

Group art therapy with sexually abused girls

Gertie Pretorius

Centre for Psychological Services and Career Development, University of Johannesburg,
Johannesburg, South Africa
hgpretorius@uj.ac.za

Natascha Pfeifer

University of Johannesburg

The psychological impact of child sexual abuse has been widely researched. The purpose of this study was to evaluate a group art therapy intervention designed by the authors aimed at reducing depression, anxiety, sexual trauma and low self-esteem among 25 sexually abused girls aged 8–11 years. The programme was based on existential-humanistic, Gestalt, client-centred and abuse-focused principles. The Solomon four-group design was used to investigate the efficacy of the intervention, and the Trauma Symptom Checklist for Children and Human Figure Drawing were used as measures for assessing symptom change. The results indicated that the experimental groups improved significantly compared to the control groups with regard to anxiety and depression. The study adds to the literature on therapeutic approaches that can be applied to sexually abused children and on the use of group art therapy as an intervention technique.

Keywords: anxiety; art therapy; depression; group therapy; group art therapy; sexual abuse; South Africa

Child sexual abuse (CSA) is recognised as a traumatic experience that can have a number of adverse effects (Bohn, 2003; Diehl, 2002). Sexually abused children generally reveal significant problems in diverse areas of functioning including those of affect, behaviour, cognition and interpersonal relationships (Browne & Finkelhor, 1986; Freeman, Collier, & Parillo, 2002; Gardner, 2002; Mazza, 2003). Finkelhor and Browne (1986) developed a conceptual framework to organise the observed effects of CSA. They proposed an analysis of sexual abuse in terms of “four trauma-causing factors” labelled as the traumagenic dynamics (Finkelhor & Browne, 1986, p. 180). This umbrella term covers the concepts of traumatic sexualisation, stigmatisation, betrayal and powerlessness. Several psychological impacts and behavioural manifestations are associated with the four traumagenic dynamics. Psychological impacts include sexual pre-occupation, age-inappropriate sexual knowledge, depression, anxiety and feelings of isolation. Behavioural manifestations include recurring sexual behaviours, sexual aggression, self-destructive behaviours, and suicide (Finkelhor & Browne, 1986).

Sexually abused children have been found to suffer from anxiety, post-traumatic stress, guilt, depression and low self-esteem (Carr, 2000; Gardner, 2002; Wade, 2000). Common behavioural symptoms found include irritability, frequent soiling, nightmares, suicide attempts and confusion about sexual boundaries (Gardner, 2002; Mazza, 2003; Sacks, McKendrick, & Banks, 2008). Research suggests that children in South Africa are at high-risk for CSA. A recent meta-analysis on the prevalence of CSA revealed that South Africa appears to have the highest incidences of CSA globally (Pereda, Guilera, Forns, & Gómez-Benito, 2009). For example, Madu and Peltzer (2001) found that 60% of males ($n = 193$) and 53.2% of females ($n = 216$) in their sample of Grades 11 and 12 students in the Northern Province (Limpopo) reported some form of sexual abuse against them as a child. The South African Police Services Annual Report (2008) also indicates that there were approximately 16,000 reported cases of rape against children (children defined between 0–18) between 2007 and 2008. A need therefore exists for effective treatment in counselling children who have experienced CSA. The purpose of this study was accordingly to evaluate a group art therapy programme — developed by the authors — for sexually abused girls in South Africa.

PSYCHOTHERAPY

Many different interventions and treatment modalities are used when counselling children who have

experienced sexual abuse (Cohen, Mannarino, & Knudsen, 2005; Lev-Wiesel, 2008; see the National Crime Victims Research and Treatment Centre & Centre for Sexual Assault and Traumatic Stress (NSVRC), 2004, for an overview of the various intervention techniques). Although sound empirical evidence exists for the efficacy of a number of interventions, various other techniques are undocumented, have not received empirical evaluation or are not suitable for the treatment of CSA (Lev-Wiesel, 2008; NSVRC, 2004).

Treatment modalities used in CSA include individual, family and group therapies (Lev-Wiesel, 2008; Tourigny, Hébert, Daigneault, & Simoneau, 2005). Trauma-focused cognitive behavioural therapy (TF-CBT) has emerged as a highly effective and widely used treatment for CSA (Chaffin & Friedrich, 2004; Cohen & Mannarino, 2008; Cohen, Mannarino, & Deblinger, 2006; Lev-Wiesel, 2008). TF-CBT is an evidence-based treatment model that is designed to reduce the emotional and behavioural sequelae attributed to traumatic events (Cohen *et al.*, 2005; 2006; Lev-Wiesel, 2008). However, TF-CBT is not an optimal solution for children with problems unrelated to trauma thus necessitating participation in other evidence-based treatments (Cohen & Mannarino, 2008).

