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Art Therapists' Approaches to the Treatment of Body
Image Distortion and Guilt in Sexually-abused Girls
Ages 4, 8, and 13.

by

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Requirements For The Degree Of

DOCTOR OF PHILOSOPHY

in the Department of Education

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ABSTRACT

Clinicians (Horowitz, 1985; Long, 1986) and researchers (Finkelhor, 1986; Haugaard & Dickon Reppucci, 1988) have concluded that there is insufficient information on how to treat child sexual abuse (CSA). The reported incidence of CSA has substantially increased, hence, the need for treatment approaches has escalated. The purpose of this study was to provide clinicians who treat CSA with a descriptive account of the methods currently used by art therapists to treat sexually-abused children of differing ages who present with different issues.

One hundred and forty-six certified and/or diplomaed art therapists, aged 26 to 66, who had training and experience in CSA treatment were solicited through the national art therapy associations in Canada and the United States. They responded to case-simulation surveys which consisted of a case history, photograph, and self-portrait of a hypothetical sexually-abused girl aged 4, 8, or 13 who presented with either the issue of body image distortion or guilt. Open-ended or multiple choice research questions on the art therapist's treatment approach, choice of media, directives, use of time, use of therapeutic interactions, use of debriefing process, opinions on the function of art in the session, and method of

evaluation were utilized to obtain a qualitative description of the art therapy approach to working with a child of a certain age presenting with a particular issue.

A content analysis of the qualitative data resulted in the identification of thematic categories which described the goals, directives, debriefing process, and the function of art in the session. The responses to the questions on time use and media were analyzed similarly. The frequency of responses for the multiple choice answers and the thematic categories were calculated and then compared across the age and issue variables, in the form of percentages. A comprehensive clinical description of the art therapists' approaches to CSA treatment was obtained for the whole sample, and across age, and issue. The subjects' responses were paraphrased to illustrate these differences for each question.

The main findings were: (a) art therapists addressed the main issues of CSA, as described by traditional verbal therapists (Sgroi, 1982), and employed both directive and nondirective styles in their approaches; (b) art therapists were sensitive to the developmental level of the child depicted in the case simulation and adapted their approach to meet the child's needs (i.e., the sessions with younger children were characterized by different media choices, and directives, the therapists spent more time being supportive and nurturing, provided physical contact, snacks,

used art-as-therapy, spent less time discussing and more time playing and doing, allowing the child to work out her issues through using her body and the media whereas with the adolescents, art was used as psychotherapy and catharsis more frequently and discussion and debriefing were utilized to help change her thinking about the abuse experience), (c) art therapists responded differently to the body image distortion and guilt case simulations (i.e., activities designed to solicit representations of feelings and of the offender were more frequently reported for the guilt case simulations while self-portraits and safe places were more frequent in the responses to the body image distortion case simulations, and (d) the findings on the function of art in treating CSA replicated the earlier study by Marrion, Landell, and Bradley (1988).

This study provided a clinical description of art therapists' approaches to treating CSA. It illustrated the function of the art directives, the use of media, the debriefing process, and the art products themselves. The descriptions of these may aid clinicians in understanding how this sample of art therapists worked with sexually-abused children and may prompt them to undertake training in this discipline as a way broadening their approach to working with sexually-abused children.

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ACKNOWLEDGMENT

The development and completion of this thesis was the result of the support, cooperation, and commitment of many people and organizations. I would like to acknowledge the Victoria Mental Health Center who provided me with the opportunity to develop clinical expertise in the art therapy treatment of sexual abuse trauma; the British Columbia School of Art Therapy who supervised my training and provided me with documents and moral support; and the British Columbia Art Therapy Association members who willingly offered their time and expertise as volunteer subjects for the pilot study.

I would also like to thank my research assistant, Diane Busch, for enduring through this project, despite her broken leg; Dr. Tara Ney and Dr. Ursula Price, for their help in establishing interrater agreement in the content analysis; Sarah Bradley and Susan Landell, who encouraged me to take our initial study one step farther; Kay Collis, who provided networking in the field of art therapy; and Dr. Peter Schieldrop, who helped me to experience that which I have written about.

I am especially indebted to my committee supervisors, Dr. Brian Harvey and Dr. Lloyd Ollila, for their support, guidance, and enthusiasm; and to my other committee members, Dr. Jennifer Hill, for her unending capacity to edit gently, and Dr. Don Knowles, for his constant supply of recent references.

Finally, I would like to thank my husband, Don, and my children, Brittany, Marina, and Dustin, for their patience with my work.

DEDICATION

This thesis is dedicated to all children who have been sexually abused, and especially to my first client, a 19-year-old woman who ran across Canada to escape her past. Needless to say, she could not escape her memories and came to know and accept herself through the art therapy process. Afterwards, she told me I should write about it so that others could learn how to help children who had been through similar experiences.

This thesis is also dedicated to all offenders. Even if only one offender comes face-to-face with a child's pain and her difficult process of healing, it will help to increase understanding and right the balance of power in that and other relationships.

Finally, this thesis is also dedicated to the memory of my niece, Becky. She allowed me to use her photograph in one of the case simulations in order to help others learn how to treat children who had been sexually abused.

CHAPTER 1

INTRODUCTION

Children who are sexually abused in a violent or painful way are traumatized by their experience (Burgess, Groth, Holmstrom, & Sgroi, 1978; Johnson, 1987). One of the immediate consequences of this severe trauma is a distortion of body image (Stember, 1980) which reflects both the terror of being physically violated and the powerlessness of being unable to escape. Ego boundaries may break or become extremely fragile, leaving the child vulnerable to further abuse (Johnson, 1987). Conversely, ego boundaries may become rigid, closed, and compartmentalized resulting in the splitting off or dissociation of aspects of the personality and developmental arrest (Ellenson, 1986; Johnson, 1987; Jones, 1983; Stember, 1980). Children may take on a sense of responsibility for the abuse and feel guilt and shame as a result. Depending on their age and their relationship with the offender, their reactions to the abuse may differ (Giaretto, 1982). Younger children may feel as if they were singled out and react with the introjection of "badness" (Miller, 1984), whereas adolescents may feel they are partly to blame because they either somehow deserved the abuse or gave off a signal that they wanted it (Burgess & Holmstrom, 1979). If the offender is a family member or relative, guilt and shame are often compounded by the use of coercion or threats concerning telling (Giaretto, 1982).

Clinicians believe that sexually-abused children require therapeutic intervention in order to work through their feelings and fears and to re-adjust to normal life (MacVicar, 1979; Sgroi, 1982; Stember, 1980), however, information on the treatment of child sexual abuse (CSA) is limited (Haugaard & Dickon Reppucci, 1988; Horowitz, 1985; Long, 1986). In a survey of 108 practitioners in private practice, Attias & Goodwin (1985) found that although over half of the respondents had treated a sexually-abused child or adult in the past year, 86.00% felt that their knowledge of treatment strategies was inadequate and requested more training in this area. Long (1986) reported that clinicians struggle in their attempts to treat this particular population, often feeling isolated from other colleagues in the field. She found that the paucity of literature related to specific treatment methods was particularly frustrating, given the increase in the number of sexual abuse cases reported.

Clinicians urgently need information on intervention techniques that have been successfully employed, however, no comparative treatment studies exist. Finkelhor (1986) strongly recommended that treatment outcome studies be conducted. He suggested that victim-related characteristics, such as age, premorbid personality, relationship to the offender, and type or severity of abuse, need to be examined in relationship to the various treatment approaches available.

Statement of the Problem

The lack of research on the treatment of CSA with regard to different victim populations and the specific issues arising from the characteristics of those populations continues to plague clinicians who are in need of treatment information (Long, 1986). Few treatment studies have presented information on specific issues or accounted for developmental factors (Burgess & Holmstrom, 1979). Reports on the different modes of therapy (e.g., art, play, drama, behavioral or verbal therapies) have not yet addressed the specific form of therapy which might work best with certain issues at different stages in childhood development. Similarly, there are no comparison studies on the different structural factors, such as individual, group, family, or community-based therapy approaches (Finkelhor, 1986; Kroth, 1979). There are also no treatment outcome studies with comparative control groups. Therefore, the factors which impinge upon successful treatment remain unclear.

Art therapists have been working with sexually-abused children for some time (Landgarten, 1987). One of the underlying premises concerning the function of art in therapy is that the art produced by the child reflects the child's inner emotional, psychological state (Levick, 1983). The self-portraits of children who had been raped or endured painful sexual molestation have been found to contain distortions in body image and other signs that indicate

regression in the children's ability to organize components of the image. Their drawings have also displayed a greater incidence of firmly drawn and horizontally placed marks in the image (Burgess, McCausland, & Wolbert, 1981; Kelly, 1984; Stember, 1980). The art therapy approach provides a graphic record of the changing psychological status of the child before, through, and after therapy. It is also reported to be an easier mode for children who have difficulty verbalizing their psychological experiences (Kelly, 1984). The process of creating visual images is transformational in itself (London, 1989) and leads to the emergence of repressed feelings and increased awareness of inner strengths (Yates & Pawley, 1987). These characteristics support the theory that art therapy may be a viable method for the treatment of CSA. However, with the notable exceptions of case studies (e.g., Burgess & Holmstrom, 1979; Goodwin, 1982; Jones, 1982, 1983, 1987; Kelly, 1984; Silvercloud, 1983; Stember, 1980; and Thomas, 1980) and post hoc descriptions of therapy groups in which art was used as a therapeutic activity (e.g., Berliner & Ernst, 1984; Carozza & Hiersteiner, 1983; Delson & Clark, 1981; Krentz Johnson, 1979; Lubell & Soong, 1982; McMillen Hall, 1978; and Naitove, 1982), there has been no systematic research on how art therapists treat CSA.

Purpose of the Study

The major purpose of the present study was to examine the various approaches used by art therapists in treating

children who have experienced sexual abuse. The researcher specifically attempted to discover, through a case-simulation method, whether or not there were differences in the treatment approaches across ages and across issues. Two issues were examined: (a) distorted body image due to the physical trauma and violation of the child's body during the sexual act, and (b) the feelings of guilt and shame caused by involvement in the sexual encounter.

The independent variables of age of the child and the therapeutic issue were considered to be crucial factors in determining appropriate treatment approaches. The impact of the age of the child on the course of treatment was examined by Burgess and Holmstrom (1974) and Burgess, Groth, Holmstrom and Sgroi (1978). Burgess and her colleagues related normal sexual developmental stages with the age of the victims to the meaning they would make of the assault. They found that very young children did not associate the assault with their sexuality; somewhat older children, between the ages of 4 - 12 years, were overstimulated and became eroticized in some interactions with other children and adults; adolescents isolated themselves from their peers as they felt sure their friends would notice that they were now different; women of child-bearing years were more concerned that their relationship with their boyfriend or husband would be jeopardized, that they might have caught a disease, and they might not be able to have children; and older women were most

concerned about the threat to their life rather than focussing on the sexual content of the assault.

Several researchers (Berliner & Ernst, 1984; Carozza & Hiersteiner, 1983; Jones, 1983; Sgroi, 1982; and Stember, 1978, 1980) have described some of the general issues which most sexually-abused children face in coming to terms with their traumatic experience. These include "damaged goods" syndrome; guilt, fear, and depression; repressed anger and hostility; impaired ability to trust; blurred role boundaries and role confusion; pseudomaturity, coupled with failure to accomplish developmental tasks; and the need to develop self-mastery and control. The ways of addressing these specific issues in therapy, however, have not been described in relation to specific victim characteristics. Clinicians recognize and respond to these issues in their clients, but they have limited descriptive clinical resources or different approaches to draw from in their practice (Long, 1986).

General Procedures

A case-simulation method was chosen to investigate how art therapists treat CSA in response to Finkelhor's (1986) request that the nature of the sample, and the nature of the abuse be described in detail so that the dynamics which lead to effective treatment could be accurately investigated. The simulations, sent to art therapists actively involved in the treatment of CSA cases, included a photograph and self-portrait drawing of a hypothetical sexually-abused child,

case information regarding the nature of the abuse, and a short scenario describing the therapeutic issue to be addressed in the treatment session. There were 6 simulations and these are contained in Appendix A. The art therapists were asked to describe their treatment approach by answering open-ended survey questions. The survey instrument is also contained in Appendix A.

The case histories were designed to incorporate factors which were thought to influence the effects of the sexual abuse experience on the child and the course of treatment. Haugaard and Dickon Reppucci (1988) listed the following as important variables to consider in assessing the impact on the child and in treatment planning: (a) the child's age at onset and premorbid personality; (b) the characteristics of the abuse, such as duration, relationship to offender, evidence of coercion, and type of sexual activity; and (c) the events subsequent to the abuse, such as the reaction of others and the need for making a court appearance. Three different aged case-simulations were developed; the first described a child aged 4; the second, a child aged 8; and, the third, described a child of age 13. In each of the short scenarios, the child was described as having recently been raped by a family relative and as suffering noticeable emotional distress, which was manifested as regressive or attention getting behavior. The sexual assault was physically damaging and the child was threatened not to

disclose. MacVicar (1979) defined this situation as nonparticipating assault on the part of the child.

By means of case-simulation methodology, the independent variables of age and issue, and the subsequent behaviors evidenced in the child as a result of the interaction between variables, could be systematically manipulated. All art therapists received similar basic case information (e.g., name of child, nature of the abuse), however, the ages, issues, and symptoms varied. The content of the case descriptions is summarized in Table 1. By varying the content, it was possible to to examine the different approaches art therapists used in the treatment of young females who had been victims of a sexual assault.

Research Questions

The investigation attempted to answer the following questions:

1. What are the demographic characteristics of art therapists who treat CSA?
2. What are the general treatment approaches used by art therapists in their treatment of CSA?
3. What is the range of media used by art therapists with sexually abused children in treating (a) a distorted body image due to physical violation, and (b) the issue of guilt? Does the range differ for children aged 4, 8, and 13?

Table 1

Case Descriptions: Independent Variables and Symptoms

| Case | Age | Issue | Symptoms | Self-Portrait |
|------|-----|----------------------|--|--|
| A | 4 | Distorted body image | Withdrawal, nightmares, separation anxiety, weight loss. | Distortion of body parts. |
| B | 4 | Guilt | Withdrawal, nightmares, separation anxiety, weight loss. | X'd out self image. |
| C | 8 | Distorted body image | Compliant, shy, compulsive behavior such as washing, enuresis, nightmares. | Transparent nightie, elongated vagina. |
| D | 8 | Guilt | Compliant, shy, compulsive behavior such as washing, enuresis, nightmares. | X'd out self-image. |
| E | 13 | Distorted body image | Truancy, poor hygiene, weight gain overt anger. | Genderless self-image. |
| F | 13 | Guilt | Truancy, poor hygiene, weight gain, overt anger. | X'd out self-image. |

4. What is the range of directives used by art therapists in addressing the issue of (a) body image distortion and (b) guilt over involvement with the offender? Does the range differ for children aged 4, 8, and 13?
5. How do art therapists structure their use of time in (a) the session on distorted body image, and (b) in the session on guilt? Does the structure differ for children aged 4, 8, and 13?
6. How do art therapists structure their therapeutic interaction when addressing the issue of (a) distorted body image and (b) guilt? Does the pattern of interaction differ for children aged 4, 8, and 13?
7. How do art therapists debrief the session on the issue of (a) body image distortion and (b) guilt? Does the format differ for children aged 4, 8, and 13?
8. What is the function of art in therapy with sexually-abused children? Does the function differ by issue and by age?
9. What criteria do art therapists use to evaluate the success of their approaches?

Definitions of terms

The following terms appeared in the case-simulation surveys and are defined for the purpose of the current study:

Range of media refers to any materials, art supplies or tools that would be available for the child's use during treatment sessions.

Range of directives refers to all instructions or
or directions given to the child by the art therapist to help
focus the child on a particular issue or process.

Use of time refers to all the various activities and the
amount of time engaged in each during a session. Activities
include greeting, artwork, snack, warning of ending,
debriefing, playing, and discussion.

Therapeutic interaction refers to the the styles,
strategies, and ways of working with the child used by the
art therapist in the session to aid the child in self-
acceptance.

Debriefing refers to any discussion or reference to the
artwork or the process of creating it as a means of closure
around the issue or of the session.

Scope and Limitations of the Study

The current study was limited to the examination of the various approaches used by art therapists in treating children who reported that they had experienced sexual abuse. The study did not attempt to examine the therapeutic methods used by other clinicians (e.g., play therapy, drama therapy) in treating sexually-abused children, nor did it attempt to examine the approaches used by art therapists in treating other forms of abuse (e.g., physical abuse, neglect). The investigation was further limited to examining the issues of body image distortion and guilt in girls aged 4, 8, and 13 by means of individual therapy. As the majority of sexually-

abused children are females, this choice was justified at this early stage of investigation. For information concerning the sexual abuse experience of males, the reader is referred to Hubberstey's (1988) phenomenological study.

Children of all ages are sexually abused, however, the selection of the specific ages was intended to provide clinicians with information that is representative of treatment approaches appropriate for pre-school children (ages 3 - 6), children in the latency period (ages 7 - 12), and children entering their adolescence (ages 13 - 18). Art therapy may not be the most efficacious approach to use with children age 2 or younger as they lack the gross and fine motor skills necessary to manipulate the media (Rubin, 1984) nor is it necessarily the best choice for older adolescents as they have reached a level of cognitive development enabling them to utilize other therapeutic approaches (Johnson, 1987). It should be noted, however, that art therapy has been used successfully with later adolescents and adults in discovering repressed memories of childhood sexual abuse (Chervick, 1977) or in working through recent sexual abuse trauma (Yates & Pawley, 1987).

Two specific issues, distorted body image due to the physical violation of the child's body during the sexual act, and the feelings of guilt and shame caused by involvement in the sexual encounter, were chosen for examination in the present study. Not only are these issues representative of

the feelings expressed by sexually-abused children, they are also commonly evidenced in their drawings. As the case simulation included a self-portrait of the child, it was important to choose issues that could be realistically illustrated. As the time involvement required from the art therapists for completion was a major factor in determining the return rates, it was important that the survey be short. Consequently, each case simulation focussed on one of the two specific issues. The current study will provide preliminary information that may be the basis for further investigation of the other issues involved in the treatment of CSA cases.

Finally, the case-simulation scenario in the present study asked for the treatment plan for individual cases rather than groups. This approach was congruent with research findings which supported individual treatment for children with severe trauma reactions prior to group treatment (Carozza & Hiersteiner, 1983; Jones, 1983). No attempt was made to generalize the results of the current study to treatment plans involving more than one individual at a time.

Summary

Descriptive investigation of the treatment of specific issues in children of different ages traumatized by sexual abuse is a new area of research. Clinicians have requested specific treatment information on the various modes and

methods in order to treat the growing victim population (Long, 1986). An emerging mode of treatment for CSA is art therapy which allows the clinician to observe visually through the child's art process the inner psychological changes that are occurring as a result of treatment. For children who encounter difficulties in verbalization, art therapy would appear to be an important intervention technique allowing expression of feelings through alternate means.

An international survey of art therapists (Marrion, Landell, & Bradley, 1988) located a sufficient number of practitioners able to provide a detailed account of their approaches to working with this population. Descriptive information was gathered with respect to the impact of several child-related variables (e.g., age; specific issues; and symptoms, and severity) on the therapist's choice of media, directives, and structuring of the therapy session (e.g., use of time).

The purpose of this study was to elicit from the art therapists their descriptions of the function of these particular variables in treatment. Data analysis included a content analysis and summary of the proportional differences across age and issue. The findings were discussed with reference to art therapy and CSA theory. Two complete examples of the survey responses were included to present a wholistic view of the art therapy treatment process.

CHAPTER 2

REVIEW OF THE LITERATURE

Child sexual abuse has a longlasting, pervasive, negative effect on the victims (Herman & Hirschman, 1981; Justice & Justice, 1979; Mieselmann, 1978; Summit, 1982). The sinister effects of this disruption begin immediately as children, by the nature of the sexual act, instantaneously experience a loss of power over their world and a loss of worth in the eyes of the perpetrator. Instead of perceiving their environment to be safe, nurturing, and supportive, they may begin to live on the edge of fear.

The reported incidence of CSA has risen substantially over the past decade. The Badgley Report (1984) stated that one in two females and one in three males had been the victims of unwanted sexual acts in Canada and that 80% of the victims had experienced the assaults during their childhood years. According to Finkelhor (1986), surveys have indicated that from 2 to 38 percent of American women had experienced unwanted sexual contact prior to the age of 18. These figures probably underpredict the number of children who may have been sexually abused because many do not report the incidents.

There is a growing recognition of the lack of treatment for sexually-abused children. Badgley (1984) reported:

Many sexually abused children either received no assessment or their needs were only partially and inadequately considered. Because of insufficient

follow-up, many were left in situations of continuing risk. This occurred because of different standards of assessment, treatment, follow-up, and protection among agencies providing service to sexually abused children. (p. 26)

The psychological sequelae of CSA are more extreme and longlasting than had been previously believed, often persisting or resurfacing in adulthood (Briere, 1984; Miller, 1984). Clinicians have felt both overwhelmed by the numbers of sexually-abused children they must treat and unprepared to provide appropriate treatment because of their lack of expertise with this disturbing social problem (Long, 1986).

This review of the literature will examine the complex factors that lead to incidents of CSA, the reactions of children of different ages to CSA, and some of the treatment approaches that have been utilized with CSA victims. The review is organized into four major sections: (a) Overview of CSA; (b) General Treatment Approaches; (c) Art Therapy Treatment Approaches; and, (d) Summary.

Overview of Child Sexual Abuse

The treatment of CSA is complex for many reasons. The lack of a single definition of CSA may unintentionally act to limit the delivery of service to children and families, especially when the court bases its assessment of need on the guilt of the offender. The numerous definitions of CSA may obfuscate the generality of research findings as there are differing standards for inclusion across CSA studies. There is insufficient knowledge concerning the

various factors which predispose the child to sexual abuse, and which affect the severity of impact of the sexual abuse on the child. A broad clinical definition of CSA, a synthesis of the findings on factors which predispose the child to sexual abuse, a summary of the severity indicators of sequelae, and an overview of the developmental differences will be presented in this section.

Child sexual abuse is defined by the Inter-ministerial Committee of British Columbia (1985) as "any sexual touching, sexual intercourse or sexual exploitation of a child and may include any sexual behavior directed toward a child" (p. 6). A more detailed definition is provided by Alexander (1986) who stated that CSA is:

The exploitation of a child by a person standing in a position of trust or authority.... Child sexual abuse includes exhibitionism (where a child is forced to look at the genitals of an older child or adult), fondling, rape and incest (sexual activity between members of the same family).... The abuse often occurs over a long period of time, starting gradually with touching and fondling and often, although not always, progressing to oral, anal and vaginal intercourse. (p. 3)

He qualified this position with the proviso that "some people feel that sexual abuse has not occurred if the child consents to the activity; but experts believe that children are incapable of giving informed consent" (p.3).

The value of comprehensive definitions such as the two presented is that they both broadly and specifically define the parameters of sexual abuse, not only within the larger social context, but also within the immediate family system.

Utilizing a clinically broadbased definition will result in many more children being identified as having been sexually abused, and therefore, eligible for treatment and for inclusion in the statistics of treatment agencies.

The factors which predispose children to sexual abuse have received greater attention since family systems theory (Minuchin & Fishman, 1981; Satir & Baldwin, 1983) has been applied to mental health treatment practices. According to Horowitz (1985), there are often "identifiable and predictable circumstances that surround the victims of sexual abuse and their families" (p. 173). Contributing familial factors include poor supervision, poor choice of surrogate caretakers or babysitters, inappropriate sleeping arrangements, reversals of role boundaries, and previous sexual abuse by a family member (Horowitz, 1985). Vander Mey and Neff (1982) examined the consistently reported characteristics of incest victims. They concluded that the preponderance of victims were females under the age of 17. The perpetrators were most often the biological fathers, although step-father were more likely to abuse their step-daughters. Adult-child incest was usually protracted, beginning before the children reached puberty. It usually occurred in intact homes (i.e., no divorce, separation, or death of spouse), and firstborn daughters were at more risk than laterborns. The fathers in families where incest occurred tended to be extremely dominant while the mothers

were indifferent, intimidated, and sexually-cold. The family was socially isolated and role disorganization was present. Such familial factors contribute not only to the risk of incest but also to the risk of extra-familial sexual abuse (Horowitz, 1985).

Finkelhor (1986), Haugaard and Dickon Reppucci (1988), and Krentz Johnson (1979) have theorized that CSA is a possible outcome in situations where children's needs for affection are not being adequately met by their parents due to family system dysfunction. In these cases, CSA may occur when needy children indiscriminately relate to adults in an affection-seeking manner in an effort to ensure their own emotional survival. In Krentz Johnson's sample of clinical cases, those children sexually abused outside the constellation of the family did not appear to be any different from children abused in incestuous family situations. Both yearned for more attention, affection, and nurturance from adults. Furthermore, these needs appeared to be present prior to the onset of the abuse. The family histories and collateral information obtained by Krentz Johnson documented the fact that the parents were either physically or emotionally unavailable to meet these children's needs for affection and comfort before the child was abused. She concluded that the sexual mistreatment of children was a family problem, rooted in the family dynamics, even in cases where the abuser was not a member of the

family. Krentz Johnson rejected such behavior as being seductive or sexualized. Instead, she proposed the behavior was representative of children's desperate attempts to meet their needs for care and attention. These needs make children vulnerable targets and at high risk for sexual abuse should they come into contact with an adult who has the potential for causing abuse. Her conclusions were later supported by Finkelhor (1986) and Haugaard and Dickon Reppucci (1988).

Several studies have investigated the various factors which determine sexually-abused children's reactions to the abuse. Most researchers have found that pathological outcomes are similar in victims of CSA (Finkelhor, 1986; Haugaard & Dickon Reppucci, 1988; Lewis & Sarrel, 1969). The factors which they found to have an important bearing on the sequelae were: the form of the attack; the frequency of the abuse; the person who carries out the action (i.e., whether or not he is known to the child); the age of the child and the level of ego development; and, the closeness of the event to the child's prevailing fantasies.

Finkelhor (1979) postulated that the potential trauma was greatest in cases where there was: (a) a close relationship between the child and the older partner; (b) a long duration of abuse; (c) an elaborate sexual activity (i.e., penetration being the most negative as opposed to exposure to an exhibitionist being the least); and, (d) when

aggression was present during the sexual act. Burgess, McCausland, and Wolbert (1981) examined the pathological reactions which occurred when children were pressured by a person in a power position, through age or authority, to engage in unwanted sexual activity. In such cases, the sexual activity is usually ongoing and longlasting, as long as the children do not report the abuse. The reactions of children differed if they did not perceive the activity to be forced or life threatening. The emotional reaction of guilt was the most extreme for the children who were pressured into sexual activity and keeping it a secret.

McCarthy (1986) stated that there are potentially hundreds of variables to consider in understanding the reactions to the type of sexual trauma experienced. There are unique characteristics to each person's experience depending on the actual incident, the individual personality characteristics, how the episode was dealt with, and so on. McCarthy recommended evaluating the following variables when completing a detailed sexual trauma history:

- 1) Physically violent vs. friendly, attentive
- 2) Family member vs. stranger
- 3) Hands-on abuse vs. hands-off
- 4) Continuous vs. single incident
- 5) Total secrecy vs. incident discussed
- 6) Manipulative exploitation vs. personal concern
- 7) Intercourse vs. viewing
- 8) Same sex vs. opposite sex
- 9) Male survivor vs. female survivor
- 10) Pain, sadistic vs. gentle
- 11) Distorted verbal rationale vs. nonverbal
- 12) First sexual experience vs. sexually experienced

According to McCarthy, each variable should be considered

continuous rather than dichotomous: greater trauma results from the first mentioned variable in each set than the later.

Children who have been sexually abused present a myriad of symptoms ranging from complete repression of the incident, to profound depression, psychoses, suicide attempts, phobias, hypervigilance, problems of impulse control, and physical aggression (Burgess & Holmstrom, 1974). Almost every symptom listed in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980) has been used to describe a child's reaction to CSA (Blake-White & Kline, 1984).

A lack of precise knowledge concerning the behavioral patterns resulting from CSA has led to the misdiagnosis of many victims (Blake-White & Kline, 1984; Ellenson, 1986; Johnson, 1987). Symptoms, rather than the underlying cause of the symptoms, have tended to be treated without identifying the impact of the abuse. Several authors have recategorized CSA as a form of physical and/or emotional trauma (Johnson, 1987), a crisis (Burgess & Holmstrom, 1974), and a form of posttraumatic stress syndrome (Blake-White & Kline, 1984). Such a viewpoint leads one to reconceptualize the cause of the symptoms to be psychological trauma induced by the emotional and physical threat of the incident. Johnson (1987) stated that "psychological trauma occurs as a response to overwhelming personal threat in which the psychic apparatus surrenders to a situation of terror and the

immediacy of death..." (p. 7). Unfortunately, as Horowitz (1985) commented, many cases of sexual abuse have gone unnoticed because even mental health professionals do not recognize that certain behavioral patterns indicate that a child has been sexually abused.

Investigations into the behavioral patterns of sexually-abused children are increasing (Finkelhor, 1986). Schultz and Jones (1983) identified several indicators of acute and chronic molestation. These include: nightmares or night terrors; arriving for school early and leaving late; a recent history of running away from home; poor relationships with adults, adolescents, or peers, accompanied by sex and role confusion; recent, inappropriate sexual self-consciousness or sexual promiscuity; and allegations by siblings of sexual mistreatment. Katan (1973) described the psychological reactions as including: sexual overstimulation and the resulting repetition compulsion in which the child attempts to master the conflict; intense confusion around aggressive and sexual impulses and the need for affection; and, possible arrest in the oral stage of development, manifested by an overwhelming need to receive consistent, congruent nurturing. Forward and Buck (1972) reported that victims experienced repressed feelings of guilt, shame, hurt, fear, and confusion, as well as a lowering of self-esteem, an increase in self-destructive tendencies, a diminished level of trust, and a variety of psychosomatic symptoms. Rizst (1979) noted

three negative behavior patterns present in women who had been sexually abused as children by their fathers: sexual promiscuity often coupled with substance abuse; inorgasmic adult sexual response; and, subsequent neurotic reactions often coupled with somatic symptoms and anxiety.

Burgess and Holmstrom (1974), in their clinical experience with both children and adults suffering from rape trauma syndrome, found that even when there were no specific signs of emotional or behavioral disorder, the abuse experience was pervasive and longlasting in its effects. The entire range of disturbance in child functioning was associated with a history of sexual abuse. Children suffered from acute traumatic reactions: sleeping and eating disorders; loss of concentration; regressive behavior; nightmares; fear responses and phobic reactions; sexualized behavior, such as acting out with toys, animals, and playmates; disturbance in peer and family relationships, including the spectrum from withdrawal to aggression; and, school problems including poor achievement, truancy, and substance abuse. Some children also experienced conduct disorders, including running away and prostitution, shoplifting, and other anti-social and delinquent behaviors; depression, suicidal ideation and behavior, and self-mutilation; somatic problems in the abdomen and head; conversion reactions; psychoses; and, sexual dysfunction, aversion to sex, and compulsive sexualization of all

relationships. Some children were found to develop symptoms immediately after disclosure, but others did not develop symptoms until after a period of apparent adjustment. The severity of symptoms ranged from mild anxiety to the ultimate: the taking of their own lives.

Developmental Differences in Reactions to CSA

Many authors investigating the treatment of CSA have reported that there were developmental differences in the children's response to the abuse (Finkelhor, 1986; Haugaard & Dickon Reppucci, 1988; Sgroi, 1982), however, some made general statements comparing children to adults, as in the case of Burgess and Holmstrom (1974; 1979) who observed both similarities and differences in the reactions of child victims as compared to adult victims. They concluded that children typically experienced the same range of somatic and emotional reactions, however, the manner in which the child manifests these reactions as symptoms is dissimilar as the child's means of expression are different.

The reasons why a given child responds to CSA in particular ways are unknown. MacVicar (1979) speculated that combinations of variables produced certain patterns of reaction. It is likely that an interaction occurs between the characteristics of the abuse situation (e.g., duration, offender relation), the child's developmental stage and personality, the family's situation, and the response to disclosure. At present, there is no reliable information

that explains accurately the factors that influence the reaction of a particular child, nor is it known what constitutes a typical reaction to sexual abuse. However, it would appear that a sexually-abused child's symptoms are developmentally distinct in many instances.

Berliner and Ernst (1984) claimed that the impact of CSA could only be understood within the context of the children's perceptions of what had happened. Children are limited by their developmental stage, the information they have about this kind of behavior, and the responses by others once the abuse is known. Berliner and Ernst asserted that the impact was related, not only to the horror of experiencing a coerced sexual act, but also to the expectation or fear of not being believed or of being held responsible for one's own victimization. In children, these reactions are compounded by the factors of immaturity and dependence. Such factors make children reliant on adults for the understanding and explanation of these experiences to them.

Funk (1980) reported that preschool children were likely to have less severe pathologic reactions to extra-familial sexual abuse than school age children or adolescents. Although preschoolers were found to be the most vulnerable to nonincestual sexual molestation, they were also characterized as being sexually curious and unaware of sexual prohibitions. They were more likely to view an extra-familial, nonviolent sexual encounter with an older person as an interesting

experience.

Kempe and Helfer (1980) found that the sexually-abused children they treated, who were under 6 years of age, showed clingy and regressive behaviors, whereas those of school age showed signs of anxiety, fear, depression, insomnia, sudden massive weight gain or loss, sudden school failure, and truancy. MacVicar (1979) found that the most common symptoms encountered in latency aged children were phobias, behavior disorders, and learning disturbances while in adolescents, depression was most often seen.

Lubell and Soong (1982) reported that sexual abuse had the greatest impact during a girl's adolescent stage. At this point, the normal adolescent's primary task is to develop an identity. The adolescent girl is in the process of maturing sexually, becoming separate and independent from her parents, and developing her own value system (Burgess & Holmstrom, 1974; Erikson, 1964). For the sexually-abused teenaged girl, this growth is interrupted. Her experiences may make her feel "different" and separate from her peers. Without feeling accepted by either family or friends, Lubell and Soong stated that it is impossible for the adolescent girl to maintain a sense of self-esteem. Kempe and Helfer (1980) also reported that adolescents often experienced a loss of self-esteem, depression, and social isolation. These symptoms were often accompanied by feelings or acts of outward aggression toward their mothers whom they believed

should have protected them from the sexual abuse.

General Treatment Approaches

After reviewing the literature on the sexual abuse of children, Horowitz (1985) concluded that information on the treatment of CSA cases is scarce, however, it would appear that there is a limited but growing number of research articles on the treatment of CSA. Horowitz urged researchers to conduct more studies comparing the various treatment options.

It appears that the diagnosis of CSA needs to be directly linked to etiology and that the treatment should be developmentally appropriate. In order to alleviate the symptoms of CSA on a long term basis, the dynamics that give rise to symptom formation must be identified and worked through, otherwise the pathology may resurface when intervention ceases. Treatment of CSA needs to be individualized as the dynamics of each child's situation differ. Clinicians writing about their treatment methods need to become more specific in describing how and whom they treat (Finkelhor, 1986; Haugaard & Dickon Reppucci, 1988). Different treatment strategies are required when treating a one-time "stranger rape" (Burgess & Holmstrom, 1974; Funk, 1980) as opposed to long-term father-daughter incest (Butler, 1988; Giaretto, 1982).

