

ESSS Outline

Experiential therapies for children who have experienced trauma

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Introduction

This evidence summary seeks to address the following question: *What are effective individual experiential therapeutic interventions for children and young people who have experienced trauma?*

About the evidence presented below

We drew on a wide range of evidence from research and practice from the last 10 years, searching several academic databases including PsychInfo, ASSIA, Sociological Abstracts and Social Services Abstracts, The Published International Literature on Traumatic Stress (PILOTS) and the Database of Abstracts of Reviews of Effects (DARE). We also hand-searched specific academic journals, including *The Arts in Psychotherapy* and *Journal of Child and Family Studies*. We used a wide range of search terms and variations on them to identify relevant evidence, including trauma, attachment disorder, depression, anxiety, post-traumatic stress (PTSD), therapy (including art, music, dance, canine, equine/hippotherapy, outdoor, adventure, yoga, experiential, expressive). We searched for evidence relating to children aged between 5 and 18; the age group supported by the original enquirer.

We excluded evidence relating to group and family therapies, and cognitive behavioural therapy (CBT), because the focus for the original enquirer for this Outline was on experiential therapies that could take place with children and young people where CBT or insight-oriented therapies would not be appropriate. Talking therapies are seen as an inappropriate intervention in this context for several reasons, including that the children may be unlikely to remember the events being talked about, and that attachment disorders associated with trauma are likely to act as a barrier for trust between the child and the therapist ([Attachment Trauma Network 2018](#)). [Gutermann et al. \(2016\)](#) emphasise the need for psychological treatments to be modified to address younger patients' specific needs.

Due to the high quantity of individual studies around experiential therapies and their effects and their lack of generalisability, we have largely included review studies (syntheses of several studies at a time based on comprehensive searches of related research) because individual studies do not provide an adequate picture of whether or not different approaches tend to result in or be the cause of positive outcomes. We have also included some scoping and literature reviews, although these do not critically assess the quality of the included papers to the same degree as systematic reviews. Where individual studies are included, these have been provided for insight into theories around *why* interventions may be beneficial, for the benefit of the original enquirer, particularly in relation to contextual considerations such as additional support needs and cultural context. We have also identified guidelines from the medical literature around condition-specific good practice.

Accessing resources

We have provided links to the materials referenced in the summary. Some materials are paywalled, which means they are published in academic journals and are only available with a subscription. Some of these are available through the [The Knowledge Network](#) with an NHS Scotland OpenAthens username. The Knowledge Network offers accounts to everyone who helps provide health and social care in Scotland in conjunction with the NHS and Scottish Local Authorities, including many in the third and independent sectors. [You can register here.](#)

Where possible we identify where evidence is published open access, which means the author has chosen to publish their work in a way that makes it freely available to the public. Some are identified as author repository copies, manuscripts, or other copies, which means the author has made a version of the otherwise paywalled publication available to the public. Other referenced sources are pdfs and websites that are available publicly.

Background

Childhood trauma

Traumatic events for children are defined by [the National Child Traumatic Stress Network \(2018\)](#) as those in which the child (either involved or as a witness) feels intensely threatened. [The International Society for Traumatic Stress \(2018\)](#) defines traumatic events as “negative events that are emotionally painful and that overwhelm a person’s ability to cope”. [Furnivall \(2014\)](#) emphasises that “not all children who have adverse experiences will be traumatised. Every child is unique and their responses to the same adversity will differ.”

Examples of trauma

[The National Child Traumatic Stress Network \(2018\)](#) identifies several causes of trauma in children, which can be the result of a wide range of adverse events experienced in childhood, including:

- Community violence: exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim
- Complex trauma: children’s exposure to multiple traumatic events (often invasive and interpersonal) and its wide-ranging, long-term effects
- Disasters: can lead to adversities including displacement; loss of home and personal property; changes in schools; economic hardship; loss of community and social supports; and even the injury and death of loved ones
- Domestic violence: witnessing (or being victim of) physical, sexual, financial, verbal, or emotional abuse
- Medical trauma: pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences

- Physical abuse: when a parent or caregiver commits an act that results in physical injury to a child or adolescent, such as red marks, cuts, welts, bruises, muscle sprains, or broken bones, even if the injury was unintentional
- Refugee trauma: experience of violence or war; lack of food, water, shelter, or medical care; torture; forced labor; sexual assault; loss of loved ones; living in refugee camps; separation from family; loss of community; harassment by local authorities; detention; acculturation stress (e.g., new school environments); resettlement stress (e.g., financial hardship); isolation and discrimination
- Sexual abuse: interactions between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer, including both touching and non-touching behaviors (e.g. voyeurism, exhibitionism, or exposing the child to pornography)
- Terrorism and violence: mass violence; acts of terrorism; community trauma (shootings, bombings, or other types of attacks)
- Traumatic grief: severe or prolonged response to sudden and unexpected, or anticipated death

Impact of childhood trauma

Traumatic experiences in childhood are associated with a wide range of adverse outcomes throughout childhood and in later life, including symptoms and experiences related to post traumatic stress and other conditions, such as intrusive memories, negative feelings, numbing and avoidance, emotional disturbances, self harm, suicidal ideation and behaviour, personality changes and depression, anxiety, suicidal ideation, substance abuse, and aggressive and violent behaviour ([Leenarts et al. 2013](#); [Silverman et al. 2008](#)).