GROUP THERAPY AND ART THERAPY AS INTERVENTION

The literature indicates that group psychotherapy may be useful as a treatment modality for sexually abused children (Aldridge & Hastilow, 2001; Brown & Latimir, 2001; Buckland & Murphy, 2001). According to Killian and Brakarsh (2004), group therapy can ameliorate difficulties encountered in the use of individual therapies with sexually abused children, including an inherent distrust of adults, fear of intimacy with and disclosure to adults, secrecy and defensive behaviour (Killian & Brakarsh, 2004). Group therapy also offers children the opportunity to realise that they are not alone in their experiences and that other children have had similar experiences (Freyd, 2002; Murphy, 2001; Yalom, 1998). This realisation may be a great source of relief that helps reduce the sense of isolation (Gallo-Lopez, 2000; Killian & Brakarsh, 2004; Yalom, 1998).

Various studies have demonstrated the efficacy of art therapy with children (Carolan, 2001; Douglass, 2001; Gilroy, 2006; Snyder, 1997; Waller, 2006). Art therapy involves a holistic approach in that it not only addresses emotional and cognitive issues but also enhances social, physical and developmental growth (Carolan, 2001; Snyder, 1997). Art therapy appears to help with the immediate discharge of tension and simultaneously minimize anxiety levels (Dwivedi, 1993; Naitove, 1986). Dwivedi (1993) and Snyder (1997) contend that the act of external expression provides a means for dealing with difficult and negative life experiences. Art therapy, therefore, not only assists with tension reduction but also with working through issues thereby leading to greater understanding (Naitove, 1986).

Children may experience difficulties integrating the experience of abuse and processing it emotionally and cognitively due to their developmental immaturity (Ryan, 1996). Difficulties associated with the treatment of sexually abused children relate to their inability to verbalize their emotions and thoughts generated by the abuse (Zinni, 1997). Children also tend to feel overwhelmed and intimidated by the verbal expression of their experience (Killian & Brakarsh, 2004; Pifalo, 2002). Art therapy is consequently perceived as a successful alternative to conventional psychotherapy for this population group (Bissonnet, 2001; Case & Dalley, 1990; Murphy, 2001).

GROUP ART THERAPY

Although the combination of group and art therapy has not been widely researched, research results indicate the effectiveness of this type of intervention with sexually abused children (Brown & Latimir, 2001; Corder, Haizlip, & De Boer, 1990; Delson & Clark, 1981; Meekums, 1999; Murphy, 2001; Rust & Troupe, 1991). The combination of group and art therapy has the advantage of treating the 'whole' child, and, consequently, this intervention technique adopts a holistic approach whereby diverse levels of functioning can be dealt with (Crafford, 1985) besides answering the child's need for group interaction, thus addressing social aspects of functioning (Dwivedi, 1993; Killian &

Brakarsh, 2004). Group art therapy further acknowledges the concrete thinking style (Brainerd, 1978) of latency-aged children and accordingly provides an opportunity for non-verbal communication (Case & Dalley, 1990; Murphy, 2001). Contact with group members may also decrease sexual and abusive behaviours toward others (Naitove, 1986; Yalom, 1998).

AIM OF THE STUDY

The study aimed to evaluate a group art therapy programme — as developed by the authors — for sexually abused girls in respect to reducing depression, anxiety, sexual trauma and low self-esteem, by using the Solomon-four group design. In order to evaluate the effectiveness of the programme, the following four factors were explored.

1. Difference in pre- and post-test scores for the first experimental group (Group 1).
2. Differences in pre- and post-test scores for the first control group (Group 2).
3. Differences in pre- and post-test scores between the first experimental group (Group 1) and the first control group (Group 2).
4. Differences in post-test scores between all four groups.

METHOD

Participants

Purposive sampling was used to select the participants (Neumann, 2000). The criterion for selection were that participants were girls, aged between 8 to 11 years, had a history of sexual abuse, were living with a non-offending caretaker and were predominantly English-speaking. These criteria were based on suggestions in extant research indicating that the therapist be the same gender as the participants (Kitchur & Bell, 1989; Murphy, 2001) and that participants in a group setting be of similar chronological age (Berliner & Ernst, 1984; Finkelhor & Berliner, 1995).

The sample, obtained from children's homes in the Gauteng area, consisted of 25 sexually abused girls aged from 8 to 11 years ($M = 9.6$). This age group was appropriate as research suggests that children aged between 7 and 13 are most at-risk for adverse impacts from the abuse (Diehl, 2002; Kitchur & Bell, 1989). The ethnic distribution was six black African girls, two coloured girls and 17 white girls. The sample was divided into four groups. Three groups consisted of six girls and one control group consisted of seven girls. As the participants were recruited from various children's homes in the Gauteng Area, each group consisted of girls from a particular home. This decision was made on the practical considerations of a) the difficulty in obtaining participants for the study, and b) the inability of the children's homes to transport the participants to a central location for each session.

