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EFFECTS OF CREATIVE THERAPIES IN WOMEN EXPERIENCING SYMPTOMS  
OF POSTTRAUMATIC STRESS DISORDER

by

Caitlin Bolte

A Thesis Submitted in Partial Fulfillment  
Of the Requirements for the  
University Honor Program

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Department of Health Science  
The University of South Dakota  
May 2018

The members of the Honors Thesis Committee appointed  
to examine the thesis of Caitlin Bolte  
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## ABSTRACT

### Effects of Creative Therapies in Women Experiencing Symptoms of Posttraumatic Stress Disorder

Caitlin Bolte

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This paper explores the observed impact that creative therapies (CTs) may have therapeutically on women (ages 18-64) who are experiencing symptoms of Posttraumatic Stress Disorder (PTSD). The goal to explore women's changes in symptoms and outcomes after the participation in a CT was achieved by conducting interviews with qualified therapists who spoke of their perceptions of their female clients' effects. The study found supporting evidence of therapists' perspectives mirroring the literature and validating the positive effects CTs have to reducing PTSD symptomology. Medication and psychotherapy are common evidence-based treatments. According to the literature, clients can use CT forms including art, dance/movement, drama, expressive art, and music in tandem with or in place of the traditional treatment methods. A qualitative approach was utilized, and data was analyzed using grounded theory methodology. Results were inconclusive, but the themes observed aligned the current literature. Social support and positive emotional affect were the most supported themes with increased prevalence after the use of CTs.

**KEYWORDS:** *creative therapy, PTSD, women, symptom reduction*

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## **Introduction**

The purpose of this paper is to further understand the observed impact that creative therapies (CTs) may have therapeutically on women (ages 18-64) who are suffering symptoms of Posttraumatic Stress Disorder (PTSD). The study's goal was to explore how therapists perceived the women's changes in symptoms and outcomes after the participation in a CT. The aim of the study was to interview practicing creative therapists regarding their perceptions of a client's positive, negative, or lack of perceived effect on the symptoms and outcomes associated with PTSD. The hypothesis is that the therapist's perspective will align with the literature and validate the positive effects CTs have on reducing PTSD symptomology in women (ages 18-64). A need for this study exists as available research reflecting the therapist's perspective exists. Any information obtained is solely for educational purposes and advancement of this field. This paper focuses on the uses of CT forms including art, dance/movement, drama, expressive art, and music. Merriam-Webster's medical definition of therapy is "remedial treatment of mental or bodily disorder" or "an agency (as treatment) designed or serving to bring about rehabilitation or social adjustment" ("Therapy", 2018). In summary, practices that are therapy-based intend to reduce symptomology of a disorder.

Posttraumatic Stress Disorder affects approximately eight million Americans civilian adults in a year (Reisman, 2016). The exact number of people experiencing PTSD is hard to calculate as many people may not have a diagnosis but may experience symptoms. That said, women are twice as likely as men to develop PTSD. One of every

nine women will experience PTSD at some point in their live (PTSD United, 2013) These statistics exemplify the significance of this topic.

Investigation of this topic is imperative to study due to the anticipated implications on the health care field. Evidence-based research illustrates use of medication and psychotherapy as popular treatments recommended by physicians, but studies are demonstrating that other methods of treatment may also be useful in symptom reduction for PTSD (Reisman, 2016). These new methods may help clients who do not respond to the current evidence-based treatments (Hamblen, Schnurr, Rosenberg, & Eftekhari, 2016). Creative therapies could be one of those new methods. Evidence is showing art-based interventions are effectively reducing psychological and physiological symptoms (Stuckey & Nobel, 2010). Incorporation of CT affords patients the safety, comfort, and ability to cope with their feelings in an expressive manner (Smyth, n.d.). Amanda Mitchell reports that dance/movement therapy can allow participants to gain internal control and a sense of safety and security (Mitchell, 2015). Creative therapies have the potential to reduce patients' symptomology and improve emotional well-being. Music therapy has shown to reduce the amount of emotional pain and strengthen social connections, thereby improving an individual's well-being (Landis-Shack, Heinz, & Bonn-Miller, 2017).

The use of CTs in the health care field is valuable. It can be anticipated that an understanding of the use of CTs may assist health care professionals in building rapport, offering advice on alternative treatments to medication, and helping patients get the care they need and desire. Using art-based interventions for treatment can be an advantage in health care because an infinite number of people can perform art, so it expands the pool

of individuals that are able to use this treatment form. As referenced in studies performed with seniors, refugees, families, children, and numerous health conditions and disorders, CTs appear to be accessible by a diverse array of ages, genders, races, and religions.

## **Literature Review**

This section provides a definition of Posttraumatic Stress Disorder (PTSD) and presents an overview of the symptoms associated with PTSD. Female clients were the primary observed population researched. Included is a brief discussion of popular treatment options, both psychotherapies and medications. This section also discusses five CTs including art, dance/movement, drama, expressive art, and music as treatment options clients can use in tandem with or in place of the traditional treatment methods. It is important to note that these CTs are neither compared in success or relevance to psychotherapies and medications, nor are those current, popular treatments refuted.

### **Posttraumatic Stress Disorder**

Both the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013) and the U.S. Department of Veterans Affairs (USDVA): National Center for PTSD (2017c), categorize Posttraumatic Stress Disorder (PTSD) as a mental health problem. People who develop PTSD have typically experienced a life-threatening or life-altering event (APA, 2013). Examples of traumatic events may include war or combat, severe accidents, sexual assaults, natural disasters, active shooters, terrorist attacks, or personal assault, among many others (USDVA, 2017c). These examples are only a few of the most prominent situations that may cause an onset of PTSD and are not a comprehensive list.

Each individual experiences an event in an entirely different manner.

Interpretations of traumatic events can vary for each person and as a result, there is a wide range of reactions after a trauma. Phenomenology is a theory that helps describe this concept. This approach focuses on the individual's bodily experience, as felt from within, to help understand the traumatic experience (Ataria, 2013). Edmund Husserl's phenomenological approach to PTSD, including his theory of consciousness and human experience, helps to understand the experiences people with PTSD symptoms face while allowing flexibility for individual variation in the experiences and recovery (Larrabee, 1995). A traumatic event may cause psychological distress to one person and not another, making that specific event one that would not trigger PTSD in the second individual (National Institute of Mental Health, 2016).

After experiencing a traumatic event, it is typical for an individual to have feelings of stress or to feel overwhelmed. This may change and/or alter behavior. For most people, these feelings and behaviors tend to decrease over time (American Psychiatric Association (APA), 2013). However, if they persist for more than three months or are causing disruption in home or work life, it is advisable to seek help in dealing with both the traumatic situation and the feelings or behaviors it caused (National Institute of Mental Health, 2016). A licensed clinician with experience or training in mental health can work with individuals experiencing PTSD. Licensed psychiatrists, psychologists, counselors, and/or therapists are all examples of capable mental health clinicians. According to the DSM-5, for a mental health professional to diagnose an individual with PTSD he or she must experience symptoms in four categories and these disturbances must exceed one month's time. In the case of a delayed onset of symptom

expression it may be six months or longer before an individual obtains a diagnosis with the disorder (American Psychiatric Association (APA), 2013).

### **Symptoms**

According to the USDVA's article "What is PTSD?" (2017c), typical symptoms of PTSD include upsetting thoughts or memories, feeling on edge, or having trouble sleeping after the traumatic event. Disruption of normal, daily activities may occur, and it may take a while for the individual to engage in his or her previously normal activities. Depending on the traumatic event, the individual, and the severity of symptoms, some may never be able to return to or complete certain daily activities. Symptoms of PTSD may start immediately after the triggering event or some individuals may experience a delay in the onset for up to a few days, weeks, or months. The length of time depends on the person and his or her personal situation. An individual's age, gender, race, cultural experiences, socioeconomic status, and/or previous exposure to a traumatic event can impact triggering events (USDVA, 2017c).

As stated in the DSM-5 (APA, 2013), a PTSD diagnosis requires a perceived traumatic event. However, this exposure does not have to be direct; a person may also witness or learn of the event. For some, the unexpected, unnatural death of a loved one in the family or a close friend can be so traumatic that it could cause an onset of PTSD (APA, 2013). Many individuals, whether affected by PTSD or not, may not realize a person with PTSD experiences symptoms that are correlated with the body's physiological response to stress. Posttraumatic Stress Disorder is not only a mental health

problem, but also a biological disorder that is continually triggering a survival response to unregulated stress in the nervous system (van der Kolk, 2015).

The DSM-5 recognizes four categories of PTSD symptoms. They include intrusive thoughts, avoiding situations reminiscent of the event, having increased negative thoughts and feelings, and hyperarousal. Nightmares and flashbacks are common instances of the first category, intrusive thoughts, and cause one to relive the traumatic experience (APA, 2013). However, picture forms (often called flashbacks) are not the only kind of these intrusive thoughts. Lee and James (2011) explain traumatic events involve all five senses. Therefore, intrusive thoughts often can include multiple senses. People may see pictures, hear sounds, smell or taste things, or have a feeling in the body. Flashback sufferers can smell things and people that are not actually there, causing threat-based emotions like fear and anxiety to emerge (Cortese, Leslie, Uhde, 2015). Because the sense of smell has the fastest route to the brain, it also makes it an excellent trigger for memories (Lee & James, 2011). Auditory flashbacks are common in combat veterans or those victim of bullying (Lee & James, 2011). Other common examples of triggers are seeing or hearing news reports or witnessing another traumatic event take place (National Institute of Mental Health, 2016). When people feel the same way they did during a traumatic event, unwanted memories, perceived as threats, may trigger them to reexperience the event.

