Group Art Therapy for Adult Female Victims of Sexual Violence

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Group Art Therapy with Adult Female Victims of Sexual Violence

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Abstract

In the United States, women are vulnerable to sexual violence regardless of their socioeconomic conditions (Black, et.al, 2010; Wadeson, 2010; Basile, 2002). Women make up 50.8 percent of the U.S. population (U. S. Census 2010). One might extrapolate from these statistics, albeit inaccurately, that women would have available to them an abundance of trained clinicians and resources ready to assist adult victims of sexual violence beyond the immediate medical attention and crisis counseling (Howden & Meyer, 2011). Most often, however, just the opposite stands true there is limited research and services available to women who experience sexual violence as an adult (Wadeson, 2010; Black, et.al, 2010; Calhoun & Atkeson, 1991). Due to shame, guilt, or other complexities of their situation, women who experience sexual violence as adults often do not seek counseling beyond the immediate crisis services that are rendered (Black et.al, 2010; Calhoun & Atkeson, 1991; Hilberman, 1976). Victims often will adapt or attempt to cope with their trauma until their symptoms worsen, at which time they are forced to seek mental health treatment (Wadeson' 2010; Pifalo, 2007; Tripp, 2007; Calhoun & Atkeson, 1991).

Victims of sexual violence should have access to treatment that is tailored specifically to address their sexual trauma, including mental health treatment that will acknowledge their feelings of isolation and that assists in healing from their traumatic experience that has changed or altered how they view themselves and the world. After review of the most commonly used treatment models for trauma, group art therapy presents promising potential as an effective treatment model for adult female victims of sexual violence experiencing post-traumatic trauma symptoms.

Dedication

I dedicate my thesis to my mother, Lacretia Bryant and my husband, Julius Adeniyi Jr., who have supported me throughout the process. I will always appreciate all they have done. I thank God for my loving family and friends who patiently waited for me to complete two years of school without complaining In addition to my mom and husband, I would like to dedicate my thesis to the loving memory of Prince Julius A. Adeniyi Sr. and Terry Bryant who both valued the pursuit of higher education.

Acknowledgements

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Chapter I: Introduction

Sexual violence is a significant problem in the United States. The Center for Disease Control reported that one in five women stated she has experienced sexual violence at some time in her life (Black, et.al, 2010). Sexual violence is defined as involving at least two people, with one-person gaining control over another person by an act of aggression, power, or violence (Calhoun & Atkeson, 1991; Burguess, 1979). Many acts of sexual violence go unreported due to fear, shame, or guilt. Although some acts of sexual violence are reported, not all are prosecuted. Studies show that regardless of whether an assault is reported or unreported, prosecuted or not prosecuted, the trauma caused by sexual violence can result in severe health and social consequences. Under the pressures of these consequences, many women are motivated to eventually seek treatment (Black, et.al. 2010; Wadeson, 2010).

Trauma is "an event in the subject's life defined by its intensity, by the subject's incapacity to respond adequately to it, and by the upheaval and long-lasting effects that it brings about in the psychical organization." (LaPlanche & Pontalis, 1973, p.465). The Comprehensive Textbook of Psychiatry further defines psychological trauma as the "feeling of intense fear, helplessness, and loss of control and threat of annihilation" (as cited in Herman, 1997, p. 33). Women who have experienced the trauma caused by sexual violence often show symptoms such as, anxiety, depression, negative self-image, social adjustment problems, phobia, and fear (Resick & Schnicke, 1992). Adult female victims of sexual violence often forego counseling or group support until they have exhausted their ability to manage these symptoms through their personal coping skills, which have varying levels of development and success. When and if the duration of these trauma symptoms persist and increase for longer than six month, diagnosis of Post-Traumatic Stress Disorder may be warranted (APA, 2013).

Through forty years of progressive study, it is well settled that sexual violence is a traumatic experience (APA, 2013). In the United States of America, gaps in effective treatment of adult female victims of sexual violence remain, particularly among those diagnosed with Post-traumatic Stress Disorder (PTSD). To date, there is a lack of in-depth study specific to PTSD symptoms experience by adult female victims of sexual violence. PTSD research has predominately studied the treatment and symptoms of sexual violence among female veterans of war (Herman, 1997), college women (Zinzow, et., al., 2010), and refugees (Roth, Dye & Lebowiz, 1988); adult female victims of childhood sexual violence (Lev-Wiesel, 1998); and immediate crisis intervention with victims of sexual violence (Spring, 2004). Through theses analogous PTSD studies, researchers can gain helpful information in treating adult female victims of sexual violence who are experiencing PTSD symptoms.

Traditional talk therapy may not be effective for someone who has suffered a traumatic experience. Traumatic experiences, including sexual violence, are imprinted in the brain (Pifalo, 2007; Talwar, 2007; Tripp, 2007; Spring, 2004; Shaprio, 2001). It has been proposed that talk therapy does not effectively or efficiently access these imprinted memories to begin treatment (Talwar, 2007; Shaprio, 2001) and therefore, other treatment methods must be considered. Art therapy accesses traumatic memories through non-verbal means (Wadeson, 2010; Kaiser, et.al, 2005). It promotes safe verbal processing for a trauma narrative.

Researcher Solomon (2003) explained how therapeutic interventions that involve emotion, the body's somatosensory activation, and bilateral information have had success with accessing traumatic memories through non-verbal means and bilateral information-processing mechanisms are effective in functionally reversing the effects of trauma. Processing the effects of trauma in a group setting provides mutual support and problem solving among the members.

Art therapy groups allow individuals to have insight, self-awareness, express feelings, discover universality of their experiences, and relate to others in the group. Art can be an important avenue of communication and expression (Wadeson, 2010; Pifalo; 2007). “The spatial character of pictures can describe many aspects of experience simultaneously” (Liebmann, 1986, p. 9).

After thorough review of evidence-based research on trauma and the most commonly used treatment models for trauma, group art therapy presents promising potential as an effective treatment model for adult female victims of sexual violence experiencing post-traumatic trauma symptoms. Otherwise, this large population of clients might risk the possibility of establishing trust in oneself and others, and a sense of safety and self-control.

Definition of Terms

Art therapy- the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma or challenges in living, and by people who seek personal development. Through creating art and reflecting on the art products and processes, people can increase awareness of self and others cope with symptoms, stress and traumatic experiences; enhance cognitive abilities; and enjoy the life affirming pleasures of making art (AATA, 2013).

Bilateral stimulation- in the therapeutic context, refers to the stimulation of the left and right brain hemispheres in order to attain equilibrium and integration (McNamee, 2003).

Complex trauma- caused by one's experience of numerous or extended traumatic events that affect the development of a person (National Child Traumatic Stress Network, 2003).

