individuals and their communities.

Important when working with traumatized children is that the sessions provide some structure to establish safety and security. Therefore the structure of the programme every week will be similar, starting with a check in activity, followed by the main activity 1, always related to the theme of the week. Then a snack break of ten minutes is held, in which the facilitators can play some music and children can do some free play. Then activity 2 is commenced, also relating to the theme of the week. Finally, a check out is done and a short preview for the following week is provided. It is important to start and finish the sessions in time, punctuality is asked from the children (and parents that bring the children to the clinic) as well as the facilitators.

Activities will be purposeful but allowing for as much freedom as possible, avoiding too much guidelines limiting artistic expression. It is believed that the artistic process itself is healing and needs to be directed by the child, not the facilitator (Virginia Axline).

The table hereunder summarized the general outlines of the therapy programme.

Week	Phase	Session theme	Activity 1	Activity 2
1	Creating a safe space	Introduction	Group rules	This is me
2		Psycho-education	Brave Bart	Scribble to music
3		Safe space	Safety symbols	Mirrored dancing
4	Telling the story	Emotion identification	Name the feeling	Emotional drama
5		Trauma telling	What happened	Bubbles of hope
6		Emotion regulation	Mask	Powerful/powerless
7	Returning to community	Strength finder	Hero's play	My favorite things
8		Community support	Music group	Helping hands
9		Meaning making	Past/Present/Future	Group photo shoot
10		Goodbye	Memory box	Certificate ceremony

8 SESSION BREAKDOWN

PHASE 1 CREATING A SAFE SPACE: SESSION 1-3

In the first phase of the intervention it is important to establish a safe space. This means for the group members to trust each other and to feel safe in the group and in the therapeutic environment. When feeling insecure and unsafe, the children will not be able to disclose what happened or express how they feel, thus benefit from the therapeutic process.

Rules about physical contact must be discussed, stating clearly that hitting or other forms of physical assault and verbal abuse are not acceptable or tolerated. Consequences of breaking the rules will be discussed. Confidentiality must be understood, except for cases of danger and harm to the child as this must be reported. Initially, rules will be established within the group and everybody gets a chance to introduce themselves.

In preparation of expressing the traumatic story (phase 2), self-care is emphasized through identifying resources, situations and strategies for reducing stress when uncomfortable feelings arise like anxiety, fear, guilt or shame. Relaxation will be practiced regularly in this phase of treatment, through breathing techniques, movement and music.

SESSION 1

Theme: Introduction

Goals: Getting to know each other, creating trust and a safe space, setting group rules

Duration: 120 minutes

Materials: Talking Teddy, Flipchart paper and markers, pen and A4 paper, music player, variety of instruments, photo camera

Check in*: 20 minutes

Goals: Opening the session, practicing sharing and listening, get a sense of how everyone is feeling, exploring goals of the programme.

Description: Every week, the session starts with 20 minutes sitting in a circle and discussing how everyone is feeling and if they want to share how their week was. Mood cards are used to indicate what emotions they are feeling. This first session specifically is also a short introduction of the programme and what the children can expect to come. Other weeks there will be a quick revision of what has been done in the previous session. What do the children remember about this and what was important to them?

Name game: 15 minutes

Goals: Learning each other names, practicing listening skills

Description: Everyone takes turns, the child has to say their name and think of an animal name that starts with the same letter as their own name. Then they are asked to act like that animal they have in mind. The whole group has to repeat this, saying out loud the name of the child and repeating the acting.

Activity 1: Group rules: 15 minutes

Goals: Setting rules, group cooperation, group collaboration

Description: The group will brainstorm about the rules they want to set for the group. Also, the facilitators can suggest some important rules if they are not being mentioned. The facilitator writes them out on a big poster format, after the group can add to it in the form of drawing symbols and 'signing' the agreement. This poster will be put up in the room every session.

Snack break: 10 minutes (during the snack breaks some music can be played and the children can engage in free play).

Activity 2: This is me: 50 minutes

Goals: Getting to know each other, sharing and creating trust, practice listening

Description: This activity consists of two separate exercises.

