Group Art Therapy with Survivors:
A Group Intervention Design for Women who were Sexually Abused

Krista Mouck

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By: Krista Mouck

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Signed by the Research Advisor:

Irene Gericke, Research Advisor

Irene Gericke, MA, ATR, ATPQ

Approved by:

Steven Snow, Chair

Stephen Snow, PhD, RDT-BCT

April 29, 2014

Date

Abstract

The intention of this research was to explore how therapeutic interventions found in the literature can be adapted and used in a closed, long-term art therapy group program for adult women who have experienced childhood sexual abuse. The existing literature is examined with a focus on perspectives of trauma-informed therapy, art therapy with sexual abuse survivors, and group therapy with survivors. Therapeutic issues and techniques in these paradigms will be explored, culminating into a proposed structure for a twenty-four session art therapy group. Guidelines will be proposed for session objectives and content based on suggestions made in the literature review. The suggested art therapy interventions will be conceptualized and described through a framework for the beginning, middle or end phases of the group process. The paper will then conclude with a discussion of my own recommendations regarding the proposed model based on my own clinical experience in leading an art therapy group specifically for women survivors of childhood sexual abuse.

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Chapter 1: Introduction

"Images and the artistic process are the shamans and familiar spirits who come to help people regain the lost soul" (McNiff, 1992).

This paper will explore how art therapy interventions found in the literature can be adapted and used in a closed, long-term art therapy group for adult women who have experienced childhood sexual abuse (CSA). There has been increasing interest in recent years in the study of the long term sequelae of childhood abuse and how it may be related to psychological and emotional difficulties, not only in relation to the survivor of abuse but also how those involved in the survivor's life may be affected. Trauma affects not only the individual but the society at large. Traumatized parents and societies can unintentionally pass down the emotional and psychological effects of trauma to their children, recreating difficulties in the development of feelings of safety and secure attachment in future generations. As Fraiberg, Adelson and Shapiro (1975) declare, "In every nursery there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening" (p. 387). When trauma is not psychologically processed by an individual, the effects may continue to haunt the person in ways that feel out of the person's control. Herman (1992) refers to memories of trauma as ghosts that the survivor attempts to bury, stating "Folk wisdom is filled with ghosts who refuse to rest in their graves until their stories are told. Murder will win out. Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims" (p. 1). Many researchers have posited that the use of non-verbal therapies can be particularly valuable for the processing of trauma and its effects, as much of the traumatic reaction is encoded in the mind on a non-verbal level, making it very difficult for survivors to process their experience in verbal terms (Herman, 1992; van der Kolk,

2002). Interpersonal trauma is also inherently a result of a relation with another and the process of healing must also involve another (Herman, 1992). An art therapy group specifically for survivors of abuse can aid in a corrective experience to counteract the secrecy and shame that society reinforces for the topic of abuse, particularly sexual abuse. In hearing others' stories similar to one's own, survivors may be able to decrease the isolation and self-blame they often experience, as Bass and Davis (2008) write, "much of the damage experienced is the result of the secrecy and silence surrounding the abuse. Trying to heal while perpetuating that lonely silence is nearly impossible" (p. xxiv). The use of images may itself involve a type of relationship and dialogue with past ghosts, as McNiff (1992) states, "It is through others that we discover who we are…on entering the world of the painting, we become aware of the many who speak through us" (p. 2). It is imperative that these ghosts be conjured in a safe and emotionally supportive environment so as to not overwhelm and re-traumatize survivors. As a neophyte art therapist, I am writing this research paper to focus on creating guidelines for working with survivors of trauma so as to reduce the fear of re-traumatizing survivors who are seeking mental health services. It is with this in mind that I will explore art therapy interventions that encourage containment during this extremely difficult healing process. My research question will therefore ask, "How can art therapy interventions found in the literature be adapted and used in a closed, long-term art therapy group for adult women who have experienced childhood sexual abuse?"

Chapter 2: Methodology

This research paper will utilize an intervention methodology. Frazer and Galinsky (2010) outline a five step procedure in conducting intervention research, including: developing problem and program theories; specifying program structures and processes; refining and confirming efficacy tests; testing effectiveness in practice settings; and disseminating program findings and

materials (p. 463). The last three steps of program evaluation will not currently be conducted with this intervention research due to the small scope of this paper. I will therefore focus on developing problem and program theories, and specifying program structures and processes. The authors state that the design of an intervention involves "delineating a *problem theory* in which potentially malleable risk factors are identified and then in *program theory* matching these risk factors – sometimes conceptualized as mediators – with change strategies" (p. 460). This design process may include assessment and integration of research, theory and experiential or dialogical knowledge and feedback. This research will therefore commence by researching problem theories through a literature review of the prevalence and common sequelae of CSA. I will subsequently outline the therapeutic observations and treatment recommendations made by recognized therapists researching and working with this population, by professionals with extensive experience in group therapy and by art therapists working with survivors of CSA. This information will be gathered through books and government reports, and databases accessible through Concordia University Library, particularly Psychinfo, PubMed, and Ebscohost, as well as articles located through Google Scholar. This paper will then attempt to integrate specific interventions into a group art therapy intervention based on the literature review. The second step of "specifying program structures and processes" is considered to be a creative process (p. 460) and the suggested guidelines for an art therapy group outlined in this paper will also be informed by my ideas and clinical experience in facilitating a group art therapy program on the theme of sexual abuse. A twenty-four session group structure will be proposed based on the identified risk factors and intervention themes suggested by therapists working in trauma-informed therapy, art therapy or group therapy. The suggested interventions will be conceptualized through a framework for the beginning, middle or end phases of an art therapy group with adult sexual

abuse survivors. The current intervention design is meant as a guideline for possible use in clinical practice settings and may be altered and tailored based on the needs of the particular client group, the setting of the group, and the therapeutic treatment plan. Throughout this text I will be using the pronoun 'she' when referring to client survivors; I chose to do this due to my clinical experience thus far of working only with women survivors of abuse, although I recognize that there are many men survivors who also request services related to their history of CSA. I also choose to use the pronoun 'she' due to the research that states that there is a significantly higher proportion of women who report sexual abuse and request mental health services related to it, although I recognize that male sexual abuse may be less pronounced in research due to the stigma that males may experience in reporting CSA. The research cited here has been focused on working with women survivors, and this paper will be limited in that regard. This research paper will draw upon trauma informed/survivor-oriented perspectives, which incorporate person-centered, psychodynamic, and cognitive behavioural perspectives (Briere, 1996, 2002; Herman, 1992; van der Kolk, 2002) in conjunction with art and group therapy perspectives.

Definition of Terms

Art Therapy: The Canadian Art Therapy Association (CATA) states that "Art therapy combines the creative process and psychotherapy, facilitating self-exploration and understanding. Using imagery, colour and shape as part of this creative therapeutic process, thoughts and feelings can be expressed that would otherwise be difficult to articulate." (CATA 2013). The American Art Therapy Association (AATA) states, "Art therapy is a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-

awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem." (AATA, 2014).

Long Term Therapy: Long term will be defined for the purposes of this paper as a 20-30 week group. Although some may define this time limit as a short term intervention, I am using the term long-term here as it applies to community and women's organizations which often are the providers of groups focused on CSA, and often have limited resources therefore making the interventions of a shorter-term duration. In my past experience in working in such organizations, 20-30 weekly sessions has been a high number of sessions for a closed group, and it is with this in mind that I have labelled this intervention guideline long-term.

Sexual Abuse: The US Department of Health and Human Services (2013) states:

> Sexual abuse includes activities by a parent or caregiver such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials. Sexual abuse is defined by the American Federal Child Abuse Prevention and Treatment Act as 'the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.' (US Department of Health and Human Services, 2013)

Chapter 3: Childhood Sexual Abuse Prevalence and Effects

Prevalence

Childhood sexual abuse has been found in two internationally focused meta-analysis' to affect 18-19.7% of women (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011), with an older Canadian study placing the occurrence of CSA at 12.8% (MacMillan et al., 1997). In a National Comorbidity Survey in the USA with 5877 subjects, the rate of CSA was found to be 13.5% (Molnar, Buka, & Kessler, 2001; Wurr & Partridge, 1996). In treatment seeking adults, Pribor and Dinwiddie (1992) found that significantly more women with a history of incest had been diagnosed with a psychiatric disorder in their lifetime compared to women without a history of incest; those with a history of incest were also found to have significantly more diagnoses' than the comparison group . In particular, the diagnosis of Post-Traumatic Stress Disorder (PTSD) has been found in 33-86% of those with a history of CSA; of those diagnosed with Borderline Personality Disorder (BPD) in particular, 67-73% have been found to disclose a history of CSA (Polusny & Follette, 1995).