Instruments

The Trauma Symptom Checklist for Children (TSCC) developed by Briere (1996) was used to assess levels of depression, anxiety and sexual trauma. Reliability alphas for the TSCC are in the mid to high 0.80s for all scales except Sexual Concerns, which has been found to be in the 0.70s (Briere, 1996). Research has indicated that reliability and validity of this instrument (Sadowski & Friedrich, 2000; Singer, Anglin, Song, & Lunghofer, 1995).

The Human Figure Drawing (HFD) proposed by Koppitz (1968) was used as a measure of self-esteem and as an additional measure of depression, anxiety and sexual trauma. The instrument has been validated internationally (Groth-Marnat, 2003; Koppitz, 1968). Research indicates the effectiveness of using drawings as emotional indicators with children in South Africa (Rudenberg, Jansen, & Fridjhon, 2001; Skybo, Ryan-Wenger, & Su, 2007).

Procedure

The study made use of the Solomon four-group design (Braver & Braver, 1988). It is important from the outset to indicate that the non-random assignment of participants violates the assumptions of the Solomon design. The limited sample size ($n = 25$) also limits the application of the design. The results

of the study should therefore be interpreted with caution as the groups were non-equivalent. It is possible that these limitations compromised the internal validity of the study (Rosnow & Rosenthal, 2008). Although this is not the ideal, Hirschi and Läge (2008, p. 100) state that this approach “is frequently applied in field research because the groups already existed before the research began”. The Solomon four-group design was used as it is a combination of the pre-test/post-test control group design and the post-test only control group design. This provided an indication of whether differences already existed prior to the treatment (pre-test scores) or whether symptom change could be attributed to the art therapy programme (post-test scores) (Kazdin, 1998).

The study used a quasi-experimental research design with non-equivalent groups (Rosnow & Rosenthal, 2008). The two experimental groups were subjected to the intervention whereas the two control groups were not. The first experimental group (Group 1) was assessed on the TSCC and HFD prior to and after the treatment. The first control group (Group 2) was assessed on the pre- and post-test in the absence of the intervention. The second experimental group (Group 3) was assessed only on the post-test after the intervention whereas the second control group (Group 4) was assessed only on the post-test in the absence of the intervention. An independent psychologist with no knowledge of the groups scored all the tests.

Ethical considerations

Permission was obtained from the Higher Degree’s Ethics Committee of the University of Johannesburg to conduct this study. It was emphasised that participation was voluntary and confidential. Informed consent was obtained from the children’s caretaker(s) and/or social worker(s) who were debriefed following the intervention by way of a confidential written and verbal report on each child’s progress. Informed consent (assent) was also obtained from each child prior to participation. The researchers provided the proposal of the research to the children’s homes prior to them agreeing to allow the research to be conducted. Both control groups received treatment following the post-test. The researcher administering the treatment was also provided with regular supervision in order to ensure that the children received optimal treatment.

Data analysis

Analyses were conducted using the SPSS statistical package. Parametric as well as non-parametric tests were used to establish treatment efficacy and between and within group variance (Pallant, 2007). The Paired Samples *t* test and the Wilcoxon Signed Rank Test were used to compare the pre- and post-test scores of the first experimental group and the pre- and post-test scores of the first control group. The differences in pre- and post-test scores between the first experimental and first control group were examined using the Independent Samples *t*-test and the Mann-Whitney Test. One-way ANOVA and the Kruskal-Wallis Test were used to establish the differences in intervention effect regarding the four groups (Pallant, 2007). The results of the analyses were considered at the 0.05 and 0.01 significant levels.

INTERVENTION

The foundation of the structured group art therapy programme was based on the existential-humanistic perspective, and incorporated principles from Gestalt therapy (Naranjo, 2000; Perls, 1990), the Client-centred approach (Rogers, 1967; Du Toit, Grobler, & Schenck, 1998) and the Abuse-focused approach (Briere, 1992). The programme consisted of four themes with eight sessions (for the purpose of space each theme is succinctly discussed). The themes of the programme included the following:

Establishing group cohesion and fostering trust

This theme focused on promoting positive relationships between group members and encouraging the process of disclosure. The programme was outlined to the participants where after the participants

introduced themselves to the other group members in the form of an animal which best represented them. This was followed by a group painting task and a discussion with the children about the activity.