Expressive Therapies Continuum (ETC)—The ETC is a continuum model that comprised of different levels that an art material or art directive can concentrate. This continuum aids the therapist in choosing a directive for a client (Lusebrink, 1989).

Posttraumatic Stress Disorder –a disorder that stems whenever someone survives, endures, or witnesses an occurrence wherein they believe that there is a risk to life or physical integrity and safety and experiences of fear, horror, or helplessness. The indicators are marked by (i) re-experiencing the traumatic event in painful flashbacks, recollections, or repetitive dreams or nightmares- (ii) reduced responsiveness, with no interest in important activities and with emotions of detachment and distance from other people- and (iii) continual physiological excitation, leading to such indicators as embellished startle reaction, disrupted sleep, trouble concentrating or remembering, survivor's guilt, and avoidance of activities which pull the disturbing occurrence into one's mind (APA,1980).

Psychological trauma- an event in a person's life defined by its intensity, by the person's incapacity to respond adequately to it, and by the upheaval and long-lasting effects that it brings about in the psychical organization (Herman, 1997).

Sexual trauma- a disturbing experience, physical or mental, relating to sex, such as rape and other sex offences. (VandenBos, 2007).

Sexual violence – Sexual violence encompasses a range of offenses, including a completed nonconsensual sex act (i.e., rape), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened rape, exhibitionism, verbal sexual harassment) (Basile, 2002, p.8).

Chapter II: Methods

An integrative systematic review of the literature was conducted to gather relevant data about adult female victims of sexual violence in the United States. The results were then analyzed to identify the hypotheses currently presented in the literature and to identify gaps in treatment for female victims of sexual violence in the United States. The search strategy for this systematic review of literature consisted of multiple data bases provided through the Indiana University Purdue University Indianapolis library.

An integrative review is a specific review method that summarizes past empirical or theoretical literature to provide a more comprehensive understanding of a particular phenomenon or healthcare problem (Whittemore, 2005). Integrative reviews are the "broadest type of research review methods allowing for the simultaneous inclusion of experimental and non-experimental research in order to understand a phenomenon" (Whittemore, 2005, p. 547). In this study, the phenomenon is the unique symptomology of adult female victims of sexual violence and the need for increased research that focuses specifically on the effectiveness of treatment models for adult female victims of sexual violence.

Theoretical and empirical data will be combined to support the effectiveness of art therapy when used in a group setting to treat adult female victims of sexual violence. Numerous sources were found by searching the IUCAT database using the keywords rape, sexual assault, sexual violence, groups and art therapy. Narrowing the topics to "adult art therapy groups," "adult sexual assault groups," and "sexual violence against women" yielded more specific articles and books pertaining to the topics needed for research displayed in Table 1. Other keywords that were helpful in this search included PTSD, trauma, sexual violence, collaborative healing and psychotherapy. Examples of databases used include Academic Search Premier,

PubMed, ERIC and EBSCO displayed in Table 2. Additional references were found in reference lists from informative articles in journals (Table 2).

The first step in selecting sources was to review the articles. The articles, books, references books, dissertations, and theses that were gathered for this integrated systematic literature review were reviewed and analyzed using qualitative and quantitative research methods (Figure 1). Figure 1 illustrates the quantity and types of resources that were reviewed for this systematic literature review. For each article, the information was organized under the following headings: Author/Title/publish date, research design, sample description and size, method, key words, outcomes/conclusions, implications, and relation to the study. Each article's data was organized by topic, noted on index cards, and then applied to a matrix. Analyzing the data for inclusion in the integrative systematic review was the final step.

Table 1

Search Terms and Phrases

Adult	Sexual Assault	Art Therapy	Group
Adult victims	Sexual assault	Art therapy	Group
Adult females	Sexual assault	Art therapy	Group
Female	Sexual assault	Art therapy	Group
Women	Sexual assault	Art therapy	Group
Adult	Sexual assault	Art therapy	
	Sexual assault	Neuroscience	
Adult victims	of rape	Art therapy	Group
Adult female	Rape victims	Art therapy	Group
Female	Rape victims	Art therapy	Group
Women	Rape victims	Art therapy	Group
Adult	Rape victims	Art therapy	Group
	Rape	Support	Group
	Rape	Neuroscience	
Adult victims		Cognitive Processing Therapy	Group
Adult female		Cognitive Processing Therapy	Group therapy
Female		Cognitive Processing Therapy	Group
Women		Cognitive Processing Therapy	Group
Adult victims	with PTSD		Group
Adult female	with PTSD		Group
Female	with PTSD	Art therapy	
Women	with PTSD	Art therapy	Group
	PTSD	Neuroscience	
Women	Violence against	United States	
	Sexual violence	Art therapy	Groups
	Sexual violence	United States	
Adult	Sexual trauma	Art therapy	
Adult	Trauma		Groups
	Trauma	Neuroscience	

