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Brief Reports

Art Therapy with Sexually Abused Children and Adolescents: Extended Research Study

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Abstract

This article reports the outcome of a four-year follow-up of a pilot study using a combination of art therapy, cognitive behavioral therapy, and group process to address the therapeutic issues related to childhood sexual abuse. All group participants were evaluated using the Trauma Symptom Checklist for Children (Briere, 1995), commonly used in trauma centers, before and after their participation in an 8-week group cycle. The results of this extended study support the combined use of art therapy (AT) and cognitive behavioral therapy (CBT) as an effective intervention to reduce symptoms most often associated with childhood sexual abuse.

Introduction

A pilot study was conducted in 2001 at an urban multidisciplinary child advocacy center that provides forensic assessment and treatment to child victims of sexual abuse and their families. The pilot study provided preliminary empirical evidence that the combined use of art therapy (AT) and cognitive behavioral therapy (CBT) resulted in a reduction of symptoms associated with posttraumatic stress disorder (PTSD) (Pifalo, 2002). Following the positive results of the pilot study, a broader same-site sampling was conducted involving children with histories of sexual abuse referred for treatment by mental health professionals in the community.

Method

All of the participants in this study met one hour weekly for eight weeks in groups that were structured to meet the developmental needs for children 8-10, 11-13, and 14-16 years of age. All group sessions utilized a treatment model that combined art therapy and cognitive behavioral therapy. This program choice was based on the rationale that both modalities have unique properties that, when combined, reduce symptoms of PTSD, a common diagnosis for child victims of sexual abuse (Pifalo, in press).

Cognitive behavioral therapy offers clear-cut goals for trauma-focused therapy; art therapy "cuts to the chase" in a way that talk therapy alone cannot because art therapy does not rely strictly on a verbal mode of communication. Art therapy is uniquely suited to promote basic goals of crisis intervention involving cognition and problem-solving, and ventilation of affect (Linesch, 1993). The use of image-based interventions such as creating containers to express and release powerful emotions, making maps to organize a coherent trauma narrative and set future goals, using multiple media to illustrate the photographic nature of traumatic memories (Johnson, 1987), and graphically representing internal and external sources of support, provides an opportunity for traumatized children to express what they may not yet be able to verbalize.

All group members were evaluated using the Trauma Symptom Checklist for Children (TSCC) (Briere, 1995) before and after their participation in the trauma-focused therapy program. The TSCC was chosen because it was designed to assess children who have experienced trauma. It is a self-report measure that has 12 subscales (two validity scales and ten clinical scales). The data presented in this study was drawn from the sample after all invalid scores reflecting under-response (a tendency toward denial) and hyper-response (a tendency to appear especially symptomatic) were eliminated to preserve the validity of the data. See Table 1 for a comprehensive descriptive overview of what is measured by the subscales in the TSCC.

The TSCC is designed to accommodate children from a range of racial and socioeconomic backgrounds, much like the multicultural population served at the agency where the study was conducted. Psychometric reliability and construct validity of the TSCC have been established in many studies (Briere & Lanktree, 1995; Elliott & Briere, 1995; Friedrich & Jaworski, 1995; Nelson-Gardell, 1995; Smith, Saunders, Swenson, & Crouch, 1995; Smith, Swenson, Hanson, & Saunders, 1994). This instrument is widely used in the field of child abuse and protection

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Table 1 The Briere Trauma Symptom Checklist for Children (TSCC): A Descriptive Account of the Instrument's Sub-Scales and Critical Items

TSCC Subscales	Specific Measure
Underresponse (UND)*	Child's tendency to deny symptoms, to be defensive about admitting symptoms or problems
Hyperresponse (HYP)*	Child's tendency to find fault with self, to be inclined to project distress, to admit problems or symptoms that are not there
Anxiety (ANX)**	The presence of anxiety symptoms from panic attacks to generalized anxiety, obsessive-compulsive symptomatology, etc.
Depression (DEP)**	The presence of depressive symptomatology, including all forms of dysphoria and its neuro-vegetatice correlates
Anger (ANG)**	The presence of angry, aggressive symptoms, antisocial behavior, and psychopathic symptoms
Posttraumatic Stress (PTS)**	Re-experiencing stressful situations, numbing to the environment and related symptoms
Dissociation (DIS)**	The presence of dissociative symptoms (amnesia, fugue, depersonalization, identity problems, etc.)
Dissociation-Overt (DIS-O)**	The presence of dissociative symptoms as evidenced mostly by nonresponsiveness to the environment
Dissociation-Fantasy (DIS-F)**	The presence of dissociative symptoms as evidenced by withdrawal from reality (e.g., day-dreaming)
Sexual Concern (SC)**	The presence of age-inappropriate sensitization to sexual matters
Sexual Preoccupation (SC-P)**	The presence of increased sexual thoughts, interests, feelings or impulses
Sexual Distress (SC-D)**	The presence of ego-dystonic feelings and thoughts to most or all matters sexual
TSCC Critical Items	1. Wanting to hurt myself 2. Wanting to hurt other people 3. Feeling scared of men 4. Feeling scared of women 5. Not trusting people because they might want sex 6. Getting into fights 7. Feeling afraid somebody will kill me 8. Wanting to kill myself
* Response Validity Subscales **Clinical Subscales	