Effects

Briere (1996) states that the effects of CSA are complex and that some survivors have experienced fewer long term consequences than others. Survivors may develop persistent symptoms of PTSD, as outlined by the Diagnostic and Statistical Manual IV. Three main categories of symptoms of PTSD include hyper-arousal (increased alertness or persistent fear of danger), constriction or avoidance (emotional numbing, avoidance of reminders of the trauma, and dissociation), and intrusive re-experiencing (invasive memories, nightmares or flashbacks) (Briere, 1996; Canadian Mental Health Association, 2014; Herman, 1992). Certain aspects are likely to increase the impact of CSA including an early onset, incest, long duration of abuse, and

other forms of abuse concurrently experienced such as physical abuse or neglect (Briere, 1996). Briere states that cognitive effects of CSA often include: negative self-evaluation and guilt; helplessness and hopelessness; and distrust of others. Emotional effects include high levels of anxiety; depression; and anger. Interpersonal effects include disturbed relatedness; idealization and disappointment; intimacy problems or sexualized relatedness; adversariality; and manipulation. The author outlines the core effects of CSA as other-directedness (relying on others' actions for safety and self esteem); chronic perception of danger; negative self-perception; 'negative specialness'(the belief that they are to blame for what others do); conditional reality (reality verified or defined by others' perceptions); avoidance (including dissociating); impaired self-functioning; and posttraumatic intrusion. Van der Kolk (1996) states that in response to early-onset trauma, survivors often have problems with affect regulation which can lead to problematic self-regulating behaviours such as self-mutilation, substance abuse or eating disorders. In a study of 152 women presenting at a Community Health Center for services, Briere and Runtz (1987) found a significant correlation between CSA and experience of battery as an adult; history of drug addiction; nightmares; anxiety attacks; sexual problems; fear of men; derealisation; current use of psychoactive medication; "spacing out"; trouble controlling temper; and chronic muscle tension, compared to women without a CSA history.

Specific Issue of Dissociation

Dissociation can be viewed as a common coping mechanism developed by those who experience uncontrollable traumatic events, particularly events that are repeated over time; the traumatized person may try to make their consciousness focus intently on the separation of their mind from their body, which helps the person deal with the trauma as it is occurring; however this can create difficulties later in life when the person can no longer control this mechanism

when they are no longer in danger (Courtois, 2010). One study reported that 41.8% of women sexually abused as children reported “spacing out” often, compared to 22.1% of the comparison group (Briere & Runtz, 1987). Courtois (2010) opens her book with an example of how a child may learn to dissociate to cope with incest: “she looks at herself from the ceiling or concentrates intensely on the wallpaper or the curtains so she can make herself be somewhere else...she pinches herself and digs her fingernails into herself for distraction and punishment” (p. 5). Dissociation may become problematic as an automatic and generalized coping method: “the subjective sense of deadness and disconnection from others which originally may have helped these individuals cope with extreme distress, is also quite a dysphoric experience” (van der Kolk, 1996, p. 189). Van der Kolk (1996) suggests that self-harming behaviours such as self-mutilation may be associated with dissociation, attempting to modulate the lack of emotional control felt by the victim and an attempt to bring their awareness back to their current physical sensations. Dissociation may also be connected to the defences that a person uses to cope with fear, including fight/flight/or freeze. These may occur when a person is in a traumatic situation that she feels she has no option or power to change (as in fight) or get away from (as in flight); she may automatically freeze, shutting down reactions, thereby feeling no control or relief when the traumatic situation changes from unsafe to safe (Trauma and Resiliency Centre Gail Appel Institute , n.d.). This freezing and dissociated response can be particularly automatic and therefore problematic for those who experience repeated childhood trauma, as children may have little power to alter or escape the abusive situation and therefore learn that the only way to survive and cope with fear and distress is to freeze and cut off emotional and cognitive processing. Due to the common issue of dissociation in therapy (Briere, 1996; Courtois, 2010;

Van der Kolk, 1996) with CSA survivors, therapy must be tailored to work through and alleviate this issue.

Chapter 4: Therapeutic Approaches with CSA survivors

This research paper will draw upon trauma informed/survivor-oriented perspectives, which incorporate person-centered, psychodynamic, and cognitive behavioural theories (Briere, 1996, 2002; Herman, 1992; van der Kolk, 2002). Trauma-informed therapy is a developing field that is specifically focused on the needs of abuse survivors and incorporates existing perspectives of therapy as well as ascribing to new ideas that apply specifically to working with abuse survivors, such as the specific goals for reducing PTSD symptoms. Due to the three core symptoms of PTDS (hyper-arousal, avoidance, and intrusive re-experiencing), three main goals of survivor therapy may be viewed as establishing decreased anxiety and increasing a state of general feelings of safety and support; decreasing dissociation and avoidance of reminders, memories and emotions; and integrating and gaining increased control over the memories and locating them in the past. I will now outline the main tenants of trauma-informed therapy as it is described in the currently developing field.

Trauma-Informed/Survivor-Oriented Therapy

Briere (1996) states that an abuse-oriented perspective incorporates cognitive, behavioural, and psychodynamic perspectives and "denies the need for convoluted concepts in the analysis of abuse-related psychological dysfunction, instead understanding such adult 'pathology' as the psychological extension of early reactions and solutions to aversive childhood events" (p. 79). He states that "One of the earliest impacts of abuse and neglect is thought to be on the child's internal representations of self and other" (Briere, 2002, p. 2) and this may be viewed through an attachment lens (Bolby, 1982) or core relational schemas (Baldwin, 1992),

which are learned internalized models or schemas of other people in the world and how the child learns to expect to be treated by, and relate to, other people. Children may develop a secure attachment style, where they feel a secure sense of worth, are able to trust others and engage in an appropriate expression of a range of emotions in interpersonal relationships. There are three types of insecure attachment styles including "Fearful (involving a high need for interpersonal acceptance and affirmation and, yet, avoidance of intimacy), Preoccupied (involving similar high needs for validation and acceptance, but with a tendency to be preoccupied with attaining such affirmation through relationships), and Avoidant/Dismissing (involving avoidance of interpersonal attachments and high needs for self reliance) (Briere, 2002, p. 3). These attachment styles are believed to develop in early infancy, and can be assessed in infants as young as 15-18 months old (Weede-Alexander, Quas, & Goodman, 2002). One study found that CSA was negatively related to secure attachment and positively correlated with avoidant coping, but these correlations did not reach significance (Shapiro & Levendorsky, 1999). It is believed that secure attachment can mediate the effects of CSA, as securely attached children may use less avoidant coping strategies to cope with abuse and seek out caretakers who have encouraged a supportive attachment (Shapiro & Levendorsky, 1999). Children are believed to learn emotional regulation skills through caregivers incrementally increasing the emotional challenges that the child faces independently, with the parent empathizing with the child and modelling how to handle challenges through teaching self-soothing techniques such as emotional identification and coping strategies such as positive self-talk, increasing the child's ability to tolerate distress (Briere, 2002). In contrast, abused children are often overwhelmed by emotional challenges that they are not equipped to tolerate, and learn to use more primitive avoidant coping strategies such as dissociation possibly due to lack of available secure caretakers. Briere (2002) states that when

children are abused they often create "conditioned emotional responses" that are not narratively based memories but rather sensory and emotional responses to stimuli, such as the darkness of a room or the sound of someone walking up stairs. These stimuli may trigger the survivor as an adult, without the survivor realizing the stimuli triggers emotional and sensory reactions in the brain such as overwhelming fear and increased heart rate and reliving of the traumatic experience. The narrative memory of the abuse situation may be encoded in fragmented ways due to the high emotional flooding of the experience, or the narrative memories may be actively supressed and avoided. They may also have occurred before the child was old enough to be able to encode the experience in a narrative language-based memory. Flashbacks and nightmares may be viewed as a way of the mind attempting to deal with and heal from avoided traumatic memories, by exposing the survivor to small excerpts of the trauma memory that has been avoided. The author states "even superficial exploration (exposure) and emotional expression (activation) of previous traumatic events in safe environments has been shown to significantly decrease psychological symptoms, as well as increasing indices of physical health" (Briere, 2002, p. 9). A central concern of therapy is maintaining a feeling of safety for the survivor while balancing the treatment goal of decreasing avoidance of memories and feelings (Briere, 2002; Herman, 1992). Herman (1992) views the three main stages of trauma-focused treatment as establishing safety by naming the problem and establishing a safe therapeutic environment and relationship; remembrance, alteration and mourning of the trauma narrative; and reconnection to self and others.