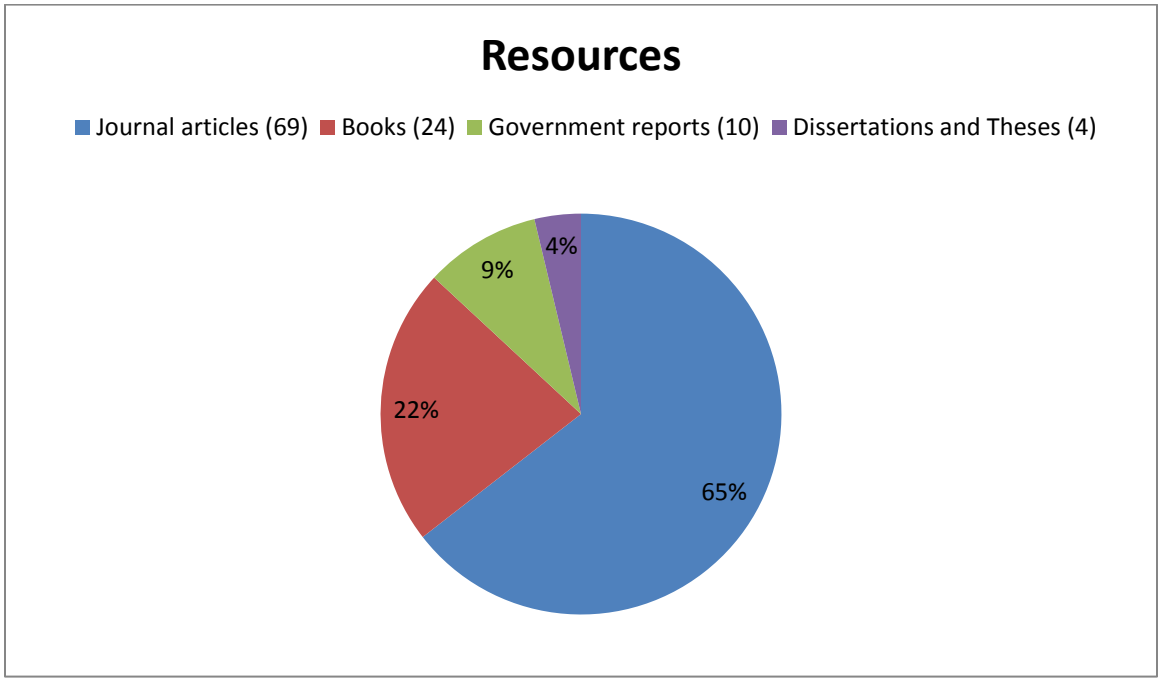
Table 2

Databases & Journals

Databases	**Journals**
Academic Search	*Art Therapy: Journal of the American Art Therapy Association*
Premier	*Canadian Art Therapy Association Journal*
EBSCO	*Contemporary Family Therapy*
ERIC	*Depression and Anxiety*
Google Scholar	*Family Therapy*
PsychArticles	*Group Dynamic: Theory, Research and Practice*
PsychatriOnline	*Harvard Review of Psychiatry*
PsychINFO	*Journal of Advance Nursing*
PubMed	*Journal of American Art Therapy Association*
Web of Science	*Journal of Consulting and Clinical Psychology*
WorldCat	*Journal of Interpersonal Violence*
	Person-Centered & Experiential Psychotherapies
	Perspectives on Psychological Science
	Psychotherapy
	Psychological Trauma: Theory, Research, Practice and Policy
	The Arts in Psychotherapy
	Theory and Practice of Group Psychotherapy
	Violence Against Women

Figure 1

Percentage of Resources



Chapter III: Literature Review

The following literature review amasses research on the subjects of sexual violence among adult females in the United States, the progression of sexual violence as a traumatic experience in the Diagnostic and Statistical Manual of Mental Disorders (DSM) , common treatment models, art therapy, and group art therapy with adult female victims of sexual violence. Additionally, the causes, criteria, and symptoms of PTSD will be presented, explored, and discussed. In order to support the efficacy of art therapy interventions with adult female victims of sexual violence, previous studies and research using art therapy interventions to treat trauma with victims of sexual violence will be reviewed. Although most research has supported the effectiveness of art therapy with children and veteran, this literature review will primarily focus on art therapy treatment with adult female victims of sexual violence experiencing PTSD symptoms.

Sexual Violence: Demographics, Prevalence, and Socioeconomics

Researches on victim demographic variables and prevalence have yielded mixed findings. Most studies have found that older women have a more difficult adjustment period following sexual violence than a child. This makes sense because an adult has an established lifestyle developed before victimization. After a sexual violence situation has occurred, a woman experiences an abundance of new information that she will need to integrate into her life. On the other hand, children who experience sexual violence may not distinguish an alternative way of living because of the prolonged duration and complexity of the early onset of their sexual violence trauma (Saltzman, Matic, & Marsden, 2013; Talwar, 2007).

In the United States, a study was conducted to validate whether there was a discrepancy among the occurrences of sexual violence amongst adult female victims of sexual violence

between race or economic status. Statistics from the Bureau of Justice 1993 - 1998 (Rennison, 2001; Weist, 2006) found the average annual victimization rate for sexual violence was 3.7 per 1,000 persons aged 12 and older for African Americans, and 3.1 per 1,000 for Caucasians 12 and older. The National Crime Victim Survey (Black et. al., 2012; Weist, 2006) reported that African-American and Caucasians experienced similar rates of sexual violence. Findings varied regarding incidences of sexual violence among races, but acknowledged that sexual violence is overall an underreported crime. Rennison (2002) estimated that only 36% of sexual violence are reported to police. Factors that influenced resistance to disclosure were perceived racism and sexism in the legal system, socioeconomic status, nature of the assault, prior negative experiences with law enforcement, and religion or spirituality (Black et. al., 2011; Rennison, 2002; Weist, 2001).

A needs assessment of African-American and Caucasian female residents of Maryland who had been victims of sexual violence was conducted to "broaden the understanding of the needs of African-American women who are sexually assaulted, their use of traditional services and resources for sexual assault and their use of alternative resources" (Weist, 2001, pg. 1). Interviews were conducted with 224 sexual assault survivors, age 18 and over; 139 of whom were African-American, and 83 of whom were Caucasian. It was discovered that there were no overall differences between the occurrences of sexual violence based on race. Nevertheless, when factoring in income, high-income African-American women were less likely to report their assault to the police than high-income Caucasian women were. Weist's (2001) non-parametric statistical analyses revealed that African-American women were no more likely to be assaulted by a stranger than Caucasian women, nor was household income or education related to whether or not the perpetrator was a stranger.

More research is needed to determine how sexual violence affects adult female victims differently due to the nature of the crime and the occurrence of sexual violence among certain demographics. The National Intimate Partner and Sexual Violence Survey 2010 Summary report stated that approximately 1 in 5 Black and White non-Hispanic women, 1 in 7 Hispanic women and 1 in 3 women who identified as American Indian or Alaskan Native women reported rape victimization in their lifetime (Black et.al., 2011). Research by Reid and Kelly(1994) identified 277 abstracts on psychological research on rape for the period of 1987-1994 and noted that only seven abstracts included the key words African-American or "black" women. Therefore, regardless of race or economic status, sexual violence produces multidimensional negative effects upon the wellbeing of victims such as, physical and psychological illness, including depression, PTSD, and anxiety (Weist, 2001; Roth & Lebowitz, 1988; Black et. al., 2011). Continued research and interventions will lead to ensuring the availability of effective treatment of trauma for all victims of sexual violence.

Sexual Violence as a Traumatic Experience According to the DSM

In 1980, traumatic stress disorder was included in the *Diagnostic and Statistical Manual of Mental Disorders,* DSM, (3rd ed., text rev.; DSM–III; American Psychiatric Association [APA], 1980), and characterized as "outside the range of usual human experience." The DSM IV-TR (2000) changed from the DSM III's concept that distress from traumatic event is possible for almost anyone to experience, defining trauma as "an event that involves actual or threatened death, serious injury or a threat to their physical integrity". The trauma must be severe enough to cause intense fear, helplessness or horror. In addition, the DSM-IV-TR (2000) criteria for identifying PTSD required that symptoms must be active for more than one month after the

trauma and associated with a decline in social, occupational, or other important areas of functioning.

Sexual violence is an interpersonal act of violence fundamentally about power, one or more individuals' use of his or her power to hurt someone else. The victim experiences a loss of power over her body, mind, identity and environment. Sexual violence, however, was not specifically included in the DSM-IV-TR (2000). It was not until May of 2013 that the American Psychiatric Association introduced the DSM-V (2013), which detailed what constituted a traumatic event, specifically including "sexual assault". The definition changes further from the DSM-IV-TR (2000), however, in that the requirement of "intense fear, helplessness, or horror" was removed because this language identified an individual's response to an event as opposed to the event itself (APA, 2013).