(Deblinger & Heflin, 1996), making even larger comparative studies more possible in the future.

Results

The results of an eight-week cycle of trauma-focused group treatment using the combined modalities of AT and CBT are enumerated in Table 2. Pre- and post-treatment TSCC scores on the 12 subscales are presented as means and standard deviations. This table also provides Fisher *t*-values for all pre- and post-treatment differences, including their corresponding *p* values. It should be noted that there is a statistically significant reduction in symptomatology scores on nine of the ten clinical subscales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, Dissociation-Overt, Sexual Concerns, Sexual Preoccupation, and Sexual Distress) in the direction of reduced pathology. (The remaining subscale, Dissociation-Fantasy, also showed a reduction but without statistical significance). These results were calculated using significant Fisher *t*-value at p - < .05 (Ferguson, 1981).

In addition to the changes in the clinical scales, the Underresponse validity scale shows a statistically significant increase from pre-test to post-treatment. Since this scale measures to what degree the respondent is likely to deny feelings, thoughts, and behaviors, a score reflecting less avoidant (endorsing fewer 0/Never items) behaviors could indicate a positive trend toward becoming more open to discussing trauma-focused topics.

Table 2
Pre- and Post-Test T-Scores on the Briere "Trauma Symptom Checklist for Children": A Comparative Analysis (N = 41)

TSCC Subscales	Pre-Test M (sd)	Post-Test M (sd)	*t* dependent samples	Significance (2-tailed) df = 40 *p*	Effect Size Eta^2
Underresponse	**51.27** (9.05)	**58.59** (16.09)	-3.92	.000*	n/a
Hyperrresponse	**53.66** (11.37)	**51.54** (10.63)	1.21	.235	n/a
Anxiety	**52.51** (12.07)	**47.56** (9.66)	3.48	.001*	.23
Depression	**51.98** (11.12)	**47.22** (10.12)	2.69	.01*	.15
Anger	**49.27** (9.44)	**45.46** (7.54)	3.12	.003*	.20
Posttraumatic Stress	**52.71** (9.18)	**46.78** (8.21)	5.11	.000*	.39
Dissociation	**53.46** (9.00)	**49.27** (9.12)	3.47	.001*	.23
Dissociation-Overt	**53.71** (9.67)	**48.78** (8.67)	4.18	.000*	.30
Dissociation-Fantasy	**52.41** (8.56)	**50.56** (10.71)	1.19	.242	.03
Sexual Concern	**60.49** (21.35)	**51.44** (15.78)	3.37	.002*	.31
Sexual Preoccupation	**55.44** (19.15)	**48.98** (14.14)	2.86	.007*	.17
Sexual Distress	**63.73** (21.86)	**54.90** (19.21)	2.97	.005*	.18

*the obtained difference between pre- and post-scores is statistically significant at *p*-values indicated.

What is somewhat obscured in this pattern of outcomes is that some of the reductions in symptoms are substantially larger than others. Although shifts in nine of the clinical subscales were found to yield statistically significant differences, this reflects nothing about the magnitude of the intervention effect. In this study, the magnitude of effect is indicated with Eta^2 values. Values from .05 to .10 indicate a small intervention effect, Eta^2 values from .11 to .29 a moderate to large effect, and an Eta^2 value from .30 up would indicate a very large effect (Cohen, 1998). Looking at Table 2, it is evident that the intervention effect was very large (Eta^2 > .30) on the following three subscales: Posttraumatic Stress (Eta^2 = .39), Dissociation-Overt (Eta^2 = .30), and Sexual Concerns (Eta^2 = .31).