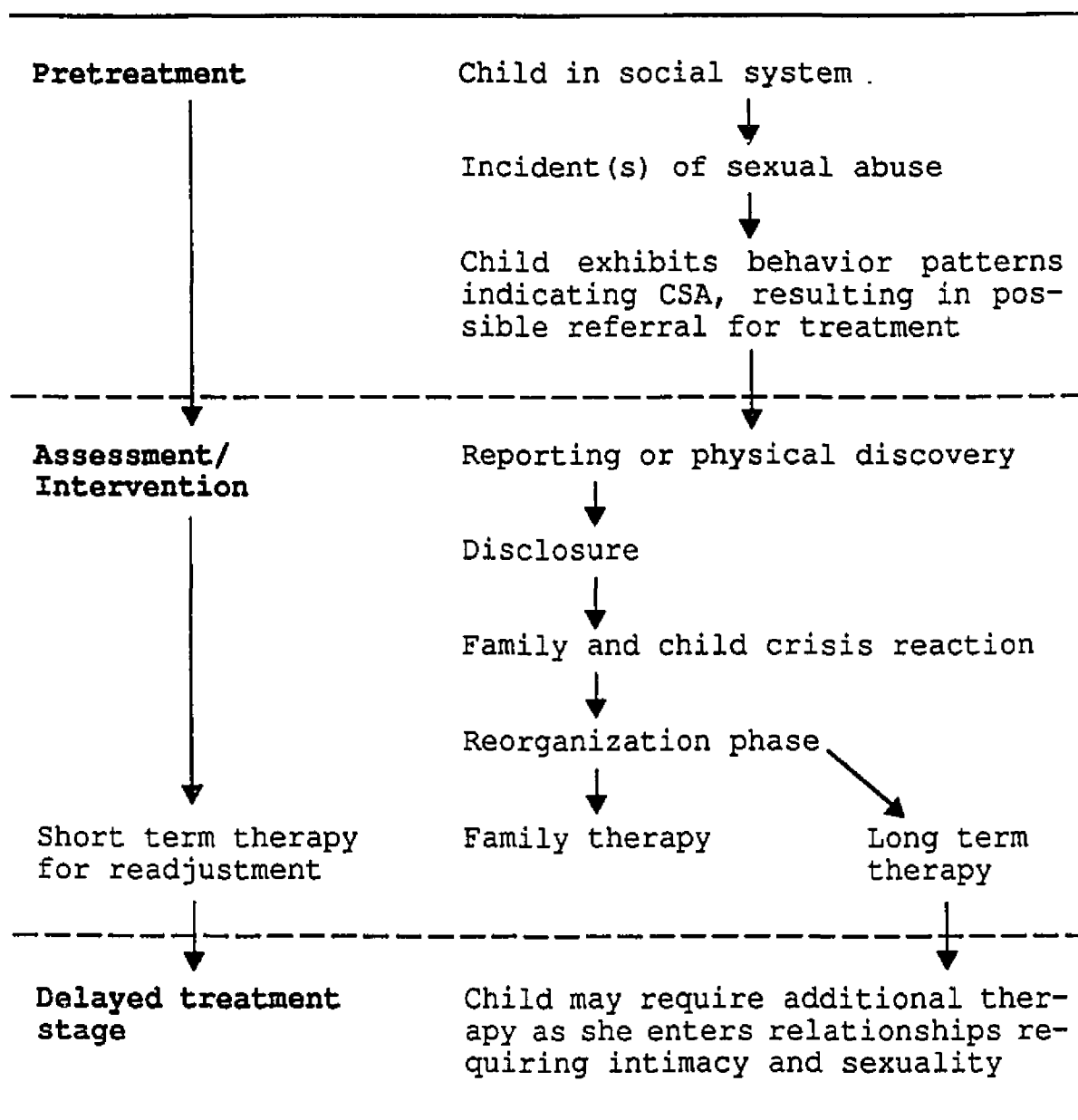
Treatment phases have been identified ranging from disclosure to crisis intervention, and from short-term

therapy to long-term therapy (Adams-Tucker and Adams, 1984; Long, 1986; McVicar, 1979). The treatment continuum that many children progress through following sexual abuse disclosure is presented in Figure 1. Children who are sexually-abused may not be identified for a long period of time, particularly if the offender has threatened the child not to tell, or if there are significant negative consequences for telling, such as family break-up. The child may exhibit behavioral cues such as depression, fear, or separation anxiety but these may not be attended to for many reasons. In some cases, treatment may serendipitously commence before disclosure, if the child is referred for behavioral difficulties.

Through the clinical process of assessment (i.e., during the pretreatment and assessment phase), therapists may uncover behavioral patterns or cues which alert them to the possibility of a history of CSA. The majority of sexually-abused children, however, begin to receive treatment at the disclosure stage. This stage is often preceded or accompanied by a physical examination at a hospital or emergency clinic.

Disclosure and the crisis it precipitates often requires intense intervention. Unfortunately, treatment often ends when the initial crisis subsides. Johnson (1987) recognized the inadequacy of this approach and described a more effective three-stage process of treatment for the victims of

Figure 1

Treatment Continuum for Child Sexual Abuse (CSA)

Note: From "Survey of art therapists' treatment approaches to practicing in the area of child sexual abuse," by L. Marrion, S. Landell, and S. Bradley, 1988. Unpublished paper, British Columbia School of Art Therapy, Victoria, B.C., Canada.

psychological trauma, such as sexual abuse: First, the victim needs to gain access in a safe and controlled way to the traumatic memories and to overcome denial or amnesia for the events; second, the victim needs to engage in a lengthy working-through process, in which the trauma can be acknowledged, reexamined, and conceptualized, resulting in a modification of intensity (i.e., the trauma is thus transformed from an intrusive reliving of the event into a memory that can be recalled when one wishes); and, finally, the client needs to rejoin the world through interaction with other trauma victims to find forgiveness for what happened and to be able to go on with one's life. Johnson observed that longterm psychological sequelae may result because the victim maintains the behavioral and psychological defense systems used to survive the ordeal long after they are useful. Termination of treatment after the crisis has subsided (i.e., after short-term therapy) may be premature and predispose the victim to further problems such as those cited by Rizst (1979) (e.g., sexual promiscuity, substance abuse).

Horowitz (1985) noted that most mental health professionals recommend a multi-component treatment program for the victim and for the abuser in cases of incest. Combinations of interventions (e.g., individual victim and abuser, victim and mother, marital, and family therapy) were seen as vital components of the incest treatment approach.

The order of such combinations appears to be crucial. The most effective sequence involves therapy for the individuals (i.e., offender, victim, and non-abusing parent), followed by treatment of the pairs (i.e., mother-daughter, mother-father, father-daughter), the family, and finally, the group (Anderson & Mayes, 1982; Deaton & Sandlin, 1980; Giaretto, 1982).

Adams-Tucker and Adams (1984) stressed that the units for family therapy should include persons who help the child heal her wounds (e.g., mothers, grandmothers, aunts, uncles, foster parents, step-parents, neighbors). Such an approach provides the child with trustworthy and supportive adults and augments her voice from within the family. Adams-Tucker and Adams suggested that a child who has been repeatedly brutalized by her natural father will require crisis intervention and longterm psychotherapy, whereas a child-victim may require only minimal treatment if she was abused once by a stranger who did not physically harm or threaten her.

MacVicar (1979) treated both accidental (e.g., stranger rape) and participating victims of sexual assault (e.g., incest) using psychotherapy groups. She found that most of the adolescent accidental victims responded well to crisis intervention therapy, however, the latency accidental victims and all of the participating victims required a much longer period of therapy to obtain any relief of symptoms. Longterm

therapy was often characterized by testing of the therapist either in the form of seductive behaviors, in the case of male therapists, or aggressively provocative behaviors, in the case of female therapists.

In the case of stranger abuse, Funk (1980) advised professionals to avoid focussing the child's attention on adult's concerns about the incident. She recommended the practice of interviewing the parents separately from the child to allay parental anxiety and to promote the normalization of family interaction through the natural communication patterns of the family.

McMillen Hall (1978) believed that all children who experienced sexual abuse of some sort should undergo a formal short-term educational process under the guidance of a qualified counselor. McMillen Hall employed a group therapy approach with sexually-abused children who suffered from role confusion, feelings of insecurity, fear, guilt, and anger (i.e., at the system and the procedures required of them). Even though children verbalized the wish to forget about the abuse and not talk about it, there were many issues confronting them that still needed to be resolved. MacMillen Hall concluded that children need to understand clearly all issues as much as possible, reestablish a feeling of safety with a family member, and free themselves of the guilt that might affect them later in puberty or adulthood.

Many victims of CSA will require long-term therapy

(Haugaard & Dickon Reppucci, 1988; Sgroi, 1982). Depending upon the severity of the reaction, the period may range from two to eight years (Fredrikson, 1989). If the victim has experienced some of the traumatic events described by McCarthy (1986) as being of primary importance (e.g., abuse that was physically violent, abuse that was perpetrated by a family member), the therapy process may be longterm. The occurrence of repression of the incident(s), flashbacks, dissociation, depersonalization, somatic hallucinations, multiple personalities, childhood amnesia, and anxiety attacks also indicate the potential need for longterm therapy (Briere, 1984; Ellenson, 1986; Johnson, 1987). Finally, many of the sexually-abused children will require additional therapy to resolve the issues of trust, intimacy, and sexuality particularly during later developmental stages (Briere, 1984; Ellenson, 1986).

CSA is an unacceptable social problem. Not only is the provision of treatment to CSA victims vital, the prevention of future sexual abuse is of utmost importance. Current research is now beginning to investigate the treatment needs of the victims. Predisposing factors have been identified and include societal values (Butler, 1988), family dynamics (Giaretto, 1982), and the individual characteristics of the victims (MacVicar, 1979). The sequelae of victims have been observed, described, and found to be dependent upon such complex factors as premorbid status, family pathology,

severity and type of abuse, developmental level of the victim, and the victim's relationship to the offender. Treatment approaches which effectively interface with these factors contributing to the sequelae must now be developed. One possible treatment approach, the use of art therapy, is gaining acceptance in clinical practice.

Art Therapy Treatment Approaches

The use of art therapy in the treatment of sexually-abused children is relatively new. A recent survey (Marrion, Landell & Bradley, 1988) of diplomaed and registered art therapists in Canada and the United States located 177 practitioners who were currently treating sexually-abused children, aged 2 to 18. When asked to justify the use of art therapy in treating CSA, over sixty different reasons were given by therapists to describe the advantages of this approach over more traditional approaches, such as verbal therapy. The responses could be grouped into five categories: (a) art therapy as an alternative to verbalization; (b) art therapy as a diagnostic tool; (c) art therapy as a means of disclosure; (d) art therapy as a developmentally appropriate approach; and, (e) art therapy as a component of a comprehensive therapy process.

The most frequent reasons given centered around the theme that art therapy bypasses difficulties in verbalization. These difficulties arise for numerous reasons. First, children lack verbal proficiency because of

their level of development. Second, they also have limited or no experience with the type of vocabulary required to describe what has happened. Third, they may be in a state of trauma shock and be unable to communicate verbally. Fourth, there may have been a violation of the child's trust in adults compounded by the development of guilt, hence the secret cannot be told directly but can be expressed metaphorically or symbolically. Finally, sexually-abused children may dissociate or split off from negative feelings and be unable to verbally identify these feelings. In all cases, art becomes a catalyst for the expression and owning of these feelings.

Art therapy can be diagnostic in nature in that this approach gives the individual the opportunity to depict feelings that may not be verbally acceptable, such as suicidal ideation and destructive tendencies. It can also be utilized as a means of assessing sexual abuse trauma (Burgess, McCausland, & Wolbert, 1981; Chervick, 1977; Delatte & Hendrickson, 1982; Stember, 1980), family pathology (Burns & Kaufmann, 1970), self-esteem (Buck, 1948; Landgarten, 1981, 1987; Rubin, 1984), and the developmental level of the child (Goodenough, 1954; Kellogg, 1970; Koppitz, 1968). As a diagnostic tool, it reveals both unconscious and conscious material through visual symbolism (Landgarten, 1987).

Art therapy can also be used as a means of disclosure.

Sexually-abused children have greater freedom to show in their artwork that which they cannot or dare not tell. This type of disclosure is tangible and has been used as evidence in the courts in the United States of America (Butler, 1988). Sexually-abused children may become retraumatized by having to frequently repeat and relive the abusive experience in the court procedures. According to art therapists, art is a much less threatening mode than verbal communication for sexually-abused children after the court ordeal.

Art therapy is responsive to the different developmental levels of the children. Practitioners described art and play as essential, age-appropriate activities for children. Art therapy taps into the preverbal realm of experience prior to the development of vocabulary to describe feelings and events, and children are comfortable and fluent with art. The age of the child needs to be considered when planning and implementing treatment approaches as it may influence the choice of treatment mode (e.g., play therapy vs. drama therapy) and art therapists report that children of different ages respond differently to different media (Rubin, 1984). Art therapy appears to be an approach suitable for most children, aged 3 and above. Generally, younger children (i.e., ages 3 - 6) prefer media with kinesthetic qualities such as clay, Plasticene, or playdough. The use of such materials may promote regression and a release of feelings. Children of this age also respond best when the choice of

bright primary colored paints or felt-pens is limited. Children, ages 6 to 12, who have developed adequate eye-hand coordination, can use more complex varieties of materials such as collage, drawing, cutouts, fabric, pencils, pens, and varied watercolors or poster paints. Adolescents enjoy a wider range of media but initially work best when art therapists give specific directives and limit the choice of types of projects until they feel at ease with the particular media.

Younger children require one-to-one supervision of art projects. They may need direct help from the art therapist to safely express their rage and anger and to ensure successful outcome of the session. Latency age children work well in groups of 4 or 5 on individual projects but require expert help from the therapist in solving the various technical and psychological problems which arise in the session. Younger children need physical contact from the art therapist or from their peers, however, adolescents can work independently on projects or in groups. Adolescents require little technical assistance but need encouragement and positive feedback concerning their work, as they are approval-seeking and self-conscious concerning their self-expression.

There may also be advantages to using art as a component of a comprehensive therapy process. The advantages listed most frequently by the art therapists in Marrion et al.'s

(1988) study included the following: (a) the permanency or record keeping of feelings, memories, and process; (b) the ego support available through creative expression and increasing mastery of the media and the self; (c) the speed in accessing feelings and conflicts; (d) the provision for growth, change, and healing which is charted by the art process; (e) the allowance for immediate primary expression of painful affect in a safe manner; and, (f) the provision for the safe containment of impulses.

The preceding study (Marrion et al., 1988) offered support for the prevailing theory that art therapy may be an effective therapeutic means for the treatment of CSA. The following section provides a review of the literature concerning the function of art in the disclosure and diagnostic process, in individual therapy, and in group therapy. The role of the art therapist and the premises underlying the use of art as a viable treatment approach for CSA are discussed first.

Art therapy is the therapeutic use of art combined with psychotherapy. It activates the therapy process by simultaneously utilizing the healing potential of the creative process through artistic activities which bypass defense mechanisms that are primarily maintained through verbalization (Naumberg, 1966). According to Sgroi (1982) art therapy is "the purposeful use of media and techniques derived from the arts themselves and psychotherapy

in order to help people to understand themselves, release tensions and anxieties, learn specific coping and communication skills, and facilitate the resolution of conflicts" (p. 306). Literature published by the American Art Therapy Association (1988) suggests that art therapy offers a means by which individuals of all ages can communicate nonverbally:

The use of art therapy implies that the creative process can be a means of both reconciling emotional conflicts and of fostering self-awareness and personal growth. When using art as a vehicle for psychotherapy, both the product and the associative references may be used in an effort to help the individual find a more compatible relationship between his inner and outer world. (p. ii)

The profession of art therapy has its roots primarily in the disciplines of art and psychology. Within the field, various approaches are recognized, including the use of "art as therapy" (Kramer, 1981), as well as the use of art as a "vehicle of psychotherapy" (Naumberg, 1966). In art as therapy, the art process itself is seen as the primary basis of personal growth. In art as a vehicle of psychotherapy, the art process, the art product, and the client's associations may be used as a means of psychological insight. Naumberg (1966), a pioneer of this approach, stated that:

The process of art therapy is based on the recognition that man's most fundamental thoughts and feelings, derived from the unconscious, reach expression more immediately in images than in words....Every individual, whether trained or untrained in art, has a latent talent capacity to project his inner conflicts into visual form. Through such use of graphic and plastic expression, those who were originally blocked in speech, often begin to verbalize in order to explain their pictures. (p. 1)

The art therapist is both an artist and a trained

therapist who supports the client's ego through the development of the creative process. The art therapist works with the client to understand visual and verbal messages, sharing thoughts and feelings, encouraging the client to recognize and extend these insights beyond the art therapy sessions, and providing a supportive attitude. Through the observation and analysis of behaviors, art products, and client communications, the art therapist integrates the understanding of the materials, the creative process, and knowledge of clinical psychology, and how these manifest themselves through art (Marrion, Landell & Bradley, 1988).

The art therapist displays knowledge of visual symbol production, understanding of normal behavior, and skill in intervention methods, and has experience with creative expression in art by individuals and/or groups, consequently, the art therapist is capable of formulating diagnostic assessments and treatment plans as part of the total therapy program (American Art Therapy Association, 1988). Among the activities involved in the duties of an art therapist, listed in the Dictionary of Occupational Titles (U.S. Department of Labor, 1984), are the following: planning, organizing, and conducting art sessions for individuals and groups in schools, other institutions and in private practice; reviewing reports from physicians, teachers, counselors, psychiatrists, and others concerning individual clients referred for art therapy; therapeutic activities involving

clinical skills which include encouraging clients to talk freely about their artwork and themselves, assisting individuals to discuss and recognize emotional problems as part of therapy, and observing and analyzing participants' behavior during art sessions; and case-related duties, including recording observations and analyses concerning client comments, maintaining an art portfolio for each client, and discussing individual cases with psychiatrists, psychologists, teachers, and counselors, and suggesting courses of action.

Stember (1977; 1978; 1980) initiated the art therapy approach to treating CSA. She believed that success experiences were ego-strengthening and that such experiences could be obtained through introducing the client to creative expressions media and modalities. She stated that, with respect to sexual abuse, it was essential for the victim to be able to separate her concept of herself from the traumatic event in order to heal. She therefore used the art process to elicit verbal and non-verbal statements and expressions (i.e., ventilation) of overt and internalized areas of conflict. She worked to elicit and identify individual symbolic repertoires and to externalize the experience of the trauma. She also believed that understanding, support, and nurturing helped combat the long-term negative effects of CSA. To this end, in short-term therapy, she worked to acknowledge and totally accept the abused child on a

physical, emotional, and ethnic basis while encouraging her to recognize that situational disturbances did not necessarily incur permanent, physical, emotional damage, social stigma, or impairment. She also worked to reaffirm the child's strengths in order to empower her to be independent. Finally, she worked with the child, at her level, with the aim of accelerating the maturation of delayed cognitive and functional behavior patterns to age-appropriate levels (Stember, 1978, cited in Naitove, 1982).

Burgess and Holmstrom (1979) described Stember's (1978) existential art therapy model as it was used with sexually-abused children in the following manner:

The therapist deals with the emerging issue, whatever it may be. The goal is to incorporate the humanistic tradition of the artist with the behavioral sciences. Behavior is understood through graphics and the existential art therapist is concerned with individuality and self-actualization within the immediate life environment. (p. 288)

Stember (1980) described her approach as a way of using art materials to help "damaged people form a supportive alliance that permits the expression of their emotions" (p. 59). She believed that art therapy could help to stabilize a temporarily disturbed development and help build self-confidence based upon existing strengths. She suggested that sexually-abused children need age-appropriate ways to vent their anger, hostility, fear, and any other feelings that might be inhibited or repressed. She stated that painting of the fantasies of the mind could be the first externalization,

the first way of bringing the incident out and that this expression helped clear the way for healing and growth to occur. Stember (1980) contended that the inner turmoil and conflict of many sexually-abused children was directly responsive to art therapy. Not only was the art healing in itself, but because the trauma of sexual abuse was primarily psychological, the artwork provided a safe vehicle for bringing it to the surface where it could be balanced with the outer world. Stember reflected that:

Many child victims suffer intense conflict and confusion in trying to disentangle their former sense of themselves -- their self-identities -- from their experiences with sexual abuse. They often have become lost in swirls of anguish as they try to find a sense of themselves separate from the violated forms of their bodies. To rebuild the self as separate from the incident takes varying lengths of time. (1980, p. 62)

Stember's sessions included an initial brief session to introduce the therapist, the media, and the techniques, followed by a warm-up activity. A core activity, designed to address therapeutic objectives, was completed and followed by a closing or declimaxing activity designed to restore the child to a pre-session level of functioning. Debriefing, or the discussion of the work accomplished and reactions during and after the activities, was also completed. The art therapy sessions were usually scheduled to last from one to two hours. Of this time, 5 to 20 minutes were allotted to end the session. One or two modalities (e.g., art and/or play) might be incorporated into the activities in a given session or a single modality might be carried over several

sessions (e.g., the creation of a sculpture or mask).

Stember (1980) included such activities as the Winnicott squiggle drawing (i.e., drawing a squiggly line with eyes closed after movement exercises) and self-portraits (i.e., past, present, and future).

The use of art therapy may be particularly advantageous during the stage of disclosure and the subsequent diagnostic interview. Thomas (1980) conducted disclosure interviews at the time of the victim's admission to the emergency department. She recommended the use of picture drawing to aid the child in communicating the details of the abuse. In her interview format, she moved from general questions concerning why the child was there, to specific probes soliciting concrete details of the abusive acts. To help young children relate their accounts, she interviewed them in a playroom. Paper and felt tip markers were provided and she directed the child to "draw a picture of what you are thinking" in response to specific questions. She then debriefed the picture with the child by asking the child to explain what was in the picture. The artwork process, according to Thomas, served as an aid to both the clinician and the child when the verbal communication system failed in the crisis situation. Thomas reported that the use of drawing enhanced the quantity and quality of information produced in the interview without further stressing the child. In addition, important clues were provided concerning

the child's psychological reaction to the trauma at that particular moment of time.

Burgess, McCausland and Wolbert (1981) examined children's drawings for indicators or markers of sexual abuse trauma during the disclosure process. Specifically, they looked at indicators of rape trauma in the drawings of a 5-year-old girl who had been sexually assaulted by a 13-year-old boy. When the disclosure process stopped due to the victim's apparent shame and embarrassment, she was directed to "draw what happened after the boy laid on top of you". Debriefing occurred as she drew. The nurse questioned her on each part as the drawing progressed enabling her to continue. The child was then asked to "draw a picture of herself." Her self-portrait was compared to previous drawings from her kindergarten class. Disorganization in the placement of body boundaries was found and the drawing was suggestive of acute impairment of her psychological integrity. Later follow-up after several months revealed improvement in her current drawings of human figures.

In another case involving ongoing sexual victimization, drawings were used to assess whether or not sexual activity was disclosed or about to be disclosed. Burgess et al. (1981) found that if the child had not disclosed, or wished not to reveal the nature of the sexual activity, the drawings often showed stereotypical forms, indicating strong defences for concealment. On the other hand, if the child was trying

to disclose, the drawings indicated the sexual activity by evidence of stylized sexual concepts in the child's drawing of genitals on human figures. Burgess et al. concluded that the primary reasons for the use of art were in gaining access to the unexpressed thoughts, feelings, and reactions of the child and taking pressure off the child to verbalize, because for victimized children in crisis, questions can stimulate many emotions and block a child's ability to respond verbally, thereby causing additional assessment and treatment problems.

Goodwin (1982) asked nine children under the age of 12 to draw several pictures as part of a psychiatric consultation to determine whether or not sexual abuse had taken place. The directives used were "draw the perpetrator," "do a drawing of your family doing something together" (i.e., a Kinetic Family Drawing), "draw your house," "draw the inside of your body," and "draw a dream." The brothers of the supposed victims were also asked to draw the same series of pictures. Goodwin found that the use of drawings was helpful in evaluating incest victims under the age of 12 for a variety of reasons. Diagnostically, the drawings aided the clinician in understanding the child's fears and anxieties, her view of her family, and her self-image. Fear and anxiety emerged in the repeated, unsuccessful attempts of the victims to draw their fathers. The occurrence of phallic objects intruding into their homes

were also seen as indicators of fear and conflict. According to Goodwin, the drawings alone were not sufficient to make a diagnosis of incest. However, they led to the child's increasing need to be able to communicate with, and be understood by, the clinician. In turn, the drawings enabled the clinician to reconstruct what was happening in the family. The discovery of a workable avenue of communication was helpful in reducing the anxiety of a child whose enmeshment in family secrets blocked the verbal means of asking for help. Goodwin reported that victims usually showed relief when asked to draw:

Asking the child to draw conveyed that the child needs to be treated as a child, that the child in play can create something the physician values, and that the child can defend herself from traumatic experience through play and drawing without having to resort prematurely to the defensive strategies of the adult world. (1982, p. 55)

Kelly (1984), in an exploratory study of the use of art therapy with sexually-abused children, ages 3 - 10, observed the inability of children to verbalize their thoughts and feelings surrounding the sexual abuse. She concluded that most children did not possess the adult vocabulary to describe the sexual acts that they were pressured, coerced, or forced to participate in with the offender. This lack of vocabulary made communication difficult for both the counselor and the child. The use of picture drawing, including such directives as "draw a self-portrait," "draw a picture of the offender," "draw a picture of what happened,"

and, "draw a picture of a whole person," enhanced the communication process. She concluded that the use of picture drawing was of significant value in counselling sexually-abused children as an assessment of the child's emotional reaction to the sexual abuse, as an indicator of the child's gender identity, as an assessment of the victim's body image, as an assessment of the victim's self-esteem, as a non-threatening mode of expressing thoughts and feelings, as a means to facilitate and encourage verbalization of thoughts and feelings surrounding the victimization, as a way to obtain information from the child regarding the details of the assault, and, as a means to monitor the changes in the emotional status of the child over time. She described art therapy as an emerging treatment modality for sexually-abused children.

In a later study, Kelley (1985) examined 120 pictures drawn by sexually-abused children between the ages of 3 1/2 and 10 years. She concluded that:

Art therapy was determined to be clinically valid in assessing the child's emotional status, body image, and self-esteem. Art facilitated the child's verbalization of thoughts and feelings related to the victimization and was a useful indicator of changes in the emotional status of the child. (1985, p. 422)

Silvercloud (1983) used psychodynamically oriented art therapy in the individual treatment of sexually-abused children aged 5 and 6. She described art expression as a "projective tool which aided free association by opening doors to blocked memories, ideas, and emotions" (p. 86).

According to Silvercloud, the unconscious, where information is potentially accessible, gives clues (which are mostly allegorical) to whatever issues are currently troublesome. When expressed visually, these clues become verbalized more easily. The hurtful event, stored in the memory as an image, is recalled and externalized as an image, and then the child is able to put the feelings and actions associated with it into words.

Silvercloud (1983) reported that the artwork, however crude, transmitted the message unmistakably and was less threatening to the child than talking face-to-face with the therapist. Graphic indicators (e.g., body image distortion) prove invaluable to the clinician because, when working with sexually-abused children, powerlessness and betrayal magnify the harmful effects of the physical violation of space and person and curtail verbal expression. Silvercloud utilized art to help her clients externalize the event so that, in a very real way, someone else was able to witness what had occurred. Artwork gave the child the opportunity to see that she was accepted, even when someone else knew fully what had occurred because "nonverbal expression may be the means by which one gets to and through the dreaded memory, to separate the self from the incident, and to gain a healthier perspective" (p. 90). The therapist must always be, according to Silvercloud, an eclectic, flexible, warm agent open to a variety of possibilities for treatment.

There are numerous accounts of the use of art therapy in the group treatment of sexually-abused children of differing ages, who have suffered from episodes of CSA. The reported advantages of using art therapy in group settings are similar to those found in individual counselling sessions. McMillen Hall (1978) used art-as-therapy and play activities with groups of children aged 4 to 7 and 9 to 13. Play and art activities were used more frequently in the younger groups, whereas discussion was the primary activity in the adolescent groups. The goals of therapy with both age groups included the opportunity to discuss and deal with anger, fear, nightmares, sadness, and grief. Goals centered on achieving greater understanding of the event and included sharing feelings through play, art, and discussion. Responsibility for the abuse was assigned to the abuser and the children were encouraged to suggest the punishment, to meet with the abuser, and to hear from him that he was responsible, had done wrong, and would never do it again. The final goal was to empower the children to handle such situations in the future.

Delson and Clark (1981) used art activities and play therapy to treat sexually-abused children aged 6 to 11. They believed that the group experience could provide the children with the knowledge that they were not unique (i.e., sexual molestation occurs in many families); that the molestation did not have to be a protected or repressed

secret, but instead could be shared; and that the reactions they were having to the sexual abuse would vary depending on the type of abuse, their family situation, and the way authorities handled it. Delson and Clark's group was predominantly a play therapy group, however, art activities and materials were used. The art directives included "draw a picture of yourselves and your family" and "draw a girl." The group went through a period of learning to trust, regressing, externalizing feelings, acting out the need for nurturance and unconditional acceptance by others, and reaching self-acceptance. An interesting finding was the need of the children for body contact. Such contact was provided by the therapists in the form of massage and blankets.

Berliner and Ernst (1984) conducted group treatment for preadolescent sexual assault victims. The content was age appropriate, covered basic themes such as acknowledging the assault experience, understanding who was responsible for the abuse, recognizing and labelling feelings resulting from being sexually-abused, affinity with other victims, and empowerment for self-protection in the future. Ego-enhancing positive interaction was structured into the group to improve the children's self-esteem. In each session, Berliner and Ernst reminded the children of why they were there, asked them to report on a positive experience, provided a snack, initiated a group activity of art or drawing, held a

discussion on a specific topic, and employed a closing exercise or activity. The group ran for six sessions and some of the directives used were "draw a name tag," "draw a picture of the offender," "draw a self-portrait," and "draw your family."

Carozza and Hiersteiner (1983) utilized group art therapy in the treatment of young incest victims aged 9 to 17. Five stages of growth were identified over the duration of the group. They included: gathering, self-disclosure, regression, reconstruction, and ending. The elements of group art therapy which made it the treatment modality of choice were "the reduction of anxiety due to universal issues faced by all group members; presence of peers which reduces isolation; and increased opportunities for trying new behaviors through role modelling" (p. 166). The approach used by Carozza and Hiersteiner allowed the girls to utilize art expression to enhance both individual and group growth and awareness, and to allow the girls to externalize and work through conflict. Underlying this approach was a strong belief in both the child's natural drive towards self-actualization and the powerful and healthy elements of art and group process.

Stember (1980) ran weekly group art therapy sessions for 20 girls who had been involved in incestuous experiences. She reported that the majority drew stereotypical graphic representations for the first four sessions and only after

individual trust had been established between the art therapist and the girls did their paintings become freer and more expressive of their inner conflicts and emotions. At that point, art began to aid them in externalizing the trauma. The externalization process included creating the artwork, looking at it and projecting onto it, and examining it through interaction with the therapist. The most frequent and strongest expressions in the symbolism of the art found by Stember were low self-esteem, guilt, diffusion, and bewilderment; shame covered by hostile acting out; and, a facade of manic exuberance. These factors contributed not only to the disturbances associated with premature sexual experience but further solidified the development of negative self-awareness as merged with and changed by the sexual molestation. Stember stressed that expressive opportunities for developing a separation of the self from the incident were built into the art therapy sessions. She felt the primary reasons for the selection of art therapy as an assessment and treatment modality in CSA were the ability to gain access to unexpressed thoughts, feelings, and reactions and the lack of pressure on the child to verbalize.

Jones (1982; 1983; 1987) utilized art and visual imagery in treating a wide range of ages in her art psychotherapy groups for sexually-abused children. Jones' approach was based on the work of both Stember (1980) and Johnson (1987) and utilized art therapy to work through the traumatic

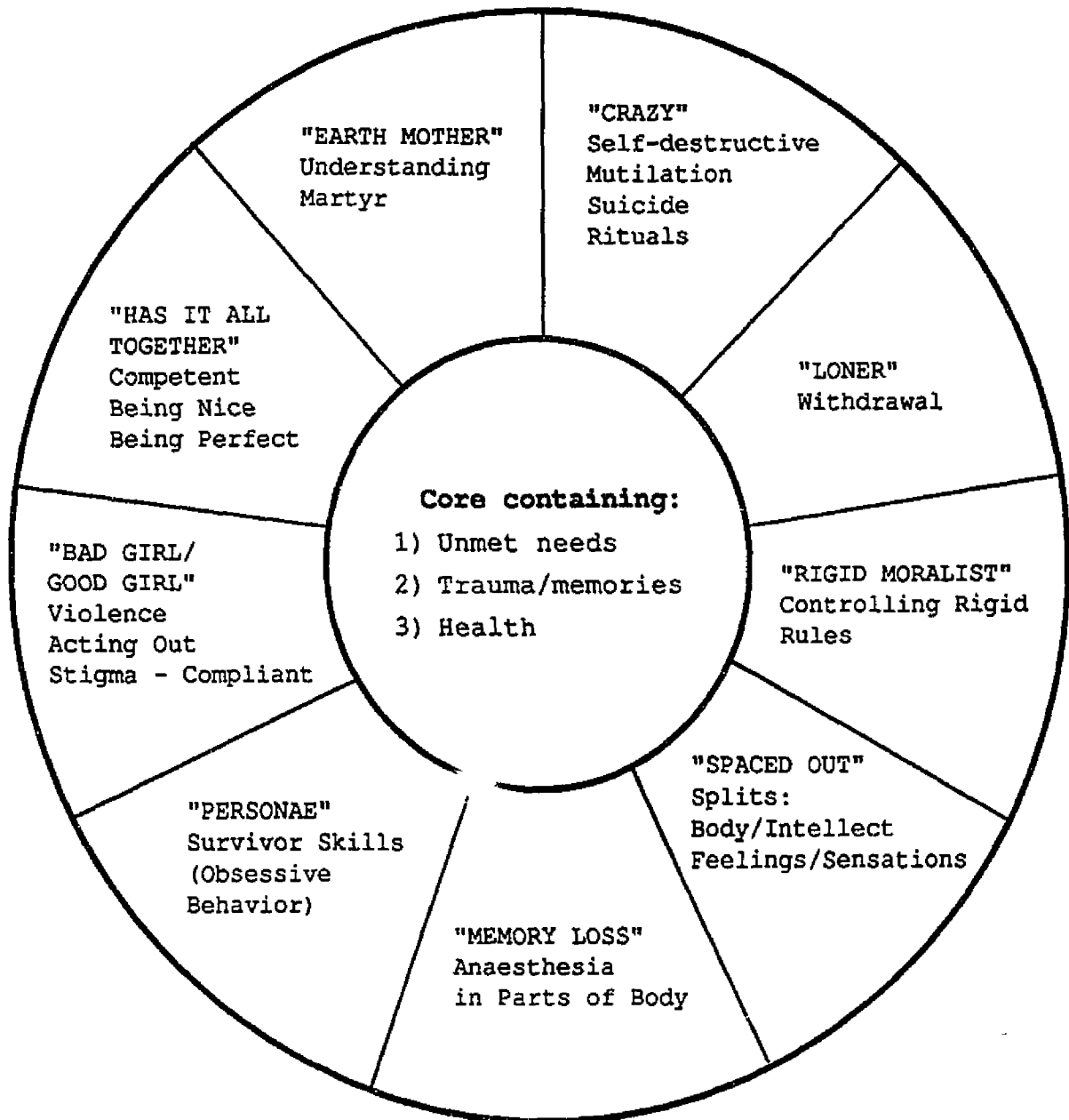
reaction of dissociation in sexually-abused children. According to Jones' view, a child's self-concept is partly determined by an internalized body image and when the child's body is painfully invaded, body image is distorted. Her powerlessness in the situation results in anxiety, fear, dissociation, and identification with the abuser. When blame is forced on the child by the offender or taken on by the child herself, guilt and lowered self-esteem result. Telling becomes more and more remote as guilt increases. Johnson (1987) described this dissociative process which results from the abuse as an attempt by the child to preserve a sense of the "good self." Those parts of the self associated with the trauma are set off from the other parts of the self. This leads to an encapsulation and elimination of all aspects of the traumatic situation from consciousness. The result of this splitting off is an overall reduction in the ability to attach words to feelings, to symbolize, and to fantasize since any link of affect with cognition might lead to the re-experiencing of the trauma. Johnson (1987) described this resulting state as alexithymia or psychic numbness.