1) “creative introduction”: an introduction in groups of two, children will get fifteen minutes to prepare a play, drawing, dance or song to introduce themselves to the group. They will be asking questions to each other and then will present their partners to the group. (this is ..., she likes ...). (30 minutes)

2) “Object blanket”: each child brings a meaningful or special object with them to the first session. They take turns telling the story of the object as they place it on the blanket. When everyone has shared their story/object, they can look at the scene they have created on the blanket and anyone can choose to then place their object somewhere else on the blanket, to refer to how they relate to the other objects/stories. Taking a picture of this to share with them at the end is a nice touch and provides a visual reminder. (20 minutes)

Check out*: 10 minutes

Goals: To recap what has been done, what has been enjoyed most about today, to check how everyone is feeling, and to see what is going to be on the programme next time.

Description: The same mood cards that were used with the check-in are used to indicate how everyone is feeling after today’s session. They can indicate what they learned, what they liked most and what they liked least. Also a quick announcement will be made about what is to come in the next session.

*this activity will remain the same every single week apart from the final session. During the check in and check out, the ‘talking Teddy’ will be used: whoever holds the talking Teddy does not get interrupted and has everyone’s full attention. If you don’t hold the talking object then you are paying attention and not talking or disrupting. If you really must comment or react, you can ask for the talking object.

SESSION 2

Theme: Psycho-Education

Goals: Normalizing feelings, opening-up communication, practicing relaxation

Duration: 120 minutes

Materials: Talking Teddy, Book Brave Bart, drawing materials and paper, recorded music

Check in: 20 minutes

Activity 1: Reading story of Brave Bart: 40 minutes

Goals: Identification with non-threatening character, normalizing feelings, opening up communication.

Description: Read the story of Brave Bart, a cat who is traumatized and participates in a group for other traumatized cats and afterwards ask these questions to the group:

- What do you think happened to Brave Bart?
- Have you ever had something very bad, sad, or scary happen to you: Do you want to tell me what happened?
- What are some feelings you have had that are like the ones that Brave Bart had?
- Brave Bart and Helping Hannah came up with a list of ways to feel better. Can you think of some ways to help yourself feel better when you are feeling sad, mad or nervous?
- Who can you talk to when you are feeling sad, lonely or mad?

Snack break: 10 minutes

Relaxation 1: Walking and breathing: 10 minutes

Goals: Control over body, physiological calming, breathing awareness

Description: This exercise starts with just breathing in and out and tuning in. Then everyone begins to walk slowly around the room with everyone following their own path. After a while, have the children count how many steps he/she is taking with each breath. After about five steps ask the child to slow their breathing so that they take three steps per breath. Continue gradually increasing the number of breaths per step until the breaths are long and slow. If time is left, this can be followed by movement to music.

Activity 2: Scribble to music: 30 minutes

Goals: Encourage spontaneous expression, “free associate” thoughts and feelings through images that communicate fears, conflicts, and other emotions

Description: This exercise can be done twice, on upbeat music and one on slower/reflective music. Children listen to the music and start drawing a series of scribbled lines on paper and then looking at those lines to see shapes, figures, or objects that can be further articulated with details and color to define them.

Check out: 10 minutes

SESSION 3

Theme: Safe Space

Goals: Enhancing feelings of safety and self-control, practicing self-soothing techniques and mindfulness
Duration: 120 minutes
Materials: Talking Teddy, Drawing materials and paper, recorded music

Check in: 20 minutes

Relaxation 2: Favorite place: 15 minutes

Goals: Distraction, self-soothing, mindfulness

Description: Start the exercise by breathing and tuning in. Help the children visualize a place that feels safe and comfortable (indoors or outdoors). Ask questions about what things would be around them. What do they see? What would it smell like? What would the temperature be? Is there music playing? Let the child be totally in control of the imaginary space.

Activity 1: Safety symbols: 45 minutes

Goals: Creating safety symbols, relaxation, providing relief

Description: A little discussion will be held about different kinds of symbols such as personal, cultural, and global/archetypal/universal and that the meanings can vary on these levels and also overlap. 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 have to create this symbol in a drawing.