[Furnivall \(2014\)](#) describes the adverse impact of trauma throughout life:

Trauma can adversely affect all areas of life and not only prevent the early development of key emotional and cognitive skills but also undermine existing abilities in older children and adolescents. Complex trauma can lead to children displaying behaviour or attitudes that meet diagnostic criteria for several different psychiatric disorders.

She also summarises the complexity of trauma recovery:

Many children recover spontaneously from trauma but even children in positive circumstances who have experienced only a single traumatic event risk continuing emotional difficulties. Long-term damage is most likely if trauma involves a repeated event (such as abuse or witnessing domestic violence) and includes betrayal by a significant adult. Moreover, if the child or a loved one is injured, or if the child believes there to be serious risk of injury or death, the impact is exacerbated. Where caregivers are traumatised by an event, or have a history of previous trauma or impaired attachments, they may be emotionally unable to help children recover. Supportive, attuned caregivers, however, can protect children from some of the destructive consequences of trauma. Children in care are likely to have experienced the most chronic and damaging forms of trauma, and are unlikely to have the internal regulatory skills to recover or the buffering support of attuned and emotionally competent adults to protect them from adverse consequences. Even in a safe setting where an overactive alarm response is no longer adaptive, traumatised children may continue reacting in an extreme way to neutral and even apparently positive cues ([Streeck-Fischer 2000](#)).

Research indicates that trauma is experienced differently by children for many reasons, including age and developmental stages ([Gonzales and Bell 2016](#)). Not all children who experience a traumatic event develop mental health issues, and of those who experience a short term reaction, most return to previous levels of functioning within a few months ([Lucio and Nelson 2016](#)). Factors that may increase the risk of longer term post-traumatic stress symptoms include a history of anxiety or mental health disorders, parental psychopathology, lack of social support and exposure to multiple traumas ([Lucio and Nelson 2016](#)).

Therapeutic interventions

Research indicates that need for therapeutic services for children who have experienced trauma, particularly sexual abuse, outstrips availability:

Referral routes are limited, leaving few options for young people who have been raped or seriously sexually assaulted to directly access support; that significant waiting lists means services must focus on reactive, rather than preventive, work; and that services are less accessible for certain groups, especially sexually abused teenagers, children with disabilities and those from Black, Asian, Minority Ethnic and Refugee backgrounds. ([Allnock 2012](#))

Given the serious long-term outcomes of trauma, including abuse and neglect, access to effective trauma support that meets the specific and varied needs of children and young people is important:

Abuse and neglect can have a long-lasting impact on the health and wellbeing of children and young people. It is important to know how to respond, and the evidence suggests that...interventions may be effective for children and young people. If possible, offer a choice and explain what each intervention will involve and how you think it may help. Not all interventions will suit everyone, and the choice should be informed by a detailed assessment. ([Social Care Institute for](#)

[Excellence and National Institute for Health and Care Excellence 2018\)](#)

Evidence suggests that no one therapy suits all children, and it is not clear what treatments are effective for what kind or severity of trauma:

At this stage, there is no clear evidence for the effectiveness of one psychological therapy compared to others. There is also not enough evidence to conclude that children and adolescents with particular types of trauma are more or less likely to respond to psychological therapies than others ([Gillies et al. 2012](#))

Gillies, D et al. (2012) Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. Cochrane Database of Systematic Reviews, 2012(12) ([open access](#))

This systematic review examines the effectiveness of psychological therapies in treating children and adolescents who have been diagnosed with PTSD. Fourteen studies including 758 participants were included. The types of trauma participants had been exposed to included sexual abuse, civil violence, natural disaster, domestic violence and motor vehicle accidents. Most participants were clients of a trauma-related support service. The psychological therapies used in these studies were cognitive behavioural therapy (CBT), exposure-based, psychodynamic, narrative, supportive counselling, and eye movement desensitisation and reprocessing (EMDR).

The authors conclude that “there is evidence for the effectiveness of psychological therapies, particularly CBT, for treating PTSD in children and adolescents for up to a month following treatment”, but say that “at this stage, there is no clear evidence for the effectiveness of one psychological therapy compared to others. There is also not enough evidence to conclude that children and adolescents with particular types of trauma are more or less likely to respond to psychological therapies than others.” They emphasise the methodological biases, small sample sizes and differences

across studies that make it difficult to compare them with each other limit the findings of the review.

Metcalf, O et al. (2016) Efficacy of fifteen emerging interventions for the treatment of posttraumatic stress disorder: a systematic review. *Journal of traumatic stress*, 29(1), pp.88–92 ([paywalled](#))

This systematic review assessed the evidence for 15 new or novel interventions for the treatment of PTSD, because although there is an abundance of novel interventions for the treatment of posttraumatic stress disorder (PTSD), often their efficacy remains unknown. 19 studies that met the inclusion criteria for the study were assessed against methodological quality criteria. The majority of the studies were of poor quality, with methodological limitations such as small sample sizes and lack of control group. Four interventions (acupuncture, emotional freedom technique, mantra-based meditation, and yoga) had moderate quality evidence from mostly small- to moderate-sized randomized controlled trials. However, it was unclear what the successful elements of these interventions were and how they differ to other existing interventions. The authors conclude that there is an insufficient level of evidence supporting the efficacy of emerging PTSD interventions, despite their increasing popularity. (Adapted from abstract)

Experiential therapy

Experiential therapy is a therapeutic technique that uses expressive tools and activities, such as role-playing or acting, props, arts and crafts, music, animal care, guided imagery, or various forms of recreation to re-enact and re-experience emotional situations from past and recent relationships. ([Psychology Today 2018](#))

Outcomes of therapeutic interventions

Research studies have indicated positive impacts of individual experiential therapies on a wide range of trauma-based psychological problems, including generalised anxiety (GAD), panic/agoraphobia (PANICAG), social

phobia (SP), separation anxiety (SEP), obsessive compulsive symptoms (OCD) and physical injury fears (PHY) ([Holmes et al. 2012](#)), social competence, behavior, social functioning (e.g., sensory seeking, inattention-distractibility), irritability, hyperactivity, social cognition, and communication, and ADHD symptoms ([Hoagwood 2017](#)).