Jones' (1987) conceptualization of the child's reaction to sexual trauma is based on Johnson's (1987) posttraumatic stress theory where a child's primary psychological defense against the physical invasion is repression in the form of denial or dissociation. According to Jones and Johnson, dissociation has occurred when subsystems or aspects of the

individual personality divorce themselves from one another, and, having broken off relations, maintain a life of their own with amnesic barriers between them in place of their usual connection. According to Jones (1987), art therapy has a special role in gaining access to these traumatic images and associations. Because the encoding of trauma may be via "photographic" visual process, a visual media may offer a unique means by which these associations may come to consciousness.

Jones (1987) reported that sexually-abused children may have three or more self-images (e.g., bad girl/good girl, crazy, spaced out) that are separate and unconscious, which have adapted to protect a secret self which is the child's inner core. Jones developed a model that depicts the core personae of the clients that she encountered in her practice. The model is shown in Figure 2. The core contains the memory of the trauma, inner unmet needs, and the potential health of the child. By shifting from the three or more part-selves or personae, the sexually-traumatized child can successfully hide her inner core from herself and the world. The central question for the therapist is how to make contact with the child's inner core without violating the child's need to protect and defend herself from the abuse memories. Jones found that using the child's creative energies opens up the senses, reclaims the ability to experience the world through the physical self, develops

Figure 2

Inner Core/Outer Personae: Teaching Model for Sexual Abuse Victims

Note: From "Art psychotherapy with children who have been sexually assaulted" by M. Jones, 1987, paper presented at the *British Columbia Art Therapy Association Conference*, Vancouver, B.C. Adapted by permission.

trust in one's perceptions, and develops spontaneity and new learning. The expressive therapies, such as art, take the child back to a pre-verbal state, shortcircuiting the defenses of denial and dissociation which are built in reaction to the violation of the child's body and the associated guilt.

According to Jones (1987), the first task of the therapist is to help the child to engage her denial through breaking down the social supports, secrecy, disbelief, and shame. The therapist's willingness work with her own denial acts as proof of her belief in the child. Jones' therapeutic process involves four steps: grounding the individual in her internal experience; fostering the external expression of the internal experience; providing involvement with other victims; and, reconstructing defenses. In the first stage, visualization and meditation are used to provoke images, sensations, thoughts, and judgments which are significant to the core self. In the second stage, these images and sensations are externalized in art form. Guided fantasy can also be used to encourage memories and feelings concerning the abuse. These memories can also be externalized with art to provide a concrete basis for modifying their impact and enhancing self-esteem. Group art therapy, in the third stage, provides peer support which increases self-acceptance. At this stage, sex education is provided to the child. Finally, a reconstruction of the

defenses can be achieved by providing intellectual understanding of the abuse and its impact on the victim. Integration of the part-selves with the core self, according to Jones, is consequently attained by the awareness, the understanding, and the acceptance of the need for the part-selves as survival mechanisms.

Summary

The consequences of CSA include among others guilt, distorted body image, victimization, low self-esteem, and developmental arrest (Porter, Blick & Sgroi, 1982). New treatment approaches are being sought out by professionals in response to the growing population of sexually-abused children requiring treatment. Art therapy, although it is as yet unproven, appears to be a potentially viable approach for working in the areas of disclosure and diagnosis of sexual abuse, as well as for the individual and group treatment of sexually-abused children. Art therapy bypasses the need for verbalization when the child is in a state of shock or dissociation and it accesses repressed memories so that the trauma can be externalized later and worked through in a supportive, therapeutic setting (Stember, 1980).

The clinical descriptions of art therapy also support the premise that it may be an effective and efficient tool for treating CSA. The range and flexibility of the media and intervention strategies in working towards resolution of sexual abuse issues also make it adaptable to all age groups.

Its properties permit the child to engage with both the therapist and/or the art materials, hence, two avenues of communication are available to the child. The art may help to bypass the verbal secrecy dynamic of sexual abuse and allow children to tap their creative potential aiding in the integration of the trauma.

The purpose of the following study is to provide clinicians with descriptive information on how art therapists currently treat sexually-abused girls ages 4, 8, and 13 with respect to two key issues -- body image distortion and guilt. It is the author's view that these two sequelae are pivotal in producing psychological trauma and dissociative phenomena. Violation of the body produces physical and emotional shock. Denial or dissociation occur when the child blocks her experience of the pain and the actual incident. Guilt and shame often occur as cognitive reactions that explain or make sense out of the experience. The post traumatic syndrome is then maintained by increasing alexithymia or psychic numbing which serves to decrease the child's involvement in external activities and in her perception of her inner feelings.

To date there have been no studies that empirically evaluate the effectiveness of art therapy. This study will attempt to describe the art therapy approach with the aim of generating future descriptive research through the case-simulation method of inquiry so that treatment outcome studies on art therapy effectiveness can then be conducted.

CHAPTER 3

METHOD

The information presented in Chapter 3 includes a description of the procedures used to investigate the therapeutic approaches of art therapists for the treatment of CSA. This research utilized a case-simulation method to investigate how art therapists treated the issues of distorted body image and guilt in sexually-abused girls ages 4, 8, and 13. The chapter is divided into the following sections: (a) Selection of Subjects and Procedure for Data Collection; (b) Development of the Case Simulation; (c) Procedure for Data Analysis; and, (d) Summary.

Selection of Subjects and Procedure for Data Collection

The subjects consisted of American and Canadian art therapists who had worked with sexually-abused children for at least 6 months preceding the study. All were registered or diplomaed members of the various national art therapy associations at the time of data collection.

A subject pool was obtained by means of a multi-step process. The names of 177 registered or diplomaed art therapists, working primarily with sexually-abused children, were obtained by surveying the memberships of the American Art Therapy Association, the Canadian Art Therapy Association, the Quebec Art Therapy Association, and the

British Columbia Art Therapy Association (Marrion, Landell, & Bradley, 1988). Additional subjects were solicited directly from members of the original pool by asking individuals for names, addresses, and phone numbers of colleagues thought to be interested in participating in such a study and who met the criteria for inclusion.

A pool of 220 potential subjects was identified. The subjects were divided into four groups on the basis of information provided regarding the ages of the clients served: Group 1 included art therapists who treated children aged 1 - 5; Group 2 included art therapists who treated children aged 6 - 12; Group 3 included art therapists who treated children aged 13 - 18; and, Group 4 included art therapists who indicated that they treated all age groups. The subjects in Group 4 were randomly assigned to one of the other three groups until each contained 60 subjects. The remaining subjects in Group 4 constituted the reserve pool. The subjects in Groups 1, 2, and 3 were then randomly divided into two subsets of 30 each.

One hundred and eighty case simulations and questionnaires were mailed out initially, one to each subject in Groups 1, 2, and 3. The following protocol was used to encourage subject participation:

1. Each subject was asked, by phone and/or mail, and to participate in the research study prior to mailing. The first mailing occurred on December 27, 1988.
2. The researcher telephoned each subject who had not

returned their survey four weeks after mailing to encourage or to remind participants to return the questionnaires.

3. After eight weeks, those who still had not returned the survey were telephoned and if a definite commitment for participation was not made, the reasons for the refusal were documented.
4. Twenty-four subjects were randomly selected from the reserve pool to replace those who dropped out of the original sample. They were instructed that a package containing instructions and the case-simulation would arrive shortly and that they should complete the survey and return it as soon as possible. The second mailing occurred on February 28, 1989.
5. All subjects who had not returned by the questionnaire by March 15, 1989 were telephoned again and encouraged to complete the survey and return it quickly. The final cutoff date for returns was set for April 15, 1989.

A total of 204 questionnaires were mailed out: 149 were returned by the cutoff date: Three returns could not be used because the respondents exclusively treated males. The return rate of usable data was 71.57%.

In order to describe the sample in depth, demographic data including age, gender, years of education, coursework in CSA treatment and theory, art therapy training, and professional registration were collected, along with the responses to the case simulation questionnaires.

Development of the Case Simulation

This exploratory study, utilizing a case-simulation methodology, was a 3 X 2 design. The two independent variables were (a) the age of the child and (b) the issue to be addressed in the art therapy session. The child portrayed

in the case simulation was either 4, 8, or 13 years of age. The presenting issue for the art therapist to address was either the child's distorted body image or the child's feelings of guilt and shame. Given the child's age and the issue to be addressed, art therapists were then asked to respond to selected questions that would provide information on the nature of the therapeutic session (i.e., the goals of the session, the choice of media, the directives given to the child, the use of time, the types of therapeutic interactions or strategies used, the debriefing process, the method of evaluating the child's reaction to the session, and the function of art in the session).

Instrument

The case histories were developed after a thorough review of the literature on CSA and with consultation from an advisory panel of art therapists currently working with sexually-abused children. Haugaard and Dickon Reppucci (1988) recommended that the following variables need to be addressed in CSA treatment: age of onset of the abuse; the response by adults to the disclosure; the relationship of the child to the offender; whether or not threats were used to maintain secrecy; the relationship of the child with her family members, especially her mother and father; the roles of the victim and/or abuser in the family system; and, the psychological reaction of the victim to the abuse trauma. Finkelhor (1986) recommended that the duration of the abuse,

the type of abuse, and the child's current symptoms should also be considered. The child's current level of school performance, the child's level of social adjustment, and the information obtained from the initial assessment process were factors that the advisory panel considered important to include in assessing treatment needs. Consequently, a brief statement addressing each of these components was included in the case description to provide subjects with sufficient detail to formulate a treatment approach for the hypothetical session. Information on the number of previous art therapy sessions and the issue to be addressed in the session was also included in the case information.

To provide the clinicians with the converging lines of evidence needed to create hypotheses concerning the diagnosis and treatment of the child in the case simulation, several additional sources of information were included. A current photograph of a child was used to illustrate age and emotional status. A self-portrait drawing provided information about the child's body image and allowed the clinician to make tentative diagnostic hypotheses concerning the child's reaction to the trauma, her sense of body image and boundaries, the degree of regression relative to her age level, and the site and type of abuse (Burgess, McCausland, & Wolbert, 1981; Cohen & Phelps, 1985; Kelly, 1984, 1985; and Stember, 1977).

Six different case simulations were developed in order

to obtain information on the three age levels (i.e., age 4, age 8, and age 13) and the two issues (i.e., body image distortion and guilt). For example, there were two case simulations of the 4-year-old sexually-abused girl, one addressed the body image distortion issue and the other addressed the guilt issue. With the exceptions of the self-portrait drawing and the issue to be addressed, the information given was the same for each 4-year-old child.

A set of questionnaires were then developed to solicit detailed information on treatment approaches. They consisted of a series of unstructured and multiple choice questions concerning the hypothetical therapeutic session. Art therapists were asked to describe how they would proceed with a therapy session with the child given the age and the issue presented. Each subject received the same questions, however, the questionnaire was designed to complement the case simulation (i.e., the name, age of client, and the issue addressed matched the information presented in the case simulation). Copies of the instruction sheet, case simulations, and questionnaire are in Appendix A.

Rationale for Age and Issue Variables. The target ages of 4, 8, and 13 were selected for the case simulations to represent three contrasting developmental stages. Younger children differ both in their symptomology as a response to trauma (Burgess & Holmstrom, 1974; Jones, 1983) and in their response to art media (Landgarten, 1987; Rubin, 1984) compared

to older children or adolescents.

In order to address these multifaceted dimensions of treatment, each case simulation was designed to reflect the developmental stage of the child. Art therapists treating CSA must consider both age and symptomology in planning treatment. The following section illustrates the relationship of developmental theories and CSA reactions as they pertain to the creation of the different-aged case simulations.

The case-simulation victims in this study represented the same sexually-abused girl, named Amanda, at the ages of 4, 8, and 13. According to developmental theorists, 4-year-old Amanda is well into the preoperational period (Piaget, 1966), resorts to egocentric and animistic thinking, and is unsophisticated in her understanding of the antecedents or consequences of her own or others' behavior. She is at the level of pre-conventional morality (Kohlberg, 1969) where she is usually obedient to avoid punishment especially with an unfamiliar adult. According to Erikson (1964), she is leaving the crisis of "autonomy vs. shame and doubt" and is moving towards the stage of "initiative vs. guilt". She is beginning to identify strongly with her mother as a female with particular roles, which she imitates while caring for her sister (Freud, 1962). She now faces the developmental tasks of learning to have physical control, of mastering the language which describes both social and physical reality, of

distinguishing right from wrong, and of interacting socially (Havighurst, 1972) as she is now in preschool.

The negative impact of sexual abuse trauma on the healthy development of a child is unavoidable. At the age of 4, Amanda's perception of the experience is affected by her limited emotional, social, cognitive, and sexual awareness. She reacts by alerting others that she has been hurt, with behavioral cues such as enuresis, nightmares, withdrawal, and depression. She is unable to comprehend the painful and violent intrusion into her body. She feels she must have done something terribly wrong to have deserved such a punishment. She dissociates from her experience of the pain and presents with the regressive and debilitating signs of trauma shock. Unable to participate in preschool activities, she vacillates between anxiety, hypervigilance, and numbness.

Amanda, at 8 years of age, reacts differently to sexual abuse trauma. According to Piaget (1966), Amanda is in the period of concrete operations and recognizes various constancies in the physical environment, including relationships of size, volume, weight, and numbers. She is very social and has a wide group of friends with whom she interacts. She identifies with her teacher and her mother as role-models. According to Kohlberg (1969), she is in the pre-conventional morality stage of naive egoistic orientation. She knows she will be punished for doing

something wrong and follows rules only when it is to someone's immediate interest. Otherwise, she acts to meet her own needs and interests and lets others do the same. Unlike Amanda at 4, Amanda at 8 is in the crises of "initiative vs. guilt" (Erikson, 1964). There are risks involved in her decisions and the consequence of wrong-doing involves guilty feelings and a growing sense of responsibility for her actions. Freud (1962) would describe Amanda as being in the latency period where her natural impulses are repressed or have temporarily subsided. Thus, her awareness of her sexuality is limited although it would be prematurely awakened or stimulated by the molestation. Amanda, in Grade 3, is engaged in the developmental tasks of learning how to get along with a peer group, learning a gender-appropriate social role, developing fundamental skills in reading, writing and calculating, developing concepts needed for everyday life and developing conscience, morality and a scale of values so that she can become autonomous and democratic in her interactions with others.

When Amanda was raped at age 8, her experience of the event was determined by her capacity to perceive. Like Amanda at 4, she has limited emotional, social, cognitive and sexual awareness and can only respond within the limits of her experience. Consequently, her reaction is similar to Amanda's at 4. She becomes withdrawn, has nightmares, wets her bed, and appears listless and sad. She becomes extremely

concerned with cleanliness and leaves the classroom to wash her hands over and over in an attempt to rid herself of the tremendous guilt and responsibility she feels for the abuse. She is frightened and repulsed by the intensely sexual feelings she experiences at night and tries to shut her feelings down. She is confused and frightened by the lack of control she experiences when waking up in a wet bed. In order to feel like a good girl again once again, she engages in ritualistic cleaning behavior. This method of coping becomes a compulsion because of the instant but temporary relief she feels as she cleans and wipes the "badness" away.

On the other hand, Amanda, at age 13, recently experienced a growth spurt and is feeling very self-conscious about the physical changes in her body. She has entered the genital stage of psychosexual development (Freud, 1962) and is acutely aware of her enlarging breasts, and the presence of body hair and oily skin. She is continually argumentative with her mother and confused by abrupt changes in her mood which seem to occur for no reason. According to Piaget (1966), she is in the cognitive stage of formal operations and is learning the logic of antecedents, consequences, natural laws, and abstract concepts. She is at the level of conventional morality (Kohlberg, 1969), but her decisions are based on the approval she will get, rather than on altruistic motives. These feelings lead to conflicts with her mother, as her loyalties have shifted to her peer group, in her

struggle to attain her self-identity (Erikson, 1964).

Amanda's psychological reaction to the experience of being raped by her uncle is affected by her developmental stage. She feels violated, physically disfigured, and unable to come to grips with who she is afterwards. She suffers episodes of acute anxiety, depersonalization, and dissociation. She withdraws from her peers as she fears they can see what has happened to her and will no longer approve of or like her. The physical evidence of her sexuality becomes repulsive to her and she rejects her role as a woman by neglecting hygiene and wearing unattractive, genderless clothing. Amanda feels extreme guilt and shame because, in her perception, she has somehow encouraged her uncle's attention by being feminine or seductive. Her behavioral reactions of regression, withdrawal, and aggression are reflected in her inner confusion. She angrily refuses to talk about the incident after returning home from the hospital, as if to deny that it had really happened.

The differences in development need to be addressed when treating children of different ages. Their conceptualizations of the experience itself differ as do their interpretations of the meaning of it (Burgess & Holmstrom, 1974; Alexander, 1985). Amanda, at 4, is less likely to view it in a sexual context as that is not an integral part of her identity. Amanda, at 8, feels dirty and unclean. She is confused and frightened by her sexual

feelings and by her loss of control over her body at night. She has nightmares about the rape and wakes up in a wet bed feeling sexually aroused. She masturbates and feels guilty, bad, and frightened. She spends the day relieving her guilt and shame by washing it off in an attempt to rid herself of badness. She feels responsible for the abuse because of the sexual feelings she now has independent of her uncle. She cannot face him or her mother and begins to live in a private inner world where she vacillates between sexual fantasy and the terror of being bad. Amanda, at 13, reacts by denying her sexuality in an effort to make her feelings go away.

The two issues, body image distortion and guilt, were selected as the focus for this investigation for the following reasons. First, both are key issues for children who have been sexually abused, around which the other reactions (e.g., victimization, damaged self-esteem) constellate. Second, these issues are able to be portrayed in the children's drawings. Body image distortion is depicted by exaggerated genitalia, the omission of body parts, and the weight with which marks were made on the paper. Guilt is depicted by X'ing out the self-portrait.

Not only does age affect the child's reaction to sexual abuse, but it also impacts on the issues of body image distortion and guilt. Younger children differ from older children in their reactions to body image distortion (Stember, 1980) and guilt (Sgroi, 1982). Amanda's self-

portraits show evidence of a distorted body image that differs according to age and to her conceptualization of her identity. Amanda, at 4, is asexual; her body has been hurt. Her self-portrait illustrates the pain she is experiencing and there are no sexual characteristics present in the drawing. Amanda, at 8, has been prematurely wrenched from latency and is overwhelmed with intense sexual feelings. Her self-portrait includes an elongated and open vaginal orifice. Amanda, at 13, is entering womanhood; her sexuality has been repressed. Her self-portrait contains no facial features or sexual characteristics. She wants to deny both her sexuality and her feelings about the abuse.

Amanda's self-portraits also show evidence of her guilty feelings. Amanda, at 4, feels that she is a bad child and needs to be punished, although she cannot remember what she did that was bad. The guilt and shame make her try to repress what happened even more, resulting in acute anxiety and fear whenever someone encourages her to tell about it. Because her uncle had threatened her not to tell after he had demonstrated the full degree of his power over her, she feels immobilized and in crisis. She has X'd herself out in her self-portrait to convey her feelings of badness and worthlessness.

Amanda, at 8, lives a double life. At night, her sexual feelings awaken and she feels pulled by sexual forces she cannot control. Her bodily actions (i.e., enuresis) alert

her mother that something is wrong. During the day, she constantly battles her feelings of guilt and shame by compulsively washing in a futile attempt to rid herself of these feelings. She has X'd herself out in her self-portrait in an attempt to deny what is happening to her during the night. Even though she is experiencing guilt, her nightie is transparent and her exaggerated genitalia are still evident.

Amanda, at 13, also feels guilt over her perceived role in the rape. She was in the process of accepting and adjusting to the physical changes heralding her new sexual identity. She feels as if her own body betrayed her by seducing her uncle. She is unable to realize that she is not responsible for his behavior. Her guilt is compounded by his threat to do it again if she tells. She cannot face another betrayal by her own body and so denies that part of her by splitting off from it. She refuses to talk about the incident and views all adults as threats to her defense system. She has X'd herself out in her self-portrait as a means of denying both the the abuse and her body.

Rationale for Survey Questions. In planning an art

therapy session, the art therapist must ideally consider both the age of the child and the issue(s) needing resolution before deciding how to proceed. In actual clinical work, however, such planned activities are often abandoned in favor of following the child's lead, if there is a crisis or apparent need to meet the child's agenda. In the planning

phase, however, the art therapists may ask themselves the following questions prior to implementing the actual activity: (a) What are the therapeutic goals I hope to achieve in this session? (b) What directives will I use? (c) What media will I have available to the child? (d) How will I structure the use of time in this session? (e) What types of therapeutic techniques could I make use of to address the issues? (f) How will I help the child to debrief the art process and product? and (g) How will I evaluate the effectiveness of my intervention? Each art therapy session is ideally organized by the art therapist on the basis of the answers to these questions.

By means of a case simulation method, the purpose of the present study was to investigate how art therapists would answer these questions in response to treating a sexually-abused child. Two additional questions were also addressed: (a) Why would you choose to use art in this way to help a child of Amanda's age work through this issue? and, (b) What would you think the function of art was in this type of session?

The literature on the use of art therapy with sexually-abused children has not examined the components of the therapeutic process in such detail, nor has there been any attempt to examine the process as it differs by age and by issue. By means of the case-simulation method, such variables could be manipulated, and the therapeutic process

could be examined in detail from the viewpoint of the art therapists rather than from simply observing or analyzing video tapes of therapy sessions.

Rationale for Method. Case-simulation has been used frequently in the measurement of attitudes (Eisenberg, 1986) and in the assessment of the performance of various professional interns including teachers, psychologists, physicians, and counselors (Carkhuff, 1969). It has also been used successfully to evaluate the attitudes of teachers with respect as to how they would respond to and place students with specific labels (e.g., mental retardation and learning disabled) in the school system (Rolinson & Medway, 1986; Schloss & Miller, 1982). According to Alreck and Settle (1985), such instruments have the advantages of being comprehensive, customized, flexible, efficient, and versatile.

Research on CSA has also utilized the case-simulation methodology. L. K. Cicchinelli (personal communication, January, 1989) used a case-simulation method to develop a "risk assessment" model for CSA victims. He selected this model specifically, for it allowed him to manipulate specific variables (e.g., the age of the victim, type of abuse, use of alcohol, and access of the perpetrator to the child) to determine which variables the clinician used in predicting whether or not a child was at risk and should be protected. Wilk and McCarthy (1986) investigated the attitudes of

protective service workers, (i.e., police workers and mental health therapists) with regard to the disposition of three simulated cases. By means of the case simulation approach, the researchers found it was possible to elicit controversial data from wary subjects. Wilk and McCarthy stated that they chose the case-simulation method specifically because of the need for anonymity of both the subject and the case to ensure cooperation and participation.

Anonymity of the child depicted in the present study was also of paramount concern to both the researcher and the participants. Art therapists are bound by ethical standards with regards to the confidentiality of information in CSA cases. It is unlikely that they would have responded to a real case; in fact, some art therapists had to be reassured that this was a hypothetical case before they would complete and return the survey. The photographs of the children in the case simulations were obtained from colleagues using the following procedure: Three children, who did not have a known history of sexual abuse, were asked if they would participate in a study which would provide help to sexually-abused children; and, an out-dated photograph (to reduce the risk of recognition) was obtained from the parents and converted through Photographic Mounting Technique (PMT) for inclusion in the case simulation. The self-portraits are actual drawings made by sexually-abused children of the ages described in the corresponding case simulation.

Permission was obtained from Wohl and Kaufmann (1985) to use the 4-year-old's and 8-year-old's drawings. Permission was obtained from a 13-year-old client (known to the author) and from her parents to use her drawing.

To ensure anonymity of the respondents, and to increase the likelihood of response, all subjects were informed prior to the start of the study that the information they supplied would be kept confidential and that all identifying information would be coded (e.g., Subject 1 or S1).

In summary, the case-simulation methodology was selected as the mode of inquiry for this study for the following reasons. Firstly, it permitted the manipulation of specific variables of interest (i.e., age and issue). Secondly, it enabled the researcher to develop a hypothetical case history, complete with additional sources of information (i.e., photograph, self-portrait), that clearly defined the parameters of the child's experience and traumatic sequelae. Thirdly, it ensured anonymity both on the level of the subject's responses, and on the level of the case information. Finally, personal communication with other CSA researchers concerning the validity of using the case-simulation method for the purposes of this study met with approval (J.A. Allan, personal communication, December, 1988; R. Badgley, personal communication, December, 1988; D. Finkelhor, personal communication, December, 1988; C. Hampton, personal communication, December, 1988; C. K. Herbert,

personal communication, November, 1988; H. Landgarten, personal communication, February, 1989; and A. Watchel, personal communication, March, 1989).

Case simulation data may not, however, reflect the actual behavior of a therapist in real life situations. Self-report measures are subject to criticism (Borg & Gall, 1983), however, due to the need for anonymity of clients and respondents, this method was chosen by necessity. By adhering to stringent criteria for participation (i.e., requirements of graduate training in art therapy and previous clinical experience with CSA cases), it was hoped that the responses offered by the art therapists would most accurately reflect their behavior in-vivo.

Pilot study. To ensure that the case simulations accurately reflected typical sexual abuse cases (i.e., the photograph, the self-portrait drawing, and the case history were consistent with the age of the child and issue to be addressed), the instrument was extensively field tested. Two stages of evaluation were conducted.

The first stage involved an open-ended brainstorming session in which an advisory panel examined each component of the case simulation (i.e., photograph, drawing, case history, and survey). Suggested revisions were then made and the case simulation was subsequently sent to ten local art therapists. The art therapists who volunteered to participate in the pilot study resided in Vancouver, British

Columbia. They were all currently working with sexually-abused children, either in private practice or in agencies which specifically treated CSA. Based on the field test results, minor changes were made to the case simulation instrument prior to final printing and distribution. The data obtained from the field tests were not included in the final data analysis.

Procedure for Data Analysis

The questionnaires included several different types of questions. Questions 1, 6, and 10 were multiple choice. Questions 2 - 5, and 7 - 9 were semi-structured. Questions 11 - 19 were structured, multiple choice questions designed to solicit demographic information regarding the art therapists (e.g., level of training, experience). Upon receipt of the surveys, the researcher initially grouped them by age of child and the issue being addressed. Responses to individual questions were then examined by group.

The responses to the multiple choice questions (Q.1, 6, and 10) were totalled for each age and issue level. As each subject could choose more than one response to each question (i.e., the response choices were not mutually exclusive), the total percentages often summed to greater than 100%. The proportions, or percentage of the total sample endorsing each choice, were compared across items, and across the age and issue variables. The proportions of the sample endorsing each item were then compared in the form of

a percentage, $(X/N \times 100)$, where X = the number of endorsements and N = the number of returns per cell.

Content analyses was performed on the data from the semi-structured items (Q.2 - 5 and Q.7 - 9). Three different types of content analysis were performed. The procedures are described in the following sections.

Information regarding the characteristics of the sample (Q.11 - 19) was tallied by question, or by each item within each question, for the total sample. It is also important to note that because of the open-ended nature of the research questions, not only were the response categories not mutually exclusive, but often cell sizes within comparisons were unequal.

Content Analysis for Qualitative Items: Q.2, Q.4, and

Q.7. Upon receipt of the completed questionnaires, the

whole datum was read by the researcher to get an overview of the various themes present in the responses to the questions on goals (Q.2) (e.g., self-image, support/nurturing, empowerment), directives (Q.4), and debriefing (Q.7). The consistent themes were isolated and listed in a coding protocol. Other inconsistent but meaningful themes were also itemized. The decision on whether or not to include a theme was determined by weighting a combination of factors which included: (a) the acknowledgment in the literature that these themes were important factors in therapy with sexually-abused children; (b) the frequency with which a particular theme

appeared over all data cells; and (c) the clinical judgment on the part of the researcher who had experience using art therapy with sexually-abused children. A research assistant, with previous experience in conducting and analyzing survey research data, including content analysis procedures, was used in the decision-making process concerning the selection of themes.

The consensual process involved a verbal discussion between the researcher and research assistant on each of the themes identified in each cell, regardless of the frequency counts. If the theme had been discussed in the literature, or appeared frequently in the responses, it was included in the coding protocol. Several themes were either combined, redefined, or renamed through the consensual process but all of the original items were integrated into the final thematic presentation. The datum was subsequently reviewed by the researcher for each cell in the 3 X 2 design and the frequency of occurrence of each theme was tabulated by cell (e.g., 4-year-old experiencing guilt vs. 8-year-old with distorted body image). The various themes which emerged in the initial reading and in the second counting phase were then independently verified by the research assistant who performed the same analysis.

In order to test the reliability of this method of summarizing the data, two judges were selected to independently code 25% of the raw data into the thematic

categories. The judges were both independent psychologists currently using art therapy with sexually-abused children and adults. There were three steps in the judging process: a learning trial; a pretest; and, a final coding of the data. The interrater agreement protocols are contained in Appendix B.

On the learning trial, judges were asked to read the definitions of each theme over until they were familiar with them. The judges proceeded on to the learning trial and coded each piece of information by theme. Support and reinforcement was given immediately after each response made by the judges to increase the speed of learning the thematic categories and to ensure the accuracy of coding. As the judges became more proficient, reinforcement was given intermittently and questions were answered as needed. After the learning trial, all responses were discussed with the judges to help solidify the learning process.

On the pretest trial, each judge was instructed that it was necessary to obtain a minimum of 80% interrater agreement, they would not receive any help, and their responses would be rechecked after they had completed coding. Both judges obtained 80% agreement or higher on the pretest trial.

The final data coding process was then conducted. The total number of codable items was generated by totalling the number of coded responses across judges. Next, concordancy

rates between the judges' coded responses were computed for each question using the following formula:

$$\frac{\text{number of agrees}}{\text{number of agrees + disagrees}} \times 100$$

There was a high rate of agreement, over 80%, for all three questions. The concordancy rates or percent agreements are reported as part of the results for each question in the following chapter.

Quantitative Analysis for Q.3 and Q.5. The responses from these two semi-structured questions on the use of media (Q.3) and the use of time (Q.5) were analyzed as follows. Media types were listed (e.g., crayons, playdough, stuffed animals) and a frequency count was conducted. They were then categorized by the activity type (e.g., collage, painting, play therapy), and again a frequency count was conducted. The responses for time (Q.5) were analyzed in a similar fashion. First, all of the different activities were listed (e.g., greeting, artwork, debriefing) and a frequency count was conducted. The data were then categorized by the activity types and the corresponding time that was used for that activity (e.g., greeting - 5 minutes; artwork - 40 minutes; debriefing - 20 minutes) and a flow chart which illustrated the differences in activities and time frames across age was constructed. The mean times and their standard deviations were also computed for the length of the sessions. For both questions, comparisons of the proportions

were made across: (a) the scoring categories, to determine their relative frequency; (b) the different age levels; and, (c) the two issues. None of the scoring categories were mutually exclusive and many subjects' responses were included in several of the scoring categories for each question.

Quantitative Analysis for Q.8 and Q.9. The responses from the questions on the use of art in relation to the age and issue variables (Q.8) and the function of art in the session (Q.9) were identical. Therefore, only the responses to Q. 8 were analyzed. These responses replicated those obtained by Marrion, et. al, (1988), consequently, they were coded into their thematic categories.

Summary

Identified art therapists working with sexually-abused children in Canada and the United States of America in 1988 -1989 were requested to participate in this investigation of therapeutic approaches appropriate for sexually-abused girls, aged 4, 8, and 13, dealing with the issues of distorted body image and guilt. By means of case simulations and a questionnaire soliciting information regarding the details of the therapeutic activities, qualitative data were analyzed to determine the salient features of the art therapy process with this particular clientele.

CHAPTER 4

RESULTS AND DISCUSSION

The information presented in Chapter 4 includes the results obtained from the investigation of the methods utilized by art therapists in the treatment of CSA. The research questions were designed to examine the differences in treatment approaches on the basis of the age of the client and the issues confronting the client following an episode of sexual abuse. The areas investigated included the general approach used by art therapists, the therapeutic goals, the directives, the media, the use of time in the session, the types of therapeutic interactions, the debriefing process, the function of art in the session, and the types of evaluation used in assessing the effectiveness of the session. The findings are discussed in relation to the developmental, art therapy, and CSA literature. The chapter is divided into the following sections: (a) Sample; (b) Analysis and Discussion of Case Simulation Data; and, (c) Summary.

Sample

A total of 204 questionnaires were mailed out; 180 were sent on December 27, 1988 and a further 24 were mailed on February 28, 1989. The second mailing consisted of replacements for those in the original sample who, for reasons of personal or situational difficulty or refusal, were not able

to return their questionnaires. By the cut-off date of April 15, 1989, 149 completed returns had been received. All but three were usable. The total return rate for usable surveys was 71.57% and the percent return by cell for the sample is presented in Table 2.

Personal, educational, and experiential variables were analyzed in terms of frequency counts which were converted into percentages of the total sample. Personal variables included the gender, age, and geographic location of each subject. Educational variables included the amount of post-highschool education, training in art therapy, and training in the treatment of CSA. The experiential information consisted of the duration of experience working with sexually-abused children, the age groups of sexually-abused children worked with, and the average number of sexually-abused children seen per week.

Personal Variables. The findings regarding gender and age of the art therapists are presented in Table 3. There were 134 females (91.80%) and 12 males (8.20%) in this sample. This proportion, of 11 females to 1 male, is representative of the ratio of females to males in the profession of art therapy throughout North America. The 1988 Directory of the American Association of Art Therapists lists 2334 females and 247 males.

The majority of subjects (84.93%) were between the ages of 26 and 50 years. The average age was 40.78 years,

Table 2

Percentage (n) of Usable Returns By Cell

| Issue | Age (<u>n</u>) | | | Total |
|--------------------------|------------------|------------|------------|-------------|
| | 4 | 8 | 13 | |
| Body Image Distortion | 70.59 (34) | 76.47 (34) | 60.00 (30) | 69.39 (98) |
| Guilt | 75.53 (34) | 70.59 (34) | 76.32 (38) | 75.58 (106) |
| Total | 72.06 (49) | 73.53 (50) | 69.12 (47) | 71.57 (146) |

Table 3

Gender and Age Distributions of Sample (N = 146)

| Gender | Females | | Males | | Total | |
|------------|----------|-------|----------|------|----------|--------|
| Age | <u>n</u> | % | <u>n</u> | % | <u>N</u> | % |
| 20 - 25 | 1 | .68 | 0 | .00 | 1 | .68 |
| 26 - 30 | 17 | 11.64 | 1 | .68 | 18 | 12.33 |
| 31 - 35 | 25 | 17.12 | 5 | 3.42 | 30 | 20.55 |
| 36 - 40 | 34 | 23.29 | 1 | .68 | 35 | 23.97 |
| 41 - 45 | 18 | 12.34 | 4 | 2.74 | 22 | 15.07 |
| 46 - 50 | 19 | 13.01 | 0 | .00 | 19 | 13.01 |
| 51 - 55 | 6 | 4.12 | 1 | .68 | 7 | 4.79 |
| 56 - 60 | 4 | 2.75 | 0 | .00 | 4 | 2.75 |
| 61 - 65 | 3 | 2.05 | 0 | .00 | 3 | 2.05 |
| 66+ | 6 | 4.12 | 0 | .00 | 6 | 4.12 |
| not stated | 1 | .68 | 0 | .00 | 1 | .68 |
| Totals | 134 | 91.80 | 12 | 8.20 | 146 | 100.00 |

however, a small proportion (8.90%) were over the age of 55. All of these were female. In fact, there was only one male over 45 years of age in the sample. This finding may reflect the relative newness of the profession itself, or it may be representative of the trend of fewer males in the helping professions in general.