The second category of symptoms as listed in the DSM-5 (APA, 2013) is avoidant behaviors. Those who are experiencing symptoms of PTSD may avoid things, people, talking, or thinking about the event in fear that it will cause painful memories to surge. Sometimes, people will keep themselves busy in an attempt to distract from remembering

the event (Lee & James, 2011). By limiting free time, an individual ensures his or her mind does not wander back to negative thoughts or experiences.

Increased negative thoughts and feelings is the third category of symptoms. After experiencing a traumatic event, a person's view of himself or herself could change. Some people may feel guilty and/or experience shame, sadness, fear, or anger (APA, 2013). The World Health Organization (WHO)'s tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), produced in 2016, also states some feelings may manifest as a sense of numbness that results in emotions becoming detached (WHO, 2018). An account of a severe trauma can also cause motivate a loss of trust in self, others, and the world. This lost trust can alter a vulnerable individual's feeling of safety in the world (Ratcliffe, Ruddell, & Smith, 2014). Loss of interest in activities that were once enjoyable to the individual is a common manifestation of negative feelings (APA, 2013). The USDVA (2017c) explains other problems stemming from the negative feelings of the traumatic experience can include depression, suicide, addictions (drugs, alcohol, gambling, etc.), physical pain, and difficulties in the workforce or relationships. However, it is important to note that these problems are not attributable to PTSD directly but to the effects PTSD can have on an individual. Additionally, an individual may be experiencing these symptoms, but it does not mean that they have a PTSD diagnosis. Instead, these concerns can arise as a side effect of suffering posttraumatic stress (APA, 2013).

The fourth and final category of PTSD symptoms is hyperarousal or hypervigilance. This sensitivity is the body's way of remaining prepared. Typically, such symptoms are not caused by triggers because they are a biological response of the trauma

(USDHHS: SAMHSA, 2014). These PTSD symptoms do not stem from substance abuse or injury, health condition, or anything else in life except the traumatic event (National Institute of Mental Health, 2016). When the body is stressed, it generates stress hormones that can cause hyperarousal symptoms making it hard to think, concentrate, sleep, eat, etc. (van der Kolk, 2015). Irritability, outbursts of sadness or anger, and reckless decisions and/or actions are common manifestations (APA, 2013).

### **Women with PTSD**

A person of any race, ethnicity, nationality, or culture can develop PTSD, including children. Younger-aged women have a genetic and physiological predisposition to pre-traumatic factors (APA, 2013). Experiencing a traumatic event is more common than one might consider. Based on the United States population,

About 7 or 8 out of every 100 people (or 7-8% of the population) will have PTSD at some point in their lives. About 8 million adults have PTSD during a given year. This is only a small portion of those who have gone through a trauma.

About 10 of every 100 women (or 10%) develop PTSD sometime in their lives compared with about 4 out of every 100 men (or 4%). (USDVA, 2016, para. 4).

According to the USDVA (2015), fifty percent of women experience a traumatic event. Although the types of events may vary, sexual assault, neglect, abuse, or domestic violence are more common in women (either as a child or adult). The National Sexual Violence Resource Center (2015) reports females are the victims 91% of rape and sexual assault cases. The Centers for Disease Control & Prevention (CDC) also reports a 2012 estimate that close to one in five women are victims of rape at some time in their life, a

potential traumatic experience that could trigger an onset of PTSD. The National Domestic Violence Hotline (n.d.) reports women between the ages of eighteen and thirty-four typically have the highest rates of intimate partner violence. It is no surprise that twenty percent of women developed PTSD symptoms because of domestic violence (CDC, 2014). Research illustrates men are more likely than women to experience a traumatic event, but women are more apt to develop PTSD as a result of their traumatic experience (National Collaborating Centre for Mental Health, 2005). This ratio of the prevalence sometimes even reaching two or threefold higher (Silove et al., 2017). Many risk factors, including psychosocial and biological, explain the cause of this occurrence (Olf, 2017).

While developing PTSD is not a typical experience, there are a multitude of possibilities why women appear more apt to develop it than men. Genetics and social roles are a couple examples of possibilities to describe this differentiation (Ford, Grasso, Elhai & Courtois, 2015). The frequency and severity of the traumatic experience and the symptoms produced are key factors in determining the likelihood of developing PTSD. David Tolin and Edna Foa (2006), suggest that women may be more likely to develop PTSD due to the disorder's defining criteria. They suggest women tend to have more cognitive and emotional responses compared to men, and these responses increase the likelihood of developing PTSD. Although men might experience more traumatic events, males do not appear to have congruent emotional responses to those events. The findings were consistent across ages. Holding the type of traumatic experience constant and only considering the frequency, the results and hypothesized explanations shifted (Tolin & Foa, 2006). The DSM-5 (APA, 2013) attributes some of this higher risk to the increased

likelihood of exposure to traumatic events that women have. This could suggest that the more frequent and severe the repercussions of the trauma, the more likely the individual is to develop PTSD (APA, 2013). Research also suggests that women have developed an evolutionary adaptive behavior when reacting to a stressful or traumatic experience (Christiansen & Elklit, 2008). Women tend to group together and seek social support, using more dissociative mechanisms, a passive defense system. This reactive behavior may have developed due to the childbearing characteristics of women (Christiansen & Elklit, 2008). Instead of using the traditional fight-or-flight mechanisms, mothers tended to their offspring, calming them down, and sought protection from others in the group. In some cases, these instinctive actions meant putting herself in danger to get her children out of harm's way (Christiansen & Elklit, 2008).

While important, these are only a few possibilities explaining the gender differentiation in accordance with the prevalence of PTSD. Every individual responds differently to a specific situation. Symptoms experienced by the individual are subjective and can sometimes be hard to measure precisely. Thus, no clear conclusions have been validated, and more research is necessary to explain why women are more apt to develop PTSD. Nevertheless, the use of CTs could potentially decrease the rate of women experiencing PTSD symptoms by addressing their sense of love and belonging, a setback in one's needs because of the traumatizing event (Zuch, 2015).

## **Treatment**

Whether or not PTSD symptoms decrease differs for every individual. Some people with PTSD improve and master their ability to cope and live with the symptoms,

but others experience symptoms regularly, especially without effective treatment. Approximately half of individuals recover within three months of the trauma, but a few people retain their symptoms for many months or years (APA, 2013). Sometimes friends, family, or religious members can help an individual ease his or her symptoms. Liu, Zhang, Jiang, and Wu (2017) found in their research, of Chinese women with ovarian cancer, that social support promotes better attitudes and outlooks in situations of chronic stress, comparable to those experiencing PTSD symptoms. They found that elevated levels of support help individuals to adjust more smoothly compared those who lack social support and have increasing difficulties recovering from their trauma. For those whose symptoms do not subside, professional treatment and effective coping can help alleviate symptoms (APA, 2013). If symptoms are not relieved, there may be a chance that those symptoms will occur fewer, less severe, or will not continue interfering with daily life (USDVA, 2017c). Posttraumatic Stress Disorder is a treatable condition (APA, 2013), but the method utilized and the outcomes observed for the treatment depend on many factors. Therefore, no single treatment, even those with the most evidence-based outcomes, will be effective for every individual who experiences PTSD symptoms (Institute of Medicine, 2014).

Psychotherapy and medication are two of the most popular, evidence-based medicine treatment options. Some people may choose to combine these two treatment forms, and others may prefer to use one over the other. Those who choose to utilize psychotherapy meet with a therapist to discuss and process the client's traumatic event. According to the USDVA's article "Treatment of PTSD" (2017b), trauma-focused psychotherapies are the most commonly recommended course of treatment for

individuals with PTSD. Such psychotherapies tend to concentrate on the traumatic event's meaning or the individual's memory of it to help process the event. Those psychotherapies with the strongest evidence include prolonged exposure, cognitive processing therapy, and eye-movement desensitization and reprocessing. Many people refer to this type of treatment as counseling or talk therapy. Some treatments utilize visualizations, talking or thinking about the event, while others aim to change a negative belief about the trauma (USDVA, 2017b). The central idea is to help the patient process the situation wholly.

Conversely, medication regimes, the other popular form of treatment, may be ideal for those who are afraid or do not wish to talk in detail of their situation. A health care provider likely will write a prescription after understanding the patient's symptoms and the traumatic experience. It seems unlikely to administer a medication that is exclusive to the patient's scenario with disregard to his or her physiology and diagnosis. The USDVA (2017a), states two effective prescription medications used to treat PTSD include selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). Interestingly, they are the same medications also used to treat symptoms of depression and anxiety. Common SSRIs include Sertraline (Zoloft), Paroxetine (Paxil), and Fluoxetine (Prozac). The common SNRI is Venlafaxine (Effexor) (USDVA, 2017a). The physiological way in which these medications work is quite simple. One's behavior, as affected by PTSD, is a consequence of an alteration of certain chemicals in the brain offsetting homeostasis in response to stress (Sherin, 2011). SNRI and SSRI medications simply help to restore homeostasis in the body and brain. As with taking any other medications, it is possible to experience side effects (USDVA, 2017a).

The USDVA (2017b) also recognizes other, less common, forms of treatment that a patient may choose to partake in besides psychotherapy or medication. Yoga, meditation, acupuncture, and transcranial magnetic stimulation, among others, are other complementary and integrative approaches. The amount of research supporting these other types is not as substantial yet. No single treatment can prove effective for everyone, so it is important for the patient to find one that fits their beliefs and values and works for them. Some people opt to not seek treatment because they do not wish to talk about their difficult life situations or do not believe in taking medication (USDVA, 2017b).