Evidence: individual experiential therapies

There is an overall lack of robust evidence relating to the impact of different forms of therapy for young people who have experienced trauma, particularly PTSD treatment for children under eight ([Miller-Graff and Campion 2016](#)), and where reviews and meta-analyses have been conducted, the findings are generally inconsistent. [Landolt and Kenardy \(2015\)](#) suggest this is due to different definitions of evidence levels and different inclusion and exclusion criteria for studies. There is a lack of evidence generally relating to the impact of therapeutic interventions on very young children, as well as in relation to specific activities and approaches:

Current evidence is insufficient to determine the effectiveness of EMDR, play therapy, family therapy and pharmacological therapy in children and adolescents. ([Landolt and Kenardy 2015](#))

Where systematic reviews have been conducted to attempt to identify general trends in the efficacy of different approaches, variations in study design and weaknesses in methodologies (for example sample size, transparency of reporting, use of a control, consistent application of an intervention) mean the conclusions are often insufficient to say that a therapeutic intervention is definitely effective. However, the majority of authors do conclude that the interventions show some promise, and suggest further, more rigorous and robust research should be conducted to confirm the impact of interventions and identify which elements have an effect.

Reviews of multiple approaches

Brown, R et al. (2017) Psychosocial interventions for children and adolescents after man-made and natural disasters: a meta-analysis and systematic review. *Psychological Medicine*, 47(11), pp.1893-1905 ([open access](#))

This meta-analytic review investigates specific psychosocial treatments for children and adolescents after man-made and natural disasters. In a systematic literature search, the authors identified 36 relevant and includable studies. Random- and mixed-effects models were applied to test for average effect sizes and moderating variables. Treatments in the studies included cognitive-behavioural therapy (CBT), eye movement desensitization and reprocessing (EMDR), narrative exposure therapy for children (KIDNET) and classroom-based interventions. These were found to have similar impact to each other.

However, the degree of impact of the same kind of therapy in different studies varied widely. The authors suggest this is because of differences in characteristics of the studies, such as the level of training of the people delivering the activities. The studies also varied widely in terms of sample size, how the therapy was used, and the kind of control used to measure the impact of the interventions.

The authors conclude that there are several effective psychosocial treatments for child and adolescent survivors of disasters, and recommend CBT, EMDR, KIDNET and classroom-based interventions equally.

Gillies, D et al. (2016) Psychological therapies for children and adolescents exposed to trauma. *Cochrane Database of Systematic Reviews*, 10 ([open access](#))

This review assesses the effects of psychological therapies in preventing PTSD and associated negative emotional, behavioural and mental health outcomes in children and adolescents who have undergone a traumatic event. It seeks to answer the questions:

1. What are the effects of psychological therapies in preventing PTSD and other negative emotional, behavioural and mental health outcomes in children and adolescents exposed to a traumatic event?
2. Which psychological therapies are most effective?
3. Are psychological therapies more effective than pharmacological therapies or other treatments?

The review includes randomised controlled trials on both children and adolescents exposed to trauma. 51 trials were included. The authors report their findings as follows:

Children and adolescents receiving psychological therapies were less likely to be diagnosed with PTSD and had fewer symptoms of PTSD up to a month after treatment compared with those who received no treatment, treatment as usual or were on a waiting list. Our confidence in these findings is limited as the overall quality of evidence was very low to low. There was no evidence for the effectiveness of psychological therapies beyond one month. There was moderate quality evidence that cognitive-behavioural therapy (CBT) might be more effective in reducing symptoms of PTSD compared to other psychological therapies for up to a month. Adverse effects were not reported. There were no studies which compared psychological therapies to drug treatments.

Few of the studies looked at the impact of non-talking therapies. One study compared CBT versus EMDR, and all reported outcomes were short term. Where CBT was found to be no more or less effective than EMDR and supportive therapy in reducing diagnosis of PTSD in the short term, the quality of the evidence was found to be very low. The authors conclude:

The meta-analyses in this review provide some evidence for the effectiveness of psychological therapies in prevention of PTSD and reduction of symptoms in children and adolescents exposed to trauma for up to a month. However, our confidence in these findings is limited by the quality of the included studies and by substantial heterogeneity between studies. Much more evidence is needed to demonstrate the relative effectiveness of different psychological therapies for children exposed to trauma, particularly over the longer term. High-quality studies should be conducted to compare these therapies.