According to the standards of the American Art Therapy Association (1988), art therapists are required to be graduates of either university, institute, or college programs and to have completed extensive practicums and/or internships prior to registration. Therefore, entry into the workforce may often be delayed until the therapists are in their mid-twenties. The finding that less than 1.00% of the respondents were under the age of 25 may reflect such a requirement.

The geographic distribution of the art therapists across North America is presented in Table 4. Areas of geographic concentration exist on the Westcoast of Canada and the United States, in the East (e.g., New York, New Jersey), and Mid-east (e.g., Ontario, Illinois). Clusters occur where training programs exist (e.g., Houston, Texas; Chicago, Illinois; Washington, District of Columbia; Los Angeles, California; Toronto, Ontario; and Vancouver and Victoria, British Columbia).

Educational Variables. The years of post-high school

education, the levels of training in art therapy, profession-

Table 4

Geographic Distribution of Sample (N=146)

| <u>Location</u> | <u>n</u> | <u>%</u> |
|----------------------|------------|---------------|
| Canada | 36 | 24.66 |
| West | 23 | 15.75 |
| Central | 13 | 8.90 |
| East | 0 | 0.00 |
| United States | 110 | 75.34 |
| West | 35 | 32.98 |
| Mid-west | 10 | 6.85 |
| Central | 23 | 15.75 |
| Mid-east | 28 | 19.18 |
| Northeast | 14 | 9.59 |
| Total (N) | 146 | 100.00 |

al training in CSA, and other self-generated types of training or related experience in CSA are summarized in Tables 5, 6, and 7.

The subjects' years of post-high school education is presented in Table 5. Most of the sample (93.83%) had at least 5 years of post-high school education and indicated that they had completed graduate level training either in art therapy or a related clinical discipline, such as psychology, social work, counseling, or nursing. Only 9 (6.16%) of the sample had four or fewer years of post-high school education while 22 (15.07%) had advanced graduate level training or held doctorate degrees in a clinical discipline. Years of education and age were related; for instance, 71.43% of the sample with nine or more years of education were above the age of 45.

The subjects' level of training and/or certification in art therapy is presented in Table 6. The criterion for inclusion in the present study was a nationally recognized diploma and/or registration as an art therapist. All subjects endorsed either one or both of these categories. As the majority of the sample (70.00%) were both diplomaed and registered, it would appear that art therapy is a profession which requires both rigorous training and experience. One quarter of the sample stated that they had additional types of training or experience relevant to their work in art therapy. For instance, S17 was a working artist and part of

Table 5

Years of Post High School Education of Sample (N=146)

| Years | Frequency | % |
|------------------|------------|---------------|
| 0 - 4 | 9 | 6.16 |
| 5 - 6 | 51 | 34.93 |
| 7 - 8 | 51 | 34.93 |
| 9 - 10 | 24 | 16.45 |
| 10+ | 11 | 7.53 |
| Total (N) | 146 | 100.00 |

Table 6

Level of Art Therapy Training/Certification Status
of Sample (N=146)

| Type of training/certification | <u>n</u> | % |
|---|----------|-------|
| Professional workshops or short courses | 35 | 23.97 |
| Graduate level course work | 22 | 15.07 |
| Internship in specialized area | 24 | 16.44 |
| Diploma or graduate degree in Art Therapy | 79 | 54.11 |
| Registration as an Art Therapist | 101 | 69.18 |
| Other relevant training in art | 36 | 24.66 |

Note. The categories in Table 6 are not mutually exclusive.
Some subjects endorsed more than one choice.

Table 7

Level of Training in CSA Treatment of Sample (N=146)

| Type of Training | <u>n</u> | % |
|--|----------|-------|
| Professional workshops or short courses | 109 | 74.66 |
| Graduate level coursework | 45 | 30.82 |
| Internship with CSA population | 59 | 40.41 |
| Graduate degree specializing in CSA treatment | 7 | 4.80 |
| On-the-job training | 32 | 21.92 |
| Reading CSA literature | 7 | 4.80 |
| Researching and publishing in CSA area | 3 | 2.06 |
| Providing training workshops for others | 7 | 4.80 |
| Supervising others in CSA treatment | 1 | .68 |
| Various other types of related experience and training | 9 | 6.16 |

Note. The categories in Table 7 are not mutually exclusive.
Some subjects checked or stated more than one answer.

a printmaking cooperative; S40 and S69 were registered play therapists; S133 had eight years post-graduate training in art; and S91 pioneered art therapy in Canada.

Although specialized training in the treatment of CSA was not a requirement of the subjects, training or education in this area was reported by all but one of the sample in the form of specialized CSA training, on-the-job-training, or other self-directed approaches. This finding was unexpected. Both Long (1986) and Horowitz (1985) had suggested that such training was not readily accessible, however, it would appear that art therapists are aware of their need for training in CSA and have actively pursued such training. The types of training in CSA treatment are presented in Table 7.

Forty percent of the sample indicated that they had other types of related training and experience in CSA treatment. Some of the more notable examples included: S2, a Department of Justice (U.S.A.) expert on CSA, who taught the first sexual abuse treatment training program for professionals, and is a regular consultant to the television program NOVA; S36 who was specially selected from Los Angeles County Children's Services to work on a model program involving an interdisciplinary approach to the diagnosis and assessment of CSA; S75 who heads an organization that has been treating this population for 12 years; and, S90 who has conducted research on the treatment of CSA and has several well-recognized publications on the topic.

Experiential variables. The art therapists in this sample were required to have treated CSA cases for at least 6 months and to be currently treating the age group whose case simulation they received. In accordance with the criterion, 100% of the sample reported they had worked with CSA clients for at least 6 months. The mean length of time worked in CSA treatment was 6.48 years ($SD=4.62$).

All of the respondents reported that they were treating sexually-abused children of the same gender and age as the child portrayed in their case-simulation. The question regarding the ages of the clients served was open-ended. Consequently, the art therapists reported ages several ways. These included (a) developmental stages (i.e., preschool, latency, adolescent, adult); (b) ranges (e.g., from age 0 - age 85); or, (c) specific age groups (e.g., age 3 - 5).

For purposes of the data summary, the ages were grouped into 3 categories: (a) preschool, age 0 - 6; (b) latency, age 7 - 12; and, (c) adolescence, age 13 - 18. The percentages of subjects who treated the variously-aged children is presented in Table 8. Some subjects treated a wide range of ages and were therefore included in more than one category.

Most respondents worked with children between the ages of 4 and 18. These results are in accord with the findings of Rubin (1984) and Johnson (1987) who related developmental capabilities to the usefulness of art therapy. Rubin (1984)

Table 8

Ages of Children Treated by Sample (N=146)

| Age Category | Frequency | % |
|--------------------|-----------|-------|
| Preschool | | |
| 0 - 3 | 58 | 39.73 |
| 4 - 6 | 107 | 73.29 |
| Latency | | |
| 7 - 9 | 115 | 78.77 |
| 10 - 12 | 127 | 86.99 |
| Adolescence | | |
| 13 - 15 | 116 | 79.45 |
| 16 - 18 | 109 | 74.66 |
| 18+ | 69 | 47.26 |

Note. Many subjects treated children of varying ages, therefore, the age categories are not mutually exclusive.

reported that very young children under the age of 3 do not have the fine motor skills necessary to manipulate drawing and painting tools. Only 39.73% of the sample reported that they treated children between birth and age 3, presumably these therapists utilized a combination of modeling or play media in conjunction with art therapy. Johnson (1987) reflected that late adolescents could utilize their cognitive skills and benefit more from verbal forms of therapy. Forty-seven percent of the sample reported that they treated clients over the age of eighteen.

When asked how many children were seen per week including those seen in groups, 37.67% of the sample replied that they treated 1 to 3 children per week, 19.86% treated 4 to 6 children, 21.92% treated 7 to 10 children, and 19.18% treated more than 10 children. Two members of the sample replied that the number of children they treated varied per week. The mean number of children treated per week was 8.65 (SD=10.85). Many therapists reported that they treated two or three sexually-abused children per week and did not have a full CSA caseload.

Case-simulation Results

The case-simulation results for the treatment approaches are presented in the order the questions were asked in the survey. The research questions regarding differences across age levels and issues are addressed by comparing frequencies of responses and proportional data of respondents, in the

form of percentages, by cell. Various statements made by respondents are paraphrased to illustrate the differences across ages and issues and to provide the reader with authentic clinical descriptions of the art therapy approaches.

Q.1: Treatment Approach Used with Sexually-abused Children.

The results on the treatment approaches used are presented in Table 9. The majority of the art therapists (84.93%) reported that they would use a mixture of both directive and nondirective approaches at different times. Very few responded that they would exclusively use one approach or the other. Fourteen percent of the total sample described alternate approaches which encompassed both directive and nondirective styles as well as other types of treatment approaches (e.g., play therapy). For instance, five art therapists indicated that they would use play therapy along with art therapy and two indicated that they would involve the child's caregivers (e.g., parents, foster parents) in the therapy session. Several respondents described the dynamics of moving from one style to the other in response to the child's needs. For example, S48 said she would try a lot of different approaches depending on the moment and upon the willingness of the child to cooperate. S60 described how she would move from nondirective to directive when necessary to allow the expression of feelings (i.e., offering suggestions but allowing the child the option

Table 9

Percentage of Respondents Using Particular Treatment Approaches by Issue and Age (Q.1)

| Treatment Approach | Issue | Age 4 (<u>n</u> = 49) % | Age 8 (<u>n</u> = 50) % | Age 13 (<u>n</u> = 47) % | Total (<u>N</u> =146) % |
|--------------------|-------|--------------------------------|--------------------------------|---------------------------------|--------------------------------|
| Mixture | BID | 75.00 | 92.31 | 83.33 | 83.82 |
| | G | 88.00 | 91.30 | 79.31 | 84.62 |
| | Total | 81.63 | 90.00 | 80.85 | 84.93 |
| Nondirective | Bid | 20.83 | 11.54 | 11.11 | 14.71 |
| | G | 4.00 | 4.35 | 17.24 | 8.97 |
| | Total | 12.25 | 6.78 | 14.89 | 10.96 |
| Other | BID | 4.17 | 23.08 | 11.11 | 13.24 |
| | G | 16.00 | 4.35 | 24.14 | 15.39 |
| | Total | 10.20 | 14.00 | 19.15 | 14.38 |
| Directive | BID | 4.17 | 3.85 | 16.67 | 7.35 |
| | G | 0.00 | 16.67 | 3.45 | 6.41 |
| | Total | 2.04 | 10.00 | 8.51 | 6.85 |

Note. The response categories were not mutually exclusive. Some subjects also endorsed the 'other' category.

BID = Body Image Distortion
G = Guilt

to say "No." She defined this approach as "leading coming out of following". S176 was nondirective in the sense that she would let the child feel in control of the material, but structured in the sense that she would create a safe, contained environment for her to work in.

Age Differences. The majority of subjects would use a mixture of both directive and nondirective approaches for each age level. Ninety percent of the responses to the 8-year-old case simulations said they would use a mixture of directive and nondirective approaches while 81.63% and 80.85% of respondents to the 4- and 13-year-old case simulations said they would use these approaches, respectively. Only one of the sample who responded to the 4-year-old simulations would be exclusively directive in her approach (i.e., 2.04%), compared to 10.00% and 8.51% of the sample in response to 8- and 13-year-old simulations respectively. This finding may reflect the tendency for some art therapists (e.g., S161) to let younger children settle in by playing and doing for themselves while the therapist builds a relationship of trust and acceptance, through regular sessions in a safe predictable environment without specifically directing unless extreme behavior, safety, or regression become issues.

Issue Differences. The nondirective approach would be used slightly more frequently in response to the distorted body image case simulations (14.71%) than to the guilt case simulations (8.97%). However, this difference was not

considered meaningful. The remainder of the comparisons were approximately equivalent.

Discussion. The approach the art therapist takes to treatment may vary depending on the client's pathology, age, and issues (Rubin, 1984). When emotional lability, psychosis, or trauma shock are present, sessions need to be structured, defenses need to be reinforced, and the child needs to be directed with activities which increase her contact with reality. Conversely, when a child is very defended, in denial, and emotionally shut-down, an unstructured but supportive approach is used which is designed to promote self-acceptance by the child while reawakening senses and feelings through the various art stimuli.

With sexually-abused children, a mixture of both directive and nondirective approaches may be appropriate depending upon the psychological status of the child. A directive approach involves giving the child specific instructions about what is expected in the session while guiding and supporting him or her through an art exercise to completion. It also involves the setting of limits concerning acceptable behavior in the session and encouraging verbal expression through using the art exercise and materials as a bridge for communication (Kramer, 1981). The art supplies and activity are chosen by the art therapist and a time limit may be set for each activity. This approach

serves to reduce anxiety and settle an unstable child while giving the art therapist the opportunity to assess the child. Conversely, the non-directive or spontaneous approach consists of allowing the child to direct her own activities. Art and play materials are available to the child and the role of the art therapist is to gently guide her to 'be' by involving herself in a process of exploration and play with either materials. The art therapist's role is to support, nurture, accept, and reflect or mirror the child's feelings or gestures to aid in the expression of feelings and conflicts. The underlying assumption is that the child will naturally do what she needs to if she feels accepted, supported, and safe (Axline, 1979). Conflicts and feelings will emerge and be worked through spontaneously as the child becomes ready, until the point at which psychological equilibrium is re-established (Naumberg, 1966).

Q.2: Therapeutic Goals

The results on therapeutic goals are presented in two ways. First, a frequency count of the number of goals described by each art therapist was made. The data regarding the number of goals mentioned by art therapists is reported in Table 10. Most subjects (79.00%) listed more than one goal for the session. The mean goals per subject were 3.27 (SD=1.77) for the total sample. Many of the goals listed reflected the issue (i.e., distorted body image or guilt) to be addressed by the art therapist in the case simulation.

Table 10

Mean (SD) Number of Goals per Session (0.2)

| Issue | Age 4 | 8 | 13 | Total |
|------------------------------|-------|------|------|-------|
| Body Image Distortion | | | | |
| <u>M</u> | 3.58 | 3.15 | 2.83 | 3.22 |
| <u>SD</u> | 2.00 | 1.85 | 1.44 | 1.74 |
| Guilt | | | | |
| <u>M</u> | 3.48 | 3.33 | 3.21 | 3.33 |
| <u>SD</u> | 1.04 | 1.50 | 1.10 | 1.49 |
| Total | | | | |
| <u>M</u> | 3.53 | 3.24 | 3.06 | 3.27 |
| <u>SD</u> | 1.47 | 1.72 | 1.62 | 1.77 |

Second, the goals were examined in relation to thematic content. The themes resulting from the analysis of the goals included building self-esteem, increasing awareness of body image, identification and awareness of feelings, difficulties with feelings of guilt, developing a sense of empowerment, and ensuring a nurturing role. These themes are described in detail in Table 11. The frequency of these themes in the data were determined overall and then calculated by age and issue. The percentages of subjects who included each theme in their goal description are shown in rank order in Table 12. Interrater agreement of 94.02% for coding the data into the goal themes was achieved by following the procedure described in Chapter 3.

The most frequent theme identified in the goal descriptions was the identification and awareness of feelings in the victim. Seventy percent of the total sample indicated that they would work with Amanda to aid her in identifying and becoming aware of her feelings in response to the sexual abuse. Various feelings which contributed to Amanda's depression, withdrawal, and feelings of badness were identified by the art therapists and included repressed anger, rage, guilt, loss, fear, shame, and self-hate.

The second most frequent theme was providing a nurturing environment (63.01%). S18 stated that she would respond to Amanda's need for nurturing and human contact because Amanda needs to feel a sense of security in her environment. S116

Table 11

Theme Definitions for Q.2: Therapeutic Goals

1. SELF-ESTEEM. includes any reference to increasing A's positive feelings about herself, decreasing A's negative or bad feelings about herself (badness introject), self-concept, sense of self, and self-awareness.
 2. BODY IMAGE: includes any reference to increasing A's awareness of her body, its functions, its roles, her feelings (+'ve and -'ve) about her body, identifying where it hurts, what parts she loves/hates, feels/ doesn't feel.
 3. IDENTIFICATION AND AWARENESS OF FEELINGS: includes any references to A's feelings and where the therapist is giving A permission to express her feelings without the consequences. The whole feeling range is included: anger, guilt, grief, loss, rage, hate, betrayal, shame, joy, etc.
 4. GUILT: includes any reference to A's difficulties with feeling guilt such as anger turned inward, shame, self-destructive behavior and feelings, anger at mother. Includes the therapist's responses of reinforcing A's innocence, placing the responsibility on her uncle, putting blame where it belongs, forgiving herself.
 5. EMPOWERMENT: includes any references to self-protection, security, assertiveness or working out of the victim stance and learned helplessness, street proofing, safety education and interventions around this, re-establishment of normal child-adult boundaries, reinforcing of disclosure as right and self-protective, and teaching appropriate touching.
 6. NURTURING: includes the caring, comforting, reassurance, support, and trust provided by the therapist and those things which the therapist models or teaches A to do for herself - accepting herself, taking care of herself, loving herself, comforting herself.
-

Note. A refers to Amanda.

Table 12

Percentage of Respondents Stating Particular Themes in
Therapeutic Goals by Issue and Age (Q.2)

| Goal Theme | Issue | Age 4 (<u>n</u> = 49) | Age 8 (<u>n</u> = 50) | Age 13 (<u>n</u> = 47) | Total (<u>N</u> = 146) |
|--|-------|---------------------------|---------------------------|----------------------------|----------------------------|
| Identification and awareness of feelings | BID | 50.00 | 65.39 | 66.66 | 60.29 |
| | G | 52.00 | 100.00 | 82.76 | 78.21 |
| | Total | 51.00 | 82.00 | 76.60 | 69.86 |
| Nurturing | BID | 100.00 | 30.77 | 66.67 | 64.71 |
| | G | 48.00 | 41.67 | 55.17 | 61.54 |
| | Total | 73.47 | 36.00 | 59.58 | 63.01 |
| Empowerment | BID | 70.83 | 46.15 | 44.44 | 54.41 |
| | G | 84.00 | 54.17 | 58.62 | 65.39 |
| | Total | 77.55 | 50.00 | 53.19 | 60.27 |
| Guilt | BID | 12.50 | 26.92 | 00.00 | 14.71 |
| | G | 80.00 | 91.67 | 86.21 | 85.90 |
| | Total | 46.99 | 58.00 | 53.19 | 52.74 |
| Self-esteem | BID | 41.67 | 69.23 | 38.89 | 51.47 |
| | G | 84.00 | 25.00 | 31.03 | 46.15 |
| | Total | 63.27 | 48.00 | 34.04 | 48.63 |
| Body image | BID | 83.33 | 76.92 | 66.67 | 76.47 |
| | G | 00.00 | 25.00 | 00.00 | 7.69 |
| | Total | 40.82 | 52.00 | 25.53 | 39.73 |

Note. The categories in Table 12 are not mutually exclusive.
Subjects stated a variety of themes in their goal descriptions.

BID = Body Image Distortion
G = Guilt

said she would provide a safe supportive container for the examination of Amanda's very painful and central emotions of guilt and shame. S135 would provide Amanda with an experience in art which fostered a sense of ownership of the pain she had experienced. Her intent would be to honor Amanda's suffering and attempt to help her discover the meaning of her pain. The nurturing dimension of the role of the art therapist was succinctly expressed by S106 who stated that she would allow Amanda, through support, empathy, safety, and the trust relationship, to verbally or symbolically express her needs, her view of herself, and her pain (i.e., externalize her inner self).

The third most frequent theme was developing a sense of empowerment. Sixty percent of the sample focussed on some aspect of empowerment as part of their goal for the session. Many subjects simply stated that they would empower Amanda, others, however, alluded to the dynamics underlying the goal of empowerment. Ideally, a state of empowerment in the context of CSA means that the victimized child has acknowledged, experienced, owned, and resolved her feelings of guilt, shame, rage, loss, and hurt to the point where she feels strong, whole, safe, and in control of her life (Stember, 1980). As a result of the abuse, Amanda has to learn new self-protective behaviors, confidence, and how to say "No" to further abuse. She has to become aware of appropriate child-adult behavior, extract herself from unsafe

situations, and know where to find help. Many of the art therapists described these various components of the empowerment process. For example, S114 would open by discussing the issue of adult responsibility to care for children and the child's innocence in the case of CSA. She would work on increasing assertiveness around body boundaries with positive and negative touches, by having Amanda practice saying 'No!' to inappropriate touches and by utilizing a body portrait to give Amanda the distance she would need to look at herself and to feel safe. S157 would try to shift Amanda from the passive stance in her self-portrait to a pro-active stance, so that she could begin to see herself as having some control in her life. S171's goal would be for Amanda to express her feelings of guilt directly and begin to identify them verbally as well as non-verbally, as a means of being able to let go of the anger at herself, and direct it towards the abuser. Such action would help Amanda reach the long-term goal of regaining feelings of control over herself and her body.

The fourth most frequent theme addressed by the art therapists involved the psychodynamics surrounding the guilt and responsibility that sexually-abused children feel. Eighty-six percent of the respondents to the guilt simulation included some reference to this theme in their responses compared to 14.71% of the subjects who responded to the body image distortion case simulation.

Working through guilt is an early and crucial phase in the sexually-abused child's therapy (Sgroi, 1982). As long as the child takes responsibility for the abuse, she feels that she is a "bad" person (Miller, 1984). In order to make sense out of an abusive relationship with an adult, a child often begins to see herself as the cause of the abuse. Threats of punishment or estrangement made by the abuser function to reinforce a sense of badness and unworthiness in the child. The threats also maintain the abuser's power over the child by invading her psychological and physical boundaries. S34, in discussing the goals related to the theme of guilt, shame, and badness, stated that she would explore more fully why Amanda felt "bad" and explain to her that her uncle had not been disallowed to see her because she was "bad" but rather as a means to protect her. S159 stated that she would try and untangle Amanda's feelings that seemed confused. She thought that Amanda's drawing suggested self-protectiveness (i.e., the crossed arms and mermaid legs) mixed with a symbolic heart (i.e., caring and/or wounded) leading to a form of self-hatred (i.e., the X). She suggested that all of these images were possibly infused with shame. In order to reach Amanda's guilt or shame, she felt that it would be important to de-tangle and separately name these feelings. S41 would also work to separate and identify the "bad" feelings in an attempt to relieve Amanda's guilt. In her opinion, at this stage, a child often creates "a muddy

kind" of artwork in which different colours and materials are all dumped together. In her experience, she found that over several sessions, the child begins to sort the colours out so that they become clear and distinct. As this happens, the feelings represented by the colours also become clear and distinct to the child.

Other responses in the area of empowerment offered by the art therapists were directed towards the dynamics of refocussing self-directed anger towards the abuser to relieve self-destructive feelings and depression. Some of S179's goals would be to assess possible suicidal ideation and to help Amanda to express her anger outwardly about the abuse and abuser rather than holding that anger in towards herself. S171 would help Amanda to express her feelings of guilt directly and begin to identify them verbally and nonverbally, as a means of being able to let go of the anger at herself and direct it towards the abuser. She felt that this process would help towards the long-term goal of Amanda regaining feelings of control over herself and her body.

Responses alluding to the process of change from the state of "I'm bad" to the state of self-acceptance were evidenced in addressing guilt issues. S95 stated that her goal would be to help Amanda begin to change her self-image of "bad" to acceptable and eventually work towards self-love and forgiveness. S94 would also work to support Amanda's ambivalent feelings towards herself (i.e., "bad" and dirty

vs. "good"). She would emphasize to Amanda that she was not responsible for the abuse, nor at fault. Other subjects indicated that they would work more confrontatively and encourage Amanda to get in touch with her rage and guilt feelings towards her uncle and at her mother, for not protecting her. The art activity was used as a safe vehicle for processing these feelings. For instance, S172 felt that by using force to pummel clay, Amanda could work out her angry feelings which underlay her guilt and fear.

The fifth theme identified concerned building self-esteem. Forty-nine percent of the art therapists identified self-esteem as key issue in the treatment of CSA trauma. Damaged self-esteem leads to victimization, depression, self-mutilation, lying, and an inability to trust or relate to others (Burgess & Holmstrom, 1974). Many who identified self-esteem as a goal said they would work in various ways to help Amanda feel better about herself. S76 stated that her goal would be to continue to address Amanda's poor self-image and low self-esteem, particularly dealing with her feelings of shame and loss of control of her body. S42 would introduce general information about the guilt experienced by abused children and explore Amanda's own self-image in this regard by offering Amanda her own and other's positive perceptions as a corrective experience as well as eliciting Amanda's positive perceptions of herself. S55 would reduce feelings of poor self-esteem and helplessness by helping

Amanda to understand that telling was the right thing to do, took courage, and that she had the right to try and stop anyone who touched her in a way that she didn't like.

The final theme which emerged was developing a healthy body image. Forty percent of the sample included goals which were related to body image; 76.47% of these had received body image distortion case simulations. The impact of sexual abuse trauma on body image has not been well documented. However, sexually-abused children may draw self-portraits which illustrate that physical violation has taken place (Stember, 1980; Thomas, 1980). Art therapists frequently use a self-portrait or whole body outline to assess a child's psychological state, to obtain disclosure information concerning the site and type of sexual assault (Thomas, 1980), to work therapeutically with the child to aid her in reaccepting her damaged physical and psychological self, and to educate the child with regard to appropriate touching. The need to develop a healthy body image was illustrated in the responses of several art therapists. S135 stated she would help Amanda increase her identification and disclosure of feelings associated with her body image; S136 stated she would encourage Amanda to further explore feelings related to her body including issues of femininity; and, S68 would try to change Amanda's body image by helping her to realize that her scars from the trauma were not evident on her body but rather within her memory, sharing a space with her emotions

(i.e., Others can't see her hurt; Amanda's experience is part of who she is, her history, but there is a future different from her past). Her goal would be to put the event and Amanda's feelings into perspective but not to disqualify them. S26 would use the self-portrait to gain clues about Amanda's psychological needs. Although she stated her goal was to facilitate body awareness and acceptance, she would use visual clues in the portrait to direct the therapy. For instance, she stated that, given the diagram's missing arms, she would focus on using tools to emphasize arm power; and, because the diagram showed a large mouth with teeth, she would facilitate Amanda to gain more verbal power. She also suggested that she would work to empower female over male by helping Amanda to use female dolls to wield power over male dolls.

Age Differences. A comparison of the percentages of the occurrence of the goal themes across ages revealed some important trends. Fifty-one percent of those responding to the 4-year-old case simulations and 82.00% and 76.60% of those responding to the 8- and 13-year-old case simulations respectively, stated goals with the theme of identification and awareness of feelings. There was a different pattern for the theme of nurturing where 73.47%, 36.00%, and 59.58% over the ages respectively, described goals within this category. When these two patterns are viewed together, it would appear that the choice of therapeutic goals by therapists reflects

their understanding of younger children's developmental limitations with respect to verbalizing their feelings (Levick, 1983) and to their greater need for physical contact.

The theme of empowerment showed a pattern similar to that of nurturing. Goals that focussed on this theme were listed by 77.55% of respondents to the 4-year-old case simulations compared to 50.00% and 53.19% respectively in the two older simulations. This trend was present again in the self-esteem theme where 63.27% of responses to the 4-year-old case simulations listed goals relating to self-esteem compared to 48.00% and 34.04% of the other two simulations respectively. These findings suggest that art therapists more frequently pursue goals of nurturing, empowerment, and self-esteem with younger children, however, such themes are of lesser importance with other children whose main need is to become aware of their feelings and resolve the issues of anger, guilt, grief, loss, rage, hate, betrayal, and shame.

Issue Differences. When percentages were compared

across the goal themes by issue, the general findings were as follows. Identification and awareness of feelings were listed 78.21% of the time by those responding to the guilt simulations but only by 60.29% of those responding to the body image distortion simulations. A similar pattern was found for the theme of empowerment but there were no major differences in occurrence of the themes of nurturing or self-

esteem across the two issues. This data suggests that it is important to focus on the process of the identification and awareness of feelings and to work to empower the child especially when guilt is an issue.

There were several strong age by issue interactions which support some of the trends just presented. For instance, 100.00% of the responses to the 8-year-old and 83% of the responses to the 13-year-old guilt simulations stated goals concerned with the identification and awareness of feelings. One hundred percent of the responses to the 4-year-old body image distortion simulations compared to 30.77% of those responding to the 8-year-old simulations, stated goals concerned with nurturing. To ensure a feeling of nurturing, physical contact such as hugging, holding, and rocking must be maintained, especially with younger children.

There was strong relationship between the goal themes endorsed and the type of issue presented in the case-simulations. Eighty-six percent of those who received the guilt simulations listed guilt issues in their response and 76.47% of those who received the body image distortion simulations listed body image goals. There was some overlap between the themes which illustrates the interconnectedness of the issues which arise in therapy with sexually-abused children.

Q.3: Use of Media

The purpose of this question was to investigate the

different types of media use with respect to the age and issue variables. According to Rubin (1984), the media used by art therapists varies considerably as a function of age and skill of the child, the issue at hand, and the experience of the art therapist. A frequency count of the art therapist's use of a particular media activity (e.g., drawing, painting) was calculated across issue and age. The percentages of endorsement of particular media activities is presented in Table 13. The most frequent media activities, in rank order, were drawing, modeling, painting, collage, play therapy, and puppetry. The media types (i.e., the tools and supplies) listed by the art therapists within these categories are presented in Table 14. For example, the most frequently chosen drawing tools were felt markers or "smelly pens" (58.90%) followed by clay (38.36%).

Age differences. There was a pattern of a higher frequency of drawing, modeling, and painting, in that order, across each age level. There was a greater incidence of play therapy and puppetry in the responses to the 4- and 8-year-old case simulations compared to the responses to the 13-year-old case simulations. The usage of drawing media was highest overall (86.00%) in the responses to the 8-year-old case simulations followed by drawing with 13-year-olds (72.34%) and 4-year-olds (69.39%). The usage of modeling and painting was also proportionately greater overall in the responses to the 4-year-old case simulations (65.31% and

Table 13

Percentage of Respondents who Reported a Particular
Media Activity by Issue and Age (Q.3)

| Media Activity | Issue | Age 4 (<u>n</u> = 49) | Age 8 (<u>n</u> = 50) | Age 13 (<u>n</u> = 47) | Total (<u>N</u> =146) |
|----------------|--------------|---------------------------|---------------------------|----------------------------|---------------------------|
| Drawing | BID | 62.50 | 94.31 | 72.22 | 76.47 |
| | G | 76.00 | 79.17 | 72.41 | 75.86 |
| | Total | 69.39 | 86.00 | 72.34 | 76.16 |
| Modeling | BID | 50.00 | 34.62 | 27.78 | 38.24 |
| | G | 80.00 | 45.83 | 62.07 | 62.82 |
| | Total | 65.31 | 40.00 | 48.94 | 51.37 |
| Painting | BID | 29.17 | 23.08 | 16.67 | 23.53 |
| | G | 64.00 | 33.33 | 51.72 | 50.00 |
| | Total | 46.94 | 28.00 | 38.30 | 37.67 |
| Collage | BID | 16.67 | 15.39 | 44.44 | 23.53 |
| | G | 28.00 | 16.67 | 17.24 | 20.51 |
| | Total | 22.45 | 16.00 | 27.66 | 21.92 |
| Play Therapy | BID | 29.17 | 7.69 | 5.56 | 14.71 |
| | G | 28.00 | 12.50 | 3.45 | 14.10 |
| | Total | 28.57 | 10.00 | 4.26 | 14.38 |
| Puppetry | BID | 20.83 | 7.69 | 00.00 | 10.29 |
| | G | 20.00 | 16.67 | 00.00 | 11.54 |
| | Total | 20.41 | 12.00 | 00.00 | 10.96 |

Note. The categories in Table 13 are not mutually exclusive.
Many subjects listed a variety of media

BID = Body Image Distortion
G = Guilt

Table 14

Percentage of Respondents who Listed Particular
Media Types by Age (Q.3)

| <u>Media Activity</u> | <u>Media Type</u> | <u>Age 4 (n=49) %</u> | <u>Age 8 (n=50) %</u> | <u>Age 13 (n=47) %</u> | <u>Total (N=146) %</u> |
|---------------------------|-----------------------------|-------------------------------|-------------------------------|--------------------------------|--------------------------------|
| Drawing | markers | 57.14 | 72.00 | 46.81 | 58.90 |
| | crayons | 10.20 | 22.00 | 14.89 | 15.75 |
| | cray-pas | 20.41 | 22.00 | 8.51 | 17.12 |
| | pencils | 10.20 | 00.00 | 19.15 | 9.59 |
| | colored pencil | 00.00 | 26.00 | 14.89 | 13.70 |
| | oil pastel | 6.12 | 18.00 | 25.53 | 16.44 |
| | other | 4.08 | 4.00 | 6.36 | 4.79 |
| Modeling | clay | 42.86 | 24.00 | 48.94 | 38.36 |
| | plasticene | 20.41 | 10.00 | 2.12 | 10.96 |
| | playdough | 18.37 | 00.00 | 2.12 | 6.85 |
| Painting | paints | 40.82 | 30.00 | 36.17 | 35.61 |
| | body paints | 2.04 | 00.00 | 00.00 | .68 |
| | finger paints | 12.24 | 2.00 | 00.00 | 4.79 |
| | other | 00.00 | 00.00 | 2.24 | 1.37 |
| Collage | magazines | 20.41 | 18.00 | 27.66 | 21.92 |
| | other | 10.20 | 00.00 | 00.00 | 3.41 |
| Play therapy | sand tray | 16.33 | 00.00 | 2.12 | 6.16 |
| | dolls | 16.33 | 6.00 | 2.12 | 8.16 |
| | doll house and furniture | 00.00 | 8.00 | 00.00 | 2.74 |
| | toys | 4.08 | 2.00 | 00.00 | 2.06 |
| | stuffed animals | 8.16 | 4.00 | 00.00 | 4.11 |
| | teaparty set | 2.04 | 00.00 | 00.00 | .68 |
| | doll family | 4.08 | 00.00 | 00.00 | .68 |
| | water tray | 2.04 | 00.00 | 00.00 | .68 |
| Puppetry | fabric | 2.04 | 00.00 | 00.00 | .68 |
| | puppets | 10.20 | 12.00 | 00.00 | 7.53 |

Note. The categories in Table 14 are not mutually exclusive.
Many subjects listed a variety of media.

(46.94% respectively). The use of modeling is also quite common with 13-year-olds (48.94%).

These patterns support the assumption that art therapists are aware and responsive to the child's developmental level. Four-year-old children are much more likely to feel comfortable playing with familiar objects (e.g., puppets, stuffed animals, dolls) or manipulating pliable, fluid, messy media (e.g., markers, clay, Plasticine, sand) because of their need of consistent familiar play objects, and kinaesthetic stimulation. They also do not have the eye-hand fine motor coordination required for drawing tools. Thirteen-year-old children, however, are sufficiently mature and have the necessary fine motor skills to engage in more sophisticated drawing materials (e.g., oil pastels, collage).

Issue differences. The data were grouped by the frequency of categories across issues and the ranking of the most frequently occurring media remained the same. Drawing media were the most frequently chosen by both samples, followed by modeling, and painting. Collage, play therapy, and puppetry followed in that order. The percentages of collage, puppetry, and play therapy did not differ when issues were contrasted. However, a higher percentage of respondents to the guilt case simulations reported that they would have used painting, and/or modeling compared to those responding to the body image distortion cases.