Behavioral responses to trauma. The DSM-V (2013) includes PTSD in a separate chapter on Trauma-and Stressor-Related Disorders. It identifies the trigger to PTSD as "exposure to actual or threatened death, serious injury or sexual violation" (APA, 2013). The DSM-V (2013) addresses the behavioral responses an individual might have to a traumatic event, such as intense fear and helplessness. They are classified into four distinct diagnostic clusters of symptoms.

The first cluster is re-experiencing. "Re-experiencing covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress" (American Psychiatric Association, 2013). A flashback could be triggered from a smell, touch, taste, image, or sound that causes the person to re-experience their traumatic event. The person may feel or act as though the traumatic event, including sexual violence, is happening again. A flashback may cause an individual to be temporarily

disconnected with present moment. If the individual is aware of what frequently causes them to re-experience their trauma, he or she will attempt to avoid their triggers such as avoid watching the news, being in crowds, loud noises, or being around strangers or strange men.

The second cluster is avoidance. "Avoidance refers to distressing memories, thoughts, feelings or external reminders of the event" (American Psychiatric Association, 2013). The victim of a traumatic event like as sexual violence may want to avoid the location of the assault or anything associated with the incident. External reminders, thoughts and feelings often have negative connotations that an individual cannot comprehend due to the nature of violence.

The third cluster is negative cognitions. "Negative cognitions and moods represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event" (American Psychiatric Association, 2013). The victim of a traumatic event like sexual violence often experience unpleasant feeling of regret stemming from the belief that they could or should have done something different at the time a traumatic event occurred. Individuals who become overwhelmed with negative cognition may isolate and become depressed and withdrawn. Others may self-medicate with alcohol or drugs as an attempt to cope with his or her symptoms.

Finally, the fourth cluster is arousal. "Arousal is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or related problems" (American Psychiatric Association, 2013). Studies show that victims of sexual violence are more likely to develop drug addictions and alcoholism as the result of the assault as opposed to the popular perception that being drunk or high cause's one to become more susceptible to sexual violence

(Corbin, et al., 2001). “High risk” behaviors are often coping skills victims of trauma, including sexual violence use in an attempt to get their power back.

The four clusters described above exemplify the experience of trauma for the victim and the brain’s response to processing the traumatic incident of sexual violence. According to Hass-Cohen (2008) fear and anxiety, stimulated by traumatic memories and triggers are controlled by the middle prefrontal cortex and nearby areas of the brain. Neuroscience research assists in bridging the gap supporting non-verbal therapy, such as art therapy for treating adult victims of sexual violence. However, the most common researched treatment methods used for victims of sexual violence and trauma are verbal therapy.

Brain and body response to trauma. A growing body of research uses the limbic system to understand memory and emotions connected to trauma. Traumatic memories do not reside in the verbal analytical areas of the brain but affect the limbic system and non-verbal area of the brain (Levine, 1997; Talwar, 2007; Rothschild, 2007). The limbic system guides the emotions and responses essential for self-preservation and survival (Rothschild, 2007). Within the limbic system are the hippocampus and amygdala, which are central to the storage and recovery of memory (Figure 1). The amygdala evaluates the emotional significance connected to extreme emotional memories like terror and remains active during the re-experiencing and remembering of the traumatic event. The hippocampus cognitively maps experiences into a sequential time line in one’s memory (Rothschild, 2007).

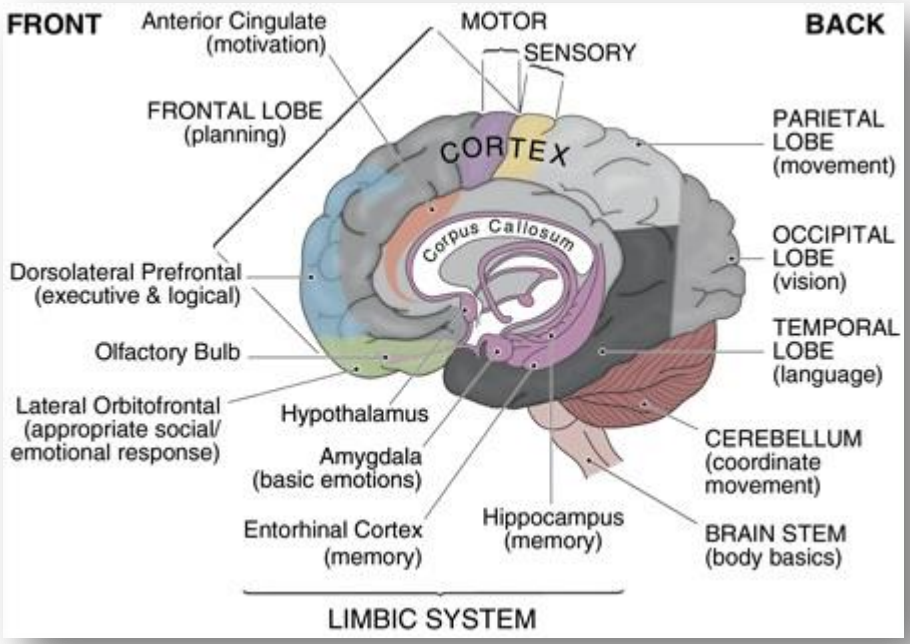
Re-experiencing the trauma has been connected with emotional processing of the trauma (Rothschild, 2007; Hass-Cohen, 2008). Traumatic memories are more often recorded in implicit memory. This causes the highly stimulated and incomplete memory to be locked in the body as a biological response to threats (Rothschild, 2007). When the traumatic event is not able to reside

in its proper place in one's timeline, it continues to attack the present cognitive state, upsetting the incorporation of the experience and memory. According to Talwar (2007), when the traumatic event(s) are re-experienced, the frontal lobes become compromised and cause the person to struggle with thinking and speaking. Rothschild (2007) and van der Kolk (1994) refer to these somatic experiences, images, and emotions as triggers and flashbacks that are elicited through exteroceptive and interceptive systems.

Exteroceptive system are senses; sight, taste, smell, touch, hearing, and balance by which one perceives the outside world. Interoceptive system communicates to the brain stimuli arising within the body, one's perception of pain and the stretching of internal organs (not muscles). Therefore, something seen, heard, tasted, or smelled connected to a traumatic event can be profoundly imprinted on an individual's mind and re-experienced without appropriate transformation. This can prohibit victims from feeling safe, creating hyper-vigilance, anxiety, and fear. These reactions are often unconscious leaving the victim without words to express this experience. Gantt and Tinnin (2009) suggested that trauma is largely a nonverbal disturbance. According to Talwar (2007), in trauma treatment, the non-verbal memory and emotional elements of the trauma are more important than the verbal account. To treat trauma successfully, therapists need to progress beyond spoken language to incorporate the emotional, cognitive and affective memory of the trauma. However, the most commonly used methods of treatment for victims of trauma, like sexual violence, utilizes primarily talk therapy to address the PTSD symptoms.