Leenarts, L et al. (2013) Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: a systematic review. *European Child & Adolescent Psychiatry*, 22(5), pp.269-283 ([paywalled](#))

This systematic review of evidence-based treatments for children exposed to childhood maltreatment describes psychotherapeutic treatments which focus on former broad range of psychopathological outcomes. It assesses 33 studies that deal with different forms of trauma including sexual abuse and maltreatment in outpatient clinics or in foster care. Findings indicate that trauma-focused cognitive-behavioral therapy (TF-CBT) is the best-supported treatment for children following childhood maltreatment. However, in line with increased interest in the diagnosis of complex PTSD and given the likely relationship between childhood maltreatment and aggressive and violent behavior, the authors suggest that clinical practice should address a phase-oriented approach. (Adapted from author abstract.)

Morina, N et al. (2016) Interventions for children and adolescents with posttraumatic stress disorder: a meta-analysis of comparative outcome studies. *Clinical Psychology Review*, 47, pp.41-54 ([paywalled](#))

This meta-analysis is aimed at determining the efficacy of psychological and psychopharmacological interventions for children and adolescents suffering from PTSD symptoms, including individual treatment programmes of CBT, EMDR, KIDNET, PDP, TARGET, and TF-CBT. 41 RCTs, of which 39 were psychological interventions and two psychopharmacological interventions, were included. The results indicated a general satisfactory level of quality for most of the publications. The results of the meta-analysis suggest that psychological interventions can effectively lower PTSD symptoms when compared to waitlist and active control conditions. The results of the meta-analysis suggest that psychological interventions can effectively lower PTSD symptoms when compared to waitlist and active control conditions. Findings suggest that psychological treatments can significantly reduce levels of PTSD among children and adolescents. The treatment for which there was the best evidence of effectiveness was TF-CBT.

Nocon, A et al. (2017) The effectiveness of psychosocial interventions in war-traumatized refugee and internally displaced minors: systematic review and meta-analysis. *European Journal of Psychotraumatology*, 8(1), pp.1-15 ([open access](#))

This narrative review and a meta-analysis assesses intervention studies providing data on posttraumatic stress symptoms (PTSS), depression, anxiety, grief, and general distress in children under the age of 18 with direct war-related trauma exposure (excluding child soldiers). 23 studies with a variety of treatments were included in the review, including studies that used interpersonal therapy (IPT), strict cognitive behavioural therapy (CBT), eclectic CBT with other elements, eye movement desensitization and reprocessing (EMDR; within a psychodynamic therapy), creative play, child-centred play therapy, writing intervention, meditation and relaxation

techniques, crisis intervention, psychosocial support, psychoeducation, a systemic approach with preventive skill building, psychosocial support combined with medical care, and mixed interventions.

The wide variations across different studies means that they cannot effectively be compared with each other to reach conclusions about what interventions may have a positive effect. The authors conclude that while some subjects might benefit from some kind of treatment, it probably has negative effects on others, which must be taken into consideration.

Wethington, HR et al. (2008) The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: a systematic review. *American Journal of Preventive Medicine*, 35(3), pp.287-313 ([paywalled](#) or [internet copy](#))

This review evaluated seven interventions using individual cognitive-behavioral therapy, group cognitive behavioral therapy, play therapy, art therapy, psychodynamic therapy, and pharmacologic therapy for symptomatic children and adolescents, and psychological debriefing. Strong evidence showed that individual and group cognitive-behavioral therapy can decrease psychological harm among symptomatic children and adolescents exposed to trauma. However, evidence was insufficient to determine the effectiveness of play therapy, art therapy, pharmacologic therapy, psychodynamic therapy, or psychological debriefing in reducing psychological harm. (Adapted from author abstract)

Adventure-based experiential therapy (AET)

Adventure-based experiential therapies (AET) range from leisure-time activities and activities that facilitate change to actual therapeutic work ([Eckstein and R uth 2013](#)).

Harper, NJ (2017) Wilderness therapy, therapeutic camping and adventure education in child and youth care literature: a scoping review. *Children and Youth Services Review*, 83(1), pp.68–79 ([paywalled](#))

This scoping review seeks to identify and articulate the extant literature of outdoor adventure programs and approaches found in child and youth care literature, including wilderness and adventure therapy, therapeutic camping, and adventure education and physical activity. Nineteen publications identified described therapeutic camps for children, youth, and families. Twelve publications described adventure education (ten publications) and physical activity (two publications). The largest number of publications in this study describe research from the therapeutic approach known as wilderness therapy. Family participation is identified as a strong predictor of outcomes. Ethical considerations, such as the rights of the child, are considered. The author argues that the insights provided from the impacts of the studies indicates “promising evidence for OA approaches in recreation programming, education, and treatment services”, and although they acknowledge that they are “openly biased toward OA approaches”, they insist the methods used in the review are transparent and replicable.

Animal assisted therapy

[Animal Assisted Intervention International \(2018\)](#) define animal assisted therapy as:

An AAT intervention is formally goal-directed and designed to promote improvement in physical, social, emotional and/or cognitive functioning of the person(s) involved and in which a specially trained animal–handler team is an integral part of the treatment process. AAT (Animal Assisted Therapy) is directed and/or delivered by a health/human service professional with specialized expertise and within the scope of practice of his/her profession. AAT may be provided in a variety of settings, may be group or individual in nature and may be implemented for persons of any age. There

are specific goals for each individual involved and the process is documented and evaluated.

There are many forms of AAT; we have provided relevant evidence around the use of dogs (canine) and horses (equine).