Both clay and paint are very pliable media and encourage

catharsis, decrease control, and invoke strong sensory and kinaesthetic responses (Rubin, 1984). The goal statements from the art therapists responding to the guilt issue also support this assumption. Catharsis, especially for the release of self-anger and the rigid self-control that the state of guilt and self-blame imposes upon the victims of CSA, is extremely important in order to reverse the victim stance. If the art therapist provides the sexually-abused child with a safe container (i.e., in the form of a symbolic object which may be part of an art product), and a safe and accepting place in which to vent her rightful anger, the child is much more likely to regain access to her feeling self. She can then begin to deal with the pain and loss, and begin healing through self-forgiveness. Media which provoke catharsis must be used with limits and with caution so that the child feels supported, safe, and powerful in allowing the anger to surface, be fully expressed, and focussed on the offender or on the act which hurt them.

Q.4: Use of Directives

The purpose of this open-ended question on directives was to obtain a detailed account of the directions or cues that might be given to a child by the art therapist to facilitate the therapeutic process. The description of these directives aids in the understanding of the therapeutic process as it is transformed from goal statements into action. There are few descriptions of the art therapy

process with sexually-abused children (e.g., Stember, 1978; 1980; Sgroi, 1982) and it is hoped that the responses to this question will help to illuminate how art therapists work with the issues of guilt and body image distortion with sexually-abused girls aged 4, 8, and 13.

Two distinct types of themes were identified in the content analysis: a) product-related themes, which included directives concerned with the making of specific art products such as self-portraits and representations of feelings, safety, or the offender, and b) process-related themes, which reflected the nature of the art therapy process. Themes of this type included the cathartic use of media, the nurturing and supportive style of the therapist, the empowerment of the child, and the ways in which the child was encouraged to use the art as a means of communication. The definitions of the product and process category themes that were identified in the content analysis are presented in Tables 15 and 16 respectively. The directive themes were reviewed for meaningfulness by two independent art therapists. The data were coded according to these themes. Interrater agreement for the coding of the directive data into these categories was 84.81%.

The frequency rates for the product-related themes are presented as percentages in Table 17. The most frequent product directive was the self-portrait. Seventy percent of the art therapists stated that they would give Amanda a

Theme Definitions for Q.4: Product-related Directives

-
1. SELF-IMAGE, SELF-PORTRAIT: includes any reference to making art products that represent some aspect of A's self or body.
 2. FEELINGS: includes any references to making art products as representations of A's feelings.
 3. SAFE PLACE: includes any references to making art products which represent safety, security, or protection for A.
 4. OFFENDER IMAGE: includes any references to making art products which depict the offender (and A's feelings or relationship to him.)
-

Table 16

Theme Definitions for Q.4: Process-related Directives

-
1. CATHARTIC USE OF MEDIA: includes any references to the use of the media to increase awareness of, to identify, to release, or to express feelings A is having as a result of the abuse (anger at the offender, self, guilt, grief, etc.)
 2. SUPPORTING, NURTURING: includes any references to how the therapist is working with A to promote self-acceptance, self-care, and self-love by praising and accepting A's work, feelings, and vulnerability/sharing.
 3. EMPOWERMENT: includes any references as to how the therapist allows and encourages A to be in control of the session and what she is doing, expressing, and feeling.
 4. ART-ENHANCED COMMUNICATION: includes any references as to how the therapist uses the art to develop a bridge and a symbolic language for A to express what has happened and her feelings about it.
-

Note. A refers to Amanda.

Table 17

Percentage of Respondents Listing Particular Product-Related Themes by Issue and Age (Q.4)

| Directive Themes | Issue | Age 4 (<u>n</u> = 49) | Age 8 (<u>n</u> = 50) | Age 13 (<u>n</u> = 47) | Total (<u>N</u> =146) |
|------------------------------|--------------|---------------------------|---------------------------|----------------------------|---------------------------|
| Self-image, self-portrait | BID | 79.17 | 96.15 | 72.22 | 83.92 |
| | G | 44.00 | 87.50 | 44.83 | 57.69 |
| | Total | 61.23 | 92.00 | 55.32 | 69.86 |
| Feelings | BID | 33.33 | 53.85 | 55.56 | 47.06 |
| | G | 68.00 | 29.17 | 58.62 | 52.56 |
| | Total | 51.02 | 42.00 | 57.45 | 50.00 |
| Offender Image | BID | 16.67 | 3.85 | 5.56 | 8.82 |
| | G | 20.00 | 37.50 | 31.03 | 29.49 |
| | Total | 18.37 | 20.00 | 21.28 | 19.86 |
| Safe Place | BID | 29.17 | 7.69 | 16.66 | 17.65 |
| | G | 4.00 | 16.67 | 17.24 | 12.82 |
| | Total | 16.33 | 12.00 | 17.02 | 15.07 |

Note. The categories in Table 17 are not mutually exclusive. Some subjects listed more than one product-related directive, while others did not list any.

BID = Body Image Distortion
G = Guilt

directive to create a self-portrait, a drawing of her self-image, or some aspect of herself or her body. An example of this type of directive was offered by S69 who would ask Amanda to draw her body using a mirror (i.e., to give her clues to ground herself in reality). She stated that she would support Amanda to draw herself as realistically as possible. S62 would also request Amanda to make a life-size drawing. During this activity, she would slowly and gently talk about Amanda's anatomy while tracing around her. She would share stories about wetting beds, and together they would share the experience of putting hands on different parts of their bodies, talking about these parts, and saying how they felt. She would then invite Amanda to paint herself freely.

There are many ways of asking a child to create a self-portrait. A self-portrait or self-image reflects the psychological status of the child (Buck, 1948; Landgarten, 1981; Polatajko & Kaiserman, 1986) and brings the child literally face-to-face with herself. The art therapist works to nurture, support, and demonstrate acceptance of the child's portrayal and, in doing so, communicates positive warmth and caring. The art therapist allows the child choice in how the project is carried to completion, all the while finding aspects to notice and praise. Working on coming to terms with who the child has become, because of the abuse, is a very important part of therapy because one of the most

pervasive signs of CSA is low self-esteem, which reflects a damaged self-image (Sgroi, 1982). Latency and adolescent sexually-abused girls often feel as if others can tell they are different and shameful just by looking at them. The use of self-portraits in therapy helps to dispel these feelings of worthlessness and shame because the art therapist can reflect back the strengths and beauty seen in the child.

The second most frequent product-related theme involved directing Amanda to create representations of her feelings. Fifty percent of the art therapists would direct her to represent her feelings connected to the sexual abuse trauma. S51 would ask Amanda to draw a happy, sad, or scary picture in order to give her permission to express some of her held-in feelings. A choice would be offered so that Amanda could feel safe and select something she could feel secure in doing. S34 would be more directive in her approach. She would ask Amanda to draw about the other times when she felt "bad" in her life. She would help Amanda to see that "this" time was different because she had disclosed and the abuse had stopped. She would subsequently ask her to draw when she felt "good" and then reassure her that her disclosure was good.

Pictures that express feelings are used by art therapists to reconnect the sexually-abused child to her inner feelings so that she can feel, acknowledge, and accept these feelings as part of herself and as part of the recovery

process. The art process reawakens the child's creativity by stimulating the senses, which in turn kindle the healing process (Johnson, 1987; Jones, 1987). The feelings of mastery, control, and self-acceptance experienced by the child in the art therapy sessions engenders hope for a better future with less pain. It rebuilds and renews self-confidence which begin to transfer to other areas in the child's life.

The third product-related theme included directives which asked the child to portray the offender and/or the child's feelings or relationship to him. Twenty percent of the art therapists included these types of directives.

The offender maintains tremendous power over the sexually-abused child and she cannot break free of its constraints until she feels safe and supported in her anger and her pain (Berliner & Ernst, 1984). The following are examples of directives which asked the child to portray the offender. S90 would encourage Amanda to draw the perpetrator so that they, together, could throw clay at it and/or tear it, in effect destroying it. S115 would ask Amanda to draw a picture of a little girl with a big person hurting her. She would tell her to draw it in any way she wanted to and then ask her to tell a story about the little girl, answering such questions as: Who do you think was bad in this story? Why? Who do you think was good? Why? She would then ask Amanda to take two pieces of clay and make the big person and the

little girl, and answer other such questions as: What do you think should be done to big people who hurt children? What would you like to do to the big person? What would you like to do to the little girl? How does it make you feel? Can you show me what you would do to the big person? How would you protect the little girl? Now how are you feeling?

The function of these directives is to empower the child through confronting her feelings in the art, so that she can begin to direct her anger outward towards her uncle and her mother, instead of staying trapped in the feelings of fear and guilt. The art provides a safe metaphor for the expression of anger towards the abuser without fear of direct retribution. This experience, coupled with support and acceptance from the therapist for the rightness of these feelings, empowers and frees the child from the victim trap.

There is controversy among clinicians over whether or not the child should, at some time, confront the abuser, whether in art or in vivo. According to Deaton and Sandlin (1980), if the offender remains in the child's life, it is essential that she be able to face him without stress and maintain her power in the relationship. An important part of therapy involves empowering the child to cope with such situations, through rehearsal in the art or in role-playing. One fifth of this sample felt that this kind of confrontation was an important part of the healing process and included it in their approach.

The last product-related theme, endorsed by 15.07% of the art therapists, required Amanda to engage in an artwork process which represented safety, security, and protection. S22 stated that she would ask Amanda to participate in a drawing of a girl with her. Afterwards, they would together draw ways to keep the little girl in the picture safe. Using this technique, the therapist believed that she would provide Amanda with support and ego strength and help her gain a sense of mastery and control. S27 would address the issue of personal safety by asking Amanda to conjure up somebody in her mind (e.g., a pretend person that is the strongest lady she could think of): somebody who could always help her when needed and rock her when she felt scared. She would then ask Amanda draw the person on her paper.

The goal of establishing a safe place or feelings of security and safety in the therapeutic relationship is a fundamental step in the working through of the sexual abuse trauma (Miller, 1984). The abuse signifies the shattering of childhood innocence and a betrayal of trust. The abused child cannot open herself to the world unless that trust is rebuilt and made secure with another benevolent adult, in this case, the art therapist. Asking the child to reach within herself and reconnect with the parts of her life that are still safe and secure kindles a reintegration of her sense of self (Jones, 1984). This process instills hope, a feeling of being cared for, and reconnects the child to her

basic neediness and her right to love, care, and acceptance. She can feel, through the process of creating and talking about the images of safe people, places, and activities, the value of trusting enough to share her pain and be comforted.

There were four process-related directive themes identified by the content analysis: providing a supportive and nurturing environment; providing art-enhanced communication; using media as a catharsis; and, developing a sense of empowerment. The frequencies of these themes are presented as percentages in Table 18.

The most frequent theme related to the supportive, nurturing approach of the art therapists. Sixty-six percent of the sample responded that they would work with Amanda to promote self-acceptance, self-care, and self-love by praising and accepting her artwork, feelings, and vulnerability. Some would even provide direct physical contact by hugging and rocking her. S5 stated that she would be very supportive and empathetic while discussing body parts with Amanda and would also keep an eye on non-verbal cues that might indicate that Amanda felt threatened or uncomfortable. S56 would support Amanda by giving her a welcome, reflecting something positive she saw about her, and by setting limits and structure in the session. S68 would use metaphor to support Amanda. She would suggest to Amanda that she had not gained control of wetting her bed because her body needed a way to cry tears. Until she could believe that what had happened was not her

Percentage of Respondents Listing Particular Process-Related Directive Themes by Issue and Age (Q.4)

| Directive Themes | Issue | Age 4 (<u>n</u> = 49) | Age 8 (<u>n</u> = 50) | Age 13 (<u>n</u> = 47) | Total (<u>N</u> =146) |
|-------------------------------|--------------|---------------------------|---------------------------|----------------------------|---------------------------|
| Supporting, Nurturing | BID | 83.33 | 65.39 | 55.56 | 69.12 |
| | G | 60.00 | 70.83 | 62.07 | 64.10 |
| | Total | 71.43 | 68.00 | 59.58 | 66.44 |
| Art-enhanced communication | BID | 50.00 | 84.62 | 50.00 | 63.24 |
| | G | 44.00 | 66.67 | 51.72 | 53.85 |
| | Total | 46.94 | 76.00 | 51.06 | 58.22 |
| Cathartic use of media | BID | 45.83 | 46.15 | 44.44 | 45.59 |
| | G | 56.00 | 75.00 | 34.48 | 53.85 |
| | Total | 51.02 | 60.00 | 38.30 | 50.00 |
| Empowerment | BID | 70.83 | 34.62 | 33.33 | 47.06 |
| | G | 56.00 | 45.83 | 34.48 | 44.87 |
| | Total | 63.27 | 40.00 | 34.04 | 45.89 |

Note. The categories in Table 18 are not mutually exclusive. Some subjects listed more than one process-related directive, while other did not list any.

BID = Body Image Distortion
G = Guilt

fault, cry the sadness from her eyes, and get angry she would need to wet her bed. S68 would tell Amanda that she would support her need to show her feelings in this way until she was able to show her her emotions in even healthier ways such as getting angry at at her uncle and feeling tears and sadness for what happened.

Support, nurturing, and acceptance are essential in enhancing the trust relationship and therapeutic bond. The sexually-abused child needs constant support, especially in the early stages of therapy, to empower her to deal with her family in the crisis provoked by disclosure (Burgess & Holmstrom, 1974).

The second process-related theme involved the process of art-enhanced communication in which art therapists would use art activities to promote the development of the child's symbolic language. Therapists would encourage Amanda to use the art process and product as a bridge to communicating about what had happened and her feelings about it. Fifty-eight percent of the art therapists included statements of this kind in their directives. S113 stated that she would ask Amanda to create a puppet of a little girl her own age and a mask of a strong helping friend. Subsequently, they would enact a play leading Amanda to speak through her puppet or her strong, helping friend.

Another aspect of art-enhanced communication is the art therapist's use of the diagnostic information available in

the art product (Burgess, McCausland, & Wolbert, 1981). The therapist may utilize such information when the child is blocked in order to help her move again. S94 stated that she would use the art from the previous session to bring Amanda back in touch with her feelings. She would tell Amanda, "Your picture from last week gives me the feeling that you feel 'bad' inside, even though you have a happy face on the outside." S28 would also use Amanda's previously drawn self-portrait as the basis for starting the session. She would choose to stay with the characteristics of arm-lessness, no body (nobody), and oneleggedness (i.e., her defenselessness). She would suggest having Amanda imagine what it would be like to have no arms, by asking such questions as: How would you touch? How would you play? Could you push somebody away? She also thought she might use role play and have Amanda and herself walk around the room, do things without arms, and report on what it felt like.

The third most frequent theme in the process-related directives was the cathartic use of media. Statements included in this category contained references to the use of media to increase awareness of, to identify, to release, or to express the feelings Amanda was having as a result of the abuse (e.g., anger at the offender and herself, guilt, grief, and shame). Fifty percent of the art therapists stated that they would use cathartic directives in therapy sessions. S158 said that she would ask Amanda to represent herself with

and without her feelings of guilt, to explore the similarities and differences, and to find out how to get from one to the other. S179, who would confront Amanda directly about her feelings of anger, would ask her to draw how she felt about herself before and after the abuse, how she felt about the abuse, how she felt towards the abuser, and how she felt about her mother. Such directives were initiated to promote the external expression of anger towards the responsible adults.

Other subjects would respond with directives which would elicit Amanda's sense of loss and pain. For example, S125 would ask Amanda to do an enlargement of her heart and fill in the page with the colors that are within her heart. Some would respond with directives which emphasized Amanda's guilty, shameful feelings. S164 said that she would ask Amanda to create a sculpture/drawing/painting showing the size, shape, and color of the guilty feelings she was experiencing.

While these directives were designed to elicit strong underlying difficult feelings, it is important to realize that the therapeutic process does not stop with the expression of these feelings. A therapeutic opportunity exists in the presence of such strong feelings. When catharsis occurs, either regression or growth can result (Miller, 1984). The art therapist can work to empower the child, rather than to contain her feelings. Regression can

occur, however, when too much has been revealed too quickly (Stember, 1980) and the child is not sufficiently supported. Growth occurs through the special role of the therapist who can aid the sexually-abused child in transforming her anger, guilt, rage, and loss into strengths and self-protective, self-nurturing qualities.

Forty-six percent of the art therapists stated that they would respond with directives related to empowering Amanda. There was a high correlation between those who responded with both cathartic and empowerment directives ($r = .9$). S170 summarized the process of how she would empower Amanda as follows:

I would explore what rape means to Amanda, validate her feelings, reassure Amanda that she is a good person, what happened to her is not her fault and she's not to blame... confirm that an adult did not conduct himself as an adult should with a child, and reassure her that she is not permanently damaged, mother doesn't blame her, loves her, and is taking steps to make certain she and her little sister will be safe and not at risk for anything like this to ever happen again. I would explore how Amanda would handle the situation if she were the parent, and ask her what she would like to see happen to the perpetrator. I would acknowledge justification for her anger, I'd ask about the child's experiences and relationships with mother's commonlaw boyfriends, and wonder aloud if Amanda has any concerns about either her little sister's or her own safety. I would ask how she feels about her uncle, being careful not to assume the child only has negative feelings about what has happened. Again, I would move at a pace right for the child and not move more quickly than she is ready to. She is in most need of validation that she is a good person, believed, and not permanently damaged.

Empowerment is the eventual goal that each therapist who works with CSA cases strives for. It does not occur early on in treatment as it is a result of a strong therapeutic

relationship in which trust, acceptance, nurturing, support, and consistency are the most salient factors.

Age Differences. There were different patterns in the frequencies of directive themes across age. In the process-related directives, there were unequal frequencies for the "draw a self-portrait or self-image" directive and for the "draw your feelings" directive (see Table 17). Ninety-two percent of the respondents to the 8-year-old case simulations said that they would ask Amanda to make a drawing of her self compared to 61.23% and 55.32% of the respondents to the 4- and 13-year-old case simulations. With younger children the art therapists often described the use of self-portraits that were full-sized body tracings in which the art therapists aided the child by drawing around her body, however, for children age 8 and 13, the self-portraits were more often smaller sketches (e.g., poster size).

The frequencies across age were also unequal in the "draw a feeling" category. Fifty-one percent, 42.00%, and 57.45% of the respondents, respectively for the 4-, 8-, and 13-year-old simulations, asked Amanda to represent an aspect of her feelings. It appears that art therapists are responsive to the differing levels of emotional maturity and work to enable the older children to face their feelings directly, whereas the younger children may still be dependent upon others to interpret and limit their feelings for them (Stember, 1980).

All of the process-related directives differed in frequency across the three age levels (see Table 18). The two directives (i.e., supporting and empowerment) had similar distributional patterns of decreasing incidence of these types of support as the age of the child increased. S67, in response to 8-year-old Amanda, said that she would begin her session by cutting out paper hearts. She would talk about her week and invite Amanda to join her. Then she would instruct Amanda to make a body map and fill in the face while encouraging her to identify the parts of her body that had been hurt, felt dirty, felt ashamed, or felt sad. Amanda would then be asked to draw on her body image any colors or shapes she chose to express hurt, dirtiness, shame, and sadness. She would then give Amanda the cut-out hearts and a box of bandaids and encourage her to put the hearts in places that needed special caring, and the bandaids over places that needed special healing. S67 would then comment to Amanda that many girls felt like she did after they had to same things happen to them.

S134, in response to 13-year-old Amanda, replied that she would begin with a review of the last drawing and ask her about the heart she had drawn. She would then ask her to reproduce the heart in another drawing, talk about her drawing, and tell about the feeling held in the heart.

By reviewing these examples across age levels, it can be seen that the art therapist provided more security, safety,

and ego support for the younger child. She was also very supportive but in a more pragmatic way by encouraging Amanda to take responsibility for her own feelings and the communication of them. She assumed Amanda would comply with her directives yet also allowed Amanda to choose whether or not to reveal and express her feelings. For the adolescent, the art therapist encouraged independent functioning in the session by providing the directives in a safe place and by allowing Amanda to interpret and carry them out herself.

The other process-related directive themes had different response patterns. The directives describing the cathartic use of media were most frequent in the responses to the 8-year-old case-simulations. However, the higher response rate was mainly accounted for by responses to the issue of guilt. The frequency of directives on art-enhanced communication had a different response pattern across age in comparison to the other process-related directives. More of the respondents to the 8-year-old case simulations utilized this type of directive with Amanda, possibly because of developmental considerations. According to Marrion et al. (1988) and Rubin (1984), art is frequently used with latency aged children as an alternative form of communication about their "bad" feelings. Kelly (1984) and Thomas (1980) also support the use of art with children of this age because they do not have the appropriate vocabulary to describe the sexual

experience nor do they want to talk about the abuse as it makes them very anxious and fearful.

Issue Differences. In the product-related directives, (see Table 17), the majority of those responding to the body image distortion case simulations (83.92%) gave directives which asked Amanda to create a self-portrait or self-image compared with 57.69% of those responding to the body image distortion simulations. Thirty percent of those responding to the guilt case simulations asked Amanda to create an image of the offender in order to focus on her guilt feelings compared with only 8.82% of those responding to the other issue. These response patterns may reflect the issues which the therapists are responding to in the case simulations. Burgess & Holmstrom (1979), Jones (1987), and Stember (1980) all use directives concerning self-portraits to work with body image distortion. The response frequencies for the other two product-related directive themes (i.e., representing feelings and creating a safe place) were similar across the issue variable indicating that both were important directives for either issue.

In the process-related directive themes, the response rates for the support/nurturing and the empowerment themes did not differ significantly by issue (see Table 18). Both types of directives were utilized for either issue with approximately the same frequency indicating that both are necessary components of effective art therapy. Those

responding to the body image distortion case simulations utilized art-enhanced communication directives more frequently than those responding to the guilt case simulations. This pattern may indicate the efforts of the art therapists to engage Amanda in communicating about her body, her physical pain, and the details of the abusive encounter (Thomas, 1980). Those responding to the guilt case simulations employed directives which entailed the cathartic use of media and feelings more frequently than those responding to the body image distortion case simulations. These findings may relate to Jones' (1987) and Johnson's conceptualization of the psychodynamics of guilt where alexithymia prevents the sexually-abused child from accessing her feelings. According to these authors, and to Finkelhor and Browne (1985), guilt is a defense which must be worked through before the child can come to terms with the "bad" parts of herself. Art therapists such as Sgroi (1982) and Stember (1980) also utilized process-related directives which engaged the guilt feelings of their clients such as "draw your feelings about yourself after the abuse" or "draw the offender."

When the two different types of directives (i.e., product and process) are examined together, a cohesive pattern emerges. The types of directives most frequently given in response to body image distortion (in order of decreasing frequency) were to create a self-image, to provide

support and nurturing to Amanda, to utilize art-enhanced communication, to provide a sense of empowerment, to use media as a cathartic agent, and to create a safe environment. The therapeutic process initiated by focussing on body image distortion when seen as a whole was that of self-acceptance. In order to see herself as separate from the sexual abuse, the child must distance herself from the way she currently feels and views herself. The art therapist provides the distance by asking her to recreate herself in the media so she can then see herself from outside as she really is, separate from the feelings connected to the abuse, which caused her to feel damaged (Stember, 1980). This internalized sense of damage and shame led her to think that the whole world perceived her in this way (Burgess & Holmstrom, 1984). The role of the art therapist is to promote reality contact through helping the child to see who she really is, recognize her strengths, appreciate and value her beauty and uniqueness, and stress the intactness of her physical body. Through this experience, it may be possible to reconnect her to the creative, healthier child she was before the abuse began.

The types of directives more frequently given in response to the guilt simulations compared to the body image distortion simulations were the cathartic use of media, representing feelings, and creating an image of the offender. Empowerment and support/nurturing directives, while reported

slightly less frequently, were also used. The dynamics underlying the formation of guilt as a defense system in sexually-abused children are created through the abuse of power by the offender over the child (Finkelhor, 1986). As long as the child perceives the offender to have the power in the relationship, she is psychologically forced to take partial or complete responsibility for participating in the abusive relationship. She blames herself, feels that she must be "bad", there must be something wrong with her, or "this must be alright because he's an adult and my feelings don't count." The child's feelings often become too intense and confusing for her to accept and alexithymia, or psychic numbing, occurs as a defense against breakdown (Johnson, 1987). The role of the therapist is to reconnect the child with her feelings so that she may regain her own power and feelings of self-worth (Jones, 1987). In order to break through the fog and numbness, cathartic exercises are often used to stimulate feelings of anger and rage. Asking the child to direct this anger at images of the offender in the presence of a supportive adult helps her to accept those feelings as her own and as rightful reactions to the abuse and abuser. When feelings of anger are regained, the child may be able to let go of her guilt and shame, free herself from attachment to her abuser and concomitant feelings of responsibility, and begin to share her pain with the therapist.

Q.5: Use of Time.

The purpose of this modified open-ended question on time utilization was to obtain a composite picture of the temporal structure of the art therapy session so that its dimensions could be described and compared across age and issue variables. Respondents were free to use their own method of description, although some guidance was given by listing some probable activities (e.g., greeting, artwork, debriefing). Respondents generally reported that they would use one of four different session lengths. These included 45 minute, 50 minute, 60 minute, or 90 minute sessions. The mean session lengths by issue and age are presented in Table 19.

The mean length of time for sessions was 56.72 minutes (SD=7.61). Fifty minute sessions were also frequently used but relatively few utilized 45 minute or 90 minute sessions. The length of the session itself did not appear to be related to age or issue but rather to the needs of the individual child or to the time constraints of the treatment agency or practitioner.

The frequency with which respondents stated they would use particular types of activities was represented by percentages which are presented Table 20 in chronological order. The general format for sessions included a short greeting of 5-10 minutes, during which time the therapist and child would get reacquainted, review the past week, and determine what was to be accomplished in the present session.

Table 19

Mean Session Lengths in Minutes of Sample who
Stated Time Lengths, by Issue and Age (Q.5)

| Issue | Age 4 | Age 8 | Age 13 | Average Session Length |
|---------------------------------------|-------|-------|--------|------------------------------|
| Body Image Distortion | | | | |
| <u>M</u> | 56.00 | 58.23 | 58.53 | 57.62 |
| <u>SD</u> | 7.00 | 3.05 | 2.94 | 4.60 |
| Guilt | | | | |
| <u>M</u> | 56.43 | 57.62 | 63.00 | 55.92 |
| <u>SD</u> | 7.14 | 5.24 | 11.38 | 10.66 |
| Average Session Length | | | | |
| <u>M</u> | 56.22 | 57.99 | 60.54 | 56.72 |
| <u>SD</u> | 7.07 | 2.13 | 8.26 | 7.61 |

Note. Not all subjects listed the length of their sessions.
These cells contain unequal n's.

Percentage of Respondents Listing Particular Activities
Engaged in During the Session by Issue and Age (0.5)

| Activity Type | Issue | Age 4 (n = 49) | Age 8 (n = 50) | Age 13 (n = 47) | Total (N=146) |
|-------------------|--------------|-------------------|-------------------|--------------------|------------------|
| Greeting | BID | 70.83 | 84.62 | 77.78 | 77.94 |
| | G | 76.00 | 79.17 | 68.97 | 74.36 |
| | Total | 73.47 | 82.00 | 72.34 | 76.03 |
| Playing | BID | 12.50 | 15.39 | 11.11 | 13.24 |
| | G | 24.00 | 20.83 | 6.90 | 16.67 |
| | Total | 18.37 | 18.00 | 8.51 | 15.07 |
| Artwork | BID | 100.00 | 100.00 | 100.00 | 100.00 |
| | G | 100.00 | 100.00 | 100.00 | 100.00 |
| | Total | 100.00 | 100.00 | 100.00 | 100.00 |
| Discussion | BID | 16.67 | 26.92 | 66.67 | 33.82 |
| | G | 32.00 | 20.83 | 41.38 | 32.05 |
| | Total | 24.49 | 24.00 | 51.06 | 35.62 |
| Snack | BID | 20.83 | 19.23 | 22.22 | 20.59 |
| | G | 40.00 | 4.17 | 17.24 | 20.51 |
| | Total | 30.61 | 12.00 | 19.15 | 20.55 |
| Debriefing | BID | 62.50 | 61.54 | 88.89 | 69.12 |
| | G | 32.00 | 50.00 | 79.31 | 55.13 |
| | Total | 46.94 | 56.00 | 82.98 | 61.64 |
| Warning of ending | BID | 41.67 | 50.00 | 16.67 | 38.24 |
| | G | 56.00 | 25.00 | 20.69 | 33.33 |
| | Total | 48.98 | 38.00 | 19.15 | 35.62 |
| Ending | BID | 12.50 | 30.77 | 27.78 | 25.53 |
| | G | 24.00 | 20.83 | 31.03 | 25.64 |
| | Total | 18.37 | 26.00 | 29.79 | 24.66 |
| Story | BID | 0.00 | 0.00 | 0.00 | 0.00 |
| | G | 16.00 | 0.00 | 0.00 | 5.13 |
| | Total | 7.87 | 0.00 | 0.00 | 2.74 |
| Time with parents | BID | 0.00 | 0.00 | 0.00 | 0.00 |
| | G | 4.00 | 4.17 | 0.00 | 2.56 |
| | Total | 2.04 | 2.00 | 0.00 | 1.37 |
| Theatre | BID | 0.00 | 3.85 | 0.00 | 1.47 |
| | G | 0.00 | 0.00 | 0.00 | 0.00 |
| | Total | 0.00 | 2.00 | 0.00 | .68 |

Note. Not all subjects listed activities. These cells contain unequal n's.

BID = Body Image Distortion

The greeting time would sometimes be followed by a play period of 10-20 minutes to relax the child. The time that would be allocated to artwork ranged from 10-40 minutes and it would consistently follow the greeting or play period. Some art therapists said that they would use two or three short art sessions of 5-10 minutes with discussion or snack in between.

The artwork would usually be followed by a discussion or debriefing period which allowed the child to reflect on what she had created and the meaning of her artwork. The discussion and debriefing periods would often include a snack and a warning of the end of the session. Some art therapists said they would offer the child continuous access to snacks of juice, milk, cookies, and fruit while others said they would offer them only at the beginning, during the greeting and play phases. Many said they would give a warning of the end of the session 5 to 10 minutes before time was up and they would also ask the child if there was anything else she would like to do, know, or say before they ended off until next time. This notification would promote a sense of control and empowerment. Art therapists reported that children were then often able to say what had surfaced in their art. Help and reassurance would be provided at this point to aid the child through the next week. Homework would sometimes be given to reinforce progress.

Sessions would be ended in various ways. Twenty-five

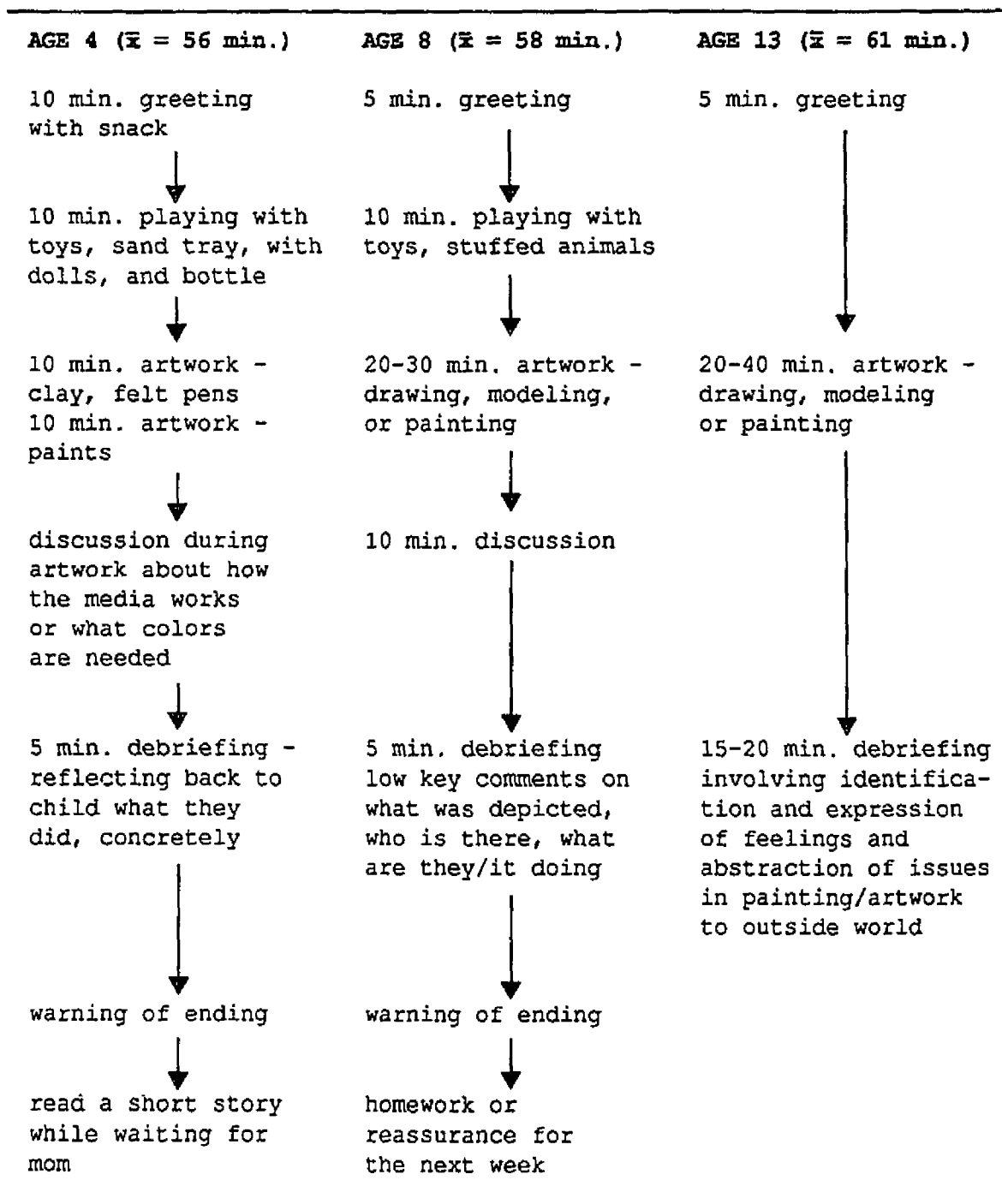
percent of the art therapists stated that they would complete the session with a brief recapitulation of what they had observed, how the child had participated, and where she was moving to. Four art therapists would end sessions by reading the child a story related to her situation. Two responded that they would spend several minutes talking things over with the child's mother at the end and several others would allow her to engage in theatre play as a way of ending the session.

Age Differences. There were some differences in the way time was structured across the three age groups. Flow charts of the types of activities and their timespan over the three age groups are presented in Figure 3. Each flow chart represents a typical session for a child of that age, according to the responses generated by the question on time utilization.

The responses to the case simulations illustrated the occurrence of specific activities which were developmentally bound. The responses to the 4-year-old case simulations indicated that art therapists would work for a shorter time period with this age group, employ more playing time, and attend to the emotional and physical needs of children of this age by providing them with snacks, stories, and a warning of the ending. The quality of the discussion or debriefing would be of a very concrete level and involve technical, problem-solving and reflective comments rather

Figure 3

Flowcharts of Types and Lengths of Activities in Typical Sessions for 4, 8 and 13-year-olds



than psychotherapy. The responses to the 8-year-old case simulations indicated an age-related increase in working time, less attention to basic needs in the form of snacks and play time, and greater emphasis on the doing and explaining of the art process. The responses to the 13-year-old case simulations also indicated an age-related increase in working time, artwork time, and debriefing time. The quality of interaction between the art therapist and the adolescent would be more abstract and of a cognitive nature involving metaphor, self-reflection, and problem solving as well as catharsis and ego support.

Issue Differences. When the particular activities were examined by issue few differences were noted between subjects responding to the body distortion case simulation versus the guilt case simulation, however, there were differences in the percentages of respondents who utilized debriefing across issues. It would appear from the respondents written comments that these differences were related more to the perceived needs of the child and the child's age rather than the specific issue at hand.