Psychotherapy and prescription medications may be the most popular, evidence-based treatments in society, but while these managements of PTSD work for some, a growing number of physicians, therapists, and researchers are investigating the effectiveness of more naturalistic interventions and lifestyle changes. These interventions could allow individuals added freedom and other opportunities to treat their PTSD symptoms. Creative therapies are one of those treatment options. Because this field is widely expanding, it is necessary to obtain more research data to illustrate the effectiveness of CTs in treating women with PTSD symptoms.

### **Creative Therapies**

This section will address each form of CT and provide a definition from the respective accrediting body for each modality. A brief discussion of each highlights the importance of each CT, its use in a therapeutical setting, and/or the benefits clients can get from partaking in these therapies. Although there are many creative modalities that, undoubtedly, therapeutically help patients, the CTs observed in this literature review

include art, dance/movement, drama, expressive art, and music. Among each of these therapies exist several techniques for creative expression including painting, drawing, sculpture, drumming, singing, movement, and improv as possibilities. Like the concept and variety of personality and learning styles, some people may be more visual, and others may be more tactile. The modality that works best for each individual can vary depending on the setting, the therapist, the client, and the objectives of the session-at-hand. Adapting to these needs of the patient is the idea of CT. Each form of CTs is unique and has its own meaning, practice or application, and most importantly, its own specific set of trauma characteristics and objectives it aims to treat.

**Art therapy.** The American Art Therapy Association (AATA) (2017), a national accrediting body in the United States, explains the importance of art therapy as “an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship” (para. 2). AATA (2017) further explains how art therapy achieves this by stating, “Art Therapy is used to improve cognitive and sensory-motor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change” (para. 3).

**Dance/movement therapy.** The definition of dance/movement therapy according to the American Dance Therapy Association (ADTA), is “the psychotherapeutic use of

movement to promote emotional, social, cognitive, and physical integration of in the individual, for the purpose of improving health and well-being” (Welling, 2014, para. 1) ADTA (2014) further goes on to identify how the mind-body connection helps achieve this improved health and well-being. “It is a holistic approach to healing, based on the empirically supported assertion that mind, body, and spirit are inseparable and interconnected; changes in the body reflect changes in the mind and vice versa” (para. 2).

**Drama therapy.** The North American Drama Therapy Association (NADTA) is the accrediting body for drama therapy. A brochure produced by this association defines drama therapy as “the intentional use of drama and/or theater processes to achieve therapeutic goals.” Summarizing how drama therapy does this they state,

This approach can provide the context for participants to tell their stories, set goals and solve problems, express feelings, or achieve catharsis. Through drama, the depth and breadth of inner experience can be actively explored and interpersonal relationship skills can be enhanced. Participants can expand their repertoire of dramatic roles to find that their own life roles have been strengthened. (NADTA, 2018, para. 1)

**Expressive art therapy.** Expressive art therapy (EAT) is a combination of artistic modalities in practice, and their use helps address medical diagnoses and improve the physical, psychological, spiritual, and mental well-being (Zuch, 2015). According to the International Expressive Arts Therapy Association (IEATA), “the expressive arts combine the visual arts, movement, drama, music, writing, and other creative processes

to foster deep personal growth and community development” (IEATA, 2017, para. 3).

Sometimes people refer to EAT as an integrative approach, wherein use of this therapy is in combination with either psychotherapy, medication, or both.

The level of medical evidence for many of these alternative treatments is limited, but countless patients and pain specialists advocate for a multimodal approach.

Patients often seek complementary therapies either before or concurrently with conventional medical treatments, and eliciting information about these therapies and incorporating them into their treatment plan when appropriate can strengthen the therapeutic alliance as well as protect patients from potentially harmful side effects (Azari, Zevin, & Potter, 2016).

Some might say this combination of treatments gives the patient the best of both worlds. Adding to the versatility of EAT is the ability for the approach to be multimodal. While many therapists may choose a single modality to work with, some see the integration of all arts as a better opportunity and a way to avoid the artistic trap that Abraham Kaplan refers to in his saying, “Give a small boy a hammer, and he will find that everything he encounters needs pounding” (Kaplan, 2009, p. 28). In this sense, using EAT can give therapists more tools to work with, if one modality or technique does not work for an individual. Conversely, therapists in specific modalities may believe an expressive art therapist does not have a comprehensive understanding of the specific modality, thus considering him or her a jack of all trades that is a master of none.

**Music therapy.** As defined by the accrediting body American Music Therapy Association (AMTA), music therapy is “an established health profession in which music

is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals” (AMTA, 2018, para 2). Using music therapy, common treatment techniques include “creating, singing, moving to, and/or listening to music” (para. 2). Music therapy is not just about listening to music. Many elements of the music help therapists to address needs. Some of those elements include melody, rhythm, harmony, timbre, tonality, vocals/lyrics, instrumentation, repetition, etc. Use of each element can be singly or in combination with others to achieve the desired effects (Regents of the University of Minnesota, 2009).

### **Creative Therapies and PTSD Symptom Reduction**

Creative therapies are becoming a more popular and accepted form of treatment as the connection to reduced PTSD symptomology becomes available. Lesley University is a private, coeducational school in Cambridge, Massachusetts offering graduate level degrees in expressive art therapies. According to their website (n.d.), “There is clear, usage-based evidence of the positive effects of expressive therapies in helping treat children and adults who've experienced trauma, cancer patients, people with post-traumatic stress disorder (PTSD), dementia and more” (para. 6). In a 2013 study performed by Cure Together surveyed 531 people with PTSD on the types of treatment that they believed were most helpful in addressing their symptoms. Naturally, Cognitive-behavioral therapy, a common psychotherapy approach, ranked number one; interestingly, art therapy ranked number four. The study was based on self-reports and illustrates an increase in patient satisfaction with their health following the participation

in art therapy (Carmichael, 2013). These results speak to the potential effectiveness art therapy and other CTs may have on patients' health satisfaction.

The suggested use of CTs is to either enhance current treatment options or provide a supplemental treatment medium, not to replace the existing treatment forms. Malchiodi (2005) offers an explanation on the difference between traditional psychotherapy and CTs. She believes creative therapies distinguish themselves from psychotherapy based on their nonverbal means of expression rooted in the arts and that the arts work in a way that the talk therapy methods, using solely verbal communication, cannot (Malchiodi, 2005). Research found that clients who partake in art-based therapies stimulate two to three times more conversation than the traditional verbal communication (Zuch, 2015). Since many people who experience trauma often isolate themselves or do not talk, communication, in one form or another, is vitally important in the healing process. According to the AMTA (2018), participation in music therapy allows individuals another method of communication that is helpful when it may be challenging to express their thoughts or feeling in words. Music can give individuals the opportunity to express what they may feel internally, if they cannot express words, by allowing them to collaborate in song and play musical instruments (Malchiodi, 2005). Bands, choirs, and other musical groups can also allow the individual to socialize with others who have an interest or passion in music.

These modalities have the potential to successfully reduce trauma symptoms by offering patients another way to heal. Drama is an excellent CT modality. This type of therapy help reduce symptomology both emotionally and physically. Drama allows the clients to tell their story and solve a problem that is associated with it. These individuals

have the ability to switch between their character roles and their personal selves. Doing so can help the client to see things that may be wrong in their personal selves when they are taking on the role of a character. They are able to release and cleanse themselves of their symptoms (Malchiodi, 2005). However, a common misconception concerning CTs is that they are completely nonverbal. To appreciate its healing powers, in art-based interventions verbal communication may still be necessary to address how the patient feels while performing the arts and/or help him or her understand the true meaning of his or her work. The nonverbal aspect of CTs allows those individuals who may not be able to put their feelings or ideas into words to express those words and emotions using a different medium. According to an article on Lesley University website, use of EAT permits clients who have PTSD symptoms to express themselves using the various modalities without extensively verbalizing the trauma or openly confronting it, if they are not ready to do so (Lesley University, as cited in Smyth, n.d.). Use of EAT can be a complement to psychotherapy and other counseling theories by integrating art-based activities into the treatment plans. Studies have found that a client's simple drawing, collage, etc. can help him or her move forward in the treatment process when talk therapy may be ineffective or resisted (Malchiodi, as cited in Gladding and Newsome, 2003).

Expressive art therapies can help a patient express himself or herself in a way that is comfortable. The focus is to make the client feel safe in the environment and maintain that sense of safety by providing them with an expressive modality that does not threaten it (Lesley University, as cited in Smyth, n.d.). This feeling of safety maintained with EAT can help reconcile both emotional and social conflict. EAT helps individuals to develop

manage their behavior, solve problems, increase self-esteem, reduce feelings of anxiety, and foster self-awareness (Malchiodi, 2005).

Unique characteristics of EAT not found in traditional psychotherapy include human imagination, active participation, and mind-body connections (Malchiodi, 2005). Human imagination really is the link between the various expressive forms (Zuch, 2015). Creative therapies require active participation, in that the patient is investing their time and energy into sensory actions used to help treat them (Malchiodi, 2005). The theories of dance/movement therapy use embodiment to help a client understand what movements mean. This modality allows clients to resolve challenging circumstances they originally may have been shutting out. Not only do the movements created remind of hopes and fears, but the movements are a language of the self when words may not be available (Serlin, 2010).

Creative therapies are like traditional psychotherapies in that they are still applying similar kinds of clinical methods to help improve the patient. The end goal is the same—symptom reduction. However, CTs utilize more sensory-based approaches compared to cognitive-based approaches in psychotherapy. Using creative and physical methods to process trauma allows clients the ability to “move through the experience with a sense of self-compassion, mastery of the trauma, and a restored sense of trust in one’s surroundings” (Schneider, 2014, para. 8). When people can trust their surroundings, they have more opportunities to interact with others in the environment and establish relationships (Malchiodi, 2005). A brochure published by the NADTA explains drama therapy benefits individuals, families, and communities by positively changing mood, insight, and empathy. It is also a healthy way to assist forming new relationships with

others. Drama therapy effectively helps those struggling to transition, experiencing loss, dealing with social stigmatization or conflict, feeling isolated, and those who have experienced trauma (NADTA, 2018). Music therapy has also shown to be effectively making progress in “overall physical rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings” (AMTA, 2018, para. 2).