Canine therapy

Hoagwood, K et al. (2017) Animal-assisted therapies for youth with or at risk for mental health problems: a systematic review. *Applied Developmental Science*, 21(1), pp.1-13 ([paywalled](#) or [author manuscript](#))

This systematic review evaluates 24 studies of animal-assisted therapies (AAT) for children and adolescents who were at risk for mental health problems (e.g., anxiety due to a medical procedure), currently experiencing mental health problems, or who had a psychiatric diagnosis. The authors suggest that the findings indicate “promising outcomes from canine therapies for childhood trauma”.

Purewal, R et al. (2017) Companion animals and child/adolescent development: a systematic review of the evidence. *International Journal of Environmental Research and Public Health*, 14(3), pp.234-259 ([open access](#))

This systematic review of 22 studies exploring the relationship between pet ownership and emotional health benefits found evidence of an association between pet ownership and cognitive benefits such as perspective-taking abilities, and social benefits such as increased social competence, social networks, social interaction and social play behaviour, but was not able to identify evidence of an association between pet ownership and behavioural development. Some studies showed detrimental effects in these areas. The authors emphasise the need for higher quality research in this area to address issues such as small sample sizes and confounding effects, to identify any causal relationships, and determine specific effects in childrens’ age and kind of animal.

Equine therapy

Equine therapy can include a variety of activities, such as hippotherapy (utilizing equine movement in physical, occupational, or speech therapy treatment), therapeutic horseback riding (THR), therapeutic carriage-driving (TCD), equine-facilitated experiential learning (EFEL), interactive vaulting, and equine-facilitated psychotherapy (EFP). THR, TCD, and vaulting use group or individual riding or driving experiences. [Selby and Smith-Osborne \(2012\)](#) emphasise that:

Although interventions involving horses may be therapeutic, the mere presence of equines in the therapy session does not fit the clinical definition of therapy...In the therapeutic setting, horses are engaged as change agents to facilitate the process of enhanced biopsychosocial development, growth, and education.

Anestis, MD et al. (2014) Equine-related treatments for mental disorders lack empirical support: a systematic review of empirical investigations. *Journal of Clinical Psychology*, 70(12), pp.1115–1132 ([paywalled](#))

The authors of this systematic review examined the quality of studies suggesting that equine therapy may not have as much impact as some authors would argue. Each of the 14 studies they assessed were “compromised by a substantial number of threats to validity, calling into question the meaning and clinical significance of their findings”. They also found that the studies “failed to provide consistent evidence that ERT is superior to the mere passage of time in the treatment of any mental disorder.” They therefore argue that “the current evidence base does not justify the marketing and utilization of ERT for mental disorders” and suggest that “such services should not be offered to the public unless and until well-designed studies provide evidence that justify different conclusions.”

Selby, A and Smith-Osborne, A (2013) A systematic review of effectiveness of complementary and adjunct therapies and interventions involving equines. *Health Psychology*, 32(4), pp.418-432 ([paywalled](#) or [author copy](#))

This systematic review examines 14 studies for the effectiveness of biopsychosocial interventions involving equines for people chronic illness or health challenges, including emotional disturbances and mental health problems including PTSD. Ten of the studies were on children and young people. The general quality of the evidence reviewed falls in the moderate-to-low range due to methodological weaknesses.

The authors conclude that “[I]n the aggregate, the evidence is promising in support of the effectiveness of complementary and adjunct interventions employing equines in the treatment of health challenges” and suggest:

Although research into the psychosocial effects of therapeutic techniques employing horses can be considered to be in its infancy, this initial review illustrates that there are a number of preliminary and pilot studies that demonstrate the promise of this approach.

However, they also emphasise the need for more rigorous research to be conducted, including longitudinal studies and research comparing the efficacy of different interventions.

Creative arts therapies

Creative arts therapy is an umbrella term used to describe the professions of art therapy, music therapy, dance therapy, drama therapy, poetry therapy, and psychodrama. Creative arts therapies are used by creative arts therapists as well as psychologists and counselors to address child trauma caused by events that affect children directly, such as abuse, or indirectly, such as divorce ([van Westrhenen and Fritz 2014](#)). Proponents of art therapy argue that trauma is stored in memory as an image; therefore, expressive art techniques are an effective method for processing and resolving it. It has

been proposed that drawing, like play, allows for visual and other perceptual experiences of the traumatic event to become represented and transformed by a child's activity ([Wethington 2008](#)).

There is limited evidence relating to the impact of art and music therapy on children who have experienced trauma. [Lucio and Nelson \(2016\)](#) suggest that while art and music therapy may be a useful tool in helping children to express their feelings, the small sample sizes, methodological limitations and confounding factors associated with relevant research in this area mean there is limited evidence of the impact of these interventions on PTSD symptoms.

Slayton, SC, et al. (2010) Outcome studies on the efficacy of art therapy: a review of findings. *Art Therapy*, 27(3), pp.108–118 ([paywalled](#))

This review focuses on the efficacy of art therapy as an intervention in treating a variety of psychological conditions. The studies included relating to children and young people explore therapeutic interventions relating to trauma such as bereavement and sexual assault, including grief, attachment disorder, self esteem, anxiety, PTSD, avoidance, and dissociation. In contrast to previous reviews of art therapy that found little evidence to support art therapy as a means of improving behaviour problems in children, the 14 studies in this review that included child subjects and 12 involving adolescents, found that there is some evidence to support the argument that art therapy can lead to positive outcomes. However, the authors also emphasised the methodological weaknesses of several of the studies, including a lack of control groups, standardised reporting and measurement of outcomes.

van Westrhenen, N and Fritz, E (2014) Creative arts therapy as treatment for child trauma: an overview. *The Arts in Psychotherapy*, 41(5), pp.527–534 ([paywalled](#) or [author copy](#))

This paper reviews creative arts therapies as an intervention for child trauma. It assesses 38 studies of children and young people aged from 16 months to

18 years who were treated with art therapy, drama, dance/movement, music, and cinema therapy. The results showed that the majority of articles reported their findings narratively, and that methodological weaknesses hindered the ability of the authors to come to any conclusions about the efficacy of the different approaches.