Transference and Countertransference Issues

The experience of childhood abuse may affect the survivor's view of others and the world as being malicious and unsafe, and the self as powerless, particularly if the trauma was recurring

and if other caregivers were unresponsive or blaming towards the child. Therapy with child abuse survivors therefore may be very difficult as the survivor has learned through repeated experience that she cannot trust the world or herself to be able to cope safely without avoidance, and the therapist is essentially asking the survivor to risk going against years of protecting herself through emotional avoidance (Briere, 2002). The therapy is affected by the attachment style of the survivor, which affects the survivor's ability to regulate emotions when confronting traumatic or stressful situations, including the therapy room. Herman (1992) points out that due to traumatic transference, it is to be expected that trust in the therapeutic relationship will be extremely difficult for traumatized patients, and that they may believe that the therapist is unable or unwilling to help, or may expect exploitative or voyeuristic intentions of the therapist: "the dynamics of dominance and submission are re-enacted in all subsequent relationships, including the therapy" (p. 138). She posits that the client may idealize the therapist as a rescuer and may displace her rage from the perpetrator to the care-giver or therapist when the therapist is unable to "save" the client. Through projective identification the therapist may enact abusive dynamics without realizing it, defending against feelings of helplessness by trying to assume various roles that lack the boundaries necessary for a corrective and empowering therapeutic experience (Herman, 1992). Countertransference can affect the therapist working with survivors by making the therapist feel many of the emotions that the client is feeling or avoiding, such as isolation, confusion, powerlessness, anger, guilt, and distrust of others as well as other strong reactions. It is therefore imperative that the therapist working with trauma survivors has regular and consistently containing supervision to monitor the therapist's own countertransference reactions that may affect the therapeutic relationship and his or her own personal life and worldview.

Therapeutic Techniques and Goals

As stated previously, due to the three core symptoms of PTDS (hyper-arousal, avoidance, and intrusive re-experiencing) three main goals of therapy may be viewed as establishing decreased anxiety and increasing a state of general feelings of safety and support, decreasing avoidance of reminders, memories and emotions, and integrating and gaining increased control over the memories and locating them in the past. Briere (2002) asserts:

> as noted by various authors (Courtois, 1991; Linehan, 1993; McCann & Pearlman, 1990; van der Hart, Steele, Boon, & Brown, 1993), therapy for severe abuse-related difficulties should generally proceed in a step-wise fashion, with early therapeutic attention paid more to the assessment and development of self-resources and coping skills than to trauma per se. (p. 12)

The author states that the therapist should have an egalitarian stance, and make the client aware that "good therapy is more an environment than an inherently curative procedure; assuming that the clinician can provide a safe, healing context, and helpful guidance, the client is in charge of her own recovery process" (Briere, 1996, p. 83). The main intention of the initial stage of therapy is to attempt to create a feeling of safety and trust through empathic listening, mirroring of emotions, and identifying emotions. The process of therapy should focus on establishing basic safety and self-care, enhancing the client's sense of competence, self-esteem and freedom, along with slowly developing trust in the therapist's reliable commitment to ensuring safety (Herman, 1992). When working therapeutically with survivors of sexual abuse, many authors recommend increasing anxiety management through grounding, relaxation/breathing exercises, safe-space visualizations, mindfulness techniques, emotional identification, and identification of triggering thoughts (Briere & Lanktree, 2013; Malchiodi,

2008; Russ & Niec, 2011). The therapist models normalization, soothing and validation to the client to encourage increased affect regulation, which can be difficult for many survivors (Briere & Lanktree, 2013). Sgroi (1989) states that survivors need encouragement to practice "checking into" their needs and emotional states, asking for help and communicating with others, utilizing self-affirming behaviours, and setting limits. Russ and Niec (2011) encourage utilizing psycho-education at the beginning of therapy, including discussing common reactions to sexual assault, which can help normalize and validate the client's reactions, as well as increase the level of trust with the therapist who is shown to understand what the client may be experiencing and decrease the level of taboo in discussing sexual abuse. Herman (1992) states that relaxation techniques and visualizing soothing imagery can be used in preparation for later stages of therapy such as trauma processing, which may include carefully preparing scripts describing the traumatic events in detail in the present tense, which are then read aloud in the therapeutic context focusing on the context, fact, emotion, and meaning that the survivor connects to the trauma. An exploration of the survivor's overall personal identity may constitute a primary objective to creating a stronger sense of self, as many survivors learn to ignore their own feelings and internal perceptions due to the need to focus on surviving the abusive situation and may have internalized negative messages that the survivor was taught as a child by the abuser or unsupportive caregivers, such as that they are to blame or that their feelings are incorrect/aren't valued. Discussion of the social analysis of sexual victimization may also be integrated into the therapeutic process, such as discussion of cultural attitudes supporting exploitation and the sexualisation of women and girls. This intervention is focused on normalizing the survivors' feelings, decreasing feelings of isolation, and encouraging a healthy anger at the "the system" that didn't support or protect her, rather than directing anger at herself (Briere, 1996).

Pacing of Therapy

Briere (1996) argues that it is a problematic risk for the therapist working with an adult with a history of CSA to push the survivor to move faster than the client is ready to go, and that it is of utmost importance to *titrate* the process of disclosure: "such adjustments allow the survivor to digest new ideas or discoveries at her own rate, as well as ensuring her continued control over the psychotherapy session" (p. 80). He states, "One is never cured of an abuse history; one can only process, desensitize, and integrate those memories, and live more fully in the present" (p. 83). The therapist must be very cautious in pushing the survivor to disclose too quickly, as this can be further damaging and traumatizing to the client causing fragmentation of the sense of self if a sense of safety is not strongly felt by the survivor. If the client does not feel in control of the process and the therapist tries to move the process faster than the client can withstand, the client may feel too threatened to continue in the group process or use dissociation as a way to protect herself. Moving too slowly in confronting avoided memories and affects is not dangerous to the survivor but risks the therapy being ineffective (Briere, 2000). It is therefore suggested to always err on the side of caution with disclosure of avoided memories and affects, as safety is the priority of the therapy. If a survivor seems to be moving too quickly in the process the therapist may intervene by encouraging the survivor to focus on her established progress and to honor her own needs for safety and security. The therapist must tailor the process to the current needs and abilities of the individual client, based on the level of stability of internal resources such as coping and affect regulation skills that the client has thus far established (Briere, 2000). Homstead and Werthamer (1989) also postulate that giving the client control over the pace of disclosure is of vital importance, as premature disclosure can increase the client's

feelings of isolation and dissociation, and that using symbolic art expressions can allow clients to experience increased control over expressing and externalizing feelings at their own pace.