Snack break: 10 minutes

Activity 2: Mirrored dancing: 20 minutes

Goals: Increase connection between children, improve self-control, improve ability to follow directions from someone else, body awareness, and mindfulness

Description: The group is going to do a mirroring activity on recorded music. The couples stand in front of each other, facing each other. One will take the lead and the other person need to copy everything the other one does, at the same pace just like he or she is a mirror. After a while the children can move from the mirroring into complimentary movements (so not copying anymore, but creating a nice flowing or unified pattern together that is also made up of individual movements/responses).

Check out: 10 minutes

PHASE 2 TELLING THE STORY: SESSION 4-6

Telling the story involves activities that encourage the children to share their traumatic experiences in order to disclose and provide relief. By telling the story the aim is that the children regain their ability to experience and enjoy life and giving the bad things that happened a place. Support is very important in this phase of intervention, and the facilitator provides a modelling role in how to be supportive to the other group members. The relaxation techniques practiced in the first phase of the intervention become very important now to reduce anxiety and stress reactions that come with the reminders of the traumatic event. It is important to continuously provide a safe space and give the children space to

express the trauma in ways and speed they prefer, as long as they don't hurt themselves or anyone else and they don't leave the space where they are being witnessed. Emotions are identified and emotional regulation is practiced.

SESSION 4

Theme: Emotion identification

Goals: Identifying and validating feelings, improving emotion vocabulary

Duration: 120 minutes

Materials: Talking Teddy, Recorded music variety, pen and paper

Check in: 20 minutes

Activity 1: Name the feeling: 30 minutes

Goals: Identifying feelings, experiencing emotions

Description: Bring a selection of music. Take turns playing the music and being the “feeling actor”. The feeling actor needs to decide what feeling that particular piece of music evokes and then act it out (with facial expression and body language). The other group members need to guess the feeling. In group discussion, the feelings are validated, and the children are encouraged to think about what they can do to experience more of the feelings they enjoy the most, that is, how could these feelings take up more space inside their lives?

Snack break: 10 minutes

Activity 2: Emotional drama: 50 minutes

Goals: Emotion identification, emotion vocabulary

Description: Write a variety of emotion words on different slips of paper and put them in a hat. Let the group create a ‘boring’ script together, a dialogue without any emotions. Read through the script once, with two children taking a role. Now every child draws an emotion from the hat, without showing the rest of the group. Each pair enacts the script, with each person enacting his/her role as if he/she was experiencing the emotion that he/she drew from the hat. Try to guess the emotions and ask feedback about why you guessed that emotion. Continue until all of the emotions have been drawn.

Check out: 10 minutes

SESSION 5

Theme: Trauma telling

Goals: Providing transformation through disclosure, giving the trauma a voice and place

Duration: 120 minutes

Materials: Talking Teddy, Drawing materials and paper, bubble blowers

Check in: 20 minutes

Activity 1: What happened: 70 minutes

Goals: catharsis, traumatic story expression, relief, giving the bad experience a space

Description: the children are asked to draw what they experienced during the traumatic event. This is a very sensitive topic and time must be taken to make sure everyone can express what happened. After this, children can make a second drawing about 'what would make what happened better'. There must be enough time to discuss and reflect.

Snack break: 10 minutes

Activity 2: Bubbles of hope & relaxation 3: 10 minutes

Goals: Regulating emotions, reducing distress, practicing relaxation, enhancing positive feelings.

Description: Blowing bubbles combined with saying things of hope

Check out: 10 minutes

SESSION 6

Theme: Emotion regulation

Goals: Understanding emotion regulation, and powerful and powerless emotions

Duration: 120 minutes

Materials: Talking Teddy, Pictures for collage, poster board, glue sticks, plain masks, decorations for the masks, paint

Check in: 20 minutes

Activity 1: Making masks: 40 minutes

Goals: develop self-concepts, regulate emotions, and differentiate between internal and external emotions

Description: Provide the children with plain masks, the children are going to decorate the masks, and distinguishing between the inside (only noticeable for yourself) and the outside (how do others see you). This exercise is introduced by teaching them that one can feel different inside than others see you from the outside.

