Expressive arts group therapy with middle-school aged children from military families☆

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ARTICLE INFO

ABSTRACT

This article describes the development and implementation of an eight-session expressive arts group therapy provided at a middle school on an active military base with youth from active military families. The structure and process of expressive arts group therapy is described with reference to goals and objectives and the integration of the multi-modal expressive arts approach within a psychosocial developmental model relevant to the middle school youth. Principles from expressive arts therapy are also discussed and illustrated in the description and discussion of the eight sessions of the group therapy process. The reader is informed as to the value of group therapy to this age group, and its relevance to middle school aged children from military families. A brief review of literature on issues relevant to military families and middle-school aged children is also included.

Published by Elsevier Inc.

Introduction

Expressive arts therapy (EXA) is an arts-based approach to addressing clinical issues with various populations. EXA (Knill, Barba, & Fuchs, 1995; McKniff, 1981; Rogers, 1993) incorporates elements from the individual creative art modalities of visual art-making, music, dance/movement, poetry and drama in therapeutic work with individuals, families, groups and communities. This *multimodal* approach to formulating clinical interventions sets expressive arts therapy apart from the other creative arts therapies. Some additional tenets of EXA include the following: an emphasis on *process* not product, intermodal exchange, and the use of artistic and aesthetic responses in the giving and receiving of feedback between participants.

Expressive arts therapists are employed in various clinical settings and are able to work under a variety of theoretical models of traditional psychotherapy. This paper describes the development and implementation of an eight-session expressive arts process group provided at a middle school on an active military base. Children referred to this group presented a variety of issues, ranging

from adjustment issues with peers, disruptive behavior disorders, and mood issues including anxiety.

Principles from expressive arts therapy

Expressive arts therapy draws on the strengths of the creative art modalities to elicit, amplify or contain the therapeutic experience of participants. In addition, expressive arts therapists often utilize a process of an *intermodal exchange* (Knill et al., 1995), where the same material can be explored through different modalities such as "moving" a drawing, writing about a drawn image, or representing a feeling state in music.

EXA generally does not focus on pathology in client's artwork, but instead uses the artistic product to increase self-expression and to deepen self-awareness. This emphasis on *process* rather than product provides less interpretation of images compared with traditional models of psychotherapy and art therapy.

In EXA group therapy, self awareness is developed and expressed through *process* which is defined as participants directly experiencing the "now" of the group in terms of thoughts, emotions and interpersonal relatedness. EXA holds the belief that through the creative act the innate expression of the self can be viewed as well as validated by others. Through individual and collective art-making, the group provides participants with both mirroring and witnessing, an interpersonal experience that allows individuals and the group as a whole to achieve the curative factors of group therapy described by Yalom (1995).

EXA utilizes both artistic and *aesthetic* responses (Knill et al., 1995) to enhance opportunities for interpersonal relations between group members as well as between the group therapist and

individual members (or the group as a whole). An artistic response is the giving of feedback or other reactions through one of the art modalities. For example, one person might give their response to another's sharing by writing a poem, creating a movement, or creating a visual art image. The aesthetic response is an attuned responsive *witnessing* by the therapist, holding the created image not in an evaluative manner, but in a true appreciation for its shared meaning and significance (personal or symbolic).

The *internal critic* refers to an individual's de-valuing of their own artistic efforts or products of their creativity. Several factors may contribute to the development of the inner critic, including past negative experiences with the arts such as reactions or negative judgments by others, lack of parental approval or validation, and Western society's collective definition of what art is supposed to be. Furthermore, art-making in Western culture is defined as a rarefied practice which often equates art with the "product" of a specialized ability and further separates art-making from the general population. Our observation of middle school youth is that they are still receptive to various art modalities while straddling two sides of creativity. On one hand they are enthusiastic and uninhibited in their creative expression, and on the other trying to find acceptance for their identity among peers.

Why group therapy with middle school youth?

Group therapy has often been a treatment modality of choice for children and adolescents (Holmes, Heckel, & Gordon, 1991). An EXA group can provide an age-appropriate safe and supportive environment to process and integrate a wide range of emotional and psychic expression for the benefit of the child, school personnel and the family. Yalom's (1995) group therapeutic factors, including group cohesiveness, universality, interpersonal learning, identification, and instillation of hope, are especially relevant to the psychosocial challenges of middle school youth. The group approach described here utilizes the expressive arts to integrate and build upon these therapeutic factors. In addition, the ability of expressive arts therapy to address a wide range of therapeutic material and the developmental needs of this middle-school population, allowed it to be offered to a diverse cross-section of students.