Chapter 5: Art Therapy with CSA survivors

Use of Non-Verbal Therapies

Van der Kolk (2002) states that an initial imperative therapeutic objective is to teach the traumatized client to observe and attend to emotional reactions and physical/somatic experiences in an incremental and non-judgemental manner, to increase affect tolerance and regulation in their current lives. He states that survivors must be taught to recognize and tolerate emotional distress in the body before confronting the trauma narrative. The author proposes that "the task of therapy is both to create a capacity to be mindful of current experience, and to create symbolic representations of past traumatic experiences with the goal of uncoupling physical sensations from trauma based emotional responses" (van der Kolk, 2002, p. 19). He encourages the use of non-verbal forms of communication in the therapeutic process, due to the common difficulty for trauma survivors to express traumatic reactions in words. Herman (1992) states:

> As the narrative closes in on the most unbearable moments, the patient finds it more and more difficult to use words. At times the patient may spontaneously switch to non-verbal methods of communication, such as drawing or painting. Given the 'iconic' nature of traumatic memories, creating pictures may represent the most effective initial approach to these 'indelible images.' The completed narrative must include a full and vivid description of the traumatic imagery…a narrative that does not include the traumatic imagery and bodily sensations is barren and incomplete. The ultimate goal, however, is to put the story, including imagery, into words. (p. 177)

Talwar (2007) explains that when discussing traumatic experiences, studies show that the prefrontal cortex which is associated with language formation, is bypassed and inactive, while the amygdala which is associated with emotion, is highly stimulated. The author states that "in an art therapy session the left hemisphere offers an explanation to the right hemispheric output in the form of a created image. The right hemisphere deals with visual motor activities, intuition, emotions, body, sensory, automatic skills and the procedures involved in what we call creativity" (Talwar, 2007, p. 26). It is thus suggested by the author that art therapy may be a specifically valuable avenue for stimulating, connecting and integrating both sides of the brain, which the traumatic experience has left unintegrated. Meekums (2000) argues that art can be particularly helpful in containing and distancing difficult emotions which may be overwhelming for the client to express verbally; in allowing the artwork to "speak for" the survivor, while giving her control over what is disclosed; in allowing an image to emerge which can be faced and witnessed by others; and in allowing unconscious, non-verbal material to be unearthed. In the creation of artwork, what is expressed and contained in an image need not be discussed until a client is ready to do so. Keaeney-Cooke and Striegel-Moore (1996) encourage the use of art materials in the creation of concrete representations of the affective experience of abuse; "by experiencing and describing the effects of abuse in words, visual arts, and movement, she receives an opportunity to give a voice to the frightened, abused child and to say what could not be said in the original abusive scene" (p. 173). Serrano states that a "victim survival strategy includes extreme intellectualization, the numbing of emotions, and body rigidity as an early defence against intrusion. Enactment in the arts is a catalyst to bypass intellectualization" (p. 114).

For some survivors, the use of art may facilitate feelings of trust, as Brooke (1997) states, "sexual abuse survivors are lied to by their perpetrator. Words become misleading and

mistrusted; therefore verbal approaches to therapy may meet with more resistance." (p. 94) Yet the opposite may also be the case, as some clients may find expression through art materials very threatening to their feeling of predictability of what may be elicited by the medium, and therefore may threaten their feelings of safety in expression. Winnicott (1965) asserts that those with a strong sense of false self, which is developed through a lack of mirroring by the primary caregivers in infancy, find it difficult to use symbolism and to act in creative and spontaneous ways. This may be particularly true of those who have suffered abuse by caregivers in childhood, as their own emotions were not valued, mirrored and nurtured as they developed a sense of self, making it difficult for them to act spontaneously and to trust and value their own feelings and impressions. Hagood (2000) proposes that survivors may resist the use of art due to low self-esteem, and that they may be fearful of what the therapist or others may think of their artistic ability; the author suggests that in this scenario the art therapist may find it helpful to begin with less-threatening media such as collage and focus on reassuring the client as she gains more confidence in both her own abilities as well as in the therapist and other group member's acceptance of the client, allowing her to slowly take more creative risks at her own pace.

Art Therapy Techniques

Erdem (2000) stresses allowing and encouraging the traumatized client to create positive representations of hope rather than focusing only on the trauma, in order to allow the client to cope, recognize strengths, and begin to see a world that is not so overrun by trauma and painful feelings. Hinz (2009) postulates that "a client with a history of child abuse unconsciously may have blocked access to sensory information processing. Because of its association with trauma, opening the sensory channel would cause a flood of uncontrollable emotion…working with the client with perceptual experiences that give shape to the fear and organize its contents around

formal elements of visual expression would help the client first identify and then work through the obstacle" (p. 236), allowing for increased control through perceptual-focused art experiences, before moving to more sensory activities when the client is ready. Brooke (1995) outlines several art therapy interventions in an eight week art therapy group for adult sexual abuse survivors. The interventions in the first session include focusing on creating a level of comfort with art products and creating cohesiveness and group sharing by clients describing themselves as a color and shape; and creating four line drawings of the emotions of sadness, anger, happiness, and fear. The second session is focused on self-perception and current emotional state, by collaging or drawing a self-portrait around a mirror glued to the middle of the page, and writing something on the portrait with the non-dominant hand. The third session focuses on gaining insight into the client's family history through clients drawing a family portrait with everyone in the house doing something. The fourth session explores dreams and unconscious material the clients may be dealing with, including the common experience of nightmares, by asking the clients to represent a recent dream and ascertain the symbols that are evoked. The fifth session explores the themes of guilt, fear and anger through asking each client to symbolize a monster through art materials and how this monster applies to her own life. The sixth session focuses on the themes of fears, coping, and hopes through asking the women to draw a wish they have. The seventh session focuses on increasing personal self-esteem and asks the members to create a personalized "free" collage. The eighth and final session is focused on closure and a feeling of accomplishment through asking the clients to create a mural together with each member drawing freely on the same large piece of paper, or alternatively to create a farewell drawing representing each of the group members. Other recommended group art therapy interventions include creating a safe space in an image, creating a containing home for a valued object, using art materials to identify

and express feelings, and using art materials in cathartic ways to express repressed anger or for self-soothing, relaxation, and affect regulation (Malchiodi, 2008). In gaining trust with the client, Malchiodi (2008) states that long-term intervention is often necessary, as is a strong structure and consistency in the way that the art therapist holds the frame of the sessions and responds to the individual client. I will next discuss the group therapy context.

Chapter 6: Group Therapy with CSA Survivors

Group Therapy Perspective

Yalom (1995) outlines the therapeutic factors of group therapy as: Installation of hope; universality; imparting information; altruism; the corrective recapitulation of the primary family group; development of socializing techniques; imitative behaviour; interpersonal learning; group cohesiveness; catharsis; and existential factors. In particular, in a group focused on CSA, universality is a central goal (Darongkamas, Madden, Swarbrick, & Evans, 1995; Yalom, 1995); Yalom (1995) states:

> An integral part of these groups is the intimate sharing, often for the first time in each member's life, of the details of the abuse and the ensuing internal devastation. Members can encounter others who have suffered similar violations as children, who were not responsible for what happened to them, and who have also suffered deep feelings of shame, guilt, rage and uncleanliness. (p. 7)

As Herman (1992) states, "Participants repeatedly describe their solace in simply being present with others who have endured similar ordeals" (p. 215).

Herman (1992) posits a view of group stages for a group focused on trauma, beginning with establishing safety; focusing on self-care and strengths; sharing day to day experiences; and focusing on cognitive and educational goals rather than exploratory processes. In her view

second stage groups should focus increasingly on exploratory processes and the trauma narrative, while the third stage may focus on the community and interpersonal feedback and relationships or conflicts within the group. She also warns that for a second stage group focusing on traumatic processing, the group must develop a high level of cohesion and each member must be clearly prepared and ready for the process, as even brief absences of a member or a lack of readiness for the process could be damaging for some clients. The specific goals of safety and universality in a group focused on trauma survivors may need to be highlighted, decreasing the focus on conflict in the group in order to solidify these goals before advancing to later group stages that focus more on interpersonal feedback and conflict exploration.

Courtois and Leehan (1982) propose that the group setting provides a particularly useful forum for confronting isolation that often accompanies the experience of abuse, but groups with child abuse survivors often present with particular challenges. One challenge the authors encountered was with crises arising frequently, which interfered with individual and group processes. These crises may trigger other members' defence mechanisms, leading the therapist to experience difficulty in structuring the group and giving equal amounts of time for each group member. The authors state, "As a result, the group leaders sometimes became involved in what was essentially one-to-one therapy or in providing the primary emotional support and assistance for those in crisis" (p. 565). The authors discuss how boundaries are often an issue in these groups, as the members may be resistant to creating strong boundaries due to past boundary violations and lack of past learning of respect for boundaries. The authors state that although difficult, maintenance of strong boundaries is paramount in these groups, and that after the group the members tend to agree that more is accomplished with the boundaries being maintained.

Maintaining strong boundaries in the group allows for explicit and implicit modelling of safety through respect for boundaries.