Several therapists reported that they would need more time for the emergence of strong angry feelings in the guilt case simulation and a consequent time period for rebuilding the child's sense of safety before she left the session, whereas, in the responses to the body image distortion case simulation, the time would be structured into the usual

hour-long framework. During this time, the therapist would provide support by letting the child work more at her own pace, helping her to process while she drew rather than during a debriefing period at the end.

Q.6: Types Of Therapeutic Interactions.

The question on type of therapeutic interaction was in the form of a forced choice. The categories (e.g., focussing, clarifying, grounding; identifying splits) had been previously established by the Vancouver Incest and Sexual Abuse Center (1988). The "other" category permitted subjects to add categories that they also felt were important in the treatment of CSA. The objective of this question was to obtain a ranking of the types of therapeutic interactions used by art therapists when treating sexually-abused children. The types of therapeutic interactions or strategies which the art therapists endorsed varied by age and by issue and are presented in rank order in Table 21.

The art therapists most frequently endorsed interaction methods that reflect effective therapeutic techniques such as empathetic listening, acknowledging, clarifying, exploring, and focussing (Oaklander, 1978; Miller, 1984). The use of safe place is a common practice with children or adults where the basic capacity to trust has been damaged as a result of abuse or neglect (Oaklander, 1978; Malachiodi & Peterson, 1985). Metaphor is frequently used by art therapists (Landgarten, 1987) and play therapists (Axline, 1979) in

Table 21

Percentage of Respondents Endorsing Particular Types of
Therapeutic Interactions by Issue and Age (Q.6)

| Therapeutic Interactions | Issue | Age 4 (<u>n</u> = 49) | Age 8 (<u>n</u> = 50) | Age 13 (<u>n</u> = 47) | Total (<u>N</u> =146) |
|--------------------------|--------------|---------------------------|---------------------------|----------------------------|---------------------------|
| Empathetic Listening | BID | 87.50 | 96.15 | 88.89 | 91.18 |
| | G | 92.00 | 100.00 | 93.10 | 94.87 |
| | Total | 89.80 | 92.00 | 91.49 | 93.15 |
| Acknowledging | BID | 79.17 | 96.15 | 83.33 | 86.77 |
| | G | 92.00 | 95.83 | 100.00 | 96.15 |
| | Total | 85.71 | 96.00 | 93.62 | 91.78 |
| Clarifying | BID | 70.83 | 76.92 | 72.22 | 73.53 |
| | G | 72.00 | 83.33 | 89.66 | 82.05 |
| | Total | 71.43 | 80.00 | 82.98 | 78.08 |
| Exploring | BID | 66.67 | 69.23 | 83.33 | 72.06 |
| | G | 72.00 | 83.33 | 86.21 | 80.77 |
| | Total | 69.39 | 76.00 | 85.11 | 76.71 |
| Safe Place | BID | 83.33 | 84.62 | 72.22 | 80.88 |
| | G | 72.00 | 79.17 | 68.97 | 73.08 |
| | Total | 77.55 | 82.00 | 70.21 | 76.71 |
| Metaphor | BID | 62.50 | 42.31 | 66.67 | 55.88 |
| | G | 48.00 | 79.17 | 72.41 | 66.67 |
| | Total | 55.10 | 60.00 | 70.21 | 61.64 |
| Focussing | BID | 58.33 | 65.39 | 83.33 | 67.65 |
| | G | 36.00 | 54.17 | 72.41 | 55.13 |
| | Total | 46.94 | 60.00 | 76.60 | 70.96 |
| Mirroring | BID | 50.00 | 53.85 | 33.33 | 47.06 |
| | G | 56.00 | 58.33 | 44.83 | 52.56 |
| | Total | 53.06 | 56.00 | 40.43 | 50.00 |

(con't)

Table 21 (con't)

| | | | | | |
|-----------------------|--------------|-------|-------|-------|-------|
| Education | BID | 37.50 | 46.15 | 50.00 | 44.12 |
| | G | 52.00 | 58.33 | 48.28 | 52.56 |
| | Total | 44.90 | 52.00 | 48.94 | 48.63 |
| Ventilation | BID | 41.67 | 46.15 | 22.22 | 38.24 |
| | G | 60.00 | 41.67 | 41.38 | 47.08 |
| | Total | 51.02 | 44.00 | 34.04 | 43.15 |
| Problem Solving | BID | 33.33 | 46.15 | 22.22 | 35.29 |
| | G | 32.00 | 41.67 | 41.38 | 38.46 |
| | Total | 32.65 | 44.00 | 34.04 | 36.99 |
| Transference | BID | 41.67 | 19.23 | 38.89 | 32.35 |
| | G | 20.00 | 33.33 | 38.93 | 30.77 |
| | Total | 30.61 | 26.00 | 38.30 | 31.51 |
| Grounding | BID | 25.00 | 30.77 | 27.78 | 27.94 |
| | G | 36.00 | 16.67 | 24.14 | 32.05 |
| | Total | 30.61 | 24.00 | 25.53 | 30.14 |
| Confronting | BID | 16.67 | 15.39 | 27.78 | 19.12 |
| | G | 12.00 | 33.33 | 31.03 | 25.64 |
| | Total | 14.29 | 24.00 | 29.79 | 22.60 |
| Identifying Splits | BID | 12.50 | 15.39 | 27.78 | 17.65 |
| | G | 8.00 | 25.00 | 27.59 | 20.51 |
| | Total | 10.20 | 20.00 | 27.66 | 19.18 |
| Rehearsing | BID | 16.67 | 19.23 | 5.56 | 14.71 |
| | G | 12.00 | 25.00 | 24.14 | 20.51 |
| | Total | 14.29 | 22.00 | 17.02 | 17.81 |
| Others | BID | 29.17 | 30.77 | 44.44 | 33.82 |
| | G | 40.90 | 29.17 | 27.59 | 32.05 |
| | Total | 34.69 | 30.00 | 34.04 | 32.88 |

Note. The categories in Table 21 are not mutually exclusive. Some subjects endorsed more than one category.

BID = Body Image Distortion
G = Guilt

response to a child's process. In the case of art therapy, the child's actions on the media, the product, and the child's communication about the product and the process may be used as metaphors for issues in their lives. The same is true for play, music, or drama therapy where the manner in which the activity is carried out may be used as a metaphor for the issues in the child's life (Johnson, 1985).

Approximately one-half of the sample endorsed mirroring, ventilating, and education. Mirroring, or reflecting back to the child their physical, emotional, and verbal communication, is especially important in the treatment of CSA. When a child is in a state of alexithymia and split off from her feeling self, mirroring helps to bring her attention back to her body and her feelings (Jones, 1987). Providing safe opportunities for the ventilation of rage and anger is also a vital component in the treatment of sexually-abused children (Marrion et al., 1988; Sgroi, 1982; Stember, 1980). Directing the child's angry feelings outward, in a focussed way toward a specific target, reduces self-blame, guilt, and self-anger. Ventilation also validates the child's sense of self, empowers her, and allows her to move beyond the victim role (Burgess & Holmstrom, 1979). Therapists treating CSA educate the child in a number of areas including: (a) the routine of court procedures; (b) the roles of the various professionals who they might be involved with; (c) the course of therapy (e.g., the stages of healing, the issues, the

normal reaction to CSA trauma); and, (d) the development of self-protection or safety skills, including assertiveness training (Long, 1986; Marrion et al., 1988; Naitove, 1982; Sgroi, 1982; Stember, 1980).

Approximately one third of the art therapists endorsed grounding and problem solving. Grounding, or the act of being able to calm oneself down and relax from a state of acute anxiety, is used frequently in the treatment of CSA (Blake-White & Kline, 1984; Jones, 1984). Grounding is particularly useful in the following situations: (a) when traumatic repressed memories resurface unexpectedly causing hallucinations, somatic symptoms, and acute anxiety; (b) during the trauma shock stage after the sexual abuse incident(s); (c) during family crises; and, (d) when the client reacts to issues which are being worked through in therapy (Blake-White & Kline, 1984).

The categories of rehearsing and the identification of splits were the least frequently endorsed items. Rehearsing, or role playing situations, is a technique which is used to help the child practice certain skills, or to help her overcome anxiety (Oaklander, 1978). With sexually-abused children, it is important to practice protection skills, assertiveness, and self-care. Often such children are unable to carry out these actions in the outside world. Rehearsing helps give them the confidence to try. The identification of splits refers to the process of alerting the child when she

dissociates, or switches from one persona to another (Jones, 1987). This helps her to identify the occurrences which trigger her defenses, so that they can be explored and worked through in therapy.

Many other strategies were identified in the "other" section. A tally of these is presented in Appendix C.

Age Differences. When the frequency of types of interactions were compared across the three age levels, some trends emerged. One trend was an increase in frequency across age for several categories. For instance, the number of subjects who endorsed focussing rose from 46.94% of those responding to the 4-year-old case simulations to 60.00% of those responding to the 8-year-old case simulations, and to 76.60% of those responding to the 13-year-old case simulations. Similar rises in frequency occurred for the categories of exploring, clarifying, confronting, metaphor, and identifying splits. This age related trend illustrates the increasing use of these kinds of interaction with latency aged children and adolescents compared to preschoolers and demonstrates that the art therapists in this sample are cognizant of the emotional and intellectual differences in maturity over age. Conversely, there was a downward trend in the use of ventilation as age increased indicating that art therapists may consider ventilation to be a less appropriate activity for adolescents. The therapists' responses may indicate that ventilation is a more appropriate strategy

for younger children as they experience but are not capable of understanding their feelings. Adolescents, on the other hand, are more capable of talking about and rationalizing their feelings.

The use of mirroring was markedly less in the responses to the 13-year-old simulations. According to Miller (1984), such a pattern may reflect the differing emotional and developmental needs and capacities of the preschool and latency age children who require greater feedback on who they are in order to get a sense of themselves as separate from others in the world. Older children are more able to rely on their defenses and social patterns. They have a more well-developed physical sense of who they are and what they are feeling and perceive themselves as separate from other people. They have more highly developed cognitive skills and are able to think and respond to the other types of interaction more easily than younger children.

There was also a marked increase in the use of education as a strategy in the responses to the 8-year-old case simulations compared to the 4- and 13-year-old case simulations. Eight-year-olds are just beginning to be involved in the mastery of content in the school system. It would appear that art therapists are taking advantage of this stage of cognitive growth to use education about CSA as another form of easily mastered content. Eight-year-olds have started to read independently and more of the art

therapists who endorsed the education category stated that they would utilize various stories in their sessions with children of this age.

Issue Differences. There were also differences in the frequencies of the number of therapeutic interaction endorsements across issues. Focussing and safe place interactions were reported more frequently for the body image distortion case simulations than for the guilt case simulations. Sixty-eight percent of the respondents to the body image distortion case simulations endorsed focussing as an important type of therapeutic interaction while only 55.13% of the respondents to the guilt case simulations endorsed this type of interaction. Similarly, 80.88% of those responding to the body image distortion case simulations endorsed the safe place category compared to 73.08% of those responding to the guilt case simulations.

One explanation of the greater incidence of focussing and safe place in response to body image distortion may relate to the type of information exhibited in the child's self-portrait (e.g., lack of arms, mermaidlike legs). The art therapist may be choosing to focus on the child's body or self-image by debriefing the self-portrait with the child for the session in order to reestablish a feeling of safety for the child. Second, because the child's self-image is dependent upon her body image, the issue of safety and the need for protection may be foremost in the art therapist's

mind. This explanation is congruent with the responses to the question on goals of the therapeutic session in which the goals for the distorted body image cases were often concerned with self-image, self-esteem, nurturing, and safety,

There were certain types of therapeutic interactions which were endorsed much more frequently by those responding to the guilt case simulations. These included acknowledging, clarifying, exploring, metaphor, ventilation, and education. These findings may reflect the way in which guilt is resolved in the therapeutic process. Guilt is caused by the blame forced on the child by the offender, the child's family, the legal system, and the child herself (Haugaard & Dickon Reppucci, 1988), therefore, it is important for the art therapist to first explore and then acknowledge the child's experience of the abuse from her own viewpoint. The therapist must establish, so there is no doubt in the child's mind, that the child was not responsible in any way for the abuse. She may do this by educating the child about sexual abuse, how it happens, who does it, and how other sexually-abused children feel. In doing so, the therapist needs to place the blame where it belongs, on the offender, and sometimes on family members for not protecting the child. She may then therefore choose to help the child ventilate her anger at the offender. In some cases, where the child is dissociating or in distress, it may be more appropriate for the art therapist to utilize metaphor to work through guilt

issues. This can be accomplished through using art or play media to symbolize her feelings, the offender, and/or the abuse. For example, S34 would ask 4-year-old Amanda to draw about other times when she has felt "bad" in her life. She would then help her to see that this time was different through comparing the past and the present. She also would ask her to draw when she felt "good" in order to reassure her that her disclosure was "good". She said that she would use many directives around what was "good" and "bad" to bring this into a focus, so that Amanda, at her level of comprehension, could understand.

Q.7: Debriefing Process

The purpose of the open-ended question on debriefing was to elicit descriptions of the varying styles of debriefing used by art therapists with respect to the age and issue variables. The data were qualitative and the written responses were analyzed by content analysis. Seven themes which described the main types of therapeutic activities or interactions engaged in by the art therapist to promote closure were identified. These themes are defined in Table 22 and they include engaging, reflecting, extending, supporting and/or nurturing, contextualizing, reframing, and closure. The frequencies or percentages of subjects who included each theme in their debriefing protocol by issue and age are presented in Table 23. The interjudge agreement rate for coding the debriefing data into the thematic categories

Theme Definitions for Q.7: Debriefing

-
1. **ENGAGING:** includes any reference to an approach which promotes A's expression of her process, such as "Tell me a story about..., Explain your drawing..., Tell me about that..., Tell me how this made you feel..., Tell me about the people in your picture...".
 2. **REFLECTING:** includes any references to mirroring or feeding back A's feelings, body position, tension/anxiety, fears, energy release, facial expression, etc. to increase A's awareness of herself and her feelings.
 3. **EXTENDING:** includes any references to drawing out particular themes or feelings with the purpose of educating, supporting, or solidifying A's perceptions. Also used to create a 'breakthrough experience' or catharsis in anger/guilt/grief issues. Is not intended to extend beyond the immediate session but is an initial experience of the locked up feelings in a safe place.
 4. **SUPPORTING, NURTURING:** includes any references to actions that the therapist undertakes to increase A's positive feelings about herself and her artwork such as pointing out the beauty in images and colors, reinforcing how good it feels to have spontaneous feelings, normalizing, accepting and praising A's anger, grief, and rage as well as her positive feelings, and giving her hugs and physical nurturing (snacks, dolls and teddys to cuddle).
 5. **CONTEXTUALIZING:** includes any reference to how the therapist puts what has happened in the present session into perspective as part of a general and larger process. This includes summarizing past sessions before proceeding with painful issues (to emphasize continuity and security), projecting into the future (asking A or suggesting to her how it will be or how she sees it), and educating (teaching A what to expect out in the world as she comes to terms with her feelings and fears.)
 6. **REFRAMING:** any reference to how the therapist makes use of the art/debriefing process to focus on an issue (guilt, blame, self-hate, fear), draw it out, and help A shift from a passive victim stance to an active and responsive child in the world (could involve homework, role playing, practising saying "NO"). Involves the cognitive transition out of victim and being overwhelmed or being shut down by feelings to empowerment and having healthy choices.
 7. **CLOSURE:** any reference as to how the art therapist summarized and helped rebalance A before she left the session.
-

Note. A refers to Amanda.

Percentage of Respondents Listing Particular
Debriefing Themes by Issue and Age (Q.7)

| Debriefing Themes | Issue | Age 4 (<u>n</u> =49) | Age 8 (<u>n</u> =50) | Age 13 (<u>n</u> =47) | Total (<u>N</u> =146) |
|--------------------------|-------|--------------------------|--------------------------|---------------------------|---------------------------|
| Supporting, Nurturing | BID | 70.83 | 76.92 | 72.22 | 73.53 |
| | G | 76.00 | 79.17 | 68.97 | 74.36 |
| | Total | 73.47 | 78.00 | 70.21 | 73.97 |
| Engaging | BID | 37.50 | 61.54 | 61.11 | 52.94 |
| | G | 64.00 | 50.00 | 44.83 | 52.56 |
| | Total | 51.02 | 56.00 | 48.89 | 52.74 |
| Reflecting | BID | 33.33 | 38.46 | 44.44 | 38.24 |
| | G | 52.00 | 54.17 | 37.93 | 47.44 |
| | Total | 42.86 | 46.00 | 40.43 | 42.15 |
| Extending | BID | 45.83 | 34.62 | 38.89 | 39.71 |
| | G | 40.00 | 45.83 | 34.48 | 39.74 |
| | Total | 42.86 | 40.00 | 36.17 | 39.73 |
| Contextualizing | BID | 25.00 | 34.62 | 33.33 | 30.88 |
| | G | 32.00 | 25.00 | 17.24 | 24.36 |
| | Total | 28.57 | 30.00 | 23.40 | 27.40 |
| Closure | BID | 25.00 | 11.54 | 27.78 | 20.59 |
| | G | 48.00 | 20.83 | 6.90 | 24.36 |
| | Total | 36.74 | 16.00 | 14.89 | 22.60 |
| Reframing | BID | 00.00 | 11.54 | 16.67 | 8.82 |
| | G | 4.00 | 16.67 | 13.79 | 11.54 |
| | Total | 2.04 | 14.00 | 14.89 | 10.27 |

Note. The categories in Table 23 are not mutually exclusive.
Some subjects listed more than one category.

BID = Body Image Distortion
G = Guilt

was 87.06%.

The most frequent therapeutic theme identified in the debriefing protocols was supporting and/or nurturing. Seventy-four percent of the sample responded that they would provide support and/or nurturing to Amanda in the debriefing process, regardless of the issue at hand. Support would be offered in the form of praise, acceptance, hugs, snacks, and compliments on her appearance and artwork. Emphasis would be on the child's strengths, and other positive esteem-building interactions. An example of this theme was offered by S135 who responded that the discussion of artwork and or process would probably occur throughout the art production as well as after completion. This would include positive feedback to Amanda concerning her choices or directness, her decisiveness, and her efforts as well as the specific content of her artwork.

The second most frequent therapeutic activity related to the theme of engaging. This category included the various approaches that would be used to promote Amanda's expression of the art process (e.g., "Tell me a story about..."). Fifty-three percent of the subjects endorsed the use of prompts to elicit engagement. S178 replied that she would work to draw out Amanda's feelings in the following way. She would discuss Amanda's feelings about the artwork, the emotions that it brought out in her, and pay special attention to her feelings of safety and betrayal. Changes in

Amanda's feelings toward herself would also be explored by this respondent. S62 would draw Amanda's feelings out by focussing on how she saw herself and felt about herself in the picture, how she felt having made it, and by focussing on the qualities she exhibited during the art process (e.g., the ability to control, to originate, to talk about, to demystify experiences and body parts).

Descriptions of reflecting or mirroring Amanda's feelings, body positions, tension or anxious behavior, fears, facial expressions, and energy levels were endorsed by 42.15% of the sample. The purpose of reflection in debriefing was to draw Amanda's attention to and increase her awareness of herself and her feelings. S10 replied that, in the debriefing process, she would use whatever method she could to reflect back to Amanda whatever she was working on. S84 would begin with a question about the art (e.g., "Tell me about these pictures"; or, more specifically, "What is this girl doing?"). She would reflect back to Amanda by using phrases such as "That child sort of feels like you do, don't they?". She stated that she would use art as a bridge to the child's experience.

The fourth most frequent theme in the debriefing process was the use of extending, a process where the art therapist works to draw out particular themes or feelings with the purpose of educating, supporting, or solidifying the child's perceptions. Extending may be used to create a breakthrough

experience or as a form of catharsis in anger, guilt, and grief issues (Oaklander, 1978). S28 would work to trigger a breakthrough response in Amanda by highlighting what they had done (i.e., water play, sand play, role play, and artwork). For instance, she might restate her observations of Amanda by reflecting that Amanda seemed to get really angry when they pretended not to have any arms. S80 said that she would work to develop, educate, and solidify Amanda's perceptions. She would question Amanda on the differences between her figures (i.e., differences as to size, clothing worn, how the figure was feeling, what they might be doing right, who she is closest/furthest from, and their likes/dislikes/fears). She would also talk about the various parts of the figures, the "best" or "worst" features, and how each figure (i.e., family member) protected him- or herself and felt safe or vulnerable.

S70 would work with Amanda to take her beyond her experience of the sexual abuse. She reported that altering a picture of a painful incident by encouraging a "how it should have been picture" was very healing to sexually-abused children. The creation of such a picture would not change the reality but gave the drawer a sense of power, of being right, of being in control, and of being able to feel that this should not have happened. Then, creating a "This should have happened to me" picture would potentially unlock the child's anger at her mother and others who should have

protected her.

Contextualizing, or helping the child to put what has happened into perspective, was endorsed by 27.40% of the subjects as an integral part of the debriefing process. Contextualizing included summarizing past sessions before proceeding with painful issues (to emphasize continuity and security), projecting into the future by asking the child to tell how it will be, and educating the child by teaching her what to expect out in the world as she comes to terms with her feelings and her fears. S55 stated that he would refer to the positive outcomes of Amanda's efforts (e.g., her self-portrait made it easier to understand what happened; she is not powerless and knows better how to protect herself in the future; people who hurt little children have their own problems; and, perhaps because of her efforts her uncle may get help). He stressed that Amanda had the right to do whatever was best for herself. He would provide examples which she could understand such as "when someone whom you know sets a fire, you must call the fire department to save the building." S126, like many others, stated it would be important to assist Amanda in understanding how the sexual trauma impacted her self-concept and to let her know that she is not alone in this experience.

Twenty-three percent of the subjects described closure as an important function of the debriefing process. Closure included any reference to how the art therapist summarized

and helped rebalance Amanda before she left the session. S131 stated that she would ask Amanda if there were any questions or anything else that she would like to do or say before leaving. Then she would talk about the week to come and seeing her again next week. S16 would allow time for Amanda to return the toys, the puppets, and the art supplies to their customary places because it would give Amanda an experience of consistency and familiarity at the end of the session.

The final theme was reframing. Only 10.27% of the sample employed reframing in their debriefing session. The process of reframing in CSA treatment involved helping the child to shift from a passive victim stance to an active and responsive one in the world. Reframing involved the assignment of homework, experiencing role playing, and practising saying "No!" Reframing is the cognitive transition out of being an overwhelmed, shutdown victim to having healthy choices and flexibility in coping with daily problems in the world (Burgess & Holmstrom, 1979). S68 would ask Amanda what she would like to change about the way she looked in order to help her shift from her current negative view of herself. She also said she would give Amanda homework to assist her in a reality check (e.g., "I want you to approach two friends in the class, initiate a chat, notice how they talk to you, what they say, and whether or not they include you.") She might have Amanda draw a

picture of this experience in the next session to help her learn she is not different to others on the outside. S68 saw this as a first step in Amanda's acceptance of herself, that she is not dirty and "bad". She reflected that, of course, Amanda would never believe this until she felt safe enough to feel her anger, loss, and sadness openly for what had happened.

Age Differences. The reported frequency of the

debriefing themes across age showed little variation (see Table 23). The therapeutic activities that were similar across age included supporting and nurturing, engaging, reflecting, extending, and contextualizing. Each of these occurred with approximately equal frequency across the differing ages and appear to be essential and universal components of the therapeutic process.

The activities of reframing and closure, however, revealed opposing patterns when compared to each other over age. Only 2.04% of the art therapists described reframing as part of the debriefing process in response to the 4-year-old case simulations while 14.00% and 14.89% of the respondents to the 8- and 13-year-old case simulations did. Reframing, as it was defined through the content analysis procedure, involved a cognitive, conceptual transition. It is unlikely that 4-year-olds are capable of such a shift as their experience of the abuse is at a more concrete level (Burgess & Holmstrom, 1974). Conversely, the frequency of closure

activities decreased as age increased. Thirty-seven percent of those responding to the 4-year-old case simulations described closure activities which promoted feelings of security and allayed separation anxiety. Only 16.00% and 14.89% respectively of the respondents to the 8- and 13-year-old case simulations described closure activities as part of their debriefing process. The activities that bring closure for children at an older level were qualitatively different from those offered to the 4-year-old case simulations. They included reassuring the child or adolescent that the therapy sessions would continue the following week and that any pressing issues or projects could be continued at that time, whereas typical activities for 4-year-olds included letting them put the dolls to bed, putting a happy face on the blackboard to greet them for next time, and talking with their mothers at the end of the session.

Issue Differences. When the debriefing themes were compared across the issue variables, many of the response patterns of the therapists were found to be similar. The themes of supporting and/or nurturing, engaging, extending, and reframing occurred with approximately equal frequency in the descriptions of debriefing with both the body image distortion and guilt case simulations (see Table 23). The greatest differences occurred in the debriefing themes related to reflecting and contextualizing across the two issues. Thirty-eight percent of those responding to the body

image distortion case simulations described reflecting as part of their debriefing process while 47.44% of those responding to guilt case simulations utilized reflecting. It appears that a greater number of art therapists included reflecting when they debriefed guilt issues perhaps because guilt is a veneer which hides the child's real but too painful feelings. The process of reflecting may help to increase the child's awareness of her true feelings underlying the guilt. S106 said, in response to Amanda regarding her drawing, that she would say to Amanda that she noticed she had crossed out her mouth and would wonder if Amanda needed to say something. She would also comment that Amanda's self-image was split up the middle under her dress and ask her if she thought she could have felt split in two. She would then identify Amanda's guilt feelings by saying that sometimes kids feel badly when they get mad at grownups.

Thirty-one percent of those responding to the body image distortion described contextualizing interactions in their debriefing process compared to 24.36% of those responding to the guilt case simulations; an opposing pattern to that found in the use of reflecting. The more frequent use of context and perspective with respect to the issue of body image distortion may be related to the therapist's attempts to try and help the child change her negative self-image by focussing on herself in the world or in the future. A number of subjects would have asked Amanda to create "before" and

"after" images of herself in order to help her realize that it was her feelings about the abuse and herself that were the source of her ongoing discomfort and pain, rather than the past physical damage. For instance, S1 said she would try to get Amanda to tell a story about the clay person (i.e., the after the abuse image) and about the person in the drawing (i.e., her original self-portrait). The therapist would then suggest that the two pieces might talk to each other about who they were, what they felt, and what they were like.

Q.8: Use of Art

In this open-ended unstructured question, art therapists were asked why they had chosen to use the art in the specific way described in their previous answers. The purpose was to identify the possible reasons why art aided the therapeutic process and how it did so with respect to the specific variables of age and issue.

Reoccurring themes were identified and frequency tallies of the occurrence of responses in each theme were calculated in the form of percentages. Definitions of the various themes related to the use of art were taken from a similar study by Marrion et al. (1988) and are presented in Table 24. The percentages of occurrence for each theme by age and by issue are contained in Table 25.

The most frequent theme was catharsis or the utilization of art to bring to awareness, express, or ventilate feelings. Forty percent of the sample described using art in this way

Table 24

Theme Definitions for Q.8: Why Would You Choose to Use Art in This Way to Help a Child of Amanda's Age Work Through This Issue?

1. CATHARSIS: includes any references to the use of art to release feelings such as the expression of feelings, connection to feelings, use of media to release feelings, etc.
 2. DEVELOPMENTALLY APPROPRIATE: includes any references to the developmental stage of the child and her natural affinity for drawing and creating such as art is natural, safe, comfortable, and age-appropriate.
 3. COMMUNICATION: includes any references to enhancing or facilitating the child's communication in the session such as helps the child to verbalize, communicate, say without words.
 4. METAPHOR: includes any references to the use of art in developing metaphorical or symbolic intervention.
 5. ALTERNATE COMMUNICATION SYSTEM: includes any references to using the art directly to communicate concrete aspects or feelings about the abuse such as the child does not have the vocabulary.
 6. EMPOWERING: includes any references to using the art to empower the child such as maintains social behavior, increases self-acceptance through mastery.
 7. HEALING: includes any references to using the art to facilitate the healing process such as the body is able to heal through kinaesthetic experiences.
 8. BONDING: includes any references to using the art to enhance the child-therapist relationship such as increases attachment, increases trust in the child-therapist relationship.
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Table 25

Percentage of Respondents Listing Particular Themes for
the Effectiveness of Art by Issue and Age (Q.9)

| Effectiveness Themes | Issue | Age 4 (<u>n</u> =49) | Age 8 (<u>n</u> =50) | Age 13 (<u>n</u> =47) | Total (<u>N</u> =146) |
|--------------------------------|-------|--------------------------|--------------------------|---------------------------|---------------------------|
| Catharsis | BID | 37.50 | 26.92 | 16.67 | 27.94 |
| | G | 28.00 | 29.17 | 86.21 | 50.00 |
| | Total | 32.65 | 28.00 | 59.58 | 39.73 |
| Developmentally Appropriate | BID | 29.17 | 34.62 | 27.78 | 30.88 |
| | G | 68.00 | 45.83 | 20.69 | 43.59 |
| | Total | 48.88 | 40.00 | 23.40 | 37.67 |
| Communication | BID | 41.67 | 53.85 | 33.33 | 44.12 |
| | G | 32.00 | 33.33 | 27.59 | 30.77 |
| | Total | 36.74 | 44.00 | 29.79 | 36.99 |
| Metaphor | BID | 16.67 | 15.39 | 27.77 | 19.12 |
| | G | 00.00 | 8.33 | 37.93 | 16.67 |
| | Total | 8.16 | 12.00 | 34.04 | 17.81 |
| Alternate Communication | BID | 29.17 | 00.00 | 00.00 | 10.29 |
| | G | 24.00 | 33.33 | 00.00 | 20.59 |
| | Total | 44.83 | 16.00 | 00.00 | 14.38 |
| Empowering | BID | 12.50 | 3.85 | 00.00 | 5.88 |
| | G | 12.00 | 00.00 | 00.00 | 3.85 |
| | Total | 12.25 | 2.00 | 00.00 | 4.80 |
| Healing | BID | 25.00 | 00.00 | 00.00 | 8.82 |
| | G | 00.00 | 00.00 | 00.00 | 00.00 |
| | Total | 12.25 | 00.00 | 00.00 | 4.11 |
| Bonding | BID | 00.00 | 00.00 | 00.00 | 00.00 |
| | G | 16.00 | 00.00 | 00.00 | 5.13 |
| | Total | 8.16 | 00.00 | 00.00 | 2.74 |

Note. These categories are not mutually exclusive.
Some subjects listed more than one theme.

BID = Body Image Distortion
G = Guilt

to help Amanda work through her problems. S65 stated that the use of art releases and transforms feelings; S108 stated that art activities allow for expression outward rather than inward. S112 said that the use of art breaks down defense mechanisms, whereas S107 described art as a fluid medium which elicits affective responses. S125 concluded, in agreement with Burgess and Holmstrom (1974), that art provides a way for the child to express her unspeakable guilt, shame, horror, and rage.

Thirty-eight percent used art because it is developmentally appropriate: a safe, natural, comfortable, and age-appropriate mode for both young and older children (Kramer, 1981; Rubin, 1984). S111 referred to art as a non-threatening, revealing tool, both natural and comfortable whereas S106 reported that, to her, art provided distance and protection from intense feelings.

The effectiveness of art as a means to help the child verbalize and communicate to the therapist was mentioned by 36.99% of the respondents. S2 reported that it was less threatening to talk about objects (art), than abuse; S11 reflected that sexually-abused children's verbal skills are dampened by emotional conflict; and S59 found, as did Kramer (1981), that art helps the child to verbalize and communicate by making a bridge or transitional object to verbal communication and discussion by externalizing the event.

The development of metaphorical or symbolic intervention

was the next most frequent theme in the responses to this question. Metaphor aids both the child and the clinician by providing a framework for integrating fragmented feelings, memories, and self-percepts. It is less invasive, permits distance between the self and the trauma, and allows internal working through without visible disclosure of details (Oaklander, 1978; Silvercloud, 1983). S23 stated that children need to use fantasy to order their stresses in real life; S04 claimed that the use of metaphor was less invasive than verbal questions; S71 used symbolism to allow Amanda to portray her feelings; and S115 used metaphor as a symbolic way for Amanda to nurture and protect herself. S152 stated that symbolism was a safe vehicle for the expression of the hidden and unacceptable aspects of the self.

The use of art as an alternative means of communication was endorsed by 17.81% of the art therapists. The following examples illustrate Stember's (1980) and Thomas's (1980) view that often, the sexually-abused child does not have the vocabulary to describe the physical or emotional aspects of the trauma. S21 stated that 4-year-olds do not have the cognitive capacity to intellectualize or verbalize the sexual experience directly, and, S59 suggested that Amanda may not have the vocabulary to describe the complex feelings, relationships, and actions that occurred during the sexual trauma. Similarly, S111 also indicated that she believed that 8-year-olds do not have the verbal capacity to express

or integrate the abuse experience.

Three other categories related to the use of art were endorsed by a small percentage of the sample. Five percent described the art as empowering the child by developing self-acceptance and helping to maintain social behavior. S31 stated that art empowers the child by increasing her sense of mastery by giving her a choice of media and expression. S64 described how through the creation of a puppet, Amanda could accept touching and acceptance through her puppet as an alter ego and begin to accept herself.

Four percent indicated that they felt that art had a healing function, that is young children could begin to heal the trauma through their body via kinaesthetic experience with art expression. S65 replied that the art itself provides a creative, sensory experience which will facilitate the integration of her kinaesthetic, emotional, mental and creative aspects. The art releases feelings and transforms them in the process.

Three percent of the sample emphasized that the use of art enhanced the trust bond between the child and therapist, thereby solidifying the therapeutic relationship and enhancing its potency.

Age differences. Differences in the response patterns

across age for all of the themes were found. As age of the child increased, certain themes decreased in importance. This trend occurred in the following themes: being

developmentally appropriate, providing alternate communication system, empowering, healing, and bonding. It appears that the older child develops a greater experiential and behavioral repertoires (Havighurst, 1972), increases her communication skills and vocabulary (Erikson, 1964), relies more completely on her cognitive powers and ability to reason rather than on her internal physical sensations (Piaget, 1966), at the same time as her need for independence increases (Kohlberg, 1969). The responses given by the art therapists reflect their sensitivity to the young child's developmental limitations. S41's response provides a summary of the art therapist's role in utilizing art to enhance the therapeutic interaction. She chose to use art because she believed that each child has a unique inner process. She felt that if she provided emotional support and safety, the child through her art and play would unravel her feelings in the way that was best for her. She wanted to give Amanda the message that, "You're all right and the way you do things is alright." She believed that sexual abuse affects the child's self-esteem at a very deep level. The message of the abuser is that "you are an object", " you do not count!" She wanted Amanda to gain esteem back by finding out that the way she does things is fine, and she has the power to heal herself. She believed the quality of the human interaction in the session would allow Amanda to heal herself: She would begin to pay attention to herself because she felt really attended

to by me.

The themes of communication, catharsis, and metaphor had differing distributional patterns over age. The response pattern endorsing the communicative functions of the art varied across the ages. There appeared to be a reciprocal relationship between the theme of communication and the theme of alternate communication for the two younger age groups. Thirty-seven percent of those responding to the 4-year-old case simulations, 44.00%, and 29.79% of those responding to the 8- and 13- year-old case simulations said that art was helpful in increasing the child's communication in the session, whereas, the use of art as a form of alternative communication decreased dramatically as age increased (e.g., 44.83% vs. 16.00% vs. 0.00% respectively). Some examples of the qualitative differences in the responses across age may aid in understanding why increased communication occurs as part of the art therapy process. S14 said art was suitable because the work could be done without depending too much on words. A child of 4 does not have the words to describe her perceptions of herself nor an understanding of words to handle this problem with the intellect of words alone. The trauma is a somatic one and most of the healing must happen kinaesthetically through the body. S17 said it was often easier for a child to describe through their art, the specifics of the abuse and the concomitant feelings. A child of 4 could not be expected to

simply disclose verbally. She believed, as did Kelley (1984), that the art became a shared experience, a common factor that child and therapist could both observe and through which the child could speak.