Figure 1

The Limbic System



http://www.brainwaves.com

Common Treatments for Trauma and Adult Female Victims of Sexual Violence

There are several treatment modalities accessible to address the trauma experienced by victims of sexual violence including pharmacology; relaxation therapy; cognitive behavioral therapy (CBT); eye movement desensitization and retraining (EMDR); psychotherapy, and group therapy. However, there is no certainty as to which intervention is superior in addressing the presenting PTSD symptoms of adult female victims of sexual violence. Few treatment methods have been rigorously tested specifically for adult female victims of sexual violence (Saltzman, Matic, & Marsden, 2013). However, eye desensitization movement and retraining (EMDR), and psychotherapy methods such as, cognitive behavioral therapy (CBT), and group therapy are the most commonly used treatment methods to address PTSD symptoms experienced from trauma, including sexual violence (Pifalo, 2003; Calhoun & Atkeson, 1991). Research has shown that EMDR, CBT and group therapy have been effective forms of treatment for victims of trauma to assist individuals in processing memories properly and developing adaptive changes in thinking. EMDR, CBT, and group therapy have been proven as effective forms of treatment for individuals who have experienced trauma and will be reviewed briefly in the following text:

Eye movement desensitization and retraining (EMDR). Developed by Francine Shapiro in 1987 after she was walking in the park and realized her eye movements seemed to decrease the negative emotion associated with her own distressing memories. She experimented to find that others had the same response to eye movements. Later adding a cognitive component with other treatment elements, and developing a standard. Eye movement desensitization and retraining was born. Controlled studies resulted in significant decreases in ratings of distress and significant increases in ratings of confidence in a positive belief (Talwar' 2007; Tripp, 2007; Calhoun & Atkeson, 1991). EMDR is an eight-step process that assists victims of sexual

violence and trauma in processing memories properly and developing adaptive changes in thinking. EMDR has an eight-step process that is tailored to the needs of the patient. The number of sessions devoted to each phase varies on an individual basis (Shapiro, 2001). Accessing traumatic memories effectively and suitably can prevent symptoms from progressing to PTSD and other mental illnesses. The goal of EMDR therapy is to promote more adaptive and realistic cognitions, which the fundamental principle of Cognitive behavioral therapy (CBT) to recondition maladaptive cognitions.

Cognitive behavioral therapy (CBT). According to Brewin (1989), CBT is fundamentally based on the premises that symptoms are developed and maintained by conditioned and learned behavioral responses and maladaptive cognitions. Most studied treatments for adult female victims of sexual violence have used cognitive behavioral techniques employed with additional techniques in the context of an empathic therapeutic relationship (Jaycox, Zoellner, & Foa, 2002). It is common for adult female victims of sexual violence view of the world and evaluation about her-self to change drastically to unrealistic assumptions of being unsafe. Cognitive restructuring reduces distress by identifying, evaluating, and modifying negative thoughts. The therapist assists the client by challenging the rationality of their beliefs with questions and replacing them with thoughts that are more realistic.

Psychodynamic therapy. Psychodynamic therapy is commonly used for dealing with trauma including, sexual violence for dealing with trauma including sexual violence (Wadeson, 2010; Regehr, Alaggia & Saini, 2009). Evolving from psychoanalytic theory, the psychodynamic perspective focuses on expression of emotions, the exploration of avoidance of distressing emotions, examining experiences, wishes and fantasies, identification of defense mechanisms, working through interpersonal relationships and using the therapy relationship to resolve intra-

psychic conflicts and interpersonal struggles (Wadeson, 2010). Bringing the client's conflicts and psychic tension from the unconscious into the conscious will lead to healthier functioning. Hence, the goal of the therapy is to uncover unconscious motives and conflicts through talking about past experiences, defense mechanisms and repetitive patterns and themes in order to experience change.

Group therapy. Group therapy is another treatment model that has been commonly used to treat victims of trauma. Irving Yalom's (1995) theory on the therapeutic principles of group therapy stated that group therapy encourages an instillation of hope, interaction, universality, catharsis, and altruism. Foy, Eriksson and Trice (2001) stated that group intervention with trauma victims is effective for two reasons; it offers survivors cost-efficient opportunities to join "fellow strugglers" coping with emotions and group intervention appeals to the experience of regaining trust after feeling ostracized.

The most common therapeutic approaches for victims of trauma are psychodynamic and cognitive-behavioral groups (Foy, Eriksson & Trice, 2001). Foy's (2001) introductory article explored three models of group intervention for adults exposed to life-threatening violence: supportive group therapy, psychodynamic group therapy and cognitive-behavioral group therapy. Foy (2001) noted the goal of psychodynamic focus therapy groups and cognitive-behavioral therapy groups are to uncover the experience by "focusing intentionally on discussion of the event and member's memories of their experiences" (Foy, Eriksson & Trice, 2001, p. 247). Foy (2001) states that "supportive group therapy's objective is to cover the traumatic event by maintaining attention to daily coping and adaptations" (p. 247). Although supportive, psychodynamic, and cognitive-behavioral therapy differs in methodology, they share the characteristics of disclosure and validation of the victims' stories. In addition, they share the

same feature of helping trauma victims in normalizing his or her traumatic experience, validating coping skills acquired at the onset of the trauma, and challenging any initial mistrust of the non-traumatized therapists' ability to help the group of survivors (Foy, Eriksson & Trice, 2001).

Even though EMDR, CBT, psychotherapy, and group therapy are the most commonly used treatment methods to address trauma, including sexual violence (Pifalo, 2007; Calhoun & Atkeson, 1991), it is imperative that effective and efficient treatment options are identified and available for adult female victims of sexual violence (Pifalo, 2007). Due to the documented residual long-term effects of sexual violence such as PTSD and depression, Helen Landgarten (1991) suggested that "clinical art therapy is capable of adapting to different theories and methods of therapy and that it is equally facile in responding to the diverse problems, opportunities, and changes in adult life" (p.xiii).

Art Therapy

Art therapy is a non-verbal process. A master's level art therapist trained to use art materials and the creative process in the context of therapy to elicit therapeutic growth conducts art therapy in groups or in individual therapy sessions. Drawings, paintings and other art expressions are the products produced in a therapy session that communicates issues, emotions and conflicts (Malchiodi, 1998). Art therapy is inherently cognitive processing. According to the American Art Therapy Association (2013) "self-expression supports individuals as they resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight".