Further validation for the combined use of the AT/CBT model is provided by the outcomes obtained on the eight Critical Items of the TSCC. These items, which examine Self-Injury Potential, Desire to Hurt Others, Fear of Men, Fear of Women, Mistrust, Fighting, Fear of Being Killed, and Suicide Risk suggest issues that require more immediate clinical intervention. The participant's pre- and post-treatment responses to the eight critical items on a four-point Likert scale are graphically represented in Table 3.

Three of the Critical Items scores (Desire to Hurt Others, Mistrust, and Sum Critical Items) were sufficiently different in the pre- and post-treatment results to achieve statistical significance. Again, the differences in scores are in the expected direction of decreased pathology. In other words, the desire to hurt others, to distrust people in general, and the cumulative Critical Items scores were substantially reduced from pre-treatment levels.

Discussion

The findings of the current expanded study suggest that a treatment model that combines art therapy and cognitive behavioral therapy is beneficial for reducing prob-

Table 3
Pre- and Post-Test T-Scores on the Briere "Trauma Symptom Checklist for Children": A Comparative Analysis of Critical Items (N = 41)

Critical Items (0-3)	Pre-Test M (sd)	Post-Test M (sd)	*t* dependent samples	Significance (2-tailed) df = 40 *p*
Self-Harm Potential	**0.49** (.71)	**0.31** (.47)	1.42	.16
Desire to Hurt Others	**0.39** (.70)	**0.17** (.38)	2.46	< .02*
Fear of Men	**0.76** (.92)	**0.59** (.77)	1.48	.15
Fear of Women	**0.34** (.73)	**0.22** (.57)	1.00	.32
Mistrust	**0.66** (.82)	**0.39** (.63)	2.05	< .05*
Fighting	**0.78** (1.01)	**0.80** (.93)	-0.18	.86
Fear of Being Killed	**0.76** (.97)	**0.66** (.76)	0.61	.54
Suicide Risk	**0.39** (.77)	**0.22** (.52)	1.48	.15
Sum Critical Items	**4.56** (3.36)	**3.37** (2.83)	2.28	< .03*

*the obtained difference between pre- and post-scores is statistically significant at *p*-values indicated.

lematic symptoms within a population of child sexual abuse victims. Following an eight-week cycle of group treatment utilizing this combined model which focuses on symptoms associated with a diagnosis of PTSD, group participants' scores were reduced on the following clinical subscales: Anxiety, Depression, Anger, PTSD, Dissociation, Dissociation-Overt, Sexual Concerns, and Sexual Preoccupation. Clinically, this means that the participants in the AT/CBT groups manifested a significant reduction in abuse related symptoms when compared with the levels exhibited at entry into this combined therapy model.

The largest reduction in symptoms was found on the scales of PTSD, Dissociation-Overt, and Sexual Concerns —areas that comprise the symptomatic core most often associated with childhood victims of sexual abuse (Finklehor, 1994). Since these were the areas targeted for treatment among this particular population, the results were encouraging. It is important to note that the largest intervention effect was also found on the PTSD subscale. Since victims of childhood sexual abuse often fall within the diagnostic criteria for PTSD, this was also considered to be a positive result.

In addition, the data indicate statistically significant reductions on three of the Critical Items scales—those that require a need for immediate intervention. The group members' scores indicated that they were less likely to desire to hurt others, distrust people in general, and they showed an overall reduction in endorsing any critical items at all following treatment.

Conclusion

The objective of the follow-up study of 2001 was to further investigate the original hypothesis that a treatment model employing combined AT and CBT would reduce symptoms of PTSD, a diagnosis found frequently in the population of children who have been victims of childhood sexual abuse.

Outcome results offer empirical evidence of the effectiveness of such a regime of treatment to reduce symptoms of PTSD. Thus, the current expanded study supports and confirms the efficacy of the combined use of AT and CBT as an intervention for victims of childhood sexual abuse. Based on the findings of this study, the goal is to continue to widen the scope among an even larger pool of participants. Other areas of future investigation will explore the possibility of replication of these results in other child advocacy centers that treat victims of sexual abuse and to compare results with models using only traditional verbal therapy in treatment.

The results of this widened scope of study give credence to the use of art therapy in trauma-focused treat-

ment. The inclusion of art therapy provides clinicians with additional tools for intervention and increases the likelihood that the symptoms of PTSD will be reduced. The visual nature of traumatic memory, the concrete, graphic approach of art therapy, and the underlying structure of the cognitive behavioral approach create a powerful, efficient, and effective treatment model within which to achieve the goals of trauma-focused therapy.

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