In contrast, S85 discussed the use of art with 8-year-old Amanda and stated this was a concrete way for Amanda to experience her body in a safe, unthreatening way. S64 stated that art offered a language for a child of 8 to express feelings she may not have the words for at first. She could use the tangible objects she created to project her feelings through and possibly could then experiment with touching and acceptance through her puppet as an alter ego. S130 stated that art was beneficial in enhancing communication with 13-year-olds because of their discomfort in verbally addressing issues around sexuality, particularly with adults.

With respect to the theme of catharsis, twice as many of the respondents to the 13-year-old case simulations endorsed catharsis than for the 4-or 8-year-olds case simulations. Over half of the respondents working with older children stated that art had a cathartic effect, particularly with sexually-abused children experiencing a great deal of guilt. Examples which illustrate the qualitative differences in the use of catharsis across age include the following. In response to the 4-year-old case simulations, S39 described the use of art to elicit catharsis on the basis of Amanda's

limitations in her ability to express words and ideas. She reported that Amanda may be able to say "I feel sad, bad, or angry" but a more demonstrable means may be more useful. She suggested that after drawing a picture of her uncle, perhaps Amanda could stomp on it, yell at it, or tear it up. She could also smash a piece of clay representing her uncle. Like Jones (1987), S39 concluded that such activities not only facilitate verbal expression but assist the child in dealing with the part of anger that is action-oriented and physical. S39 suggested that CSA victims often become passive, as indicated in the case description, and an active means of expression would be very important for Amanda to feel she had some control, was entitled to her feelings, and that her feelings are important.

In response to the 8-year-old case simulations, S95 commented that making art allows a child of Amanda's age to express what she is feeling, how she perceives herself in the situation, and what happened to her, without words. Because she may be unable or unwilling to verbalize, encouraging her to create in a non-directive way with 'controlled' materials may allow her to have a sense of being in charge and of having boundaries.

There were several different descriptions of how the art could be used cathartically in the responses to the 13-year-old case simulations. S175 said she found it helpful to empower adolescents to combat their feelings of hopelessness,

helplessness, and lack of power because this allowed them to change a negative way of viewing themselves to a more positive one. It was a concrete way for them to use visualization. The act of creating the molester and then destroying or mutilating him was very cathartic. S157 found that 13-year-olds were usually resistant to putting feelings into words or trying something in real life that might fail so she used art as a practical way to get in touch with Amanda's feelings and to let her try on a new way of being, without the consequences (i.e., clay is mud, formless and forgiving). S170 stated that 13-year-old Amanda was reworking her own identity issues. The artwork she created and her associated feelings indicated that she was severely traumatized by the sexual experience. The artwork provided a way of helping Amanda get distance from her feelings, separate the incident from herself, and become more objective in exploring all aspects of what happened and how she was coping with it. Paints and clay could be used to loosen up primary process material, tap inner strengths, and give form to help express the experiences she may not be able to verbalize. The artwork provided ongoing material for reviewing progress, and charting what S170 referred to as Amanda's "temperature and emotional heartbeat".

The symbolic use of metaphor occurred more frequently as age increased. Only 8.16% of the respondents to the 4-year-old and 12.00% of respondents to the 8-year-old case

simulations described the symbolic use of metaphor compared to 34.04% of the respondents to the 13-year-old case simulations. This age effect may represent the developmental differences in children of differing ages in response to abstract capacity (Levick, 1983). In order to comprehend and utilize metaphor in the therapeutic setting, the art therapist must present metaphors in ways which children can work with them. These qualitative differences are illustrated in the following examples. At the 4-year-old level, S04 stated that with someone that young, direct questioning, especially in such a fragile state, would be invasive. She preferred to use metaphor to give Amanda a sense of autonomy and the ability to help her inner child. S21 described how art for preschoolers provides structure and metaphor through which the child can play out their fears and concerns and project their feelings into the image. She also concluded that 4-year-olds do not yet have the cognitive ability to intellectualize or verbalize experience directly. S46 felt that at 4-years-old, Amanda would most often deal with issues symbolically. Paint would allow her the freedom to develop an abstract image quickly, call it anything she needed to, and just as quickly obliterate it with other colors and/or action with the brush.

The use of metaphor was similar at the 8-year-old level. S117 replied that, in her opinion, children of Amanda's age tended to use play and metaphor to process their traumas.

She felt that the work of the therapist would be concerned more with making interventions and interpretations in their metaphors and less on instructing the children to do something because they have many of their own ideas and it is important to follow the child's lead. According to Naumberg (1966), at this age level, the child is often creating her own metaphors through her own spontaneous art and play. The role of the therapist is to coach her in verbalizing and extending these metaphors while at the same time enhancing her ego strength. At the 13-year-old level, the use of metaphor was more abstract and cognitive and the therapist tried to encourage the child's reliance on her own interpretations of her art. S137 stated that Amanda seemed to have suffered through feelings of powerlessness and lack of control, and as a consequence, her many losses were likely to have become overwhelming. By giving Amanda scissors and the freedom to give female characters a 'voice' to express their 'inside feelings', she could also be giving herself a voice and an opportunity to feel control. S136 replied that, because she was only 13, Amanda was probably still trying to develop a female identity. She suggested the use of clay because it leaves things wide open with no assumptions or standards for what femininity should be for her. She saw the process of molding as a metaphor in which Amanda was literally molding her own female identity.

Issue differences. When the use of art themes were

compared across the issue variables, many of the response frequencies differed. Only the themes of metaphor and empowering appeared equivalent in terms of frequency of response. However, there appears to be an age by issue interaction for the metaphor theme. Metaphor was reported in 16.67% of the responses to the 4-year-old body image distortion case simulations but in none of the responses to the corresponding age guilt case simulations.

The themes that were more frequent in response to the body image distortion issue when compared with guilt were communication and healing. Those themes that were more frequent in response to the guilt issue when compared to body image distortion were alternate communication system, bonding, developmentally appropriate, and catharsis. It is difficult to infer what these findings mean. Perhaps, guilt is a much more complex and longlasting phenomena than is body image distortion, requiring multiple levels of intervention in order to resolve it. Hence, many more types of themes are reported in response to guilt issues compared with body image distortion.

Q.9: Function Of Art

Art therapists were asked to describe the function of art in their approach in order to provide information on how they saw it working in the therapeutic setting. An open-ended format was used in this question in order to elicit a wide range of responses.

Consistent thematic content with respect to the age and issue dimensions was examined in the content analysis where reoccurring themes were identified and frequency tallies of the occurrences of responses in each theme were made. The themes that emerged in this question on the function of art (Q.9) were identical to those described in Q.8, on the use of art. Indeed, many subjects either commented in Q.9 that they had already answered this question above, or, that Q.9 was the same as Q.8. Consequently, the data from Q.9 were considered to duplicate Q.8 and no further analysis is warranted.

Q.10: Evaluation of Effectiveness

The data from the question on the effectiveness of art therapy were generated from a forced choice format. Subjects were instructed to check off one or more of the following four choices: (a) the child's self-report of how she is feeling and how the session went; (b) the assessment of the child's reaction; (c) the use of indicators or markers in the child's artwork; and/or, (d) a change in the psychological status of the child. Additional methods they might use for evaluation were also solicited.

The response categories were not mutually exclusive and the data were analyzed by tabulating the art therapists who endorsed each choice. Proportions were calculated across the age and issue cells to determine if differences were present. The percentage of occurrence for each choice across age and

issue is presented in Table 26.

Ninety-five percent of the art therapists reported that they would evaluate the effectiveness of their treatment session by assessing the child's reaction. Several subjects spontaneously described what to look for in the child's reaction. S23 said it was important to assess the child's ability to release her tensions and let go of some of her fears. She stated that the more Amanda was able to let go emotionally and not bottle up her fears in the session, then the better she would be. S52 included an assessment of Amanda's body posture, voice tone, eye contact, movement, and her responses to the therapist's verbalizations. Both S88 and S68 felt that Amanda's reactions after the session were important to assess. For instance, the session was deemed to be effective if Amanda was more responsive in the next session (S88), and if she was willing to do some homework (S60). S128 evaluated Amanda's capacity to stay in process, maintain focus, accept challenges, and discharge feelings.

The next most frequently endorsed category was evidence of a change in the psychological status of the child over the session. Sixty-three percent of the art therapists endorsed this method of evaluating the effectiveness of their treatment. S46 determined the session was effective if Amanda developed self-control and expressed anger and negative feelings appropriately. S87 looked for a decrease in bedwetting, an increase in the number of positive

Table 26. Percentage of respondents endorsing particular types of evaluation by issue and age (Q.10)

| Type of Evaluation | Issue | Age 4 (n = 49) | Age 8 (n = 50) | Age 13 (n = 47) | Total (N=146) |
|--------------------------------------|-------|-------------------|-------------------|--------------------|------------------|
| Assessment of child's reaction | BID | 83.33 | 100.00 | 100.00 | 94.12 |
| | G | 100.00 | 100.00 | 86.21 | 94.87 |
| | Total | 91.84 | 100.00 | 91.49 | 94.52 |
| Change in psychological status | BID | 66.67 | 80.77 | 77.78 | 75.00 |
| | G | 64.00 | 70.83 | 62.07 | 65.39 |
| | Total | 65.31 | 76.00 | 78.09 | 63.15 |
| Child's self- report | BID | 45.83 | 76.92 | 55.56 | 60.29 |
| | G | 52.00 | 50.00 | 68.97 | 57.69 |
| | Total | 48.76 | 64.00 | 63.83 | 58.90 |
| Use of art markers | BID | 41.67 | 50.00 | 38.89 | 44.12 |
| | G | 44.00 | 25.00 | 55.17 | 42.31 |
| | Total | 42.86 | 38.00 | 48.94 | 43.15 |
| Check with significant others | BID | 12.50 | 3.85 | 5.56 | 7.35 |
| | G | 24.00 | 8.33 | 6.90 | 12.82 |
| | Total | 18.37 | 6.00 | 6.38 | 10.27 |
| Counter- transference | BID | 8.33 | 00.00 | 00.00 | 2.94 |
| | G | 00.00 | 8.33 | 00.00 | 2.56 |
| | Total | 4.08 | 4.00 | 00.00 | 2.74 |
| Other | BID | 12.50 | 00.00 | 00.00 | 4.41 |
| | G | 8.00 | 00.00 | 00.00 | 2.56 |
| | Total | 10.20 | 00.00 | 00.00 | 3.43 |

N.B. The categories in Table 26 are not mutually exclusive.
Some subjects endorsed more than one category.

BID = Body Image Distortion
G = Guilt

statements Amanda made about herself, and a decrease in the number of negative self-statements. S161 felt a good indicator of effectiveness was evidence of Amanda's ability to move on psychologically by responding to what was produced or to what was said.

Child's self report was chosen as a means of evaluating the treatment session by 58.90% of the respondents. S93 used a report of the child's behavior, at home and at school, to ascertain how the treatment session affected Amanda. S175 counted primarily on what the child told her because she believed that Amanda really had all the answers and that her job was just to help Amanda uncover or discover her own answers for her own survival.

Art markers, or indicators in the art (Stember, 1980) of the child's psychological status (e.g., exaggerated genitalia) were used by 43.15% for evaluation. For example, S136 looked at any changes made in the actual art piece during the session, or at changes in the follow-up piece. S170 evaluated the session by also viewing the artwork and listening to Amanda's associations, comparing work done at the beginning of the session with work done at the close of the session.

Several other evaluative methods were described by the subjects. These included checking with significant others (e.g., parents, teachers, daycare staff) about the child's reaction to the session, and relying on countertransference

feelings to judge how the session affected the child. Ten percent of the sample said they would rely on information from significant others. For example, S39 would get reports from Amanda's parent(s), her daycare staff (if applicable), and her teacher over the course of the week between sessions as well as anyone else who was likely to be around and observe her behavior and emotional state.

Three percent also relied on their countertransference reactions to the session in evaluating its effectiveness. For example, S106 stated that she relied on her personal affect at the end of the session (e.g., feeling stuck, angry, comfortable, contaminated or icky) as part of her evaluative method.

Ten percent stated that they would not be able to evaluate the effectiveness of the treatment approach in only one session. S10, along with several others, replied that they could not make an evaluation of one session because, in their opinion, working through the trauma of sexual abuse was a longterm process which took time to evaluate.

Age Differences. There were several age differences in the response patterns. While all art therapists relied on assessing the child's reaction as their primary method of evaluation, those responding to the 4-year-old case simulations were less likely to use child self-report and more likely to check with significant others to verify that the session was effective compared to the 8- and 13-year

olds. There was a pattern of increasing reliance on the child's self-report accompanied by less checking with others in the responses to the older children. However, the frequency with which respondents utilized art markers as indicators of effectiveness did not differ greatly across age. These differences are likely to be related to the developmental capacity of the children involved. Younger children may not be able to communicate to the therapists at a level which answers all their concerns. The art therapists apparently needed to utilize many sources of information to evaluate their sessions but also relied on additional, outside objective information with younger children.

Issue Differences. There was only one type of -----
evaluation method that differed across issue. Change in psychological status was relied on slightly more frequently by those responding to the body image distortion case simulations, possibly because these types of changes are more readily visible in the child's artwork. The remainder of the evaluative types were utilized equally across issues.

Summary

The study examined how registered and/or diplomaed art therapists with training in CSA treated sexually-abused children age 4, 8, and 13 with either the issue of body image distortion or guilt, by utilizing a case simulation method. Information on the various facets of the therapy session (i.e., treatment approaches, therapeutic goals,

directives, media, time use, debriefing, use of art, and method of evaluating the effectiveness of the session) was presented. Differences were identified across age (in percentages) and by issue, to a lesser extent. The findings support the premise that there are developmental differences in sexually-abused children's reactions and treatment needs and they reflect the art therapists' responsiveness to such children's developmental differences in cognitive capacity, emotional maturity, and motor ability.

CHAPTER 5

SYNTHESIS OF THE ART THERAPY TREATMENT PROCESS

The previous question-by-question analysis of the case-simulation survey responses focussed on the key themes of the art therapist's treatment approaches, goals, directives, interactions, debriefing patterns, opinions on the function of art, and ways of evaluating art therapy in treating sexually-abused children of different ages and psychological sequelae. While it is important to identify those themes in terms of their relative frequency with respect to treatment, age, and issue variables, this type of analysis is a rather crude and reductionistic representation of what actually occurs in the therapeutic process.

The previous analysis may help to alert the reader to the types of activities that art therapists most frequently report using and, in this way, provide a stimulating array of choices and new ways of thinking about the therapeutic process. It may, however, mislead one to interpret this as a blueprint model for art therapy with sexually-abused children. The function of therapy is to help individual children with their specific issues and conflicts -- to let the child lead, with leading from the therapist coming out of following the child in her process (S60). Such a perspective is not always evident in the preceding analysis. The purpose of this chapter is to

counterbalance these interpretations by providing a synthesis or integrated picture of two individual art therapists' treatment approaches.

This chapter is presented as a response both to the many subjects from this sample who expressed an interest in knowing how other art therapists were treating CSA and to Long (1986), who stated that therapists "want to see what other clinicians are doing with young victims of sexual abuse, how they are doing it, and what their thoughts and reactions are in this work". (p. 220) The chapter is divided into the following sections: (a) Selection Process; (b) S18: Response to 4-Year-Old Body Image Distortion Case Simulation; (c) S170: Response to 13-Year-Old Guilt Case Simulation; and, (d) Summary.

Selection Process

Two complete surveys, from contrasting age and issue cells, were selected for presentation in full. In order both to provide contrast between the two approaches and to illustrate the age and issue differences reported in the previous analysis, one example was selected from the youngest and one from the oldest case simulations. As 4-year-olds were reported to have a more difficult time adjusting to the physical violation and resultant body image distortion and 13-year-olds appeared to have a more difficult time resolving their guilt issues, one example was selected from each of these samples.

The process of final selection involved the following steps. First, the surveys for the 4-year-old body image distortion and the 13-year-old guilt case simulations were separated from the others. Second, of these, all subjects who had treated CSA for a minimum of 5 years were selected as possible choices. Third, these examples were read for content and cohesiveness by the researcher, and three were selected from each cell as possible choices. Fourth, they were subsequently ranked in order of preference according to the clinical viability of the approach, readability, and the density of detail in the description of the process. Fifth, they were read and ranked independently by a local art therapist, who had extensive experience in treating CSA, and by the research assistant. Finally, consensus between the researcher, the research assistant, and the art therapist was obtained for the final choices. Verbal permission from those subjects was obtained to present their responses in total.

S18: Response to 4-Year-Old Body Image Distortion Case

Simulation

S18 is 33 years old. She has worked with sexually-abused children for 7 years, treats children ages 4 - 18, and sees an average of 15 children per week. Her training includes a diploma and graduate degree in art therapy, registration as an art therapist, professional workshops in the treatment of CSA, and leadership of workshops of this type herself.

In her response to the case simulation describing 4-year-old Amanda with a distorted body image (see Case Simulation A, Appendix A), she reported that she would use a mixture of directive/structured and nondirective/spontaneous approaches when working with Amanda.

Her goals for the session reflected the themes of nurturing, body image, and empowerment:

I feel a need to respond to this child's need for nurturing and human contact. Her distorted body image and regression into a fetal position suggest a need to allow the transference of a symbiotic and protective relationship with me. She needs to feel a sense of security in the environment before she can begin to deal with her distorted self image.

S18 would use both play therapy and drawing media as well as providing Amanda with a baby doll and bottle, art markers, and paper.

Her directives reflected the themes of self-image, safe place, support/nurturing, and empowering. They were given as follows:

I would begin this session by giving Amanda a life-like baby doll I have in my office and asking her if she would like to feed the doll. I would offer my lap as a place where she could sit. As Amanda fed the doll and started to relax herself, I would begin to softly rock Amanda in the same way. I may teach her how to correctly hold and even burp the baby. We may do this the entire session. I would focus verbally on Amanda's perceptions of what the baby needs. I may ask how often we should rock a baby and what the baby likes to eat. I may ask if anyone even took care of her like that when she was a baby. I will praise her ability to care for her baby. I will comment on how safe and secure her baby must feel when she holds it. If Amanda would begin to get restless, I may then offer magic markers and paper and ask her to draw a picture of herself and her baby doll.

S18 would have organized the session into the following time frames: Five minutes would be spent on greeting and getting comfortable with the session, 20 to 25 minutes would be spent working with the baby doll, followed by 10 to 15 minutes of drawing time. She would have concluded the session in the last 5 minutes.

She would have used the following type of therapeutic interaction in working with Amanda: mirroring, metaphor, transference, and safe place. Her debriefing process reflected the themes of support/nurturing, engaging, reflecting, extending, and closure. She described the debriefing process as follows:

In the session I have described, the debriefing actually occurs in the artwork. The processing of nurturing, feeling safe, feeling secure were all experienced with the baby doll. The artwork is used as the means of solidifying and taking ownership of the feelings of strength she may have experienced through the nurturing/nurturer process.

S18 chose to use art in this way to help a child of Amanda's age work through body image distortion because she felt "that art was more effective than verbal therapy for a child of this age -- she simply does not have the verbal skills". The themes of providing opportunity for communication and providing developmentally appropriate activities were evident in her response.

She would evaluate the effectiveness of her session by using art markers and by looking at the change in psychological status of Amanda over the session.

S170: Response to 13-year-old Guilt Case simulation

S170 lists herself as being over 50 years of age. She works two days a week with sexually-abused children of all ages. At the time of answering this survey, these days were devoted to working with 5- to 13-year-old children in a children's residential treatment center. She has been working with sexually-abused children for the past 11 years and now sees, on average, 10 to 15 children per week. Her training includes a Masters degree in psychology, seminars, a graduate degree in art therapy, registration as an art therapist, certification as a medical psychotherapist, certification as a mental health counselor, and certification as a behavioural therapist. She has completed professional workshops and graduate level training in CSA. Her training included an internship in CSA treatment.

S170 said she would use a mixture of directive and nondirective approaches in the session with 13-year-old Amanda who was experiencing guilt (see Case Simulation F, Appendix A). Her treatment goals were as follows:

- 1) Verbally validate hearing Amanda's sense of loss. At the same time provide myself as a friend, and sounding board to help her clarify, objectify, and resolve troubling issues of guilt, anger and mistrust and begin to...
- 2) Help Amanda to utilize art therapy activities to engage her in creative self-expression, comfortably interact with another person, talk about her feelings, and increase her coping ability by helping her to put the sexual abuse into perspective and lessen feelings of guilt. Reassure Amanda that she is believed and that what happened to her is not her fault. Tell her that she was right in reporting the

incident and explain that by doing so, she has taken steps to prevent her uncle, the adult, from continuing inappropriate behavior that endangers the wellbeing of children. When beyond volition spontaneous symbolism externalizes the emotionally charged gut issues, help Amanda stay focussed on the content for safe distancing.

- 3) Offer Amanda opportunities to experience success and gain a more realistic, less threatening view of her world. Nurture strengths and help Amanda to recognize self-defeating behavior, and gain more of a sense of control over her life and what happens in the future.
- 4) Help stabilize her relationship with her mother.

S170's goals reflected the themes of identifying feelings, building self-esteem, lessening guilt, increasing empowerment, and nurturing.

She would have offered Amanda a limited choice of media:

I would offer paints and clay, taking my cues from Amanda, so that she would not feel imposed upon by my being overly directive. I would encourage Amanda to look at and describe the drawing she previously created and perhaps, have her stand in that position and talk about body position and arms. I might mirror the position and ask her to tell me what it looks like I'm doing and feeling. Painting and clay work would help her to loosen up gut feelings and perhaps enable her to get distancing to sort out and talk about misdirected anger and guilt feelings.

The directives used by S170 reflected the process themes of catharsis, empowering, support and nurturing, and art-enhanced communication. Product themes included the representation of feelings and offender images. Her directives were:

Open-ended questions about her earlier artwork. I would explore what "rape" means to Amanda, validate her feelings, reassure Amanda that she is a good person, what happened to her is not her fault and she's not to

blame...confirm that an adult did not conduct himself as an adult should with a child, and reassure her that she is not permanently damaged, mother doesn't blame her, loves her, and is taking steps to make certain she and her little sister will be safe and not at risk for anything like this to ever happen again. I would explore how Amanda would handle the situation if she were the parent, and ask her what she would like to see happen to the perpetrator. I would acknowledge justification for her anger, I'd ask about the child's experiences and relationships with the mother's commonlaw boyfriends, and wonder aloud if Amanda has any concerns about either her little sister's or her own safety. I would ask how she feels about her uncle, being careful not to assume the child only has negative feelings about what has happened. Again, I would move at a pace right for the child and not move more quickly than she is ready to. She is in most need of validation that she is a good person, believed, and not permanently damaged.

S170 did not list the time lengths for each part of the session but instead described the atmosphere she would set up in the sequence as it would occur:

The session would be fairly informal. I would lower my chair as much as possible or sit down on the floor with the child after the initial greeting. Then I would ask her to put her drawing up on the wall so that we/she can tell me a little about it. (I wouldn't be surprised if the drawing unconsciously represents the uncle and mixed feelings she has about him and what happened). Paint and clay supplies would be offered to help the child loosen up and explore gut feelings. While she paints or works with the clay I would chat with her and explore issues if she seemed open to doing this. Time would be set aside for looking at the artwork from a distance, objectively talking about the symbolic content, and addressing underlying needs as they come up. I would find time to briefly review the session, validating that I had listened to everything she said, understand her feelings, and like her. We might or might not have a snack. I would ask her if there were any special supplies she might like to work with during our next session, and I would ask if there was anything she wanted to talk about before we ended the session, and if she was feeling any better.

The types of therapeutic interactions endorsed by S170

included empathic listening, education, focussing, exploring, clarifying, acknowledging feelings, mirroring, metaphor, grounding, and safe place. The themes presented in S170's debriefing process reflected engaging, support and nurturing, reflecting, and reframing. She described the debriefing process as follows:

In addition to putting the artwork up and talking about it, I always have clients use their left over paints and clay-wiped paper towels for projective imagery exploration and relating the symbolic content to one's life via free association. A wealth of material often comes up unexpectedly and it is a good way to use the left over supplies. I encourage blot paintings, outlining shapes which the clay has made on the paper towels, and trying to develop the shapes into animals, masks, people, or things to take the work further. Stories or poetry may be incorporated... depending on the child's receptivity to doing so.

S170 said she chose to use art in this way for the following reasons:

The youngster is reworking her own identity issues. The artwork she created and her associated feelings indicate that she is severely traumatized by the sexual experience. The artwork provides a way of helping Amanda get distancing on her feelings, separate the incident from herself, and become more objective in exploring all aspects of what happened and how she is coping with it. Paints and clay can be used to loosen up primary process material, tap inner strengths, and give form to help express experiences she may not be able to verbalize. The artwork provides on-going material for reviewing progress, and taking what I refer to as charting one's temperature and emotional heartbeat.

Her responses concerning the reasons for choosing to use art in this way reflect the themes of catharsis, symbolism/metaphor, and communication.

She described the function of art in the session as

follows:

Helping the youngster free up, get distance, and talk about issues that are traumatizing her. The youngster is in charge of how much or how little she wishes to share both in producing the artwork and in discussing the end results. Forbidden wishes, scary feelings, and impulses can be symbolically expressed, and discharged within a safe environment. The main purpose of the art is therapeutic, i.e., to relieve this child's emotional suffering and help her increase her coping ability.

S170 would have evaluated the effectiveness of her session by using self-report, by assessing the Amanda's reactions, by observing the change in psychological status of Amanda over the session, and by viewing the artwork and listening to Amanda's associations. She would also have compared work done at the beginning of the session with work done at the close of the session.

Summary

These survey responses illustrate the contrast between treatment approaches for the different age and issue variables and are in accord with the previous results from the content analysis. S18's goals of providing a nurturing, safe, secure environment through physical contact such as hugging and rocking exemplify the treatment approach most frequently reported by other art therapists in response to the 4-year-old body image distortion case simulation.

S170's treatment approach and goals also exemplified the approach most frequently reported by the other art therapists who responded to the 13-year-old guilt case simulation. She focussed on the identification of feelings,

empowerment, building self-esteem, and education in order to help Amanda work through her guilt feelings. She provided media with cathartic characteristics such as clay and paint and supported Amanda both in working metaphorically with the images she created and in making her own sense out of her process.

The presentation and contrasting of the two subjects' completed surveys illustrates the art therapy process more fluidly than the simple counting and reporting of the thematic content over the sample. The flow of the approaches is easier to follow than a question-by-question analysis of group answers and hints at the flexibility and grace of the constantly changing real life art therapy session. These illustrations also demonstrate how these subjects responded differentially with respect to the cognitive, emotional, and physical levels of the child in addressing her issue.

CHAPTER 6

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to provide clinicians who treat CSA with a descriptive account of the methods currently in use by art therapists to treat sexually-abused children. In order to elicit clinical information which could be applied to a wide number of clients, case simulations were developed which described sexually-abused girls ages 4, 8, and 13 who were working through the issue of body image distortion or guilt. Both quantitative and qualitative data were obtained, based on the responses of the sample to the six case-simulations. The case simulations consisted of a photograph of the child, a self-portrait, and a case history. Respondents answered an open-ended survey which elicited information on the structure and process-oriented aspects of their therapeutic approach. The art therapists provided demographic information concerning their education, training, and experience in CSA treatment and art therapy.

A comprehensive description of the methods used by 146 experienced and certified and/or diplomaed art therapists in treating sexually-abused children was obtained. Research questions on their therapeutic approaches, their therapeutic goals, their use of media, their use of directives, their use of time, their use of therapeutic interactions, their use of debriefing, their understanding of the function of art, and

their methods of evaluating the effectiveness of their sessions were analysed qualitatively and quantitatively. Age and issue differences were identified and described. The analyses provided a framework for examining the CSA treatment process, and resulted in a clinically based description of the art therapy process.

Several important findings were identified in the analyses of the research questions. A summary of these findings, their relation to the CSA and art therapy literature, and some general conclusions concerning the use of art therapy in treating CSA are presented in the following chapter. The limitations of this study are also presented along with suggestions for future research directions.

The findings of this survey are summarized as follows. The majority of the sample reported that they would use a flexible mixture of both directive/structured and nondirective/spontaneous treatment approaches. The aim of the art therapists was to strike a balance between being both directive and nondirective in response to the child's needs at any given time, regardless of their age or the issue. This finding was congruent with the treatment approaches of other modes of therapy for children such as play therapy (Axline, 1979) or dance therapy (Johnson, 1987).

Art therapists reported that they would have several treatment goals in mind when planning the session ($X= 3.27$, $SD=1.77$). There were six themes in the therapeutic goals

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described by the art therapists with respect to treating the issues of body image distortion and guilt. These were promoting identification and awareness of feelings, nurturing, empowering, lessening guilt, building self-esteem, and improving body image. These goals were similar to those described by Carozza and Hiersteiner (1983), Jones (1987), and Stember (1980). The primary goal appeared to be directly related to the specific treatment issues at hand: body image distortion or guilt. The other goals appeared to be related to the child's psychological reaction and the way in which this was expressed behaviorally (i.e., bedwetting, ritualistic washing) and according to the developmental stage the child was in. Thus, the therapists were responsive not only to the treatment issue but also to the individual child and her capacity for engaging in therapy.

The kinds of therapeutic goals differed by age and by issue. Physical nurturing, empowering, and self-esteem were more frequent for the 4-year-olds while goals relating to the identification and awareness of feelings were more frequent for the older children. Goals relating to the identification and awareness of feelings and empowering were more frequent in response to the guilt case simulation.

The use of media in art therapy with sexually-abused children has not been explored in any depth in previous studies. Rubin (1984) describes the characteristics of particular media and the capacities of children of different

ages with respect to working with the media, however, she did not relate these ideas to treatment of sexual abuse. The present research details the media, the activities, and the rank order of the activities by age and by issue.

Various activities and media were described by the art therapists. These activities, in rank order across ages, included drawing, modeling, painting, collage, play therapy, and puppetry. The percentage of therapists using play therapy, puppetry, painting, and modeling was comparatively greater in the responses to the 4-year-old case simulations than in the case simulations of the older children. The more frequently suggested media, in rank order across age, included felt markers, clay, paints, collage materials, craypas, oil pastel, crayons, and colored pencils. Those responding to the guilt case simulations described the use of cathartic media such as clay and paint almost twice as frequently as those responding to the body image distortion case simulations.

The art therapists reported that they would use two types of directives. These included either product-related directives in which respondents asked the child to create self-images, feelings, safe places, or offender images; and, process-related directives which described the nature of the therapist-child relationship such as the cathartic use of media, providing support and nurturing, empowering, and art enhanced communication. Directives concerned with providing

support and/or nurturing and empowering were most frequent in response to the 4-year-old case simulations; directives concerned with self-image, the cathartic use of media, and art enhanced communication were most frequent in response to the 8-year-old case simulations; and directives which were concerned with the expression of feelings were most frequent in response to the 13-year-old case simulations. Self-images, support and/or nurturing, and art enhanced communication were most frequent in response to the body image distortion issue while catharsis, feelings, and offender images were most frequent in response to the guilt issue. The use of product-related directives has been reported by Carozza and Hiersteiner (1983), Goodwin (1982), and McMillen Hall (1978). Process-related directives, however, have not been previously described. The description of this component of the art therapy process is of great importance because such description not only provides other clinicians who work with CSA with a framework for understanding the process, it also focusses attention on the process or transformative aspect of the art therapy process for the child. Levick (1983) and Naumberg (1966) stated that art expression allows the child to express her inner unconscious conflicts. Art therapists provide action-oriented transformative experiences for traumatized children by focussing on their process by utilizing directives which facilitate particular types of responses or shifts in the

child's thinking, feeling, and awareness around specific issues.

The art therapists' session lengths ranged from 45 to 90 minutes. Although the average time length was 57 minutes, there was a minor trend of increased session length over age. The session time was divided into a greeting period, a play period, artwork, discussion, snack time, debriefing, warning of ending, and a period of closure or ending. The responses to the 4-year-old case simulations indicated that art therapists used slightly shorter work periods with this age group, employed more comfort-oriented activities, and used art activity as therapy. The responses to the older case simulations indicated that art therapists utilized art as psychotherapy and spent more time on art-related activities with greater emphasis on discussion and debriefing. These differences in the structuring and use of time illustrate that the art therapists are responsive to the emotional, cognitive, and physical developmental levels of the child.

The majority of art therapists replied that they would use such therapeutic interactions as empathetic listening, clarifying, exploring, safe place, metaphor, and focussing in treating CSA. These types of therapeutic interactions are not specific to art therapy and illustrate that art therapists rely on the same kinds of strategies as other therapists (e.g., play therapists, drama therapists). Increases in the use of focussing, exploring, acknowledging,

confronting, metaphor, and the identification of splits occurred as age level increased. Conversely, the use of mirroring decreased as age increased reflecting the art therapists' responsiveness to the changing developmental needs of the child. Focussing and safe place were more frequently endorsed in response to the issue of body image distortion. Acknowledging, exploring, metaphor, ventilation, and education were more frequently endorsed in response to the guilt issue.

Seven types of therapeutic activities were identified in the debriefing process used by art therapists to treat CSA. The activities, in rank order across age groups, are as follows: supporting and nurturing, engaging, reflecting, extending, contextualizing, closure, and reframing. Reframing was used most frequently in response to the two older case simulations while closure was used most frequently in response to the 4-year-old case simulation. The rank order of responses to each issue differed with reflecting occurring more frequently in the responses to the guilt issue where its purpose was to effect catharsis; contextualizing occurred more frequently in response to the body image distortion issue where its function was to improve the child's negative self-concept through reality or future based exercises. The majority of the debriefing activities appeared to be employed universally across age and issue. Although the debriefing process was often shorter and less

complex in response to the 4-year-olds, very similar types of activities and support occurred.

These are important findings as they support the theory that CSA therapy is built around similar core processes regardless of age or presenting issue. This aspect has not been formally described in other art therapy or CSA treatment investigations.

The art therapists' responses to the question on the function of art contained eight themes. These themes were identical to those reported by Marrion, Landell, and Bradley (1988), thus replicating their findings. These included, in rank order across age groups, catharsis, being developmentally appropriate, enhancing communication, providing an alternate communication system, empowering, healing, and bonding. There was a decrease in the frequency of being developmentally appropriate, providing an alternate communication system, healing, empowering, and bonding as age increased. Conversely, the themes of metaphor, catharsis, and enhancing communication increased in frequency over age. The themes of enhancing communication and healing were more frequent in response to the body image distortion issue while the themes of catharsis, being developmentally appropriate, providing alternate communication system, and bonding were more frequent in response to the guilt issue.

Art therapists would have evaluated the effectiveness of their sessions in numerous ways. Many endorsed several of

the available categories as well as contributing other methods. The most frequently endorsed methods, in rank order across age groups, were the assessment of the child's reaction, the change in the child's psychological status, the child's self-report, the use of art markers, checking with significant others, and relying on one's own countertransference reactions. Those who responded to the 4-year-old case simulations were less likely to have chosen the child self-report method and were inclined to seek information from significant others in the child's life to confirm their assessment. Apparently, art therapists utilize the same multiple clinical sources of information as do other traditional therapists, however, they also have both the art product and process information to guide their approach as well.