Eye movement desensitisation and reprocessing (EMDR)

EMDR is a psychotherapeutic approach developed in the late 1980s by Francine Shapiro. [Moreno-Alcázar et al. \(2017\)](#) describe it as:

[A]n eight-phase treatment approach based on a standardized protocol. Briefly, it consists of history taking, preparation, assessment, desensitization, installation, body scan, closure, and reassessment. This protocol facilitates a comprehensive evaluation of the traumatic memory picture, client preparation, and processing of (a) past traumatic events, (b) current disturbing situations, and (c) future challenges.

In general, studies relating to EMDR have indicated promising results in the reduction of “problem behaviors and memory related distress in adults”, but have found less of an impact for children ([Lucio and Nelson 2016](#)). There is limited evidence relating to the impact of EMDR on children who have experienced trauma, and issues with sample size and research methods have limited its endorsement and implementation ([Lucio and Nelson 2016](#)).

Chen, R et al. (2018) The efficacy of eye movement desensitization and reprocessing in children and adults who have experienced complex childhood trauma: a systematic review of randomized controlled trials. *Frontiers in Psychology*, 9(1), pp.1-11 ([open access](#))

This systematic review assessed randomized controlled trials which recruited adult and children with experience of complex childhood trauma, which compared EMDR to alternative treatments or control conditions, and which measured PTSD symptoms. Six studies were included in the review, three of which were on children, and the three studies focused on different traumatic

experiences. The studies have very small sample sizes and are designed very differently (see table 1), which limits the ability of the review to come to any conclusions about the impact of EMDR on whom for what problem.

The results of the studies indicated that EMDR was associated with reductions in PTSD symptoms, depression and/or anxiety both post-treatment and at follow-up compared with all other alternative therapies (cognitive behavior therapy, individual/group therapy and fluoxetine) and control treatment (pill placebo, active listening, EMDR delayed treatment, and treatment as usual). However, the studies were significantly limited by variations in the people involved in the studies, length of treatment, when follow-ups took place, who the group being treated was compared with, and how outcomes were measured. One study had a high risk of bias. The authors however conclude that the findings suggest that there is growing evidence to support the clinical efficacy of EMDR in treating complex childhood trauma in both children and adults.

Field, A and Cottrell, D (2011) Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: a systematic review of the evidence for family therapists. *Journal of Family Therapy*, 33(4), pp.374-388 ([paywalled](#))

This systematic review included eight studies on the use of individual EMDR. All the articles discussed detected a positive treatment effect for EMDR. The authors found tentative evidence in these studies that EMDR was better than waiting list conditions (i.e. no treatment) at reducing symptoms of post-traumatic stress, and possibly also of associated depression and anxiety. The studies included found significant improvements in groups receiving either CBT or EMDR following treatment. The authors emphasise that due to the small sample sizes and other methodological problems, the results should be interpreted with a degree of caution, but suggest some promising developing evidence for EMDR.

Moreno-Alcázar, A et al. (2017) Efficacy of eye movement desensitization and reprocessing in children and adolescent with post-traumatic stress disorder: a meta-analysis of randomized controlled trials. *Frontiers in Psychology*, 8(1750), pp.1-10 ([open access](#))

This meta-analysis of eight randomised controlled trials on children and adolescents with PTSD. The majority of studies were found to be of good or high quality. The review found that EMDR therapy was superior to waitlist/placebo conditions and showed comparable efficacy to cognitive behavior therapy (CBT) in reducing post-traumatic and anxiety symptoms.

Play therapy

It is believed that play links a child's internal thoughts to the outer world by allowing the child to control or manipulate outer objects. Play connects concrete experience and abstract thought while allowing the child to safely express experiences, thoughts, feelings, and desires that might be more threatening if directly addressed ([Wethington 2008](#)). Play therapy is considered a developmentally appropriate approach for younger children (aged 2-10) to express themselves ([Gonzales and Bell 2016](#)).

There are a number of different approaches to play therapy, including child-centred and relational-cultural. Relevant systematic reviews are presented below.

Jordan, B et al. (2013) A case for child-centered play therapy with natural disaster and catastrophic event survivors. *International Journal of Play Therapy*, 22(4), pp.219-230 ([paywalled](#))

This article reviewed the literature regarding the use of child-centered play therapy with children who have experienced natural disasters and catastrophic events. It provides a literature review supporting a case for child-centered play therapy for children experiencing natural disasters. It identifies several individual studies that may be of interest in making the case for the utility and impact of play therapy.