Self-expression is critical in the use of CTs to heal. The point of this concept is not to interpret the work the individual produces but to facilitate the individual in discovering and understanding the personal meaning of the work they produced. Story-telling and memory-sharing are great ways that allow individuals to experience their story. Sometimes self-expression in a therapy setting can increase self-exploration (Malchiodi, 2005). Both a client and therapist use self-expression of feelings and perceptions to further understand the self, resolve personal conflict, heal emotions, and improve well-being (Malchiodi, 2005).

Quantification of the physiological and behavioral reactions to music and music therapy interventions may explain why music therapy is possibly the most widely researched modality (Malchiodi, 2005). Music therapy programs at Cleveland Clinic are allowing patients to listen to music as another means of healing. A former music therapist at Cleveland Clinic, Mia Roberge feels, “Music therapy is a place where [patients] can feel safe, comfortable, and in the driver’s seat...if the patient goes from maybe having a little bit of a frown or their body is tense to relaxing or smiling, or if I help to bring their pulse down or their heart rate is a little bit better, I’ve done my job” (Cosgrove, 2014,

para. 11). As evidenced by improvements in emotions, reasoning, physical functioning, and behavior, dance/movement therapy also provides physiological changes (Malchiodi, 2005). Additionally, research is investigating how CTs, especially music, can have calming effects on the brain. The study even proposes that the observed effects could potentially help restore immune functioning (Lesley University, n.d.).

Recent studies are showing that patients' adherence to their PTSD treatment is largely dependent upon whether they possess a choice in their method of treatment (Melville, 2017). Nancy Melville (2017) found that a randomized trial showed PTSD patients not given a choice in their method of treatment dropped out of therapy three times more often than patients who were satisfied with their treatment option. A further look into the dropout rates for common therapy treatments shows rates for psychotherapy and pharmacotherapy estimated to be 18% and 30%, respectively (Melville, 2017). This is not to say that psychotherapy and pharmacotherapy are not beneficial treatments. It just may not have worked for those respondents. These statistics show how crucial it is for patients to be involved in their care. This shared decision approach, one of the Institute of Medicine (IOM)'s core aims for patient-centered care and research, shows it is associated with increased positive patient outcomes including knowledge, treatment satisfaction, and improved symptoms (Watts, Zayed, Llewellyn-Thomas, & Schnurr, 2016). Giving patients a choice which treatment option they would like to pursue can make the healing process and PTSD symptom reduction more personal and meaningful. Literature illustrates that patient participation in health care is correlated with improved outcomes in treatment (Vahdat, Hamzehgardeshi, L., Hessam, & Hamzehgardeshi, Z., 2014). The patient should feel like he or she is benefitting from the chosen treatment option. Not

giving a patient a preference in treatment may cause the individual to feel forced to adhere to a course of action, taking away his or her autonomy. Creative therapies provide clients with another treatment option to choose from.

In summary, CTs effectively cause reduction of PTSD symptomology in many ways.

All people have an innate ability to be creative. The creative process is healing. The expressive product supplies important messages to the individual. However, it is the process of creation that is profoundly transformative. Personal growth and higher states of consciousness are achieved through self-awareness, self-understanding, and insight. Self-awareness, self-understanding, and insight are achieved by delving into our emotions. The feelings of grief, anger, pain, fear, joy, and ecstasy are the tunnel through which we must pass to get to the other side: to self-awareness, understanding, and wholeness. Our feelings and emotions are an energy source. That energy can be channeled into the expressive arts to be released and transformed. (Rubin, 2016, p. 246-247)

As the research and testimonials illustrate, each modality has its own ways of making these improvements in the affected individuals. “Art-based assessments have been more extensively studied and efficacy studies in the areas of trauma and emotional disorders are receiving more attention” (Malchiodi, 2005, p. 13). Most of the observed changes are those that happen in the social realm and those that happen in the cognitive and emotional realms of an individual.

**Limitations in the Literature**

Creative therapies are no exception to limitations. While people of all ages and a variety of disorders can utilize these treatment interventions, there is no magical promise that these modalities are the right option or will work for everybody. For instance, people who may be hesitant in their ability to be creative or believe they are not capable of being artistic may not engage in this type of treatment intervention. Therapists could also encounter clients who are resistant to actively participating in the expressive modality (Malchiodi, 2005). These patients cannot be simply disregarded. A different treatment option may just be a better option for them. The opposite could be true as well. When working with people who are talented in a specific creative expression it may be hard for them to set aside the specific rules, norms, or parameters they normally operate under and instead express themselves spontaneously (Malchiodi, 2005).

Limitations also exist in therapists as well. Inappropriately trained therapists, or those who do not have an extensive amount of experience yet, may try to interpret the expression of their clients. While therapy is important for making progress in one's health and well-being, it is not for a therapist to draw his or her own conclusions of a client's work. Conclusions a therapist draws of a client's artwork typically reflects his or her own thoughts, not the clients (Malchiodi, 2005). While a client's drawing of a dark alleyway could mean potential threats or flashbacks to a therapist, in the eyes of a client with PTSD symptoms it could represent a place of comfort or symbolize quiet time to oneself to think and understand a situation. Therapists can, however, help support the client's understanding of his or her own artistic expression by offering approaches that assist in the process of obtaining a more profound comprehension of what those experiences

represent (Curtis, 2011). Additionally, it is vitally important to consider the client and his or her condition, history, needs, and goals before choosing a specific modality to work with. Therapists want their clients to succeed and using a CT modality that will not benefit them or is not applicable to them is essentially setting them up to fail, because the chances they will succeed may be slim.

## **Methodology**

This section describes the methodology used in this research protocol. The research design provides an explanation as to why a qualitative approach was chosen as opposed to a quantitative approach. Participant population, reliability, and validity of the population are considered. The instruments used and the procedure followed to obtain results are also outlined. An explanation for the data analysis method utilized is provided.

## **Research Design**

Both the Institutional Review Board (IRB) and the Honors Thesis Committee at the University of South Dakota have approved this study. All information gained in the research is solely to add to the existing research on the discovery and efficacy of CTs in connection with PTSD symptoms. The research design utilized an interview-based qualitative study. A qualitative approach was adopted instead of a quantitative one because although CTs are a recent field of study, the data pertaining to therapist's perspective of the selected population in this research is not abundant. Statistical information is relevant for many areas of study, but for the purposes of this paper the statistical data does not pertain to the goal of the study. Therapeutic effects and observed reduction in PTSD symptomology are better explained in words and personal anecdotes than in statistical evidence, as feelings and emotions are abstract topics that can be hard to precisely measure. Conducting interviews offered participants the opportunity to explain their answers in an open-ended question format. Using closed-ended questions

(such as those that may be found in a survey format) could have skewed the data or allowed for bias. The opportunity to let the conversation flow naturally and not in a forced, awkward manner allowed the student researcher not only to build rapport with the participants, but also allowed for a greater appreciation and interest in the participants' field of expertise.

### **Participant Population**

The participant eligibility criteria included the following: interest, career, experience, or knowledge in the field of creative therapies and holding a therapy license. Each therapist acknowledged his or her professional background and provided insight to the amount of time he or she has spent working in the field. The participants interviewed included one therapist from each modality of interest including art therapy, dance/movement therapy, drama therapy, expressive art therapy, and music therapy. A total of six individuals participated, one male and five females. Only information from four of the five female interviews was utilized as one participant did not practice therapy. Access to the desired participant population was obtained through both faculty connections and therapist listings on websites of national accrediting bodies in the United States. No specific ethnic group, race, culture, or religion was targeted. The study's subjects also were not classified as vulnerable.

It is important to note that the participants partaking in the study were different from the population of interest addressed in the purpose of the research. The population of interest, women (ages 18-64) experiencing PTSD symptoms, was selected based on the prevalence of PTSD occurrence in this age range. As a precautionary measure, the

student researcher opted not to directly interview women who may be experiencing PTSD. While direct responses from those women would be beneficial, that specific population is considered vulnerable. Individuals experiencing symptoms of a mental health disorder may not be open to talking with others about their experiences. Reaching out to them in a qualitative interview could increase the potential for psychological or social risk, thereby disturbing or regenerating negative feelings of the trauma. Minors, those under the age of eighteen, also were not selected as part of the interest population due to additional increased likelihood of risk and/or vulnerability as well as extensive privacy measures.

### **Reliability & Validity**

Phenomenology was based on subjective perspectives to gain enough data that was reliable and credible to use. An important consideration is to determine how reliable and each participant was. Obtaining real-life experiences is a vital component in assuring the quality, reliability, and validity of the paper. To ensure credibility, during the screening process only those therapists licensed and practicing in the CT fields were selected.

### **Instruments**

The instrument used in the interviewing process was a questionnaire developed by the student researcher and administered in the English language. The questionnaire was suited to CT and PTSD symptomology topic because the questions included were created to answer the research hypothesis being investigated. The questionnaire had no intention

of diagnosing PTSD. A written informed consent was provided to each participant before the interview began. It explained all necessary details, provided contact information for all researchers (the student and committee members), and gave the participant the option for disclosure of information. Respondents could either choose to have their interview and any personal identifying information remain anonymous (in which a pseudo name was given) or they could choose to be identified. The questionnaire included open-ended questions, giving each participant the opportunity to answer as they felt most appropriate. Questions asked the participant to state their subjective views regarding their female clients. All interviews were conducted in a two-week period.