Images existed before we had words (Wadeson, 2010). "Art in a supportive environment can evoke whole-body thinking; it can activate consciousness between polarities of individual and world, subject and object, mind and body" (Landgarten, 1991, p. 6). Margaret Naumburg

(1987), a pioneer of art psychotherapy, identified artistic expression as the springboard for the patient's associations and the therapist's interpretations. Edith Kramer (2001), another pioneer of art therapy, emphasized the "healing potentialities of the psychological processes activated in the creative act" (Wadeson, 2010, p. xi). Creating art provides a concrete record of the inner process that can then be discussed between the therapist and the client. Wadeson (2010) noted that imagery taps into an individual's "primary process and enhances the creative process, both narrowly in an artistic sense and broadly in the creation of solutions in living" (p.11).

The connection: Art therapy, neuroscience, and trauma. The connection between art therapy and neurobiology has an increasing interest for therapists and researchers in the field. Advances in neurobiology and psychotherapy have informed the practice of art therapy (Talwar, 2006). Findings have established that there are key brain configurations and pathways linked with retaining the traumatic incident process. Bogousslavsky (as cited by Talwar, 2007) found that brain activity shows that when carrying out an art task, a "complex combination of sensory, cognitive and motor activities immediately emphasizes the holistic functioning of the brain in creativity" (p.25).

Hass-Cohen (2008) presented a case study using art directives that may aid in repairing the limbic functions by reducing reactions from chronically experiencing flashbacks and nightmares. In the study, Hass-Cohen (2008) considered art therapy directives that were uncomplicated and repetitive like cutting paper into shapes, stringing beads together, or kneading a piece of plasticine while verbalizing difficult memories. This process aided in decreasing the disturbances caused by fragmented sensory and emotional memories. Creativity engages multiple areas of the brain and it is probable that the brain's hemispheres are involved by the art process in accessing memories and processing emotions (Talwar, 2007).

The art therapy process allows the traumatized victim of sexual violence to sublimate unspeakable terror into an art product, with the art therapist to re-examine and discuss. In art therapy, the left hemisphere of the brain offers an interpretation to the right hemisphere of the brain, and together creates an image. “Unhealed memories attach to artistic symbolic language through neurological function. The image becomes the message, the art expression becomes the sender, and the victim-artist becomes the receiver who translates the message into linguistic form.” (Spring, 2004, p. 206).

Art therapy: Expressive therapies continuum. An art therapists’ understanding of the expressive therapies continuum (ETC) is a framework that supports the benefits using art therapy with adult female victims of sexual violence as treatment model. Kagin and Lusebrink (1978) developed the ETC. The ETC is a foundational theory in the field of art therapy that assists in defining and explaining the myriad therapeutic uses of art expression and provide framework that organizes media interactions “into a developmental sequence of information processing and image formation from simple to complex” (Hinz, 2009 p.4). The ETC is arranged in a visual diagram, organized hierarchically, with three bipolar complementary levels; the sensory/kinesthetic level, perceptual/affective experiences, and complex cognitive processes (Hinz, 2009; Lusebrink, 1990). Each of the three complementary levels represents the various ways in which information is taken in, processed, and used therapeutically. The ETC’s fourth level is Creativity. Creativity can occur on any level of the ETC or it can involve the integration of functioning on all levels (Hinz, 2009).

When choosing what media to use with clients “the art therapist needs to consider the relevance of the medium to any creative intention, in addition to its ability to be used successfully by a particular person or group” (Rubin, 1984, p.11). The different properties that a

material/media can incorporate are the ability to be fluid or resistive, simple or complex, structured or unstructured. Media (pencil, paint, chalk, wood, collage, clay, pastels, and markers) provide insight to the client's developmental level in the use of materials, response to media properties, use of structured verses non-structured formats, and the capacity to express affect (Rubin, 2001). For example, on the media continuum of the ETC, pencil and eraser are the most resistive media on the ETC, which allows the client to "undo" mistakes and distance himself or herself from affect. Color pencils are resistive media, but they provide color. The use of colors provides affect for the client. Markers are less resistive than colored pencils but yet, fluid and more affect provoking. Lastly, chalk pastels are fluid and an affect provoking media, which provides the least amount of control for a client (Hinz, 2009).

The ETC underscores validates the correlation between art therapy and neuroscience, supports the compatibility of art therapy as a treatment model, and illustrates the importance of a master's level art therapist facilitating art therapy interventions that integrate the traumatic memory of adult female victims of sexual violence.

Compatibility of Art Therapy with the Common Trauma Treatment Models

Cathy Malchiodi (1998) defines the scope of art therapy as bringing together and containing "aspects of the visual arts, the creative process, human development, behavior, personality, and mental health among others" (p.4). Thus, the congenial combination of art therapy and the commonly known trauma treatment models is imminent. Moreover, the non-verbal aspect of art therapy is unique and lends itself to address the symptoms specific to adult female victims of sexual violence that has changed or altered how victims view themselves and the world, safety, and trust.

Art therapy and EMDR. Savneet Talwar (2006), an art therapist, was influenced by Shaprio's (2001) Eye Movement Desensitization and Reprocessing (EMDR) and proposed an art therapy trauma protocol (ATTP) designed to address the non-verbal core of traumatic memory, which she utilized with adults clients in her clinical practice. The ATTP was designed to address the non-verbal core of traumatic memory. The ATTP grew out of clinical practice to give clients "the tools to create sensory awareness, which promotes affect and emotional regulation" (Talwar, 2006, p. 34). The ATTP was designed for adult victims of trauma believing that "each individual has the innate ability to construct adaptive resolutions to negative experiences and to integrate positive and negative motional schemata" (Talwar, 2006, p. 27).

The ATTP is a three-phase process. During the first phase, the client is instructed to suspend all thought and paint with tempera on a 22" x 29" sheet of Bristol board taped to the wall or easel while standing, the client has to travel from the paint to the board and the board to the paint to permit full use of the body. The process of walking back and forth encouraged bilateral stimulation activating the mind and the body and is intended to "activate dual processing of the left and right hemispheres of the brain" (Talwar, 2006, p. 29). Once the participant finishes, he or she is asked to "put into words the dominate emotion associated with the painting or element in the painting" (Talwar, 2006, p. 30).

During phase two, the client is asked to identify for each memory "the negative self-representation or the negative cognition" such as, "I am not valuable." "I am not loved." or "I am a bad person" along with the alternate desired, positive self-representation or the positive cognition such as, "I am loved" or "I am a good person" while at the same time identifying the alternate desire, positive self-representation, or the positive cognition (Talwar, 2006). The client rates on a scale of 1 to 7 the validity of the positive cognition to indicate how true the cognition

felt at that moment. Next, the client is then asked to paint with his or her non-dominate hand, images, and memories as they emerge, while keeping the negative cognition and physiological sensation in mind.