Schottelkorb, AA et al. (2012) Treatment for childhood refugee trauma: A randomized, controlled trial. *International Journal of Play Therapy*, 21(2), pp.57-73 ([paywalled](#))

The authors investigated the effectiveness of child-centered play therapy (CCPT) in comparison with an evidence-based intervention, trauma-focused cognitive-behavioral therapy (TF-CBT) with traumatized refugee children aged 6 to 13. Thirty-one traumatized refugee children were randomly assigned to participate in CCPT or TF-CBT in the elementary school setting in the northwest United States. Results indicated that both CCPT and TF-CBT were effective in reducing trauma symptoms according to child and parent report. Findings support the use of CCPT in treating traumatized refugee children. (Author abstract)

Vicario, M et al. (2013) Relational-cultural play therapy: re-establishing healthy connections with children exposed to trauma in relationships. *International Journal of Play Therapy*, 22(2), pp.103-117 ([paywalled](#))

In this article the authors discuss and illustrate a relational-cultural approach to play therapy designed to help children who have experienced trauma in relationships to reconnect to others in healthy and emotionally beneficial ways. (From author abstract)

Yoga and meditation

We were only able to identify one systematic review that included yoga- or meditation-based therapy with children. The other reviews identified focused solely on treatment for adults with PTSD and other trauma-based conditions.

Nguyen-Feng, V et al. (2018) Yoga as an intervention for psychological symptoms following trauma: a systematic review and quantitative synthesis. *Psychological Services*, April 2018 ([paywalled](#))

The review of 12 studies (one of which involved children aged 7-17) focused on studies with a comparison group that measured psychological symptoms before and after yoga-based interventions for people who had experienced

trauma. The systematic review and quantitative synthesis did not find strong evidence for the effectiveness of yoga as an intervention for PTSD, depression, and anxiety symptoms following traumatic life experiences due to low quality and high risk of bias of studies.

Contextual considerations

Many of the studies presented in this summary emphasise the importance of ensuring therapeutic interventions take into consideration the contextual circumstances and needs of the children and adolescents they are supporting. This includes social, cultural and cognitive considerations.

Gonzalez, CL and Bell, H (2016) Child-centered play therapy for hispanic children with traumatic grief: cultural implications for treatment outcomes. *International Journal of Play Therapy*, 25(3), pp.146-153 ([paywalled](#))

This paper provides an overview of childhood traumatic grief and the grief process in Hispanic culture. It may be a useful example of how cultural context may place children at greater risk of experiencing trauma and how cultural context can influence children's experiences of trauma (in this case traumatic grief). It provides an example of how child centred play therapy may be an effective approach to support Hispanic children experiencing traumatic grief, taking into consideration the need to ask sensitive questions, listen to cultural meanings, and the benefits of providing culturally sensitive toys and representative materials (e.g. multi-ethnic dolls, crayons in multiple shades of skin tone).

Guest, JD and Ohrt, JH (2018) Utilizing child-centered play therapy with children diagnosed with autism spectrum disorder and endured trauma: a case example. *International Journal of Play Therapy*, 27(3), pp.157-165 ([paywalled](#))

This paper provides a case example of how child-centred play therapy as a specific approach may be beneficial for children with autism who have experienced trauma. The authors consider how “the mental rigidity, impaired emotional insight, and poor cognitive coping skills characteristically associated with ASD can actually exacerbate the trauma response” and how this should be taken into account when supporting children with ASD in this context. The authors argue CCPT is an “open and inclusive therapy that is adaptive to diverse clients and needs” and suggest the article may be useful for practitioners:

This article provides viable information about the characteristics of clients with ASD, treatment options for this population, what play may look like in sessions with children on the spectrum, and the influences of trauma on the ASD population.

Miller-Graff, L and Campion, K (2016) Interventions for posttraumatic stress with children exposed to violence: factors associated with treatment success. *Journal of Clinical Psychology*, 72(3), pp.226-248 ([paywalled](#))

This review and meta-analysis assesses 74 studies examining a variety of treatments (individual and group) for children exposed to violence. Results indicated that individual therapies and those with exposure paradigms within a cognitive-behavioral therapy or skills-building framework show the most promise, but treatment is somewhat less effective for those with more severe symptomology and for younger children. The authors conclude that future treatments should consider the developmental and social contexts that may impede treatment progress for young children. (Adapted from author abstract)

Condition-specific guidelines

The National Institute for Health and Care Excellence (NICE) produce guidelines relating to a wide range of mental health and behavioural conditions, which may be of relevance. These include guidelines on PTSD, self harm and depression.

Post-traumatic stress disorder

National Institute for Health and Care Excellence (forthcoming - 2018) Post-traumatic stress disorder ([website](#))

This guidance will partially update the following: Post-traumatic stress disorder: management (CG26).

National Institute for Health and Care Excellence (2013) Post-traumatic stress disorder: Scenario: Children with PTSD. Clinical knowledge summary ([website](#))

This summary provides information about management and treatment for PTSD in children.

National Institute for Health and Care Excellence (2005) Post-traumatic stress disorder: management. Clinical guideline CG26 ([website](#))

This guideline covers recognising, assessing and treating post-traumatic stress disorder (PTSD) in children, young people and adults. It aims to improve quality of life by reducing symptoms of PTSD such as anxiety, sleep problems and difficulties with concentration. Recommendations also aim to raise awareness of the condition and improve coordination of care.

Self harm

National Institute for Health and Care Excellence (2011) Self-harm in over 8s: long-term management. Clinical guideline CG133 ([website](#))

This guideline covers the longer-term psychological treatment and management of self-harm in people aged 8 and over. It aims to improve the quality of care and support for people who self harm and covers both single and recurrent episodes of self-harm.