These results would not have been as specific or comprehensive if a different method of inquiry had been selected. The case simulation method of inquiry was chosen to investigate how art therapists treated sexually-abused children of different ages with different issues for the following reasons. First, this unique method provided the researcher with the opportunity to manipulate the variables of the child's age, issue, history, and abuse characteristics. According to Finkelhor (1984), such control within the design results in more reliable and specific findings and treatment recommendations. Second, the survey

instrument design allowed the researcher to quickly and economically obtain a wide sampling of art therapists' approaches to the treatment of CSA. It was relatively short, visually attractive, and guaranteed anonymity of both the subjects and the children depicted in the case simulations. The latter two reasons were of utmost importance. Anonymity of the subjects was necessary because, as Wilk and McCarthy (1986) reported, wary subjects will not participate in controversial research which addresses the taboo subjects of our society. This method also protected the anonymity of sexually-abused children because the case simulation involved hypothetical information only. This aspect of the instrument increased the response rate because, as many subjects commented, they would not break their professional code of ethics of confidentiality and participate if a bonafide sexually-abused child had been portrayed. Third, this study provides an indepth clinically-based description of how art therapists treat the two key issues of body image distortion and guilt in sexually-abused children ages 4, 8, and 13.

There are no descriptions of therapy sessions for specific issues in the literature. The goals, directives, media, time use, type of therapeutic interaction, debriefing process, function of art, and methods of evaluation for each issue were described. As the issue variables were manipulated while the other case factors remained constant, the data for each issue condition was free from the confounds

which occur in anecdotal clinical case studies or post hoc group treatment summaries.

As the age variables could also be held constant, these data were also free of the confounds found in mixed-age groupings. Therefore, the findings and recommendations of this study are specific to particular ages and issues.

Age differences were found in the response patterns to all questions. These findings indicate that art therapists must be sensitive in their treatment practices to the physical, emotional, and cognitive development of sexually-abused children. These findings provide clinicians with practical choices with respect to choosing goals, giving directives, choosing media, selecting the kinds of therapeutic interactions that might be most effective, structuring their time, conducting the debriefing process, and evaluating the session.

Specifically, according to this sample, preschool children need more physical contact and comfort such as hugging, being held, rocking, snack, and shorter work sessions. The media should be familiar and simple (i.e., toys, crayons, primary colored paints, felt pens). They need to work on their issues kinaesthetically by physically manipulating the media, by using art-as-therapy, and by expressing their conflicts metaphorically rather than through direct confrontation. The therapist must work to establish feelings in the child of being supported, nurtured, safe,

protected, and accepted. The debriefing process is often informal and involves reflecting and mirroring the child's process rather than reasoning, or making sense out of her experiences. The art itself is a developmentally appropriate and familiar activity that may be used as an alternate means of communication to obtain detailed information about the child's experiences, her family, the abuse, and the offender. The evaluation of the child's progress and reactions should include checking with the significant others in the child's life, as well as monitoring her psychological status during the session.

The findings on the latency aged child suggest that she should be encouraged to focus on the identification and awareness of her feelings about the abuse. Self-esteem and empowerment are also essential aspects which need special attention in the therapy process. The latency age child needs to be recognized with a personalized greeting before beginning the session. Drawing with felt pens, modeling with clay, and painting with poster paints are recommended as activities. Appropriate images for this age group to create include self-portraits; representations of their feelings about the abuse, themselves, the offender, and their family members; and images of the offender. The art is used to enhance communication and to help the child externalize her feelings. The process-related directives should be aimed at providing a supportive and nurturing experience for the

child. Cathartic activities can also be encouraged as a way of externalizing anger, guilt, and loss. The debriefing process should be characterized by a supportive, nurturing approach which focusses on facilitating the child to tell about her artwork and to translate and to share with the therapist what she has created in her images. The art is a developmentally appropriate activity which can be used to enhance communication with the goal of sharing painful feelings with the therapist. The child's self-report is valuable in assessing the session as is the observed change in her psychological status and reactions.

The therapist needs to work with the young adolescent to help her identify and become aware of the feelings associated with the abuse, to understand her innocence in the abuse, to empower her to overcome her victimization, and to learn to care for and nurture herself.

Greeting time, discussion time, and debriefing time are all important aspects of the session for adolescents. They need time to be recognized and received, to discuss their feelings and lives, and to utilize their thinking skills and problem solving abilities in making sense out of the abusive experience. Adolescents appear to be most comfortable with drawing or modeling activities. According to the present findings, they like to use felt markers, oil pastels, clay, paint, and collage materials. Product-related directives should include abstract activities such as drawing their

feelings about the abuse, and creating self-images as ways of coming to terms with their identities as females. Process-related directives should include supportive, nurturing experiences, cathartic experiences, and empowering experiences. The art can be used as an effective means of catharsis, as metaphor for illustrating the effects of the abuse on their lives, and for enhancing communication and sharing.

Therapists can rely primarily on their assessment of the adolescent's reaction to the session and to their change in psychological status as a means of evaluating the session. However, self-report and the examination of changes in the adolescent's artwork are also good indicators of how the session went.

These findings do not provide a prescription but instead aid clinicians to devise unique and alternate ways of working with sexually-abused children of different ages with different issues. The results of this study illustrate that treatment for sexually-abused children is developmentally bound; that is, children of different ages have different needs in the therapy situation. It is therefore recommended that art therapists working with sexually-abused children have substantial training in both child development and in CSA treatment. Training which ensures a good foundation in child psychology and CSA should be included in the course requirements of the various art

therapy programs across Canada and the United States.

Issue differences were also found in the response patterns across several questions. The goal to be focussed on for the issue of body image distortion is assessing the child's body image and its relation to her self-esteem. Both drawing (e.g., in the form of body tracings) or clay work (e.g., in the form of modeling a self-image) address this goal. The artwork can then be used to enhance the child's ability to communicate and share about her body and her feelings since the abuse. Adequate debriefing time should be set aside for this process. The therapist may employ such therapeutic strategies as focussing on parts of the self-image that indicate either strengths or deficits and then asking the child to clarify, using words, what different parts of the image mean, or make the child feel.

The goals to be worked on when guilt is an issue include identifying the child's feelings and increasing her awareness of them, empowering her, building her self-esteem, and helping her to acknowledge her innocence. Modeling or painting media are useful as cathartic agents in releasing the child's feelings of guilt, anger, and loss. Such directives as creating the feelings around the abuse, portraying how the child feels about herself before and after, or creating an image of the offender may help to release these strong feelings. It is important for the therapist, when working with guilt, to acknowledge all of the

child's feelings as they appear and to permit their expression, regardless of the intensity. Metaphor may be useful in creating a situation where the child faces no consequences for expressing her anger or pain. Thus, the creation of the offender with the aim of venting anger directly upon it, or the creation of her mother with the aim of telling her how she should have protected her, can act as effective metaphors for the expression of locked up feelings. The therapist should utilize reflecting in the process of debriefing as a way of bringing the child back in touch with her feelings. Reflecting nonverbal tension or asking the child to tell where the feeling is held in her body also bring her back to her awareness of her pain and anger. The main use of art with the issue of guilt is as a cathartic agent to stimulate the expression of blocked feelings. It is also used as a form of alternate communication, to allow the expression of feelings which are too painful to describe verbally. These findings offer the clinician treating CSA with specific treatment information with regards to the issues of body image distortion and guilt. It is recommended that training in CSA treatment incorporate these findings which provide specific issue related information.

Many age by issue interactions were also identified in the results of this study. For instance, nurturing was a very important goal for 4-year-olds with distorted body image compared to 8- and 13-year-olds. The identification

and awareness of feelings was endorsed by 100% of the sample who received the 8-year-old guilt simulations, but by far fewer of those receiving the other aged guilt simulations. Painting media were considered most appropriate in response to the age 4 and 13 case simulations where guilt was an issue compared to body image distortion. A supportive, nurturing, and empowering experience with an extended debriefing time was suggested for 4-year-olds with body image distortion most frequently compared to the other age or issue simulations. Similarly, those responding to the 8-year-old guilt simulation more frequently utilized cathartic activities and emphasized using the art as a means of enhancing communication. The findings on the use of art also reflected age by issue interactions. Art was used cathartically most frequently by those responding to the 13-year-old guilt simulations, yet it was not used at all by these respondents as a form of alternate communication. These interactions illustrate the need for training in both child development and CSA treatment. Perhaps, as Johnson (1987) suggests, therapists who work with sexually-abused children should not only acquire training in art therapy but in the other expressive therapies as well (e.g., play therapy, dance therapy).

This study provides a unique description of how art therapists currently treat CSA. The description of the specialized art directives, the discriminate use of media,

and the debriefing part of the art process and product may aid clinicians (e.g., social workers, psychologists, counsellors) in understanding how art therapists work with sexually-abused children and may prompt them to undertake training in this discipline as an alternate way of working with this population.

Art therapy appears to be a potentially viable treatment approach for children of differing ages who have been sexually-abused. However, treatment outcome studies comparing art therapy treatment with other types of treatment or with nontreatment control groups must be conducted before the efficacy of this mode can be proven. Nevertheless, the findings of this study offer new way of thinking about treatment. Current training of clinicians appears to be inadequate (Long, 1986), there are insufficient practitioners to treat CSA (Horowitz, 1985), and there is a need for communication between clinicians who utilize different treatment approaches (i.e., play therapists, drama therapists, psychotherapists). According to these findings, efforts should be made to incorporate CSA theory, CSA treatment practices, and child development into a specialization which could be obtained through various clinical programs in art therapy, expressive therapy, or psychology programs across Canada and the United States.

School counsellors, art teachers, social workers, and court workers need to be educated with respect to the art

and psychological trauma indicators that may alert them to identify potential victims or children at risk of being sexually-abused. New approaches for the treatment of CSA are being actively pursued by clinicians and the governmental health departments. Because of the rising caseloads of sexually-abused children, it is paramount that all reasonable treatment avenues be explored. Art therapists report that they are able to treat the sequelae of CSA, yet their methods have not been well documented, publicized, nor accepted.

This study was designed to elicit an in-depth description of art therapists' approaches to the treatment of CSA, over one session, in response to one issue. It is not the purpose of this author to fully describe the complexity of CSA treatment as multiple issues arise in every session. There are a number of key issues (Sgroi, 1982) which were not specifically addressed by the method used, yet they appeared spontaneously in the thematic content of the answers as part of the agenda that the art therapist would address. Some of these issues include self-esteem, empowerment, and the victim-stance.

In order to follow up on these findings and advance clinical knowledge in this area, further research should focus on the following areas. First, the research method and instrument (the case simulations) should be developed more fully so that the art therapy treatment of

such issues as victimization and damaged self-esteem can be investigated.

Other age groups, including adults, should also be compared and contrasted in terms of treatment issues, developmental differences, and longterm sequelae. This type of research will expand clinicians' abilities to refine their treatment approaches and enable them to make better predictions about treatment outcomes.

The treatment needs of sexually-abused boys should also be investigated. This study focussed on the treatment of girls simply because sexual abuse is more frequently reported for girls and the data on the characteristics, reactions, and developmental differences is more readily available. Boys require adequate treatment and it appears that they may have some very different issues arise such as fear of homosexuality when the offender is also a male (Hubberstey, 1988).

Third, the survey questions could be developed so that other modes of therapy (e.g., verbal, play, movement, drama) could be compared using the same case-simulation design. This type of information would ultimately provide clinicians faced with treating CSA with a wide array of approaches and choices which could be individualized depending upon the child's needs and capabilities. Art therapy appears to be a viable treatment approach for sexually-abused children, however, other expressive therapies offer similar advantages,

especially for those victims who are unable, unskilled, or unwilling to participate in art activities.

There is also a need for followup studies on the efficacy of these various treatment methods. Future research should included pre- and post- treatment evaluation of art therapy interventions on specific groups of children with regard to the variables of age and the various characteristics of the abuse situation. As Finkelhor (1986) commented, this type of empirical evaluation will improve not only the treatment approaches but also their credibility.

The main theoretical contribution of this research is the integration of the literature on CSA theory and the art therapy process data. This integration avails clinicians with evidence, in the form of qualitative description and quantitative comparison, of the ways in which art therapy is reported to disentangle the defense systems of sexually-abused children so that they may come to trust others, accept themselves, separate from the abuse experience, and begin the healing process.

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Appendix A

Survey Package Components

1. Cover letter
2. Consent form
3. Instructions
4. Case simulation A: Age 4, Body Image Distortion
5. Case simulation B: Age 4, Guilt
6. Case simulation C: Age 8, Body Image Distortion
7. Case simulation D: Age 8, Guilt
8. Case simulation E: Age 13, Body Image Distortion
9. Case simulation F: Age 13, Guilt
10. Questionnaire for Art Therapists who treat child sexual abuse

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January 1989

Dear Colleague:

Thank you for your participation in the research sponsored by the B.C. School of Art Therapy related to the use of Art Therapy Treatment in cases of Child Sexual Abuse. You should have recently received a summary of those results; if you have not, please let me know and I will rush you a copy.

You indicated your willingness to be involved in further research in this area. I am now investigating how Art Therapists treat some of the specific issues of sexual abuse in girls of different ages. Could you please help me by completing the following case-simulation survey. I have piloted it on 18 local art therapists and it takes approximately 30 - 45 minutes to complete in one sitting.

Please set aside some quiet time where you will not be disturbed. Read the instructions and proceed to complete the case-simulation survey. I have enclosed a pen and a self-addressed and stamped envelope for your convenience. If you need any help in completing the survey or would like to discuss any aspects of it, please call me collect at 1-604-477-8326.

Thank you again for your cooperation. A summary of the results will be mailed to you upon completion of the study.

Yours truly,

Leslie V. Marrion,
MA Psych., Dip. ATh.,
Faculty, B.C. School of Art Therapy

- I, _____ consent to participate in the study. **The Art Therapy Treatment of Sexually Abused Girls Aged 4, 8, and 13.** I am aware that I may withdraw from the study at any time and that data I provide will be used for the purpose of analyses only. The researcher guarantees anonymity and all returned information will be kept secure and confidential.

Signature _____

Date _____

.....

OPTIONAL

- I, _____ would like to add my name to the network list for the purposes of sharing information with other professionals working in this area.

Name _____

Address _____

Phone number(s) _____

Speciality areas (list 2 or 3) _____

INSTRUCTIONS FOR COMPLETING THE CASE-SIMULATION SURVEY

1. Please set aside 45 minutes of uninterrupted time in a quiet location to enhance your concentration for this research project.
2. Next, read and sign the Consent Form on Page 1.
3. Then, complete the optional Network Information on the bottom of Page 1 if you wish.
4. Turn to the case-simulation on Page 2. Read the information which describes a sexually-abused girl who is now in therapy. The protection issues have been addressed and she is now coming to terms with her distorted body image. She is in the middle phase of therapy and is comfortable using art as an expressive medium for communicating her feelings and conflicts. Look at the photograph and the self-portrait and read the case history carefully. Consider the issue of distorted body image and how you would conduct the next art therapy session with her in order to address that issue. Use the facts that you have available such as her age, the length and type of abuse, and her reaction to the abuse. Please draw on your experience with other children (individual or in groups) of the same age dealing with a distorted body image due to sexual abuse.
5. After you have read the case-simulation details, questions on the media, the directives, the way you would structure the use of time, the types of therapeutic techniques you might employ, and how you would debrief a child of this age will be presented to you. You may want to think out what you would do in advance on a piece of scrap paper.
6. Turn to Pages 3 to 6 and answer the survey questions in a way that portrays your approach to treating the sexual abuse issue of distorted body image in a child of this age.
7. When you have completed the questions on Pages 3 to 6, please fold the entire contents of the survey and place them in the self-addressed and stamped envelope. It is important that everything is returned to the researcher.
8. Please mail as soon as possible.
9. If you have any questions, please feel free to call collect:
Leslie Marrion, 1-604-477-8326

Thank you again for your participation.

INSTRUCTIONS FOR COMPLETING THE CASE-SIMULATION SURVEY

1. Please set aside 45 minutes of uninterrupted time in a quiet location to enhance your concentration for this research project.
2. Next, read and sign the Consent Form on Page 1.
3. Then, complete the optional Network Information on the bottom of Page 1 if you wish.
4. Turn to the case-simulation on Page 2. Read the information which describes a sexually-abused girl who is now in therapy. The protection issues have been addressed and she is now coming to terms with her feelings of guilt from the abuse incident. She is in the **middle** phase of therapy and is comfortable using art as an expressive medium for communicating her feelings and conflicts. Look at the photograph and the self-portrait and read the case history carefully. Consider the issue of guilt and how you would conduct the next art therapy session with her in order to address that issue. Use the facts that you have available such as her age, the length and type of abuse, and her reaction to the abuse. Please draw on your experience with other children (individual or in groups) of the same age dealing with the issue of guilt as a result of sexual abuse.
5. After you have read the case-simulation details, questions on the media, the directives, the way you would structure the use of time, the types of therapeutic techniques you might employ, and how you would debrief a child of this age will be presented to you. You may want to think out what you would do in advance on a piece of scrap paper.
6. Turn to Pages 3 to 6 and answer the survey questions in a way that portrays your approach to treating the sexual abuse issue of guilt in a child of this age.
7. When you have completed the questions on Pages 3 to 6, please fold the entire contents of the survey and place them in the self-addressed and stamped envelope. It is important that everything is returned to the researcher.
8. Please mail as soon as possible.
9. If you have any questions, please feel free to call collect:
Leslie Marrion, 1-604-477-8326

Thank you again for your participation.



Four-year-old Amanda disclosed in an investigatory session with a hospital social worker that her maternal uncle had 'lied on her and hurt her'. Medical-legal evidence consisted of lacerations, bruising of the vaginal area and a positive sperm test. Amanda had difficulty talking about the incident and the social worker helped her disclose by asking her to draw what happened.

Amanda is the eldest daughter in a single-parent family. Her mother divorced when she was 2 and has had several common-law boyfriends. Amanda often cares for her baby sister. Her uncle has been charged and is prohibited from seeing Amanda. Her mother was shocked and confused but is now concerned, supportive and attending a parenting group to learn how to protect and care for her children.

Amanda is described by her pre-school teacher as shy, passive, and compliant. Since the sexual abuse crisis, Amanda has been more withdrawn in class and seldom plays. She seems unusually tense, anxious, and clings to her mother in the morning. She has been having nightmares, has lost weight, and appears listless and sad.

You have done art therapy with Amanda for three months. She is comfortable with you and likes to draw, paint, play and talk. She drew the above self-portrait without any arms in the last session and then curled up into a fetal position and rocked herself for half an hour. She then said she wanted to be hugged and held. How would you plan the next session in order to help Amanda work towards a more complete body image?

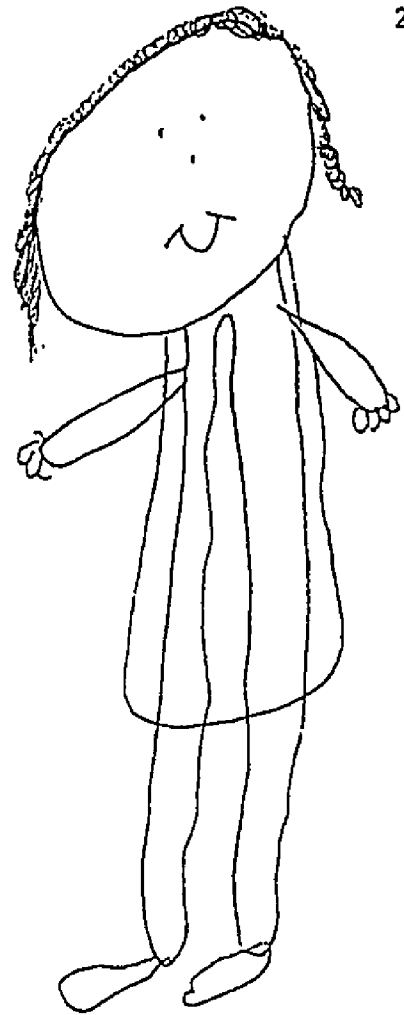


Four-year-old Amanda disclosed in an investigatory session with a hospital social worker that her maternal uncle had 'lied on her and hurt her'. Medical-legal evidence consisted of lacerations, bruising of the vaginal area and a positive sperm test. Amanda had difficulty talking about the incident and the social worker helped her disclose by asking her to draw what happened.

Amanda is the eldest daughter in a single-parent family. Her mother divorced when she was 2 and has had several common-law boyfriends. Amanda often cares for her baby sister. Her uncle has been charged and is prohibited from seeing Amanda. Her mother was shocked and confused but is now concerned, supportive and attending a parenting group to learn how to protect and care for her children.

Amanda is described by her pre-school teacher as shy, passive, and compliant. Since the sexual abuse crisis, Amanda has been more withdrawn in class and seldom plays. She seems unusually tense, anxious, and clings to her mother in the morning. She has been having nightmares, has lost weight, and appears listless and sad.

You have done art therapy with Amanda for three months. She is comfortable with you and likes to draw, paint, play and talk. She drew the above self-portrait in the last session and then X'ed it out and said she was bad. She says both her mother and uncle think she is bad and she can't see her uncle anymore. How would you plan the following session in order to help Amanda deal with her feelings of guilt about the abuse?



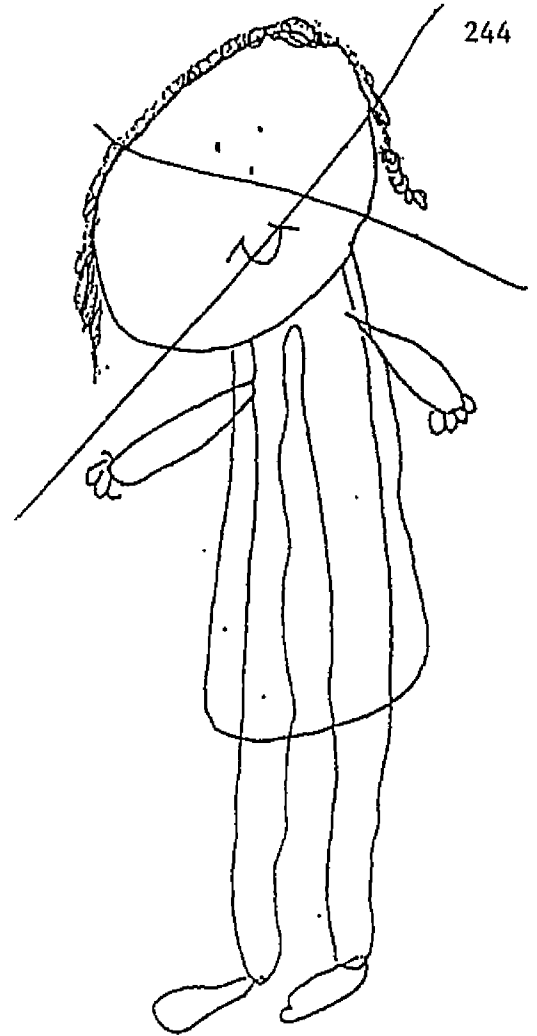
Eight-year-old Amanda disclosed in an investigatory session with a hospital social worker that her maternal uncle had 'hunched her and hurt her down there'. Medical-legal evidence consisted of lacerations, bruising of the vaginal area and a positive sperm test. Amanda had difficulty talking about the incident and the social worker helped her disclose by asking her to draw what happened.

Amanda is the eldest daughter in a single-parent family. Her mother divorced when she was 6 and has had several common-law boyfriends. Amanda often cares for her baby sister. Her uncle has been charged and is prohibited from seeing Amanda. Her mother was shocked and confused but is now concerned, supportive and attending a parenting group to learn how to protect and care for her children.

Amanda is described by her grade three teacher as shy, passive, and compliant. She had recently been more withdrawn in class and exhibits compulsive behavior such as leaving the classroom to wash her hands over and over. She has been having nightmares, enuresis, and appears listless and sad.

You have done art therapy with Amanda for three months. She is comfortable with you and likes to draw, paint, and talk. In the last session, she drew the above self-portrait and talked about how ashamed and scared she was when she woke up with a wet bed. How would you plan this session in order to help Amanda deal with her distorted body image?

CASE-SIMULATION



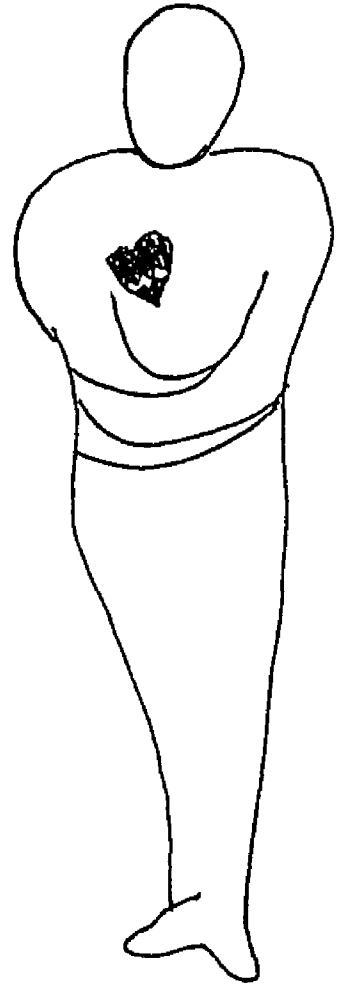
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Eight-year-old Amanda disclosed in an investigatory session with a hospital social worker that her maternal uncle had 'hunched her and hurt her down there'. Medical-legal evidence consisted of lacerations, bruising of the vaginal area and a positive sperm test. Amanda had difficulty talking about the incident and the social worker helped her disclose by asking her to draw what happened.

Amanda is the eldest daughter in a single-parent family. Her mother divorced when she was 6 and has had several common-law boyfriends. Amanda often cares for her baby sister. Her uncle has been charged and is prohibited from seeing Amanda. Her mother was shocked and confused but is now concerned, supportive and attending a parenting group to learn how to protect and care for her children.

Amanda is described by her grade three teacher as shy, passive, and compliant. She had recently been more withdrawn in class and exhibits compulsive behavior such as leaving the classroom to wash her hands over and over. She has been having nightmares, enuresis, and appears listless and sad.

You have done art therapy with Amanda for three months. She is comfortable with you and likes to draw, paint, and talk. In the last session, she drew the above self-portrait and X'ed it out saying she feels she is very bad and her mom says she isn't allowed to see her uncle anymore. How would you plan the following session in order to help Amanda deal with her feeling of guilt about the abuse?

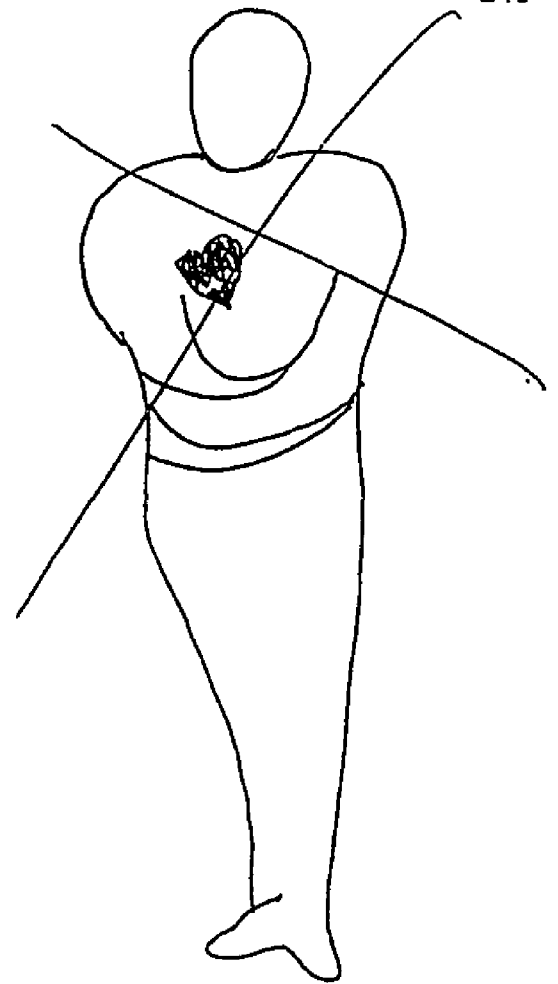


Thirteen-year-old Amanda disclosed in an investigatory session with a hospital social worker that her maternal uncle 'had raped her'. Medical-legal evidence consisted of lacerations, bruising of the vaginal area and a positive sperm test. Amanda had difficulty talking about the incident and the social worker helped her disclose by asking her to draw what happened.

Amanda is the eldest daughter in a single-parent family. Her mother divorced when she was 11 and has had several common-law boyfriends. Amanda often cares for her baby sister. Her uncle has been charged and is prohibited from seeing Amanda. Her mother was shocked and confused but is now concerned, supportive and attending a parenting group to learn how to protect and care for her children.

Amanda is described by her home-room teacher as a moody, depressed, or angry child who has recently alienated herself from her peers. She seems withdrawn and day-dreamy, has been truant from school, gained weight, and lost interest in her daily hygiene.

You have done art therapy with Amanda for three months. She is comfortable with you and likes to draw, paint, and talk. In the last session, she drew the above self-portrait and began to cry. She said she hated her body and wished she was not a girl. How would you plan the following session to help Amanda work towards a more integrated body image?



Thirteen-year-old Amanda disclosed in an investigatory session with a hospital social worker that her maternal uncle 'had raped her'. Medical-legal evidence consisted of lacerations, bruising of the vaginal area and a positive sperm test. Amanda had difficulty talking about the incident and the social worker helped her disclose by asking her to draw what happened.

Amanda is the eldest daughter in a single-parent family. Her mother divorced when she was 11 and has had several common-law boyfriends. Amanda often cares for her baby sister. Her uncle has been charged and is prohibited from seeing Amanda. Her mother was shocked and confused but is now concerned, supportive and attending a parenting group to learn how to protect and care for her children.

Amanda is described by her home-room teacher as a moody, depressed, or angry child who has recently alienated herself from her peers. She seems withdrawn and day-dreamy, has been truant from school, gained weight, and lost interest in her daily hygiene.

You have done art therapy with Amanda for three months. She is comfortable with you and likes to draw, paint, and talk. In the last session, she drew the above self-portrait. X'ed it out, and began to cry. She said she feels so angry at herself for what happened and wishes she were dead. She isn't allowed to see her uncle anymore and hates her mother. How would you plan the following session in order to help Amanda deal with her feelings of guilt about the abuse?

5. Describe how you would plan to use the time in the session. (List the different activities and the amount of time you would engage in each during the session; include such things as greeting, art work, snack, warning of ending, debriefing).

6. Check off those types of therapeutic interaction that you would employ as you proceeded with the session.

- | | |
|---|---|
| <input type="checkbox"/> empathic listening | <input type="checkbox"/> confronting |
| <input type="checkbox"/> education | <input type="checkbox"/> ventilation |
| <input type="checkbox"/> focussing | <input type="checkbox"/> problem solving |
| <input type="checkbox"/> rehearsing | <input type="checkbox"/> metaphor |
| <input type="checkbox"/> exploring | <input type="checkbox"/> transference |
| <input type="checkbox"/> clarifying | <input type="checkbox"/> grounding |
| <input type="checkbox"/> acknowledging feelings | <input type="checkbox"/> safe place |
| <input type="checkbox"/> mirroring | <input type="checkbox"/> identifying splits |

others (please list) _____

7. Describe the debriefing process you would use in a session like this. (Debriefing includes any discussion or reference to the artwork or the process of creating it as a means of closure around the issue or of the session).

8. Why would you choose to use art in this way to help a child of Amanda's age work through this issue?

9. What would you think the function of art was in this type of session?

10. How could you evaluate the effectiveness of this session? (Check one or more.)

child's self-report

assessment of child's reaction

use of art markers

change in psychological status of child over session

other (please describe) _____

Section 2: Demographic Information

11. What is your gender? M F Age? _____

12. How many years/months experience do you have working with sexually abused children? _____

13. Which age groups do you treat? _____

14. On average, how many sexually abused children do you treat in one week (including those in groups)? _____

15. How many years of post-high school education do you have? _____
16. What level of training do you have in Art Therapy?
- Professional workshops or short courses
 - Some graduate level coursework
 - Internship in specialized area
 - Diploma or graduate degree in Art Therapy
 - Registration as an Art Therapist
 - Other _____
17. What level of training do you have in the treatment of child sexual abuse?
- Professional workshops or short courses
 - Some graduate level coursework
 - Internship with this population
 - Graduate degree specializing with this population
 - Other _____
18. Do you wish to receive a summary of the results of this study? Yes No
19. Would you consider participating in further research of this type? Yes No

Thank you for your participation. Please use the remaining space to express your thoughts, suggestions, or concerns about the study.

Appendix B

Interrater Agreement Protocol

Instructions for judges:

1. Read the category definition sheet for question 2 (Q2) over until you understand the definitions and can refer to them easily.
2. Read each practice item and assign category numbers to each statement (or segment) that fits within a category according to the definitions. Put the category numbers beside the line you are coding and put a bracket at the end of each segment:

Eg. (To recognize her innocence and let go of her anger) 3
3. Each subject may have more than one category present in their response. Use all the categories that fit.
4. Try the practice items until you get them correct. Ask the researcher questions to refine your choices and to come to agreement on the categories. When you feel confident, proceed to the pretest items. You must achieve at least 80% accuracy on these items before proceeding to the data.
5. Turn to the data sheet for Q2 on therapeutic goals. Follow these instructions:
 - a. Read the question that the subject answered and then read their response.
 - b. Assign each segment or statement the appropriate category number, as listed on the category sheet.
 - c. Take your time and recheck your answers when you have finished.
 - d. Reread the data sheets and write on the additional category sheet any new categories you feel are missing and are important. Please define these new categories. Write the appropriate subject numbers under your new categories.
6. Turn to the category sheet for Q4 and follow the procedure outlined in steps 1 through 5 again.
7. Turn to the category sheet for Q7 and follow the procedure outlined in steps 1 through 5 again.
8. Return all sheets and responses to the researcher. Thank you for your help.

Appendix C**Summary of "Other" Types of Therapeutic Interactions (Q.6)**

Summary of "Other" Types of Therapeutic Interactions (Q.6)

| Types of Interaction | Subject Response |
|----------------------|---|
| Building self-esteem | <p>S19: esteem building</p> <p>S32: acceptance</p> <p>S46: clarify not her fault, she's OK, people love her now</p> <p>S49: reassurance - you had few choices</p> <p>S60: messages of acceptance, warmth, give positive experience of self</p> <p>S87: positive affirmation</p> <p>S91: supportive. Amanda would be supported in learning to accept herself, particularly the physical Amanda. I would support her healthy sexual feelings. The goal is self-acceptance.</p> <p>S105: building ego strength</p> <p>S129: I consider nurturing to be therapeutic and it is displayed through the therapists' overall attitude and manner</p> <p>S172: be sure to express my sincere anticipation in meeting with Amanda, the following day (or week)</p> |
| Labelling feelings | <p>S46: you are showing me how it was for you</p> <p>S49: labelling some feelings and what they mean (i.e., 'bad,' responsible, in relationship to abuse). Check it out with mom, ask mom if she's 'bad.'</p> <p>S56: reflective feedback</p> <p>S60: provide opportunity to express feeling</p> <p>S138: integrating feelings with body sensation</p> <p>S158: gentle guiding of the client, understanding their sense of responsibility for their own feelings</p> <p>S159: naming of feelings in order to (later) gently confront them</p> <p>S161: containing painful and/or dangerous feelings</p> |

(con't)

| | |
|---|---|
| Modeling | S56: Modeling body language, reflective feedback S135: possibly modeling if client had chosen body tracing in which clinician would be involved in art making process |
| Touch, physical contact | S09: hugging or holding her hand S106: physical contact in appropriate way is sometimes really needed - check if OK - but a hug or a hand on the shoulder with a verbal statement to clarify |
| Role playing | S03: role playing S28: role playing |
| Humor | S129: some use of humor at appropriate times S130: use of humor |
| Reframing | S113: possibly reframing S159: neurolinguistic programming |
| Setting limits/boundaries | S88: clarify boundaries (begin/end session) distance control by clients, re: closeness of therapist S123: boundaries set |
| Allowing symbolic reenactment of trauma | S46: encourage symbolic reenactment of trauma S55: symbolic reenactment of trauma |

Note. Some of the "other" responses could have been checked off by the subjects in the multiple choice list. However, as they chose to list them as "other," they have only been counted here.