In phase three of the ATTP, the client continues to paint, but switches between his or her dominant and non-dominant hand and starts on a new sheet each time. "Thus the client works through the memory until there are no longer feelings of disturbance at the recall of the traumatic event" (Talwar, 2006, p. 31). Talwar (2006) explained that during this process the left brain is "deciding between colors, brushes and sequential decisions using analytical thinking, alternate with right brain processes (Figure 5) activating the spatial, visual motor, emotions, and sensor regions" (p. 34). Art making engrosses integration and planning functions of the prefrontal cortex, which allows the client to process a narrative of a beginning, middle and end to his or her traumatic memory.

The difference between EMDR and the ATTP is what constitutes as a target memory at the onset of treatment. Both therapies elicit the left and right hemispheres of the brain in order to process traumatic memories, but here are some distinct differences. In EMDR, the target memory must be an event on a life events list that the client can recall and discuss (Shaprio, 2001). In the ATTP, the client does not have a specific list to choose a life event. The imagery created in an art therapy session reflects the client's state of being more accurately than words, "capturing their somatic memory and stands as a testimony to their felt experiences (Talwar, 2006, p.28). Research has proved that individuals who experience trauma often express having the lack of words to express his or her traumatic life event.

In the ATTP, the client uses both hands during art making to process traumatic memory and address his or her emotional distress from the trauma. EMDR is limited to the verbal processing of the client's traumatic memory.

Although the ATTP method has not been a researched study, its' effectiveness has been documented through the results of Talwar's (2006) client's report, which showed positive result "in processing speechless traumatic memories" (p. 33). For adult female victims of sexual violence who are ready to confront their trauma and their somatic memory. The ATTP appears to be a promising therapy method because of its effective processing of the somatic memory of victims of trauma, like sexual violence.

Art therapy and CBT. Terry Pifalo's (2007) treatment model proposed that the "unique properties of art therapy and CBT combine to create an effective model: a dynamic, synergistic pairing that is a powerful tool in trauma focused treatment" (p. 170). In Pifalo's (2007) treatment model CBT sets the goals for treatment and art therapy interventions facilitate the achievement of the goals in a "non-threatening efficient and organized manner providing tools to express and process complex and often conflicting emotions" (p. 175).

As Wadeson (2010) stated, "we think in images. We thought in images before we had words" (p. 8). The survivor's phenomenological interpretation of the trauma produces and preserves intrusive symptoms. Introducing the cognitive process of recognizing the sequence of events and perspectives, these connections serve to increase the survivor's insights into his or her mistaken beliefs and attitude and to further activate the prefrontal cortex, which will help lessen the increased sensory experience during art making (Saltzman, Matic, & Marsden, 2013). According to Pifalo (2007), Pennebaker and Beall (1986) researched this technique of writing about a previous trauma consecutively four times and discovered that it facilitates cognitive

integration and positive physical effects. According to Rankin and Taucher (2003), the narrative art intervention is used to enhance reconstructing the trauma story "whereas management –type interventions are used to regulate increased anxiety and destabilization that may occur during the narrative process" (p. 141) over three consecutive sessions. Writing about the trauma is useful when victims are unable to talk about their experience to the therapist or others (Calhoun & Atkeson, 1991; Pifalo,2007). However, Malchiodi (1998) stated by asking the client to "draw from within" he or she can express through images that which comes from inside, feelings, perceptions, and imagination, thus the therapeutic relationship guides the art making experience in a supportive environment to help the individual find cognition and structure to their traumatic experience.

Group art therapy. Group art therapy provides a collective ownership in creating imagery. "Unconscious themes of the group were often reflected in images made by group members, allowing a powerful group consciousness to develop" (Walker, 1993, p. 9). Wadeson (1987) stated group members come to know one another in a new way, a way in which individuals in our society seldom know one another, including those in verbal therapy groups. The non-verbal aspect of group art therapy provides a communal sharing of imagery and art based on the understanding and awareness. Visual languages are developed, expressed, and shared. "The dimension of imagistic conceptualization and expression is exposed and communicated. Through this sharing, those in an art therapy group come to know one another's imagistic symbols, styles, themes, and to be known by others for the characteristics of their own visual expression" (p. 143). The art making process, in group art therapy, engages the body and the mind holistically as it evokes traumatic narrative and self-awareness in a supportive and less

threatening therapeutic environment (Saltzman, Matic, & Marsden, 2013; Talwar, 2007; Tripp, 2007).

Research has presented treatment plans that combined art therapy in conjunction with other commonly used therapeutic approaches to reduce PTSD symptoms for trauma victims and enhance the potential for positive outcomes that can be tailored specifically for adult female victims of sexual violence.

Group Art Therapy with Adult Female Victims of Sexual Violence

Effective treatments strategies are necessary to deal with the effects of sexual violence after the immediate trauma in order protect the effects from progressing to a diagnosis of PTSD. Talk therapy groups including psychodynamic and CBT groups may appear too invasive for some adult female victims of sexual violence. This is because sexual violence is interpersonal violence. It illustrates how a human being(s) is capable of inflicting violence on another human being. This evokes feelings of fear, lack of trust, and uncertainty in adult female victims of violence. Group art therapy, on the other hand, allows members of the group to reveal substantive emotions and memories through seemingly superficial acts.

For adult female victims of sexual violence, group art therapy can address the client's presenting symptoms and help them gain control, support, understanding, and management of symptoms. Trauma is largely a nonverbal disturbance (Gantt & Tinnin, 2009). The process by which "information is encoded, stored in memory, and recalled" (Resick & Schnicke, 1992, p. 748).

Chapter IV: Results

Through this research, it is anticipated that group art therapy interventions will be effective with adult female victims of sexual violence to help victims gain control, support, and understanding and management of symptoms. The following proposed adult female sexual violence 90-minute support group will meet once a week for eight consecutive weeks. The group will be comprised of six women and an art therapist facilitator. It is important to note that only a master's level registered art therapist can facilitate this group.

Goals of Group Art Therapy for Adult Female Victims of Sexual Violence

Helplessness and loss of control are primarily feelings of adult female victims of sexual violence. Such as, the art therapist must allow each client to experience a sense of control during the group process and establish safety in the therapeutic relationship (Wadeson, 2010). Due to the nature of sexual violence, trust in others may have been shattered, as well as the "destruction of a belief in oneself in relation to others" (Wadeson, 2010, p. 84). Wadeson (2010) explains the importance of loss as a component of trauma, a loss of safety, sense of self and control. It is imperative that this loss is explored with caution, support, and sensitivity to each individual client's need to control the pace of the exploration. To this end, the initial goal of group art therapy with adult female victims of sexual violence is to provide a safe atmosphere for healing to begin, utilizing art therapy to help individuals express deep emotions about their sexual assault trauma (Pifalo, 2013; Rappaport, 2010; Wadeson, 2010; Rankin & Tauchner, 2003; Calhoun & Atkeson, 1991).