Group norms and boundaries were then established. To initiate introspection and minimize anxiety a relaxation exercise (in the form of a guided fantasy) using clay was conducted. After this a story with anatomically correct dolls was made; each child was asked whether the story was similar to their own lives in any way.

Exploration of feelings associated with the abuse

This theme focused on exploring feelings associated with the abuse. The children were asked to draw and discuss different feelings. They were then asked to draw or paint a 'happy box' and an 'unhappy box' in which their feelings could be stored. Hereafter the children drew the person who abused them (as an animal, shape or colour) and their feelings toward the perpetrator.

In order to further address any unfinished business regarding the abuser, the girls were given the opportunity to verbally or physically express their feelings, which could then be placed in the happy or unhappy box. This was followed by a discussion on how it felt to express these feelings.

Sexual behaviour and prevention of revictimisation

This theme aimed to explore awareness of sexual behaviour and boundaries, and trust and prevention of further abuse. Various forms of touch were role-played and a discussion held on the meaning of different touches. Physical boundaries were then explored through role-plays.

The meaning and aim of sexualized behaviour, as well as age-appropriate ways of gaining rewards and having needs fulfilled was explored using mutual storytelling. Different scenarios similar to those in which sexual abuse might occur were selected and the children were given the opportunity to role-play these situations. These role-plays were discussed in terms of appropriateness of behaviour and possible alternative behaviours.

Group separation

The last theme was used to conclude the programme and help the children to reflect on the learning that took place. The children were asked to think about what they liked and disliked about the programme, and anything that was very special for them. Members then painted, drew or sculpted their feelings associated with leaving the group.

RESULTS

The parametric and non-parametric analyses yielded similar results, and, consequently, the results of the non-parametric statistics are not reported here. A Paired Samples *t* test was conducted to evaluate the impact of the intervention on girls' pre- and post-test scores for Group 1. The results for Aim 1 indicated a significant improvement in depression (as measured by the TSCC) (pre-test $M = 75$, $SD = 11.576$; post-test $M = 52.33$, $SD = 18.206$; $p = 0.046$) and anxiety (as measured by the HFD) (pre-test $M = 2.5$, $SD = 0.548$; post-test $M = 1.17$, $SD = 0.753$; $p = 0.025$). A Paired Samples *t* test was conducted to determine the results of Aim 2. The results indicated that Group 2 did not show any significant changes from the pre- to the post-test scores on the variables with the exception of a deterioration in the depression (as measured by the TSCC) variable with the mean score for depression increasing from pre- to post-test (pre-test $M = 54.17$, $SD = 12.254$; post-test $M = 65.17$, $SD = 5.742$; $p = 0.041$).

Aim 3 was concerned with the difference in pre- and post-test scores between the experimental group (Group 1) and the control group (Group 2). Comparison of the pre-test scores between Group 1 and Group 2 was done by means of an Independent Samples *t*-test. The analysis indicated similar results for anxiety (Group 1 $M = 2.5$, $SD = 0.548$; Group 2 $M = 3.17$, $SD = 1.169$; $t(10) = -1.265$) and depression (Group 1 $M = 1.33$, $SD = 1.033$; Group 2 $M = 1.83$, $SD = 0.753$; $t(10) = -0.958$) as

measured by the HFD. However, statistically significant differences were found in anxiety (Group 1 $M = 77.5$, $SD = 10.252$; Group 2 $M = 55$, $SD = 14.394$; $t(10) = 3.119$; $p = 0.011$) and depression (Group 1 $M = 75$, $SD = 11.576$; Group 2 $M = 54.17$, $SD = 12.254$; $t(10) = 3.027$; $p = 0.013$) pre-test scores as measured by the TSCC. This implies that Group 1 and Group 2 were not similar to begin with. In order to conduct an Independent Samples t test on the post-test scores of the two groups, the differences in scores between the pre- and post-test scores for Group 1 and Group 2 (post-test scores minus pre-test scores) were first determined. The results indicated statistically significant differences between the pre- and post-test scores of the first experimental group and the first control group on depression (Group 1 $M = -1.1667$, $SD = 1.16905$; Group 2 $M = 0.1667$, $SD = 0.75277$; $t(10) = -2.349$, $p = 0.41$) and anxiety (Group 1 $M = -1.3334$, $SD = 1.0328$; Group 2 $M = 0.5$, $SD = 0.54772$; $t(10) = -3.481$, $p = 0.003$) as measured by the HFD. A significant difference was also found on depression (Group 1 $M = -22.667$, $SD = 21.0776$; Group 2 $M = 11$, $SD = 9.85901$; $t(10) = -3.544$, $p = 0.005$), anxiety (Group 1 $M = -12.334$, $SD = 12.5486$; Group 2 $M = 7.8347$, $SD = 7.985$; $t(10) = -3.321$, $p = 0.008$) and sexual trauma (Group 1 $M = -11.834$, $SD = 17.76982$; Group 2 $M = 11.1667$, $SD = 17.475$; $t(10) = -2.261$, $p = 0.047$) as measured by the TSCC.