Creative Therapy Group for Women Survivors

Two treatment plans for creative group therapy for women survivors were found in the literature, with the first being a twenty session program (Meekums, 2000) and the other being an eight session program (Brooke, 1995). Meekums utilizes a longer-term format, and utilizes the trauma theories and stages of therapy outlined earlier on survivor therapy (Herman, 1992). The information suggested by Meekums will be used as a format for the group art therapy intervention in the next section of this paper, with alternate exercises adapted for use in a group utilizing art therapy rather than creative therapy, as many of the suggestions by Meekums focus on movement rather than art therapy. The author suggests structuring group creative therapy with CSA survivors into a beginning phase, a middle phase, and an end phase, with closed group sessions consisting of twenty sessions of six to eight participants. She recommends 20 sessions, as this time frame allows for some in-depth group work while also respecting that many organizations cannot provide services for more extended periods of time due to limited resources.. In terms of the number of recommended participants, the author states that if more than this, the members may feel overwhelmed by the number of people, while less that 6 may increase the likelihood that the group will fold if more than one person drops out, and may suffer from insufficient witnessing and contributions by group members. She states that in her experience, it is crucial to screen the group members for similar stages of recovery and their ability to function within the group and work towards similar goals.. The therapist should meet with each potential client for one to two occasions for assessment purposes, covering topics such as confidentiality, explanation of the plan for the group, realistic aims for therapy, existing ways

of coping, and suitability of the art modality to the client. Assessment should consider the client's "goals and expectations; the ability to talk about the abuse and express affect; the amount of previous therapy; current health; self-destructive behaviours; and motivation" (Meekums, 2000, p. 127). The author and other verbal and art therapists (Briere, 1996; Brooke, 1997; Herman, 1992; Sweig, 2000), also recommend that clients be in or have access to individual therapy concurrent to the group, in order to deal with difficulties that may arise in the group and in order to get more individual attention for in-depth exploration of the trauma narrative and specific issues that the client is facing. Exclusion criteria include: "volatile, aggressive, manic or disruptive behaviour; the client being overly manipulative or fragile; drug and alcohol dependence; active self-mutilation or suicidal behaviour; psychosis, disorientation, or heavy medication." (Meekums, 2000, p. 127). Assessment is the beginning of the structured group program, and the structured process of the program is meant to model boundaries and create consistency within the group. The author states that modelling boundaries in a CSA survivors group is very important due to the fact that the survivors have had their boundaries violated in the past by their abuser and possibly others, which threatened her very sense of self; as well, some of the member's families may have had rigid boundaries and punitive rules that may need to be reworked. In order to model boundaries within the group, she recommends "a set number of sessions; starting and finishing on time; keeping confidentiality; avoidance of talking about one's own personal life, except when this is in the service of therapy; not offering therapy to a friend or family member; not developing a friendship with a client; not engaging in sexual activity with a client; making the space safe, ie not intruded upon by others during the session; not leaving confidential material lying around; not having photographs of your own children on the desk; not giving clients your home phone number; and having an ex-directory telephone

number." (Meekums, 2000, p. 123). The first 4-6 sessions of a 20 week program should focus highly on establishing safe and predictable boundaries within the group.

Meekums (2000) states that in the early phase of the group, she focuses on the therapeutic alliance; conditions of safety and containment; formulation of assessment; developing coping skills; establishing realistic goals; and crisis management if necessary. The author references Simonds (1994) ideas, stating that it is imperative that the therapist realize if the survivor needs to focus "on containment, exploration, or expression, at any one time. To facilitate expression when the client needs to work on containment…could lead to a sense of being overwhelmed, resulting in possible setback or flight from therapy" (p. 43). Meekums (2000) presents her group model and tasks of the recovery process as follows:

1. Striving: struggling to survive (eg. self harm, absenteeism), burial (dissociation, numbing), and the dilemma of disembodiment (disconnection from the body)
2. Incubation by letting go into the art form: unearthing (eg. improvisation/letting things arise spontaneously/Winnicott's potential space/unconscious arising to consciousness), facing the reality (eg. drawing the traumatic location, disclosure/exposure), and speaking the unspeakable (eg. trauma narrative and witnessing, using art as the "speaker" through safe distancing and decreasing intellectualization)
3. Illumination: gaining a new perspective (ex. recognizing strengths, empathizing with the inner child, decreasing generalizations, cognitive change)
4. Evaluation: laying the abuse to rest and gaining temporal and spacial distance (eg. identifying more with adult self, feeling more in control after mourning and being witnessed with acceptance, being able to think of the past non-intrusively, hope for future)

This format will be used to illustrate a treatment plan that may be utilized for a twenty-four session or longer art therapy group for sexual abuse survivors.

Role of the Group Art Therapist(s)

If possible it is recommended that groups for survivors be led by two group co-leaders (Herman, 1992; Meekums, 2000), and that those co-leaders both be female if leading an all-female group. The reason for this is that power imbalances based on gender may be highly triggering for some survivors, although for survivors in later stages of recovery it may be recommended for a group to be led by a male and female therapist of equal status in order to encourage processing feelings towards men in a safe therapeutic relationship. Co-leadership is recommended as a way to model equality and resolution of differing perspectives between the group leaders, for the clients to have the possibility to project different roles onto the therapists to be explored, and for the leaders to be able to process group dynamics and countertransference reactions together that may be quite difficult for one therapist to process alone, even with supervision (Meekums, 2000). Countertransference issues may create conflicts between the co-therapists, and this is to be expected and worked through as a dyad in supervision and can lead to great insight into the underlying dynamics of the group process (Meekums, 2000).

The art therapist's role includes providing a structure for the group, maintaining the agreed upon set of boundaries to create a sense of safety for group members. Herman (1992) states that the trauma-informed therapists must reflect on their own experiences and affirm a stance of solidarity with the victim, having an understanding of the fundamental injustice of the traumatic experience; this "expresses itself in the therapist's daily practice, in her language, and above all in her moral commitment to truth-telling without evasion or disguise" (p. 135). In terms of group therapy with survivors, the author states, "a group must have a clear and focused

understanding of its therapeutic task and a structure that protects all participants adequately against the dangers of traumatic re-enactment" (p. 217) and that the therapists should facilitate so that each member be given the opportunity for similar amounts of "air time" to foster safety and equality. Meekums (2000) states that the basic therapeutic skills of non-possessive warmth, empathy and genuineness, are of utmost importance for the group art therapists, as well as not expressing shock with what the survivors create and disclose, making it clear that survivors are not to blame for the abuse, and assuring that the survivor be empowered with choice within the agreed upon boundaries. The art therapists must create boundaries to maintain confidentiality, encourage non-judgemental witnessing and processing of the art work made by the members, encourage respect and value for individual differences and art works, carefully time interventions based on the needs and abilities of each member, and emphasize that each member has the right to say no to participating in an activity or in verbal sharing about a piece of art. In the art making process, the art therapists encourage and model a non-judgemental space for reflection on images and honor the value inherent in each creative expression. As Wadeson (2010) states, the art therapists should not be engaged in art making in the group, as this may become a focus for the therapists' own issues or concerns which should not be worked through with their clients, and it may create a feeling of intimidation in the clients if the therapists use more advanced artistic skills.

Chapter 7: Sexual Abuse Art Therapy Group

Structure

I will now discuss the proposed art therapy group treatment for CSA survivors based on the previously outlined theories and recommendations. The suggested art therapy group intervention consists of a closed group of 24 weeks or longer, which will include a weekly two

hour session with four to seven adults who are self-referred for services related to the experience of CSA. The therapist meets with each individual who is a candidate for the group for a one-hour individual assessment session, one month to one week before the commencement of the group to determine the needs of the individual and the appropriateness of the group for the individual's current goals and resources. It is recommended that each group member has begun individual therapy at least six months prior to the commencement of the group in order to establish a level of comfort with the therapeutic process and to allow the client to receive individual attention for her individual disclosure process and needs; ideally the members continue to participate in individual therapy (or at minimum have the resources and willingness to seek individual sessions) throughout the length of the group, in order to process what arises in the group context as well as to process her own personal experience in more depth than a group context can allow. The main goals of the group may include increasing the grounding and coping strategies and increasing a feeling of safety; discussion and normalization of common symptoms experienced by CSA survivors; decreasing avoidance of emotions and memories related to the abuse; and increasing feelings of universality and installation of hope within the group. The inclusion criteria include the individual's ability to discuss the abuse; the coping skills and resources that the individual currently uses in relation to stress; the ability to listen to others; organization of thought processes; the capacity for insight; the ability to contain affect; an openness to use of art materials; and the engagement and motivation of the client. Counter-indications for admission include paranoid or psychotic traits; aggressive or excessive defensiveness; and low impulse control or high risk of self-harm based on past and current coping history. Once a list is generated for possible members, each individual is contacted to discuss the recommendations of the art therapist, whether it be inclusion in the group, recommendation for another type of group,

further processing time in individual therapy before involvement in the group, or other pertinent resource recommendations.