Snack break: 10 minutes

Activity 2: Powerful/powerless: 40 minutes

Goals: Distinguishing between powerful and powerless, identifying powerful feelings

Description: Create a collage that represents what the feelings of powerful and powerless mean to you." If I am working with a group, I might initiate a short discussion about these two feelings and give them some options for how to construct the collages. Suggest that they can fold the paper in half and put the images of powerful on one side and images of powerless on the other. Or, if they want to, you can mix them up in any way that you like." After everyone finishes creating the collages, let each present their pictures to the group. Have each child talk about at least one image in his or her collage that represents "powerful" and one that was chosen to show "powerless." Depending on how the discussion unfolds, participants may want to share their own experiences with trauma, including whether they have been the targets of bullying (powerless) or been a bully (powerful).

Check out: 10 minutes

PHASE 3 RETURNING TO COMMUNITY: SESSION 7-10

The final stage of the intervention focusses on preparing the children to go back to their normal lives and to give the traumatic experience a place. This means the focus will be on resilience and coping strategies. Communal support is very important. A part of the final phase of the intervention includes revising accomplishments and achievements and emphasizing children's strengths as a source of self-esteem. Enough time should be taken to prepare the goodbye to the group, especially due to the history in the children's life of abandonment.

Announcement of termination should be mentioned every session in this phase, so they can slowly get used to it. Available support in future should be highlighted.

SESSION 7

Theme: Strength Finder
Goals: Emphasizing strengths and reminding of favorite things as coping strategy
Duration: 120 minutes
Materials: Talking Teddy, Song my favorite things, arts and craft materials, clay

Check in: 20 minutes

Activity 1: Hero's play: 50 minutes

Goals: Emphasizing strengths, expressing powerful emotions

Description: The group is going to create their own story about a hero and then act it out. First some elements are established for the story: when is it taking place, where, some colors that must appear in the story, who is the main character? All children take turns telling the story, by saying 'yes and', so to continue as follow up on the previous sentence(s). Make sure all elements are coming back. Then the group is split into two and the two groups make their own play based on the story that has been told. At the end a reflection will emphasize the strengths that the hero has, and how they can relate to their own strengths in their lives.

Snack break: 10 minutes

Activity 2: My favorite things: 30 minutes

Goals: Reminder of favorite things, coping at bad times

Description: First the group will sing the song of the sound of music of 'my favorite things'. Then the children can create a collection of their favorite things, making them from clay or drawing them on paper, anything they prefer.

Check out: 10 minutes

SESSION 8

Theme: Community support
Goals: Emphasizing group connection and support networks
Duration: 120 minutes
Materials: Talking Teddy, Diverse musical instruments, paint, pen and paper

Check in: 20 minutes

Activity 1: Musical group: 20 minutes

Goals: Group connection, finding your place in the group, learn to listen, communicating without words, enhance team building

Description: The group is divided into two; one group starts clapping a rhythm, one person after the other adding their own rhythm to the group, finding their place in the group. The other group can then respond to that by making sounds with the mouth or instruments, also one after the other, finding their voice in the

group. Then the two groups were combined. It can be experimented with sounds and songs.

Snack break: 10 minutes

Activity 2: Helping hands: 60 minutes

Goals: Emphasizing support networks, teaching emergency actions

Description: This activity consists of 2 exercises.

1. The children are going to draw the outline of their hands on a paper and in every finger they write a person that they have in their lives that can help them in times of emergency. This can include the therapist or other children in the group. Then they can decorate it however they like.
2. Now with their individual drawings they make a community collage. Put a big piece of paper on the wall and let them place their hand drawings/collages on them, and keep re-arranging or placing until it feels just right in terms of where they fit in the community and with themselves. This relates back to the object blanket from the first session. Take a picture and send/give to each child to remind them that they were/are part of a bigger picture.