The difference in post-test scores between all four groups was determined by means of ANOVA. The analyses show that the two experimental groups yielded similar results on the post-test for all variables (Table 1). Group 1 and Group 4 obtained significantly different post-test scores for depression ($p = 0.001$) and anxiety ($p = 0.000$) on the HFD. Group 1 showed significantly lower scores compared to Group 4 (Table 2). Group 2 showed significantly higher scores in anxiety ($p = 0.009$) and depression ($p = 0.002$) on the HFD compared to Group 3 (Table 3). No difference in post-test scores was indicated between the two control groups (Table 4). Group 3 and Group 4 differed significantly regarding anxiety ($p = 0.000$) and depression ($p = 0.001$) as measured by the HFD. Group 3 showed significantly lower post-test scores than Group 4 (Table 5).

Table 1. Significance of difference between post-test scores for Group 1 and Group 3

Variables	Mean difference (Group 1 – Group 3)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	0.00	1.000	-1.19	1.19
Anxiety (HFD)	-0.50	0.818	-2.07	1.07
Low self-esteem (HFD)	0.33	0.820	-0.72	1.39
Depression (TSCC)	-12.83	0.557	-39.55	13.88
Anxiety (TSCC)	-3.00	0.968	-21.16	15.16
Sexual trauma (TSCC)	-14.33	0.648	-47.94	19.27

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist

Table 2. Significance of difference between post-test scores for Group 1 and Group 4

Variables	Mean difference (Group 1 – Group 4)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	-1.83	0.001**	-2.98	-0.69
Anxiety (HFD)	-3.12	0.000**	-4.64	-1.60
Low self-esteem (HFD)	-0.38	0.732	-1.40	0.63
Depression (TSCC)	-17.67	0.257	-43.41	8.07
Anxiety (TSCC)	-1.55	0.995	-19.05	15.95
Sexual trauma (TSCC)	-0.14	1.000	-32.52	32.24

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist

* $p < 0.05$ (2-tailed); ** $p < 0.01$ (2-tailed)

Table 3. Significance of difference between post-test scores for Group 3 and Group 2

Variables	Mean difference (Group 3 – Group 2)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	-1.83	0.002**	-3.02	-0.64
Anxiety (HFD)	-2.00	0.009**	-3.57	-0.43
Low self-esteem (HFD)	-0.83	0.157	-1.89	0.22
Depression (TSCC)	0.00	1.000	-26.71	26.71
Anxiety (TSCC)	5.33	0.850	-12.83	23.496
Sexual trauma (TSCC)	8.33	0.903	-25.27	41.94

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist
* $p < 0.05$ (2-tailed); ** $p < 0.01$ (2-tailed)

Table 4. Significance of difference between post-test scores for Group 2 and Group 4

Variables	Mean difference (Group 2 – Group 4)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	0.00	1.000	-1.15	1.15
Anxiety (HFD)	-0.62	0.678	-2.14	0.90
Low self-esteem (HFD)	0.12	0.988	-0.90	1.13
Depression (TSCC)	-4.83	0.954	-30.57	20.91
Anxiety (TSCC)	-3.88	0.928	-21.38	13.62
Sexual trauma (TSCC)	5.86	0.959	-26.52	38.24

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist

Table 5. Significance of difference between post-test scores for Group 3 and Group 4

Variables	Mean difference (Group 3 – Group 4)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	-1.83	0.001**	-2.98	-0.69
Anxiety (HFD)	-2.62	0.000**	-4.14	-1.10
Low self-esteem (HFD)	-0.71	0.239	-1.73	0.30
Depression (TSCC)	-4.83	0.954	-30.57	20.91
Anxiety (TSCC)	1.45	0.996	-16.05	18.95
Sexual trauma (TSCC)	14.19	0.628	-18.19	46.57

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist
* $p < 0.05$ (2-tailed); ** $p < 0.01$ (2-tailed)

DISCUSSION

Regarding Aim 1, a decrease in depression was found in the first experimental group. The results of Aim 2 indicated that depression increased from pre- to post-test in the absence of intervention in the first control group. This may be explained in terms of the girls' demonstration of a desperate need for treatment. Events outside the therapy may also have contributed to an increase in symptoms. However, because the two experimental groups yielded similar results, and the two control groups yielded similar results, the implication is that history and maturation effects were not present.