Each weekly group therapy session may be structured with an opening and closing ritual of 5-10 minutes each, such as a check in and/or check out on how each client is feeling, a relaxation exercise, ideas about how each client has or will utilize self-care this week, or how each client perceives the group processes thus far. The art-making process will consist of 45 minutes of art making, 5 minutes for clean-up, and a following discussion of 50 minutes. The themes of each group are suggested at the beginning of each group in order to give containment and structure to the clients, with the voiced acknowledgement that the group is meant to serve the group members and if a group member does not wish to address the suggested theme, she is encouraged to voice this and to focus on what is most pertinent to her that week for group processing as the group is meant as a safe place of support to explore issues related to the abuse. In the first session the group leader goes over the group therapy contract already discussed in the individual assessment sessions, outlining the time frame of the group and the rules of the centre where the group is held, such as non-violence and rules of attendance such as the need to evaluate involvement in the group if an individual misses more than three sessions in a row without serious reason. Members are then asked to generate group guidelines with the help of the group leader, which will be maintained throughout the group to facilitate safety of expression, such as the importance of consistent attendance, respectful language (non-racist, non-sexist, non-homophobic, etc.), non-judgemental statements, respect for each client’s need for personal space, etc. The group leader records these group guidelines on a large sheet of paper that is put on the wall for each upcoming group, and members are encouraged to add to the guidelines throughout the length of the group meetings if they so wish. The members may also be asked to mark or sign

the group guidelines in some way as a form of contract using art materials, such as through tracing their hand on the open space of the list of guidelines with a color that they identify with. The group leader then may explain the intentions of art therapy; show the group all of the available materials in the room; and where the artwork will be stored throughout the length of the group.

Chapter 8: Examples of Beginning Stage Exercises

(Objectives: Safety, Containment and Emotional Regulation)

I will now discuss possible exercises or themes that could be suggested in the beginning, middle or end stages of the art therapy group, which may be adapted for the particular group needs or objectives. More exercises will be suggested for the first stage of the group focused on containment, as there is often progression and regression in this phase of therapy; particularly in the need to maintain feelings of safety and coping skills, and themes may re-emerge and be reprocessed as needed. I will be outlining twenty four activities that can be chosen for use within a group, based on the group's particular needs, length and objectives. Some of these activities may be carried out for more than one session, if the group leader deems it therapeutically necessary and if time allows.

1. Personal Folders

Objective. For clients to become comfortable with art materials in a non-threatening way, to introduce themselves to, and encourage cohesion among, the group members, and to create a containing and consistent object that safely holds the art creations and symbolically holds emotional expressions made throughout the group.

The members are first asked to create a folder for themselves with their own name or a nickname with which they identify themselves written on the folder. They are then asked to try

out any materials that they are drawn to, to decorate their folder and to express themselves in whatever way they wish. They are encouraged to try to not worry about the artistic results as this is an exercise to get used to using materials and that they may continue to alter the folder throughout the length of the group. After about 40 minutes of artwork, the members discuss how it felt to use the art materials in the context of the group and if there were any materials they enjoyed using most and why.

2. Safe Space

Objective. To teach containment and affect regulation skills by incorporating a safe image in the clients' minds that can evoke feelings of safety and calm. Drawing the space encourages self-soothing through the materials, and concretely representing details of the space fosters ease in remembering the space outside of therapy.

The group leader reads a relaxation exercise based on the visualization of a safe space where the members feel safe and protected (Bass & Davis, 2008, p. 38). When doing the guided imagery exercise, ask the clients to try to focus on their feelings in that safe place, and to try to imagine it as clearly as possible, such as what colors and objects are there that help them feel safe, and if they are alone or if they prefer to have someone there with them. The members are then asked to make a two or three dimensional representation of this place, and to share the experience and artwork with the group.

3. Body Scan

Objective. To connect the mind and body through identifying current sensations in the body; to give the clients a tool for muscle relaxation; and to identify possible signs or triggers of emotional states within the body.

The members are first asked to do a short body scan or progressive muscle relaxation that the art therapist leads them through. The therapist asks the clients to sit and close their eyes if they are comfortable (or to lower their eyes to the table in front of them), then to notice the sensations in their bodies progressively going from each large section of the body such as their head, their face, their shoulders, their chest and abdomen, their back, their pelvis, their legs and their feet. The members are asked to relax each section of their body, imagining the tension draining away from each section of their body subsequently while going through the scan. The therapist may then go through the body scan again, this time asking the members to imagine that they are feeling an emotion that they had difficulty with in the past week, such as fear, sadness, or anger, and to notice if there are any differences in their bodily sensations between the first scan and the second scan. The members are then asked to create art as a response to the overall experience of the exercise and what they observed, and to share with the group.

4. Support

Objective. Symbolic containment of difficulties and emotional states; identification of what the members need to feel supported within and outside of the group.

Clients are asked to think about people in their lives who have supported them. What does support mean to each member, and what does each member need from the group to feel supported? Each member may then write down on a small colored piece of paper the main difficulties that they are experiencing in their lives right now., They are told that they do not need to share this if they do not wish to. The members are then asked to integrate this piece of paper into a piece of artwork that shows this paper being supported somehow, by being held or contained by someone/something, surrounded by a healing color or environment, or protected in some way, followed by group sharing of their experience.

5. Difficulties and Hopes

Objective. To normalize the common symptoms of PTSD, allow for sharing of issues and identification of similarities among the group members and increase hope.

The group leader may bring in a list of common symptoms related to trauma, and first engage the group in making a list of trauma-related problems that they are experiencing or have experienced in their lives such as nightmares, difficulty concentrating or “spacing out” (dissociation), difficulty with relationships or trust, etc. Following a discussion and normalization and validation of common symptoms that the members have been experiencing, the members may be asked to create an artwork based on the theme of hope, either what hopes they have of change in the future or what things give them hope in their lives today.

6. Wise Inner Advisor

Objective. To concretely symbolize clients’ internal resources, such as the ability for self-care behaviours and positive self-talk which may be used as coping strategies.

The group leader begins the session with the “Wise Inner Advisor Visualization” (Vivyan, 2009, p. 19). The group members then discuss their experiences of the visualization, and create an artistic representation of their wise inner advisor. If any members have problems visualizing an inner advisor, they may be asked if they can identify if there was a color or a part of themselves that they can draw on for support and healing wisdom and how this color or part of themselves may be symbolically represented, or they can think of a word or phrases that are healing or inspirational that they may represent in a poem, story or drawing.

7. Container of Feelings and Coping

Objective. To express feelings that the client feels today which are connected to past abuse, in a contained way that focuses on coping skills and ways to get through the difficult feelings.

The clients are asked to draw a shape of their choosing of any size that will hold words and symbols of the feelings they have been dealing with in the past week which they feel are related to the abuse. The clients are then asked to draw words or symbols outside of the shape that represent things that give them strength or help them to get through the difficult feelings.

8. Intention and Witness Process

Objective. To encourage defining and exploring an issue or question that the client is facing in relation to her recovery process, and deepening the clients' engagement and reflection on the art process (Adapted from Pat Allen, 1995).

The clients are asked to write down a one sentence question or issue that they have been facing and want to explore in the group. This question or issue may be something that led them to seek out therapy or an issue that has come up for them recently which they feel is related to the abuse. Once the clients write down their intention for exploration, they are asked to create spontaneous artwork using any material they wish. They are encouraged to attempt to allow the artwork to be more spontaneous than planned. After art making, clients are given a sheet asking the following questions: First describe what you see (Describe the actual image, ex. There is a blue bird flying towards a bent tree branch with blue sky in the background…etc.; describe the colors, shapes, lines, space, pressure/thickness of paint, etc.); Then describe the steps of how you made the artwork (ex. After cutting out the bird from a magazine, I drew a tree branch on the paper with pencil crayon and then glued the bird onto the paper, etc.); Write down what is

coming up for you in the moment. Locate yourself in the present moment, your energy, emotions, boredom, hunger, etc. Write down random feelings. (It's cold in here, I'm hungry, my foot feels funny, this is stupid, etc.) Give an honest assessment; Now try to "dialogue with the image," ask it a question, listen to your feelings and intuition for a response. Does it have anything to tell you or make you wonder about? What does it make you think of? Write down anything that freely enters your mind, any words, a poem, an image, a feeling, whatever comes up spontaneously for you. After the process of answering these questions, clients are asked to reflect on any connections they may find between their original intention and the artwork, and to share any insights they wish to with the group

9. Group Symbol Object

Objective. To create a feeling coherence during a group break such as holidays; to encourage grounding and coping through the use of a transitional object.