Check out: 10 minutes

SESSION 9

Theme: Meaning making

Goals: Reflection on learning and emphasizing growth

Duration: 120 minutes

Materials: Talking Teddy, Pictures for collage, glue sticks, photo camera, arts materials

Check in: 20 minutes

Activity 1: Past/present/future: 40 minutes

Goals: Reflection on therapy process, emphasizing transition and growth

Description: The children can make a threefold collage, summarizing where they were when they came into the group, how they are feeling now, and how they see their futures. Collages can be presented to the group at the end.

Snack break: 10 minutes

Activity 2: Photo shoot: 40 minutes

Goals: Enhance group cohesion, making memories

Description: In order to make a memory and to give the children something to take home next session that reminds them of the group, this time will be spend on doing a nice photo shoot. Children can create things for the photo shoot (i.e. hats, glasses) and think of some happy poses, as well as places in and around the venue where they can make pictures.

Check out: 10 minutes

SESSION 10

Theme: Goodbye

Goals: Saying goodbye to the group, leaving them with hope and positive memories

Duration: 120 minutes

Materials: Talking Teddy, Arts materials, decorative materials, medium boxes, group photos, certificates

Check in: 20 minutes

Activity 1: Memory box: 60 minutes

Goals: Emphasizing learnings, lessons, strengths, group support, making something to take home

Description: Children are provided with medium boxes made out of paper and are asked to decorate their boxes. In addition to crayons, colored pencils, and markers, a variety of decorative materials are provided such as feathers, glitter, stickers, fabric, and pipe cleaners, which they are encouraged to use. Participants are asked to write down one or two central ideas they are going to take with them from the group and put these messages into their box. Also, they are asked to write messages for other members of the groups, and combined with the photos from the previous session they can take this home along with all other arts and crafts produced in the sessions.

Snack break: 10 minutes

Activity 2: Certificate ceremony: 20 minutes

Goals: Emphasizing growth, strength, achievement of finishing the therapy, closure ritual

Description: Finally, there is a certificate of completion for all group members to put into their boxes. A ceremony is held, in which the children are praised for their participation, courage and one or two special skills are emphasized of each child.

Check out: 10 minutes

9 PROGRESS NOTES TEMPLATE GROUP

Date: _____ Group facilitator (s): _____

Number of attendees: _____ Names of absent children: _____

Time started: _____

Time finished: _____ Topic: _____

Comments on group:

Participation:

Behavior/emotions:

Stressors/Extraordinary events/New issues presented today:

Goals/objectives progress:

Facilitator 1: _____

Facilitator 2: _____

Supervisor: _____

Date: _____

Date: _____

Date: _____

10 PROGRESS NOTES TEMPLATE INDIVIDUAL

Date: _____ Group facilitator (s): _____

Topic: _____ Name of child: _____

Mood check-in: _____ Mood check-out: _____

PARTICIPATION *(Check all that apply):*

ATTENTION	<input type="checkbox"/> Normal <input type="checkbox"/> Confused	<input type="checkbox"/> Inattentive <input type="checkbox"/> Passive	<input type="checkbox"/> Distractible
ATTITUDE	<input type="checkbox"/> Cooperative <input type="checkbox"/> Irritable <input type="checkbox"/> Hostile	<input type="checkbox"/> Uninterested <input type="checkbox"/> Suspicious <input type="checkbox"/> Variable	<input type="checkbox"/> Resistant <input type="checkbox"/> Friendly <input type="checkbox"/> Dependent
AFFECT & MOOD	<input type="checkbox"/> Normal <input type="checkbox"/> Euphoric	<input type="checkbox"/> Anxious <input type="checkbox"/> Labile	<input type="checkbox"/> Depressed <input type="checkbox"/> Angry
THOUGHTS	<input type="checkbox"/> Goal-directed	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Loose associations
INTERPERSONAL	<input type="checkbox"/> Showed empathy <input type="checkbox"/> Not respectful of others	<input type="checkbox"/> Discussed meaningful personal issues <input type="checkbox"/> Attention-seeking Disruptive	<input type="checkbox"/> Provided helpful feedback
GOALS	<input type="checkbox"/> Significant change throughout the session. Please see comments below		

COMMENTS:

Facilitator 1: _____
Date: _____

Facilitator 2: _____
Date: _____

Supervisor: _____
Date: _____