### **Procedure**

The study began with initial collection of participant information to determine eligibility. Upon confirmation, the student researcher contacted each individual to see if they were interested in completing an in-person or telephone (for those participants farther distances) interview concerning the relationship CTs may have to PTSD symptom reduction. To ensure comfort, satisfaction, and privacy, the interviews were conducted in a location of the participant's choosing. Upon completion of participant interviews, the collected audio recordings were transcribed individually in a Microsoft Word document and any identifying information was replaced with pseudo information (per the participant's request to remain anonymous). To further ensure privacy, the interview audio recordings were kept on the student researcher's password protected laptop only accessible to the researchers of the study.

### **Data Analysis**

The student researcher analyzed the data using Juliet Corbin and Anselm Strauss's (2008) grounded theory methods. The grounded theory method allowed utilization of the hypothesis to generate the literature and ask any additional, unanswered questions lacking in the literature, thereby evaluating the student researcher's hypothesis. This theory was grounded in the research articles and studies that have been performed with this population. However, a lack of professional perspective exists, so this method examined these perspectives to show how they are related to the available literature. The hypothesis is that the therapist's perspective will align with the literature and validate the positive effects CTs have to reducing PTSD symptomology in women (ages 18-64).

The coding process went as follows. First, all interviews were transcribed in a Microsoft Word document from the raw audio recordings. The transcribed data were then separated into individually numbered lines with ten words per line. A line with fewer than ten words was given a new line number only if the speaker changed. Each line was evaluated individually, and a code word or short phrase was given for that line. Once all the lines were coded for, the student researcher went through the interview line by line and selected information that was relevant to the research goal. After all the interviews were coded, a codebook was created with the selected information. Code families were established based on the commonalities among all interviews. These families illustrated themes in the interviews that were relevant to the research aim. Code families were then defined and the quotes from the interviews were used to supplement the relevance to the topic.

## Results

This section explains the results of the analyzed data. Results include the themes generated from the interviews, a description of each, and supplemental quotes.

Although only five interviews were analyzed, two primary themes emerged—Pre-CT Symptoms and Post-CT Outcomes. The two themes consisted of twelve coded categories. Pre-CT Symptoms were listed first followed by the Post-CT Outcomes, and all corresponding codes were organized in alphabetical order.

### Pre-CT Symptoms

This code family included codes that pertained to women experiencing PTSD symptoms before becoming involved in creative therapy. These were often negative symptoms experienced from a traumatic event. Codes included provided explanations for their feelings and emotions and for disruptions in their day-to-day lives because of their symptoms.

**Disrupted daily functions.** Disruption of daily functioning is the inability or decreased ability to sleep. Lynn Chapman is a dance/movement therapist. She testifies to this disruption as seen in the incarcerated women she works with. “It definitely would disrupt sleep. I hear about that constantly. Sleep is a very difficult thing. Whether that’s just through feeling hypervigilance, like you can’t sleep, or waking up from nightmares, having panic-like or anxiety-like symptoms, that can be really exhausting” (LC 214-218).

**Isolation.** Isolation is described as an avoidance of social interaction with others or with possible triggers. This categorization was created based on knowledge of the DSM-5's symptom of avoidance. It emerged as a code following the trend of physical absence or being among the interviews. Four of the five interviews referenced a feeling of isolation in the women that each of the therapists worked with. Sally Baily, a drama therapist, noted that "they're dealing with feeling isolated" (SB 432) and noticed that many of her participants were "not mentally and physically in the space" (SB 432). According to LC 277-279, the trauma a woman experiences could initiate a "retreat response where she is isolating." If experiencing enough of a crisis, expressive arts therapist Serene Thin Elk explains, "they [clients] might struggle more and might not even know it, but their anxiety might make them want to avoid treatment" (STE 219-220). Sometimes a woman may find the trauma "constricting her life, and [she may be] avoiding, consciously or unconsciously avoiding, anything that could be triggering to her or could be overwhelming to her" (LC 272-274). Art therapist Lisa Brunick reflects on the effects of one of her client's trauma, "And then just the distance of isolation, the feelings of isolation" (LB 65), and "she was terrified to come to our group of these women" (LB 315-316). As a refugee experiencing trauma, she needed to adapt to a new way of living, but it was not easy for her. The woman had stated "in my home country I had a wall built around me" (LB 151-152). While each individual's reason for isolation is personable to him or her, Thin Elk realizes, "I know when they pull away it's because they feel scared, or they feel defensive, or they might be leery of me, they're paranoid" (STE 486-488).

**Loss of trust.** Loss of trust is defined as losing one's sense of trust in others and in one's own self. Many women experiencing PTSD symptoms may report that "they're dealing with trust issues" (SB 85). Conversely, they may trust themselves but may be faced with decreased trust in those around them. According to SB 141, clients often "didn't trust other people." The refugee woman Brunick reflected on lost her sense of trust, further stating, "In my country I was very scared because I'm scared of foreign people because they don't look like us and I didn't know if they would hurt us, so I was very, very scared to come here" (LB 144-147). Women who have had a traumatic experience "have to trust others, and that can be difficult" (LC 149-150).

**Negative emotional state.** A negative emotional state can encompass many things including feelings of depression, apprehension, vulnerability, fright, and loss of self-esteem. Individuals can also have a heightened sense of feeling overwhelmed. As referenced in LB 64: "depression is of course always a big one." Being depressed can make people feel very overwhelmed (LB 65) and for some "there's a huge loss of self-esteem" (LB 71-72). Chapman shares that some women, "have a small window of what is tolerable emotionally" (LC 289-290). A statement such as "I can't handle big feelings anymore. I can't handle feeling very afraid. I feel very easily afraid" (LC 282-284) may be reason to believe that for traumatized women "life becomes small" (LC 280). It may be that "she feels vulnerable" (LC 276) and "she's fixating, she's depressed, so kind of a collapse or shutdown going on" (LC 278-279). However, occasionally a traumatic event is "so overwhelming that you can't put it into words" (SB 240-241). For these

individuals, this lack of words may be a variation of a translation that “they're really struggling” (STE 265). They could be “nervous or anxious going back into that building” (STE 419-420) or it might be that they are just “struggling, in particular, and having any sort of depression-anxiety responses” (STE 233-234).

**Numbness.** Numbness is categorized as a loss or confusion of emotional state and being unaware of personal feelings. “Sometimes you have people who are so traumatized that they can't tell you their trauma” (SB 87-88). A numb individual may not know what they are feeling or even have the words to express it. This numb feeling is seen when Bailey shares the words of one of her clients, “I just don't know what I feel, they ask me what I feel but I don't even know my emotions” (SB 202-204). According to STE 194-197: “some people might be having trauma responses and they don't even know that is what’s happening. So, they might feel a little more pulled away or more anxious, but they may not know.” Chapman provides an explanation for why some people feel this way. “They feel kind of numb, and that might be from walking around in a somewhat dissociated state” (LC 297-298).

### **Post-CT Outcomes**

This code family included codes that pertained to women’s PTSD symptoms after partaking in a creative therapy. It illuminates how each changed when compared to the Pre-CT Symptoms and demonstrates their positive outcomes. Codes included provided explanations for their emotional state, social acceptance, cognitive processes, symptom alleviation, bodily engagements, and a desire to participate in their recovery process.

**Cognitive processes.** This code represents outcomes related to developing coping skills, improving causal thinking, and recognizing and containing emotions. Women with PTSD symptoms who utilize EAT “build new coping skills” (STE 323) which allows them to “make positive choices as opposed to destructive choices or avoiding choices” (SB 337-338). Bailey believes “drama really helps with causal thinking” (SB 159-160) because it is “using humor, using distancing, using metaphor, and so you can look at really difficult things and contain it” (SB 102-103). These therapies aid women in learning how to both handle and acknowledge emotions (SB 189-192). In the eyes of Dr. Mark VandeBraak, a music therapist, understanding emotions can also help women to “be able to control the mindset versus it controlling your mindset. [In other words,] always being on the offense versus being on the defense” (MV(2) 70-72). The ability to understand these cognitive processes and, in turn, contain the emotions brought on by them may be an important healing process of some individuals. The logic might be like, “I recognize I’m feeling this way, so I just need to breathe through it” (STE 213-214). VandeBraak’s clients utilize music therapy, a CT modality, and he expresses that, “they are definitely there for coping” (MV(2) 143). Similarly, Thin Elk’s perception of her past clients’ participation in EAT was that it “was their coping mechanism that served them” (STE 343).

**Desire to participate in recovery.** Desire to participate in recovery is based on clients showing an increased interest and participation in therapy sessions. The realization that “I need to work on my trauma so I'm going to go to this group” (LC 468-469) may

not be something that many of these women initially think, but Bailey has found that “after the first day when they came and we had a really great time, then they wanted to come back, and they would never miss a group” (SB 357-360). Apprehension or doubt when first attending a CT could be a source of many things. However, “when they start going to events more regularly” (LC 444) they may realize that “they have a lot of fun” (SB 99-100). “They say they love it and wish they could do it every day” (SB 301-303). Chapman has often heard the women in her therapy sessions express their enjoyment and aspiration to come in phrases like, “I like that in your group we can move. I like that in your group we can just be ourselves. I like that there's music in your group. There is always something new. It really connects with us” (LC 375-379). She also hears things like, “I am here. I am back. I am safe now. I am good. I am so happy to be back. Now I can focus on these things I've needed to work on for all this time” (LC 328-333). Undoubtedly, such statements are fantastic news that any therapist would like to hear. A client’s desire to actively partake in their recovery process using CT treatments can show that they have accepted or acknowledged the bad and are ready to move forward in the finding the good. This change from negative to positive could potentially be linked to increased positive effects in other Post-CT outcomes.