Differences in the pre-test scores existed between Group 1 and Group 2. For this reason, the scores between these two groups were calculated. The results indicated that depression, anxiety and

sexual trauma improved significantly for Group 1 from pre- to post-test as opposed to Group 2 whose members did not receive the intervention. These findings appear to be consistent with the results of previous research. Burke (1988) and Lindon and Nourse (1994) found a significant reduction in anxiety and depression following group therapy, and Kelley (1984) found a significant decrease in sexual trauma following art therapy. Low self-esteem was the only variable that remained stable from pre- to post-test for both Group 1 and Group 2. These results are inconsistent with findings by Kelley (1984), Lindon and Nourse (1994), Reeker and Ensing (1998), Corder *et al.* (1990) and Rust and Troupe (1991) who found that low self-esteem reduced significantly after group and/or art therapy.

The findings of the present study suggest that the programme does not target low self-esteem as successfully as depression and anxiety. Alternatively, the findings may reveal that the HFD is not sensitive to changes in self-esteem symptoms. The HFD did not indicate any sexual trauma symptoms among the groups in this study. Possibly, the HFD is not as sensitive as the TSCC in tapping symptoms associated with sexual trauma.

The results associated with Aim 4 indicate similar scores for the two experimental groups and for the two control groups. The experimental groups differed significantly in post-test scores from the control groups. The findings reveal that following the intervention, the experimental groups demonstrated improvement in depression, anxiety and sexual trauma as compared to the control groups.

LIMITATIONS AND RECOMMENDATIONS

The research was subject to many limitations. The small sample size ($n = 25$) is a significant weakness of this study. The limited number of participants assigned to each group is likely to have an adverse impact on the validity of the obtained results. The results must therefore be viewed with caution. Future studies should address this weakness and explore the usefulness of this therapeutic approach with different samples (both in terms of ethnicity and size). Because each group originated from a different children's home, it is not clear whether the difference in environments can be linked to the variability found among the groups and whether this may have influenced the findings of the study.

Grouping the participants from different children's homes may be useful in reducing the confounding variables that were present in the study (i.e. use random assignment of participants to groups). This also raises the questions as to whether certain homes receive children with more or less severe symptoms than other homes and whether particular homes exacerbate or improve symptoms. The improvement in symptoms could also be attributed to the therapist as only one therapist conducted the treatment programme.

CONCLUSION

The study aimed at contributing to the CSA intervention literature by applying and evaluating a newly designed group art therapy intervention with sexually abused girls. The results suggest that this group art therapy programme may ameliorate symptoms of depression and anxiety. This study is another building block in the literature on sexual abuse intervention and it is hoped that future studies on the effectiveness of this programme for sexually abused children are performed.

REFERENCES

- Aldridge, F., & Hastilow, S. (2001). Is it safe to keep a secret? A sibling group in art therapy. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 167-183). East Sussex: Brunner-Routledge.
- Berliner, L., & Ernst, E. (1984). Group work with preadolescent sexual assault victims. In I.R. Stuart & J.G. Greer (Eds), *Victims of sexual aggression: treatment of children, women, and men*. New York: Van Nostrand Reinhold Company.
- Bissonnet, J. (2001). Tell me your story so far: A developmental approach to art therapy. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: lost for words* (pp. 126-139). East Sussex:

Brunner-Routledge.