Two developmental stages represented in Erikson's (1950) psychosocial model are relevant to this age group: (1) *Industry vs. Inferiority* (trying to develop a sense of self-worth by refining skills), and (2) *Identity vs. Role Confusion* (work toward integration of many roles such as child, sibling, student, athlete, worker into a self-image under role model and peer pressure). These stages over-lap for middle school children who are chronologically between latency and adolescence. Expressive arts group therapy also addresses Maslow's hierarchy of (Maslow, 1954) needs including belonging and love, self-esteem, cognitive (knowledge, meaning, self-awareness) and aesthetic needs of this age group.

Psychosocial issues of children from military families

As of 2009, over a million children and their families have now experienced the stress of deployment when a family member has been deployed to Iraq or Afghanistan since 9/11 (McFarlane, 2009). For the active military service member and their families, the high operational pace of the current conflicts and multiple and extended deployments are extremely stressful and greatly impact daily functioning and mental health. In this regard, Chandra, Lara-Cinisomo, et al. (2010) identified a number of issues for youth aged 11–17 years and their non-deployed caregivers (*n* = 1507):

- Children had more emotional difficulties compared with national samples.
- Older youth and girls of all ages reported significantly more school-, family-, and peer-related difficulties due to parental deployment.
- Length of parental deployment and non-deployed caregiver mental health issues were significantly associated with a greater number of challenges for children both during deployment and deployed-parent reintegration.

In a second study, Chandra, Martin, Hawkins, and Richardson (2010) also identified the following issues and dynamics regarding military children's functioning as observed by school staff:

- Some children coped well with deployment, however, for many, anxiety related to parental absence, increased responsibilities at home, declines in mental health of non-deployed parents, and difficulty accessing mental health services affected the ability of students to function well in school.
- School staff reported that students are losing resiliency as multiple deployments continue. Whereas these children, while having been able to adapt to the initial deployments, are becoming less engaged in school work, have increased use of avoidant behaviors, and many develop some health risk-taking behaviors.
- Many children had lost their support systems among family and peers and have difficulties reengaging with others.
- Many children experienced role reversals, taking on parental roles or becoming the emotional partner of their home caregiver which placed undue burdens on their lives.
- While schools are becoming the "stable place or sanctuary" for these students, this may overtax the school staff when children becoming overly needy or overly abundant in the school.

Consideration for the actual current stage of deployment the family is experiencing as well as the history of adaptation to past deployment stages is crucial in understanding the child's experience within the family and at school (McFarlane, 2009). The five stages of military deployment include predeployment, deployment, sustainment, redeployment, and post deployment. Stress and challenges in functioning can occur at any stage and continue into the next stage (Fitzsimons & Krause-Parello, 2009; Pincus, House, Christenson, & Adler, 2007). Each deployment stage is characterized by particular emotional challenges for the family and child, within a specific time frame. The family's situation can also change unpredictably, based upon the needs and mission of the military. While the family is expected to respond and adapt to these changes they may not be ready to do so or lack necessary resources to do this successfully, adding to family stress.

For instance, during the redeployment phase when the deployed parent returns, many challenges may arise. The returning parent may now be different due to the effects of PTSD, TBI, loss of limb or other physical functioning, chronic pain, other serious mental health issues, or chemical dependency/substance abuse, which can have significant adverse impacts on the entire family. Some families are able to adapt, while others may struggle and possibly separate or divorce. Role ambiguity also impacts family dynamics during both the deployment and redeployment phases as the family adapts to loss or reintegration of a family member.

During combat-related deployments, Gibbs, Martin, Kupper, and Johnson (2007) found that child maltreatment increased and neglect of children was nearly twice as great. One study reported that children over the age of 3 are at significant risk of developing depressive symptoms and/or more prone to externalizing behaviors which can develop into a coping style during school years (Chartrand, Frank, White, & Shope, 2008). In addition, the at-home caregiving parent's anxiety has a great impact on the children and