**Embodiment.** To embody is to represent an idea, quality, or feeling in a clear and obvious way as in being a symbol or example of something. Chapman explains the importance of the embodied approach utilized by her clients saying, “our relationship with our body, our ability to kind of understand what's going on and regulate ourselves and find creative expression, it's all really integrated in trauma recovery and in living

well, living in a kind of stable, balanced, regulated way” (LC 91-95). Discovering the idea of embodiment, women stated they were “bringing awareness and attention to the body. We are honoring the body. We're listening to it” (LC 233-235). They learned that there are benefits of being embodied. Raising the awareness of the body means to “sit there and do noticing of what's going on in our bodies and breathing” (STE 532-533). It is “tolerating what's going on in my body, work up to it, and actually being aware and actually feel and actually sense this sensation” (LC 239-241). The benefit of embodiment is to “expand that window of tolerance and be able to be inhabited in our bodies and have a full range of emotions” (LC 292-294). When asked about the embodiment outcome of dance/movement therapy, Chapman responded it is essential to “focus on our experience in our own body and how we are in a relationship with the self and with others in an embodied nature” (LC 528-530).

**Expression.** Expression is understanding the healing that is taking place and affecting the individual and then outwardly making those thoughts and feelings known. According to SB 247-253: “If you have a piece of artwork, whether it’s a scene or a mask that you've made or a map to recovery that you've drawn, you have something outside of yourself that you can look at, and then you can talk about it and then you're able to find the words when you're looking at something that's outside of yourself.” CTs improve personal expression because “just talking, that's invisible, but if you're doing something with your body or you're creating an object in space, then you can see, and you can feel like you're getting it out and also understanding it better” (SB 270-273). According to SB 264-267: “doing art or writing a poem or doing a play takes it from the inside and puts it

outside so that it's not inside you anymore." Bailey further asserts that the women, "they've learned how to express themselves better, both physically and emotionally and verbally" (SB 138-140). When they "create a sense of trust in expression" (STE 619) they find it is easier "getting things to come out" (MV(2) 47) because they "learn how to name feelings, which usually they can't do in the beginning" (SB 299-300).

Bailey told the story of a woman she worked with. As seen in SB 324-328: "she made a mask, and the outside of the mask was a puzzle that was together, and the inside of the mask was a puzzle that was apart. And she absolutely expressed what was going on with her through the mask." CTs help reduce symptoms of PTSD because the affected women "they have something they can talk about, and once they begin to talk about those feelings then that kind of breaks the dam or the block and they begin to be able to talk more and more about it without those distanced objects. But sometimes you need those distancing things, which the arts provide, to be able to get the verbalization to start" (SB 257-264). She also explains that using roleplay is another method of expression that is helpful to understanding other aspects of a trauma better and making progress in recovery (SB 215-217). VandeBraak also used the example of song lyrics to show that, "music is a great way to put into words what you are feeling" (MV(2) 84-85).

**Physical health.** Physical health is an outcome that includes improved physical activity, appearance, and appetite of an individual. As a result of using CTs, physical health may improve. Overall, according to MV(1) 135-136: "they find themselves with more energy." Chapman states, "LC 191: absolutely there's a benefit to physical health" She first explains, LC 199-201: "I see improved physical activity. So, they might start

exercising more, they might go out to yard and walk when it's their time to go leave the building and exercise” Then she attests these women will “be making just generally better self-care choices including their hygiene and what they eat” (LC 221-222). Sleep is a large function of day-to-day lives that is negatively affected in traumatized women, but with the use of CTs, “people report improved sleep, or less nightmares” (LC 416).

Improved quantity and quality of sleep can “give them [clients] the energy to move. It can give them the energy to kind of look at things in a different perspective” (MV(2) 14-16). When these women are not tired their “facial expressions become more animated, eye contact becomes more comfortably strong, body posture shifts” (LC 429-430).

**Positive affect.** Positive affect is defined as feelings of happiness, peace, and control; increased confidence, resilience, and strength; and decreased stress and apprehension (especially in a new country). According to MV(1) 88-89: “If you deal with the grief, then the symptomology and symptoms of PTSD go away.” Chapman expresses “the symptoms of hypervigilance and hyperarousal, as well as dissociation and depression are either being super chronically up-regulated or down-regulated. So those symptoms start to find more balance and they gain some skills on how to regulate themselves and get themselves back into a safe, balanced feeling in their body-brains self” (LC 410-415). Speaking to this balanced body-brain self, Thin Elk states, “I absolutely have seen reduction in symptoms rate, reduction of hypervigilance, reduction of reactivity, less irritability. I have witnessed and observed those things sometimes even within one session” (STE 468-471). CTs allow women to see they are in full control (LC 394). “They're voices are more confident” (LB 106), “there's more alertness, there's more

smiling, and kind of understanding” (MV(2) 54), and “they're happy to come in and they're not scared anymore” (LB 114). According to MV(2) 18: “[It] gives some mindfulness and kind of relaxation” and they “they talk about things in a more mindful way” (LC 448-449), allowing them to feel more comfortable and become “ready to open up a little bit more about their story” (STE 324-325).

VandeBraak believes CTs give psychological retreat (MV(2) 20). He testifies that these therapies influence this affect stating “absolutely, because from a music background begins a release from all that, kind of emotionally and psychologically and physically, physiologically, adding up in size. So, music permits them to heal” (MV(1) 104-106). Bailey agrees with this release. According to SB 305-306: “they feel relief. They feel they understand things in a new way.” Thin Elk takes it one step further in saying that the women “feel pretty proud” (STE 212) of themselves when they can open up in front of others. As Brunick puts it in LB 87: “towards the end of our sessions they are happier, they carry themselves, their presence is just more confident.” Thin Elk says she has also witnessed this same experience in her past sessions saying she is able to, “witness and observe them kind of putting their guard down in the midst of the session” (STE 473-474). Chapman recognizes this increase in positive affect happens as “they are becoming more emotionally healthy and more resilient.” (LC 313-314). She explains, “I get to witness all the time how incredibly strong women are, and how resilient they are” (LC 568-570). If strong, resilient women are “willing to open their hearts, unbelievable change happens” (MV(2) 150-151). The “payoff seems to be really significant for them” (LC 406).

**Social support.** Social support is classified as bonding as a group; sharing values and cultures with others; forming connections with others through art; having increased feelings of love, support, and encouragement from others; building friendships; improving trust; and feeling comfortable around others (decreased isolation). The women Brunick works with, “they use art as communication” (LB 103-104). She appreciatively explains this concept. “The language barrier is a huge thing for us here, but the art becomes our language, becomes a common language, and so they compare images, they compare art-making, and they find commonalities through that process and through those images” (LB 162-166). This statement shows the power that creative therapies can have in uniting people in a common language, not verbally but through expression.

Communication is a vitally important piece of the healing process for women experiencing PTSD symptoms. When a common language exists, Baily perceives “the more layers of information they can communicate, I know that change is happening” (SB 313-314). As they began to express themselves and communicate “they began to trust the people in that group” (SB 141-142). Knowing that a sense of trust exists in the group gave each woman “more ability to tolerate being in crowds” (LC 417). It was easier to feel safe among those familiar faces, and “they actually really bond as a group” (LB 89). When people are familiar with one another they may “start sharing again and feeling comfortable” (STE 495). VandeBraak echoes this saying that communication (whether it is the same language or not) with others in the group give them comfort (MV(2) 112).

The sense of comfort made it easy for one to “see the connections between the actions that people make” (SB 162-163). The flow of the conversation, the ease of the interactions, and lack of worry helped make each person feel more supported, have more

social strength, and develop healthier relationships (LB 286). In building these relationships “they learned how to have patience with each other. They learned how to listen to other people instead of just reacting, and therefore their impulse control improved. They learned how to trust other people, how to ask for help, and how to offer help in a sensitive way” (SB 130-135). These inclusion dynamics helps them because, according to SB 315-320: “the less they get into arguments with other people. I know that they are learning how to listen and how to respond appropriately to other people. And when they make connections with other people in the group as the group goes on through time, I know that it's working for them.”

Brunick attests that the idea of social support was working for one of the women she worked with. In LB 155-157, she explains “she was able to let her guard down with us and welcome in friendships and new possibilities.” Before starting the art therapy sessions, none of the women knew each other. This woman grew close to one of the ladies she met in her therapy session. Brunick was eager to report that “they just met and they're like really good friends” (LB 131). This heartwarming story is only one of the many relationships that form during these CTs. Observing all these new friendships, Brunick noticed that “they laughed, they cried together, they make art together, there's just this bond, and it's a community that they have lost when they move here” (LB 99). The “opportunity to build a friendship, you know, and in a scary new place, it's so beneficial” (LB 133-134).

The relationships do not end there. “They get to share their stories and kind of compare notes and share art with each other. It's a huge relief for them, and they see that they're not alone, and just that factor right there is just a huge relief” (LB 93-97).

Chapman seconds the feeling as stated in LC 161-164: "There's a lot of shared experience that can be really validating and encouraging, and hope can be shared among the group...installation of hope and motivation." This motivation inspires each of the women to keep working on their healing journeys. The woman who initially was terrified, felt isolated, and had made the comment that she felt like she had a wall built around her was the same lady whose social support excelled. At the end of her art therapy sessions, she gave a card to Brunick thanking her. It read, "thank you so much for your support to find our ways. You guided us to open our minds and kept encouraging us always. We got your love and could bloom our flowers" (LB 308-311).