- Bohn, D.K. (2003). Lifetime physical and sexual abuse, substance abuse, depression and suicide attempts among Native American women. *Issues in Mental Health Nursing, 24*, 333-352.
- Brainerd, C.J. (1978). *Piaget's theory of intelligence*. Englewood Cliffs, NJ: Prentice-Hall.
- Braver, M.C.W., & Braver, S.L. (1988). Statistical treatment of the Solomon Four-Group design: A meta-analytic approach. *Psychological Bulletin, 104*, 150-154.
- Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. California: SAGE Publications.
- Briere, J. (1996). Psychometric review of the Trauma Symptom Checklist for Children. In B.H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation*. Lutherville, MD: Sidran Press
- Brown, A.M., & Latimir, M. (2001). Between images and thoughts: An art psychotherapy group for sexually abused adolescent girls. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 184-200). East Sussex: Brunner-Routledge.
- Browne, A., & Finkelhor, D. (1986). Initial and long-term effects: A review of the research. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse*. Beverly Hills: SAGE Publications.
- Buckland, R., & Murphy, J. (2001). Jumping over it: Group therapy with young girls. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (143-166). East Sussex: Brunner-Routledge.
- Burke, M. (1988). Short term group therapy for sexually abused girls. *Dissertation Abstract International, 49*, (5-B).
- Carr, A. (2000). *Family therapy: Concepts, process and practice*. Chichester: John Wiley and Sons.
- Carolan, R. (2001). Models and paradigms of art therapy research. *Art Therapy: Journal of the American Art Therapy Association, 18*, 190-206.
- Case, C., & Dalley, T. (1990). *Working with children in art therapy*. London: Tavistock/Routledge.
- Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26*, 1097-1113.
- Cohen, J.A., & Mannarino, A.P. (2008). Trauma-focused cognitive behavioural therapy for children and parents. *Child and Adolescent Mental Health, 13*, 158-162.
- Cohen, J.A. Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.
- Cohen, J.A., Mannarino, A.P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29*, 135-145.
- Corder, B.F., Haizlip, T., & De Boer, P. (1990). A pilot study for a structured time-limited therapy group for sexually abused pre-adolescent children. *Child Abuse & Neglect, 14*, 243-251.
- Crafford, W. (1985). *Hulpverlening in die voorligtingsielkunde: 'n Funktionele integrasie* [Assistance in counselling psychology: A functional integration]. Ongepubliseerde meestersverhandeling, Rand Afrikaanse Universiteit, Johannesburg.
- Delson, N., & Clark, M. (1981). Group therapy with sexually molested children. *Child Welfare, 60*, 175-182.
- Diehl, A.S. (2002). Self-efficacy and learned optimism: The treatment of post-traumatic stress disorder in children. *Dissertation-Abstracts International, Sciences and Engineering, 62*, 5369.
- Douglass, L. (2001). Nobody hears: How assessment using art as well as play therapy can help children disclose past and present sexual abuse. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 50-65). East Sussex: Brunner-Routledge.
- Du Toit, A.S., Grobler, H.D., & Schenck, C.J. (1998). *Person-centered communication: Theory and practice*. Johannesburg: International Thomson Publishing.
- Dwivedi, K.N. (1993). *Group work with children and adolescents: A handbook*. London: Jessica Kingsley Publishers.
- Finkelhor, D., & Berliner, L. (1995). Research on the treatment of sexually abused children: a review and recommendation. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1408-1423.
- Finkelhor, D., & Browne, A. (1986). Initial and long-term effects: A conceptual framework. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse*. Beverly Hills, CA: SAGE Publications.
- Freeman, R.C., Collier, K., & Parillo, K.M. (2002). Early life sexual abuse as a risk factor for crack cocaine use in a sample of community recruited women at high risk for illicit drug use. *The American Journal of Drug and Alcohol Abuse, 28*, 109-131.
- Freyd, J.J. (2002). Memory and dimensions of trauma: Terror may be "all-too well remembered" and