The group leader passes around a basket filled with different small objects such as rocks, feathers, sea shells, gems, sticks, dried flowers, candles, or other materials such as images from magazines or paintbrushes or colored pencils. The members are asked to choose 1-3 objects to take with them over the break to remind them of the group and to help them feel grounded. Each person is encouraged to discuss what objects they chose and why, and where they are planning on keeping the object during the break. The members are asked to bring the objects back after the break. Each participant is also asked how they feel about the group break, what they plan to do to support themselves during the time that the group is usually held, and what kinds of self-care they can use during the length of the break.

Chapter 9: Examples of Middle Stage Exercises

(Objectives: Exploration, Trauma Narrative and Expression)

10. Embarking on the Journey

Objective. To create cohesiveness in the group while focusing on individual challenges and goals; to symbolically prepare the clients for difficult aspects of the group including confronting and sharing painful past experiences.

The members are asked to imagine that they are about to embark on a journey down a path together. Members are asked to use two dimensional art materials, with each person drawing a personal piece of the path (each on the same sized paper), representing what fears/barriers they may personally encounter along the journey of the group and how they may overcome these challenges. The paths are then combined into one large artwork of a path connected together, with a list of one individual goal for growth from each member at the end of the path. The members are then asked, "What do we need to feel safe and supported on this journey together?" with possibilities such as understanding, empathy, reliability and patience.

11. Picturing the Effects

Objective. To assess and explore the individual issues which each client is facing related to the abuse; to assess the ways clients have coped in the past, and increase group cohesiveness and trust.

The group leader hands out the questionnaire "Assessing the Damage" from the Courage to Heal Workbook (Davis, 1990, p.124). The members are given time to fill out this questionnaire, and are then asked to draw, sculpt, paint, or collage the ways that the abuse has hurt them or continues to affect their lives. They are given time for these artworks and then asked to make a second artwork that represents the strengths they used to survive (this may need to be suggested in a subsequent session, depending on time available). The experience is then shared

with the group, ending with each group member writing down a word of strength that helps her, on small pieces of paper one for each of the other members to take home.

12. Visual Timeline

Objective. To begin the process of looking at the clients' past personal histories including abusive events as well as positive influences and accomplishments; to begin to see connections between past events and subsequent ramifications in their lives.

The members are given the directive to make a continuous line representing feelings related to events and milestones in their life from the time they were a child to the present, including both positive and negative influences from their past. The line can be made of any material, color, or shape. The events can be labelled or represented by a drawing or symbol along the timeline. These events may include births, deaths, painful experiences such as traumas, and enlightening experiences or milestones such as moving into your first self-chosen home. When the clients are finished they may personally reflect on their timeline, asking how the abuse may have affected life events or trajectories, along with positive events or accomplishments. In the following group the members may be asked to create a future timeline, representing an imagined idea for the future and what events and milestones the client hopes to experience. This may allow the clients to identify future goals or to use their imagination in visualizing a possibility of a future that is increasingly within their control.

13. Writing a Traumatic Experience

Objective. To process a traumatic narrative individually and safely with the support of other group members with similar experiences to decrease avoidance and feelings of isolation.

Each client is asked choose a traumatic or painful experience from her timeline; an experience that she feels continues to affect her life and she feels she wants to explore most in

therapy. Each client is asked to write down what happened to her and her feelings in her mind, body and spirit, and that afterwards she may choose 1-2 sentences that she would like to share with the group. The group leader can explain the reason for limiting the sharing, emphasizing safety and that “The main reason for this activity is to be honest with yourself and to express how you felt, and to be in a group with others who are going through a similar process. Try to not judge or sensor your writing, as this is a way to heal for yourself, not to meet any expectations.” The sharing is kept to 1-2 sentences in order to express the most painful aspect of the experience, and to maintain feelings of safety for all clients and contain the process within the limited time frame. If the group is a more advanced long-term group that could maintain feelings of safety while verbally sharing more of the writing, this may be done in subsequent sessions with a set amount of time for each individual to share. Before beginning the writing, ask the clients to be aware that the writing will be limited to 30 minutes in length so that they have a controlled amount of time, and that they may always return to it at another point. Afterwards, each client is asked to share with the group what the writing experience was like for her; it may also be important to iterate that some people may feel the need for sharing this writing with the group while others may not find sharing their own writing as healing right now, and that each decision is honored in terms of each individual’s healing path, and they may choose to share this writing in their individual therapy sessions.

14. Inner/Outer Self Box

Objective. To process the feelings about the abusive situation that the client may not have been able to express at the time; to explore how the client coped with the initial disclosure and the concurrent emotional reactions.

The members are asked to bring in a box from home, or to choose a box from a selection provided, which they will use to represent themselves after an abusive experience. They are asked to decorate the box on the outside representing what feelings and aspects of themselves they showed to the world, while the inner part of the box is made to represent what they kept hidden on the inside. The members are then asked to reflect on the differences between the inside and the outside of the box, and how they coped with the abuse in order to survive. This activity may bring up the feelings about the process of initial disclosure and how those around them reacted supportively or unsupportively. The group leader may want to encourage a discussion on methods of coping and defences, and how everyone needs to feel protected and to defend themselves against more emotional pain; and that sometimes people cope in ways that may cause further problems later such as dissociation or avoidance. These problematic coping strategies may be viewed as ways that the client survived the abuse as best she could, but that these avoidant ways of coping may now need to change in order to cope in more effective and fulfilling ways. The members are asked in the next session to write down supportive and understanding words, a poem, a letter, and/or make an image for a person who has just experienced abuse as they did, with a focus on what the person may need at that moment; this may be placed inside the box as a healing force.

15. Family of Origin

Objective. To process family context and relationships, including supportive, unsupportive, and abusive; to explore how past relationship dynamics affect the clients' current relationship dynamics; to decrease feelings of self-blame and mourn abusive family situations.

Each member is asked to draw a representation of herself with her childhood family and those people who influenced her both positively and negatively, which may include

grandparents, babysitters, church members, etc. The members are encouraged to draw each of the people doing something in the picture, and told that it is not important how realistically the people are represented, as the focus is on the exploration of feelings and relationships. Participants are encouraged to reflect personally on their drawing, paying attention to things such as space, size and placement and the activities that each person is engaged in, whether alone or with others. The members are then asked to share their feelings and observations with the group, including how the abuse is reflected in the image and how family members reacted to disclosure of abuse.

16. Claywork

Objective. To process feelings of anger and explore clients' beliefs about expressing anger.

Each client is asked to represent her feelings of anger, which is first discussed as an emotion that sometimes people have trouble feeling. The members may be asked, "How do you know when you feel angry? Do you believe anger is positive, negative, or both? How are some ways that abuse may affect the expression of anger? Are there times when anger may be used positively, in your experience?" Each member is then asked to try to get in touch with feelings of anger and to make large gesture drawings using red oil pastel on a large sheet of paper. She may write a name, the word abuser, or a symbolic word/drawing of an abuser or someone who did not support her when she needed that support. Each member is then asked to manipulate the clay to express anger and/or form clay into a symbol of her own experience of anger and rage. The members may choose to use their clay on the large drawing, integrating the two media together if they are inclined. Afterwards the members may share their experiences and feelings, and they may choose to keep the artwork as a symbol of their anger or to alter it before the session is over,

by ripping the paper or smashing the clay during the group discussion of their feelings of the experiences. It is suggested to place the anger symbol into a container if the client wishes, to hold the strong feelings before terminating the session, and much time should be left for processing and for containment.

17. Letter Writing

Objective. To express and process feelings towards a particular person that the client was not able to express in the past. (Adapted from Meekums, 2000)

Members are asked to write a letter of their choosing which will not be sent, such as a letter from the survivor to the abuser; from the survivor to someone who may have been supportive had they been aware of the abuse (or for example to a deceased person who was not available then); from the survivor to an unsupportive person to whom she disclosed; from the survivor now or in the future to the survivor immediately following the abuse; from the survivor immediately following the abuse to herself now; or from the survivor to someone who was or is supportive. The members then share about the experience and may share the letter with the group if they so wish.