### **Discussion & Conclusion**

The goal of this research study was to explore how therapists perceive changes in PTSD symptoms and outcomes in women after their participation in a CT. Experiences provided from the professionals' interviews appropriately aligned with the themes and concepts discussed. Pre-CT Symptoms were observed to have primarily negative effects and few to no positive effects compared to the Post-CT Outcomes which were observed having primarily positive effects and few to no negative effects. This flip in positive and negative PTSD effects after receiving CT treatment is an inverse relationship. Overall, the professionals' perspectives show positive effects of CTs toward symptom reduction in women (ages 18-64) experiencing symptoms of PTSD.

In the Pre-CT Symptoms, Disrupted Daily Functions was the least supported code or the one with the least negative effect, while the remaining codes were supported consistently, deeming them more frequent and/or detrimental PTSD symptoms. It can be concluded that negative physical symptoms are not as prevalent or unfavorable as negative emotional and social symptoms. On the other end of the spectrum, in the Post-CT Outcomes both Positive Affect and Social Support were the most abundant and supported codes testified in the interviews. This means that the outcomes associated with these codes were the most beneficial and/or were observed more frequently. All other codes within the theme appeared in smaller scales demonstrating that other outcomes may still be improved, but not as prevalently. These relationships lead the student researcher to believe that the biggest positive effects CTs have on PTSD symptom

reduction occur socially and affectively. Similarly, the literature found that the biggest reduction of PTSD symptoms were the CTs that had the most positive increases in both emotional and social health. For women who have PTSD it makes sense that the social and emotional aspects are more affected as PTSD is classified as a mental health problem (USDVA, 2017c). Depending on the traumatic event, some physical injury or disease may occur (as in rape or severe motor vehicle accidents), but it is not standard in all cases. If PTSD were strictly a physical condition, it would be likely that physical health improvements would be more justifiable than those of social health would.

The therapists each worked with a different population of women. This variation corresponds to the literature in that PTSD is a mental health problem that can affect any age, gender, race, ethnicity, and religion. Some of the subpopulations referred to in the interviews included women who were refugees, non-English speakers, women who were incarcerated, veterans, substance abusers, and those experiencing other mental health problems in addition to PTSD.

Overall, findings of the study were not conclusive since the small sample of therapists interviewed were not representative of the entire population and the results could not be generalized. The therapists in this study were in various regions in around the Midwest, but the literature reviewed comes from across the United States. Even though the sample size was small and the results may not be conclusive or exhaustive, information obtained in the interviews still present valuable information. Themes observed in this study appear to be consistent with their meaning and use in both the Midwest and the rest of the United States. However, research in the CTs field is ongoing. The extent of the knowledge will continue to grow as more exposure, research, and

statistical data showing the positive, negative, or no relational influence becomes available.

### **Limitations**

While this study was beneficial in adding more information to the field of CTs, it had limitations. The primary limitation to this study was the student researcher's limited time allotment for this study. This time constraint could have been a barrier to the study. If a greater period were allotted for research, more literature may have been evaluated to reach saturation and more interviews could have been conducted to gain a more representative sample.

A lack of therapists' perspective in the literature made it harder to review the effects CTs can have. Additionally, since CTs are newly being used, they appear to be disproportionate in the Midwest region, as compared to the East and West coasts. This distribution of licensed therapists across the United States also made finding therapists in each modality to interview a challenge. During the initial phases of the study, a technical malfunction of the recording device during the recording of music therapist Dr. Mark VandeBraak's interview caused a loss in the information obtainable for transcription. This participant was re-interviewed via phone on another day. The data collected was still coded using the same method as the other interviews. This limitation may have altered the data because any individual's response to questions can differ on any given day. Another limitation in the interview phase involved the participant demographics. As no specific ethnic group, race, culture, or religion was targeted, the demographics of those

involved could be considered a limitation as the diversity of age, gender, environment, and/or race may not be representative of the entire population.

Since the data analysis process primarily involved the student researcher, it was important for her to maintain objectivity between interview transcripts to avoid overlap or blending of information. To do this, the student researcher worked on coding one interview per day, completing it in its entirety before moving on to the remaining, uncoded interviews. Maintaining objectivity, questions of the coding and analysis process were addressed with her committee members. She also verified that the code words and themes generated were appropriate for the data being analyzed. Her committee did not influence how her data was coded. They only assisted in the processes of learning, understanding, and clarifying.

Finally, although interviewing the clients who utilize CTs would have provided more valuable information, this population classifies as vulnerable and would have been at risk for psychological harm. While it was a possibility to interview the clients, special procedures and precautions would have had to have been taken, which would have taken more of the student researcher's allotted time. For this reason, therapists of various CT modalities were chosen to be interviewed for their subjective views about their clients. Another limitation important to consider when interviewing clients directly is the lack of self-report from women who may experience symptoms of PTSD, as they may not want others to know they are suffering or may not want to share that information.

**Implications**

Adding data to the field of CTs can help raise awareness about these therapies and improve the likelihood of using CTs as a course of treatment (whether individually or in conjunction with another method) for women who are experiencing symptoms of PTSD. The professional's perspective enriches the evidence that CTs appear to be beneficial for individuals. Future studies can be repeated and amplified with a larger, more diverse sample size, deemed representative of the entire population, as saturation may be reached with a larger group. Interview questions could be adapted to specifically target various or specific areas one wishes to investigate. Spending more time and involving more individuals' perspectives in the analysis of the data could improve saturation of the themes developed.

**Conclusion**

The purpose of this paper was to further understand any observable impact that creative therapies (CTs) may have on women suffering symptoms of Posttraumatic Stress Disorder (PTSD). The overall goal to explore how creative therapists perceive the women's changes in symptoms and outcomes after the participation in a CT was achieved by conducting interviews with qualified therapists who spoke of their perceptions of their female clients' positive and negative effects. The hypothesis that the therapist's perspective would align with the literature and validate the positive effects CTs have to reducing PTSD symptomology was supported.

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APPENDICES

## APPENDIX A

## IRB Approval



February 23, 2018

The University of South Dakota  
414 E. Clark Street  
Vermillion, SD 57069

**PI:** Jamie Turgeon-Drake, Shana Cerny, Alison Boughn **Student PI:** Caitlin Bolte  
**Project:** 2018.021 - Honors Thesis: Expressive Arts and Therapies and Their  
Therapeutic Effects in Young Adult Women with Post-Traumatic Stress Disorder  
**Review Level:** Expedited 7 **Risk:** No More than Minimal Risk  
**USD IRB Project Approval Period:** 2/23/2018-2/22/2019  
**Continuation or Closure due before:** 2/8/2019  
**Approved items associated with your project:**  
Interview Questions  
Date Stamped Informed Consent  
Advertisement

The study submission and informed consent for the proposal referenced above has been reviewed and approved via the procedures of the University of South Dakota Institutional Review Board .

Prior to initiation, promptly report to the IRB, any proposed project updates / amendments (e.g., protocol amendments/revised informed consents) in previously approved human subject research activities.

Any research-related injuries (physical or psychological), adverse side effects or other unexpected problems encountered during the conduct of this research study needs to be reported to the IRB within 5 days of notification of the occurrence.

The forms to assist you in filing your: project closure, continuation, adverse/unanticipated event, project updates /amendments, etc. can be accessed at <http://www.usd.edu/research/irb-application-forms>

You have approval for this project through 2/22/2019 . When this study is completed please notify the Office of Human Subjects Protection. If the study is to last longer than one year, a continuation form is to be submitted at least thirty days prior to the expiration of the study.

If you have any questions, please contact: [humansubjects@usd.edu](mailto:humansubjects@usd.edu) or (605) 677-6184.

## APPENDIX B

## Drafted Email for Participation

Dear [Participant Name],

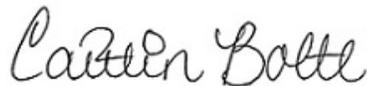
Hello! My name is Caitlin Bolte, and I am a senior Honors student at the University of South Dakota. Currently, I am pursuing a Bachelor of Science in Health Science degree. I am contacting you today to request your participation in either an in-person or telephone interview for my research. Completion of the Honors Program at USD requires each student to submit a senior thesis. The purpose of this thesis research is to conduct interviews to further understand the observed impact of Expressive Arts and Therapies (such as dance, music, and art) and additional creative therapies to see if they have therapeutic effects in adult women (ages 18-64) with Post-Traumatic Stress Disorder (PTSD). The goal of this study is to explain how women manage their PTSD symptoms most effectively. The data collected will be incorporated into a literature review/analysis. Its sole purpose is to further the education and better understand this field. You were selected to participate for your interest, career, experience, or knowledge in this field.

If you choose to participate, I am requesting 30-60 minutes of your time to complete this informal interview. Please respond to this email if you would like to participate in this study. Should you choose to participate, I will be in contact with you to send you more detailed information and to schedule a time for either a telephone or in-person interview. Please note that the interview will be audio recorded for authenticity purposes in transcribing and writing.

For any questions, comments, concerns, or for more information on my research, please contact me via e-mail at [Caitlin.Bolte@coyotes.usd.edu](mailto:Caitlin.Bolte@coyotes.usd.edu). I look forward to hearing from you soon.

Thank-you for your time and consideration in advance.