- betrayal buried. In J.R. Conte (Ed.), *Critical issues in child sexual abuse: Historical, legal and psychological perspectives*. Thousand Oaks, CA: SAGE.
- Gallo-Lopez, L. (2000). A creative play therapy approach to the group treatment of young sexually abused children. In H.G. Kaduson, & C.E. Schaefer (Eds.), *Short-term play therapy for children* (2nd ed.). New York: Guilford Press.
- Gardner, R.A. (2002). *Sex abuse trauma?: Or trauma from other sources?*. New York: Creative Therapeutics.
- Gilroy, A. (2006). *Art therapy, research and evidence-based practice*. London: SAGE Publications.
- Groth-Marnat, G. (2003). *Handbook of psychological assessment*, 4th ed.. Hoboken, NJ: John Wiley and Sons.
- Hirschi, A., & Läge, D. (2008). Increasing the career choice readiness of young adolescents: an evaluation study. *International Journal for Educational and Vocational Guidance*, 8, 95-110.
- Kazdin, A.E. (1998). *Research design in clinical psychology*. Boston: Allyn and Bacon.
- Kelley, S.J. (1984). The use of art therapy with sexually abused children. *Journal of Psychosocial Nursing & Mental Health Services*, 22, 12-18.
- Killian, B., & Brakarsh, J. (2004). Therapeutic approaches to sexually abused children. In L. Richter, A. Dawes, & C. Higson-Smith (Eds), *Sexual abuse of young children in Southern Africa* (pp. 367-394). Cape Town: HSRC Press.
- Kitchur, M., & Bell, R. (1989). Group psychotherapy with preadolescent sexual abuse victims: Literature review and description of an inner-city group. *International Journal of Group Psychotherapy*, 39, 285-310.
- Koppitz, E. (1968). *Psychological evaluation of children's human figure drawings*. New York: Grune and Stratton.
- Lev-Wiesel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Children and Youth Services Review*, 30, 665-673.
- Lindon, J., & Nourse, C.A. (1994). A multi-dimensional model of group work for adolescent girls who have been sexually abused. *Child Abuse and Neglect*, 18, 341-348.
- Madu, S.N., & Peltzer, K. (2001). Prevalence and patterns of child sexual abuse and victim-perpetrator relationship among secondary school students in the Northern Province (South Africa). *Archives of Sexual Behavior*, 30, 311-321.
- Mazza, D.L. (2003). Dangerous behavior in children and adolescents. *American Psychoanalytic Association Journal*, 51, 651-666.
- Meekums, B. (1999). A creative model for recovery from child sexual abuse trauma. *The Arts in Psychotherapy*, 26, 247-259.
- Murphy, J. (2001). Introduction. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: lost for words* (pp. 1-15). East Sussex: Brunner-Routledge.
- Naitove, C.E. (1986). Arts therapy with sexually abused children. In S.M. Sgroi (Ed.), *Handbook of clinical intervention in child sexual abuse*. Canada: D.C. Health and Company.
- Naranjo, C. (2000). *Gestalt therapy: The attitude and practice of a theoretical experientialism*. UK: Crown House Publishing.
- National Crime Victims Research and Treatment Centre & Centre for Sexual Assault and Traumatic Stress. (2004). *Child physical and sexual abuse: Guidelines for treatment*. Retrieved March 8, 2008, from http://academicdepartments.musc.edu/nvcv/resources_prof/OVC_guidelines04-26-04.pdf
- Neuman, W.L. (2000). *Social research methods: qualitative and quantitative approaches*, 4th ed. Boston: Allyn & Bacon.
- Pallant, J. (2007). *SPSS survival manual*, 3rd ed. Berkshire: Open University Press.
- Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review*, 29, 328-228.
- Perls, F.S. (1990). Gestalt therapy verbatim. In C. Hatcher, & P. Himelstein (Eds), *The handbook of Gestalt therapy*. New York: Jason Aronson.
- Pifalo, T. (2002). Pulling out the thorns: Art therapy with sexually abused children and adolescents. *Journal of the American Art Therapy Association*, 19, 12-22.
- Reeker, J. & Ensing, D. (1998). An evaluation of a group treatment for sexually abused young children. *Journal of Child Sexual Abuse*, 7, 65-85.
- Rogers, C.R. (1967). *On becoming a person, a therapist's view of psychotherapy*. USA: Constable.
- Rosnow, R.L., & Rosenthal, R. (2008). *Beginning behavioral research: A conceptual primer*, 6th ed. Upper

Saddle River, NJ: Pearson Education.

- Rudenberg, S.L., Jansen, P., & Fridjhon, P. (2001). Living and coping with ongoing violence. *Childhood, 8*, 31-55.
- Rust, J.O., & Troupe, P.A. (1991). Relationships of treatment of child sexual abuse with school achievement and self-concept. *Journal of Early Adolescence, 11*, 420-429.
- Ryan, K. (1996). The chronically traumatized child. *Child and Adolescent Social Work Journal, 13*, 287-310.
- Sacks, J., McKendrick, K., & Banks, S. (2008). The impact of early trauma and abuse on residential substance abuse treatment outcomes for women. *Journal of Substance Abuse Treatment, 34*, 90-100.
- Sadowski, C.M., & Friedrich, W.N. (2000). Psychometric properties of the Trauma Symptom Checklist for Children (TSCC) with psychiatrically hospitalized adolescents. *Child Maltreatment, 5*, 364-372.
- Singer, M.I., Anglin, T.M., Song, L.Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association, 273*, 477-482.
- Skybo, T., Ryan-Wenger, N., & Su, Y. (2007). Human figure drawings as a measure of children's emotional status: Critical review for practice. *Journal of Pediatric Nursing, 22*, 15-28.
- South African Police Services (SAPS). (2008). *Crime situation in South Africa 1 April 2007 to 31 March 2008. Trends, spatial distribution and interpretation*. Retrieved August 31, 2009, from <http://www.saps.gov.za/statistics/reports/crimestats/2008/docs/>
- Snyder, B.A. (1997). Expressive art therapy techniques: Healing the soul through creativity. *Journal of Humanistic Education and Development, 36*, 74-82.
- Tourigny, M., Hébert, M., Daigneault, I., & Simoneau, A.C. (2005). Efficacy of a group therapy for sexually abused adolescent girls. *Journal of Child Sexual Abuse, 14*, 71-93.
- Wade, G. (2000). *Hurting and healing: How to overcome the trauma of sexual abuse and rape*. Shaftesbury: Element.
- Waller, D. (2006). Art therapy for children: How it leads to change. *Clinical Child Psychology and Psychiatry, 11*, 271-282.
- Yalom, I.D. (1998). *The Yalom reader*. New York: Basic Books.
- Zinni, V.R. (1997). Differential aspects of sand play with 10- and 11-year-old children. *Child Abuse and Neglect, 21*, 657-668.

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