Chapter 10: Examples of End Stage Exercises

(Objectives: Reconnection to Present Self and Others, Termination and Hope for the Future)

18. Inner Child

Objective. To encourage the client to identify with current feelings related to her past sense of self as a child; to identify strengths the client has and how to be supportive to herself in the present; to develop a more positive and empowered self-image and self-acceptance.

Each client is asked to create a portrait of herself as a child, and to represent what was happening in a traumatic situation in the background. Each member is then asked to write with her non-dominant hand what her child-self was thinking and feeling about herself, others, and the world. She is then asked to make a portrait of the strong and caring aspect of her adult self in a larger format, helping the child in some way. Clients are asked to write with their dominant hand how this adult self could respond supportively to the child's thoughts and feelings, and what they could say to support a child in a similar situation. The feelings about the process are then shared with the group.

19. Representation of Relationships in your Life

Objective. To explore the support network that the client has developed and if there is a need to develop a supportive support network; to prepare clients for the ending of the group by focusing on current relationships outside of the group.

Each client is asked to make a list of people who she interacts with on a regular basis, and to evaluate if each person is considered supportive, unsupportive, or both. The members are then asked to choose those on the list whom the client considers most supportive in their day-to-day lives, and to make an abstract representation of themselves with these people using art materials. The members are then encouraged to discuss how they felt doing this exercise, and if anything surprised them or what they may have realized. The members may be asked what they need to build up an adequate support system, and if there is anyone in their lives who may be a source of support that they have not currently utilized.

20. Body Safety

Objective. To encourage members to explore safe boundaries in regards to current adult sexuality and to name boundaries concretely.

Members are asked to write down any issues they may be dealing with about sexuality in their current life. This will not be shared. They are then asked to reflect on whether the issue is something that they want to work on and if so, do they want to work on it for their own satisfaction or for someone else's expectations. Discussion may focus around the need for boundaries in ensuring safety and self-support, and that everyone's boundaries are different and acceptable. Clients are then asked to fill out the "safe-sex guidelines" (Davis. 1990. p. 443) of sensual or sexual activities that feel safe, possibly safe, or unsafe. The sheets are not shared, but the group is asked to share what activities that they can do for themselves to soothe themselves and care for/connect to their body.

21. Worry and Strength Holders

Objective. To create two transitional objects that allow the client to symbolically contain her worries and to act as a symbolic connection to support and inspiration from the group.

Members are asked to sew two small bags out of fabric, and to choose two ribbons or another material to tie each bag closed. One bag is for worries that the client currently has which she writes down on small pieces of paper, and the other is for inspirational phrases that the client writes down and can use to help herself through difficult times. Clients may share inspirational phrases with each other than may be helpful to include in their bags of inspiration.

22. Artwork Review

Objective. To encourage reflection on the overall process of the group for each individual over time, and to begin processing feelings of closure for the therapeutic process.

Members are asked to gather together all of the artworks that they have created throughout the length of the group, and to lay them out in chronological order. Each member is asked to reflect in writing on themes that they find between artworks that they have created, and

any changes or insights they realize through this reflection on their overall creative and therapeutic process. Members are then asked to share any realizations they feel comfortable sharing with the group. This process may also be extended to last several sessions, with each member hanging up their artwork in chronological order to be reflected upon verbally by the group as a whole.

23. Group Mandala

Objective. To create a sense of accomplishment and connection among the group members; to process termination of the group and positive growth experienced together.

Each member is given a piece of strong paper in the shape of a pie slice, that together create one large circle. Each member is asked to decorate and write things on her section that expresses herself and her positive experiences within the group. The circle pieces are put together and taped to a large sheet of paper, and members are asked to share their perceptions of the experience.

24. Closure

Objective. To establish feelings of closure within the group and focus on the future.

The group members are asked in the previous session how they would like to structure the last group, if there is anything they would like to do as a free socializing space. The group may also be asked to do an activity where each member draws a name of a group member from a hat, and then tells that group member the strengths that they see in that member and things that they wish for them in the future. The group members may also be asked to choose a small gem from a bowl that they may take with them to keep in their inspiration bag created in a previous session, to ground them and remind them of the support they received as a member of the group.

Chapter 11: Discussion

The intention of this research paper was to suggest a model for a longer-term art therapy group with survivors of CSA, integrating theory with practice. The reason for this undertaking was that I found a gap in the literature while looking for resources for a group that I was planning and conducting. I found that there was limited information available of practical and theoretically linked models for an art therapy group with CSA survivors, which would fit my intentions for the 24 week group I was planning. I therefore created this paper for myself and other art therapists as a possible guide for inspiration that is grounded in theory. This model is intended to be flexible for art therapists to adapt for use with their own particular group and its needs, and to be adapted to the pace of the clients within the group. I found using this model helpful for inspiration for my own group in understanding my overall goals for the group, but I also adapted the pace and group exercises to fit with what the clients' needs were each particular week. As stated in the theory section of the paper, it is critical to assess and alter the process based on the readiness of the clients to explore particular issues related to the trauma, in order to prevent re-traumatization of clients. Based on my experience of conducting the group, I would suggest focusing on feelings of safety as the paramount goal, along with encouraging feelings of universality amongst group members. If group members are able to consistently process current difficulties while maintaining feelings of safety, the group may proceed to exploration of the traumatic narrative to decrease avoidance of the memories. As stated earlier in this paper, assessment and screening for the stage of recovery of each client is critical, and the leader may want to put restrictions on the number of sessions a client can miss in the group, especially if the group is going to be focused on disclosure of the details of the traumatic experiences to the group. This restriction is intended to discourage sporadic attendance due to avoidance of the

process, or crises that occur throughout the process. I suggest explaining to clients that the reason for the limited number of absences is to create a consistent space of safety and support, and to ensure that clients maintain active engagement in their own recovery process and the recovery process of the other group members. It may be useful to suggest that group members attend and let the group know when they are feeling less able to share, rather than missing the group. In order to respect the pace of clients, it may be recommended for some clients to participate in a group such as this several times to deepen their experience and exploration, while modelling the process to other members with less group therapy experience. It may be explained to the clients that recovery is a process which takes time to work through, with many normal progressions and setbacks. In terms of discussion within the groups during art making, I recommend stating that some members may want to talk during the art making while other members may not want this in order to maintain focus on the artwork and their own internal processes. I would recommend discouraging conversation during particular activities that require a high level of internal exploration of painful emotions, particularly those in the "middle phase" of the model.

This model may be adapted for clients focusing on other forms of trauma such as childhood physical abuse or other PTSD focused groups. Groups with mothers whose children have disclosed sexual abuse may find this model useful, with adaptation of the exercises focused on personal sexual abuse such the assessment and the sexuality activities. Groups focused on exploration of other forms of trauma such as war-based trauma may find the overall framework useful while some activities would need to be adapted for the specific needs of the client population. It is paramount that therapists leading groups focused on trauma seek out a consistent, supportive and experienced supervisor to deal with the therapists' own issues related to leading groups such as these. It is also recommended that therapists participate in their own

personal therapy and consistently maintain self-grounding activities in their daily lives in order to prevent the common reaction of vicarious traumatization when working with trauma survivors. Future recommendations for this research paper would include use of the model with a high number of groups with different therapists and to conduct qualitative research on the themes that the therapists and clients find most salient for using and improving the model.

Conclusion

This research paper has outlined theoretical and practical suggestions for a long-term art therapy group with women survivors of CSA. Trauma-informed therapy is a developing field that can help art therapists in structuring and guiding their practice with traumatized populations who may greatly benefit from an expressive, non-verbal form of intervention. It is my hope that this paper can inspire other art therapists to feel confident in working with survivors during this difficult process in an ethical and theoretically informed manner. I believe that with the use of suggestions outlined in this paper which were inspired by therapists who have worked in this difficult field for many years, I as a neophyte therapist may evolve my understanding of my clients, their experiences, and my role in their process. With the use of this structured model as a background to continue to guide my work in the future, my intention is to use this structure as a flexible guideline to understand the overall goals of the process, while maintaining my focus on the therapeutic relationship with my clients and their individual needs.

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