Cordially,



**Caitlin Bolte**  
University of South Dakota  
Honors Student - Class of 2018  
Pre-Medicine/Health Science Major  
Interdisciplinary Science Minor  
National Society of Collegiate Scholars - President  
Health Science Club - Treasurer

## APPENDIX C

## Informed Consent

IRB Approval effective from: 2/23/2018  
 IRB Approval not valid after: 2/22/2019  
 USD IRB

**INFORMED CONSENT**  
**The University of South Dakota**

**TITLE:** *Expressive Arts and Therapies and their therapeutic effects in adult women (ages 18-64) with Post-Traumatic Stress Disorder (PTSD)*

**PROJECT DIRECTOR:** *Jamie Turgeon-Drake*  
**PHONE #:** *605-658-5955*  
**Department:** *Health Sciences*

**WHAT IS THE PURPOSE OF THIS STUDY?**

You are invited to participate in a research study conducting interviews to further understand the observed impact of Expressive Arts and Therapies (such as dance, music, and art) to see if they have any therapeutical effects on women suffering symptoms of PTSD. The goal of this study is to explain how women manage their PTSD symptoms most effectively. Interviews will be conducted with therapists/experts in this field. Data collected will be incorporated into a literature review/analysis. The sole purpose of this study is to further the education and better understand this field. You were selected as a possible participant because of your interest, career, experience, or knowledge in this field.

**HOW MANY PEOPLE WILL PARTICIPATE?**

Approximately 5-10 clinicians will take part in this study.

**HOW LONG WILL I BE IN THIS STUDY?**

Your participation in the study will last 30 to 60 minutes via telephone call or in-person in a location of your choosing.

**WHAT WILL HAPPEN DURING THIS STUDY?**

As a participant in this study, the researcher will contact you via telephone or sit down with you in-person at a location of your choosing. The researcher will proceed to go over the consent form and ask for identifying information preferences. Upon completion of the consent form, audio will begin being recorded. It is at this time that the informal interview will begin. The researcher will begin asking questions. As the participant, please honestly answer each of the questions to the best of your ability or simply express your discomfort with the question and state that you would prefer not to answer. In such a case, the question will be skipped, and a new question will be addressed. Question-answer format will continue until the maximum 60 minutes is complete, the researcher runs out of questions, or the participant is done sharing information, whichever is first. Following the interview, the researcher will ensure that you are satisfied with everything that was said during the recording. If not, measures will be taken to address that concern. Any technical terms related to the study will be identified in the questions themselves.

**WHAT ARE THE BENEFITS OF THIS STUDY?**

You will not benefit personally from being in this study. However, we hope that, in the future, other people might benefit from this study because of the knowledge that that may be gained.

IRB Approval effective from: 2/23/2018  
IRB Approval not valid after: 2/22/2019  
USD IRB

#### **ARE MY RECORDS CONFIDENTIAL?**

The records of this study will be kept confidential to the extent permitted by law. In any report about this study that might be published, you will not be identified, unless your permission is otherwise given. Your study record may be reviewed by government agencies, Office of Human Subjects Protection and The University of South Dakota- Institutional Review Boards.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of deidentifying any given information during the initial hearing of the files and a generalized or neutral name will replace your name. Data will be stored in its own folder on a password-protected laptop with a secure internet connection that is accessible only to the 4 investigators listed below. Any information obtained in the interview regarding a third-party non-participant (i.e. client of yours, etc.) will also be kept confidential. Only the first name of this individual will be used, unless you request to use something else.

This information in this study may be used in a report or article. The study results will be described in a summarized manner so that you cannot be identified, unless you choose to be by initialing below.

The study is to be audio recorded for authenticity purposes, given your permission. As a participant, it is your right to review your specific tape recording. The only individuals who will have access to these recordings and any identifying information will be the 4 investigators listed below. Audio is used for transcribing and writing purposes only. Identifiable recordings will be erased upon completion of the research study. The deidentified information extracted from the recordings will be kept in the Primary Investigator's office for a period of 3 years, per federal law.

#### **IS THIS STUDY VOLUNTARY?**

Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time. Your decision whether or not to participate will not affect your current or future relations with The University of South Dakota.

#### **WHOM MAY I CONTACT IF I HAVE QUESTIONS?**

You may ask any questions you have now or later.

The researchers conducting this study are:

*Caitlin Bolte* 605-280-6345  
*Alison Boughn* 605-661-8115  
*Shana Cerny* 605-658-6376  
*Jamie Turgeon-Drake* 605-658-5955

You may call these numbers during the day if you have questions, concerns, or complaints about the research.

If you need to change your appointment, please contact Caitlin Bolte at 605-280-6345.

IRB Approval effective from: 2/23/2018  
IRB Approval not valid after: 2/22/2019  
USD IRB

If you have questions regarding your rights as a research subject, you may contact The University of South Dakota- Office of Human Subjects Protection at (605) 677-6184.

- You may also call this number about any problems, complaints, or concerns you have about this research study.
- You may also call this number if you cannot reach research staff, or you wish to talk with someone who is independent of the research team.

I give consent for my quotes to be used in the research; however, I will be identified.

Please initial:      \_\_\_ Yes      \_\_\_ No

I give consent for my quotes to be used in the research; however, I will not be identified.

Please initial:      \_\_\_ Yes      \_\_\_ No

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Subject's Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Subject

\_\_\_\_\_  
Date

## APPENDIX D

## Interview Questions

**Interview Format/Questions**

*Provide Informed Consent for participant. Review the consent form with the participant and get their signature indicating preferences on identifiable information. Keep the signed copy and allow participant to keep the additional copy for their records.*

*After completion of the consent form:*

First off, I would like to thank you for taking the time to meet with me today. Your participation is genuinely appreciated. As stated in the consent form, the purpose of this study is to further understand the observed impact of Expressive Arts and Therapies to see if they have any therapeutic effects on women suffering symptoms of Post-Traumatic Stress Disorder (PTSD). This study will help explain how women with PTSD manage their symptoms most effectively. Information collected is intended solely to further the education and better understand this field.

You are welcome to share as much or as little as you wish. These are your rights as a participant. Per your selection on the consent form, any identifiable information will/will not be retained in the final project. As always, please remember if you feel uncomfortable in any way, do not wish to answer a question, or wish to stop the interview, do not hesitate to speak up.

1. Can you tell me a little about your background?
  - o What made you interested in working with this population?
  - o Professional background?
  - o How long have you worked with this population?
  - o In your practice, what are the most common PTSD/trauma symptoms that you observe in adult female clients?
  
2. What kind(s) of art/therapies do you teach/train?
  - o Dance, Music, Art, Painting, etc.
  - o Any others that were not listed?
  
3. Do you instruct these in a group setting or individual basis?
  
4. As a therapist, where do you feel your clients prefer to *[insert whichever art/therapy form applies to them]*?
  - o Where do they see the best results/feel most comfortable?
  - o What is their ideal location?
  
5. Would you say that this/these expressive therapy/therapies influence(s) their physical health *[If distinction is necessary: physical health concerns nutritional habits, sleeping quality and patterns, and how you physically feel]*? If so, do you believe it is a negative or positive influence? How so?

- What about their emotional health?
    - *If distinction is necessary: emotional health involves expression and control of emotions*
  - Is their mental/psychological health improved?
    - *If distinction is necessary: mental health encompasses things such as reasoning, cognitive thinking, attention/focus, processing information for memory and recall*
  - *[If applicable]* Has their Spiritual health improved?
6. How many hours would you say you spend in a 24-hour period working with clients and instructing/teaching *[insert whichever art/therapy form applies to them]*?
    - In a week?
    - In a month?
  7. How long have you been instructing/teaching this/these activity/activities?
    - Years, months, days?
    - Consistent? (Every day, every other day, every week, just when feel the need, etc.)
  8. On average, how long do your clients work with you?
    - Do you see the same clients consistently?
    - How much time do you feel is necessary for each client to spend *[insert whichever art/therapy form applies to them]*?
  9. What is your purpose for instructing/teaching *[insert whichever art/therapy form applies to them]*?
  10. Do you feel it is better for your clients to partake in *[insert whichever art/therapy form applies to them]* instead of other common activities (i.e. shopping, drinking coffee or alcohol, etc.)?
    - How so?
  11. The symptoms of PTSD are as follows: *(list symptoms from research)*. Do you feel that any of the aforementioned symptoms describe your clients, their outward feelings/expressions, or their experiences?
  12. When your clients partake in arts/therapies, do you feel it alleviates any of their symptoms?
    - If so, which ones? Why?
    - How can you tell? Are there outward changes to their personality, feelings, actions, etc.? Do they express this alleviation (verbally, nonverbally)?
  13. Do your clients share with you what they think/feel while *[insert whichever art/therapy form applies to them]*?
    - If so, what feelings/emotions/thoughts do they share that they experience?
    - What do they report to you regarding improvements in their PTSD symptoms?

14. What types of outcomes do you measure in your clients following this therapy? How do you determine successful intervention?
- For example:
    - Mood changed?
    - Eating improved?
    - More mentally alert?
    - Sleep better at night?
    - Experience any negative flashbacks, memories, etc. during or after partaking in these therapies?
    - Better able to focus during the day?
    - Decreased stress?
    - Brighter/better outlook on life?
    - Easier to trust people or have relationships with people after arts/therapies compared to before?
15. Do your clients seek [*insert whichever art/therapy form applies to them*] as a coping mechanism? Or is it more just for fun/enjoyment?
16. What word(s) would you or your clients use to describe effects of [*insert whichever art/therapy form applies to them*]?
- Soothing? Healing? Effective?
  - In terms of PTSD?
17. Tell me more about your thoughts concerning Western Medicine compared to other Complementary Medicine forms such as Alternative, Traditional, or Natural medicine forms? How does the use of medications in Western Medicine make you feel?
18. Is there anything else that you would like to share with me today that you feel is important to be emphasized, recognized, or may be useful either to me in my research and/or anyone else who may read this article?

Thank you so much for sharing your information with me today. Your time and participation is greatly appreciated. I will be contacting you within the next few months to verify that the information extracted from the interview is accurately reflected. If you have any follow-up questions for myself, or any of the other faculty member researchers in this project, do not hesitate to contact us. Our contact information is listed in the consent form as well.