National Institute for Health and Care Excellence (2004) Self-harm in over 8s: short-term management and prevention of recurrence. Clinical guideline CG16 ([website](#))

This guideline covers the short-term management and prevention of self-harm in people aged 8 and over, regardless of whether accompanied by mental illness. It covers the first 48 hours following an act of self-harm, but does not address the longer-term psychiatric care of people who self-harm.

Depression

National Institute for Health and Care Excellence (2017) Depression in children and young people: identification and management. Clinical guideline CG28 ([website](#))

This guideline covers identifying and managing depression in children and young people aged between 5 and 18 years. Based on the stepped care model, it aims to improve recognition and assessment and promote effective treatments for mild, moderate and severe depression.

National Institute for Health and Care Excellence (forthcoming - 2019) Depression in children and young people: identification and management ([website](#))

This guidance will partially update the guideline: Depression in children and young people: identification and management (CG28).

Summary

There is limited high quality evidence of the impact of experiential therapies on children and young people who have experienced trauma. It is important to be aware of the limitations of the studies that report positive outcomes and to treat these as tentative findings until further, more robust evidence becomes available. Where systematic reviews and meta-analyses compare experiential therapies to TF-CBT, they tend to compare unfavourably, with the exception of EMDR, which has in some instances been found to be equally effective. This is not, however, conclusive evidence that experiential therapies have *no* benefit for children who have experienced trauma, and may highlight the methodological and practical challenges of conducting robust and rigorous experimental research in this field.

Further reading

Boyd-Webb, N (2015) *Play therapy with children and adolescents in crisis: individual, group, and family treatment: a casebook for practitioners.* London: Guilford Press ([book](#))

Guide to working with children and adolescents who have experienced trauma, family upheaval, violence at home, school or the community, and loss. Presents a range of play and creative arts therapy techniques organised around case study examples. Encompasses work with adolescents and younger children and includes sections to encourage reflection and study. (NSPCC catalogue)

Bush, M (ed.) Addressing adversity: prioritising adversity and trauma-informed care for children and young people in England. Young Minds ([pdf](#))

This collection of papers aims to raise awareness about the impact of adversity and trauma on the mental health of children and young people. It includes examples of emerging good practice that may be of interest.

Landolt et al. (2017) *Evidence-based treatments for trauma related disorders in children and adolescents*. Springer International Publishing ([ebook](#))

This handbook presents the current evidence-based psychological treatments for trauma related disorders in childhood and adolescence and in addition provides clearly structured, up-to-date information on the basic principles of traumatic stress research and practice in that age group, covering epidemiology, developmental issues, pathogenetic models, diagnostics, and assessment. Each of the chapters on treatment, which form the core of the book, begins with a summary of the theoretical underpinnings of the approach, followed by a case presentation illustrating the treatment protocol session by session, an analysis of special challenges typically encountered in implementing this treatment, and an overview of the current evidence base for the treatment approach. A special section considers modern treatments in particular settings, such as schools, hospitals, and juvenile justice systems, and the concluding chapters provide an integrative discussion on how to treat traumatized children and adolescents and an outlook. The book will be invaluable for clinical child and adolescent psychologists, child and adolescent psychiatrists, psychotherapists, and other mental health professionals working with traumatized children and adolescents. (Author abstract)

Macdonald and Millen (2012) Therapeutic approaches to social work in residential child care settings: literature review. Social Care Institute for Excellence ([pdf](#))

This review explores the range of therapeutic approaches taken to work with children and young people in residential care in Northern Ireland. It describes the origins, content and evidence base of the models, analyses the similarities and differences between them, and considers the extent to which each model makes clear its theory of change. It looks at Children and Residential Experiences (CARE), Model of Attachment Practice (MAP), the Sanctuary model, ARC (Attachment, Self-regulation and Competency), Resilience model and Social Pedagogy. They conclude that the evidence available is insufficient to draw any conclusions:

Taking seriously what we know of what counts as good evidence, the answer to questions about the effectiveness of the models is, at the moment “we don’t know”. There are few studies designed to rule out competing explanations for change over time, or that explore the differences between the implementation of a model and standard residential care. Those studies that exist are conducted by, or in conjunction with, programme developers. There is an inherent conflict of interest in these studies and a bias in favour of the model/intervention in question.

However, the report may provide a useful background and/or source of further reading.

Moore, K (2016) Following the evidence: sensory approaches in mental health. Sensory Connection Programme ([pdf](#))

This literature review provides some potentially useful references and links to research around sensory-based interventions. It has been produced by the Sensory Connection Programme, which has an explicit interest in this type of intervention; nonetheless the academic research referenced may be of value and the general overview provided may be of interest.

Soleimanpour, S et al. (2017) Adverse childhood experiences and resilience: addressing the unique needs of adolescents. *Academic Pediatrics*, 17(7S), pp.S108-S114 ([open access](#))

This paper discusses how the mental health needs of adolescents who have experienced adverse experiences can be met, including considering confidentiality concerns and emerging independence; tailoring and testing screening tools for specific use with adolescents; identifying effective multipronged and cross-system trauma-informed interventions; and advocating for improved policies. (Adapted author abstract)

Treisman, K (2016) *Working with relational and developmental trauma in children and adolescents*. London: Routledge ([book - available through NHS libraries](#))

This book focuses on psychotherapeutic work with children and adolescents who have experienced relational and developmental trauma, loss and disrupted attachment. Explores the impact of toxic stress on children's bodies, brains, relationships, behaviours, cognitions and emotions. Draws on a range of theories through reflective exercises and case studies. (NSPCC catalogue)

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