The second goal might be to utilize art therapy to gain mindfulness, insight, and self-awareness to help reframe and or replace ineffective self-talk and destructive behaviors (e.g. guilt and self-blame). The ability for an adult female victim of sexual violence to process the

trauma through a trauma narrative is essential to his or her healing and recovery (Pifalo, 2013; Wadeson, 2010). "In contrast to the actual trauma, which had a beginning, a middle, and an end, the symptoms of PTSD take on a timeless character" (van der Kolk , 2003, p. 172). The client, therefore, can experience gaps in her memory and or repeatedly relive her sexual violent experience. Telling her story through imagery is beneficial even if the story may not be shared with others, knowing the story for her-self is healing and provides the foundation for gaining a sense of control (Calhoun & Atkeson, 1991).

The last goal of the group might be to provide empowerment, basic education about sexual assault, and information on positive ways to reduce anger, depression, and anxiety. Psycho-education about the myths and perceptions of sexual violence is imperative to the healing process. Calhoun and Atkeson (1991) explained that fear and anxiety are the most pervasive problems victims of sexual violence experience. Integrating cognitive and emotional aspects of the trauma is essential to healing. Providing reassurance to the client that their symptoms are similar to those experienced by other victims of sexual violence normalizes the situation and helps reduces distress. Exploring belief and attitudes about sexual violence using art therapy will reduce and identify misconceptions and harmful thoughts that adult female victim of sexual violence may experience (Calhoun & Atkeson, 1991, Wadeson 2010).

The overarching goal of group art therapy for adult female victims of sexual violence is that members will end the group art therapy sessions with increased feelings of "resolution, integration of the experience, a revised sense of self and the world that moves the client from helpless victim to empowered survivor, and a movement to getting on with one's life" (Wadeson, 2010, p.10). For some survivors helping other victims of sexual violence is identified as a feeling of being productive and an essential part of his or her healing process. Individuals who complete

the eight-week group and express this desire, should be encouraged to participate in future adult female victims of sexual violence groups to encourage new group participants. Others may want to participate in the eight-week group again because each group series may differ based on the emotional state and willingness of participation of the group members. Either way, it is beneficial for group members, like all clients, to understand that the process of healing is often not quick.

Evaluation

To collect data for further research on the effectiveness of group art therapy with female adult victims of sexual violence it is imperative that evaluations are gathered from the group participants at the start and end of the eight-week sessions. This is essential, because group art therapy data can be obtained from the group members to assess the therapeutic factors the group members found the most or least helpful (Yalom, 1970).

Factors to Consider

Adult female victims of sexual assault may bring with them to group all sorts of feelings. Outside influences may affect individual's attitudes and feelings. It may influence the facilitator's choice of directives for making art if group members are "feeling flat, high, anxious, preoccupied, or simply very tired at the beginning of a session- it may influence your choice of activity or help you (the art therapist facilitating) realize your opportunities or likely limitations to achievement that session" (Liebman, 1986, p.21). Starting group with a routine such as meditation, relaxation, allowing group members to check in, and rate their emotional state will help the members acclimate to the group environment providing a snack. In addition, the facilitator must be allow for flexibility and have awareness of the group members affect during

discussion, these two are important factors to consider that can possibly address or identify potential concerns that could affect the overall group.

Group Structure

- Group opening
    - Members can arrive fifteen minutes early
        - Relaxing music played as group members arrive
        - Water and popcorn or granola bars
        - Kleenex
        - Members can "remove" negative thoughts by writing them down and putting them in a sealed envelope before group begins (optional)
- Introduction and weekly check in (10-15 minutes)
    - Rate anxiety 1-10 (1 = low, 10 = high)
    - Group rules made at the first meeting and remain posted
- Art therapy (50-60 minutes)
    - Intervention
    - Discussion
    - Education
- Group closing (10 -15 minutes)
    - Take away from group discussion and art therapy
        - Integrate group experience and provide closure

Group Art Therapy Interventions

Session 1

Intervention: Scribbles

Activity: Each group member will name a feeling and all the group members will choose a color crayon, close their eyes (or look up at the ceiling) and scribble the emotion anywhere on the paper. After the scribble is completed, each member will record the name of emotion in the color used on the corner of the paper. If all the group members are shy, the art therapist can participate and name the first feeling. After everyone has had a turn to name a feeling. Allow all the members to view their scribbles and others by walking around the room.

Materials: 24 x 36 inch white paper, tape, and crayons
(Tape paper to table so it does not move around while scribbling)

Goal: The goal of this intervention is to establish a foundation of safety to express feelings, introduce art therapy, provide a non-judgmental atmosphere, and an introduction group dynamics.

Directive: Name a feeling, pick a color crayon to scribble how that emotion feels, close your eyes (or look up) and scribble.

Rationale: Crayons and scribbling has connection to the first experience with art and art materials. Typically, a non-judgmental early experience, scribbling provides an opportunity for the client to create spontaneous imagery by tapping into the unconscious and not feel preoccupied with being judged by others in the group.

Discussion: How did you feel about being asked to scribble?

Notice how all the scribbles are different. Are there any similarities in colors used for certain feelings?

Do certain colors have specific meanings to you?

Is there a theme to the type of feelings all the group members choose?

Was there a feeling named that you did not want to scribble? Why?

How do you feel after scribbling emotions?

Is there any feeling that was not mentioned that anyone would like to scribble?

Session 2

Intervention: Collage

Activity: To identify and create a safe place using magazine cutouts that can represent their ideal or existing safe place. After the collage is completed, reflect why this place is safe and share with the group.

Materials: Magazines, pre-cut magazine images, glue sticks, scissors, 11 x 17 inch and 8 ½ x11 inch white drawing paper or card stock

Goal: The goal of this intervention is to create an image of safety to help relieve tension and discover mental images that enhance a sense of safety.

Directive: Using magazine images create your safe place

Rationale: To identify if individuals have a real or imaginary safe place. Individuals who have experienced sexual violence may feel depressed, anxious or in crisis. Maslow's (1949) the hierarchy of needs theory second basic level of need is safety. Before an individual can desire to move to a higher level their basic needs must be met. The process of art making in-group may provide a positive sensation allowing them to identify a safe place or feel safe in the group to express the need for safety. Group members can normalize why their sense of safety has been shattered and the importance of establishing a sense of safety.

Discussion: Each member can share their safe place collage with the group members.

What elements make the place in your collage safe?

How often can you go to this place?

What do you experience looking at what you created?

Identify where you would you be in your safe place collage.

How often do you feel safe?

How can you use this image to feel safe when you are not near your safe place?

Session 3

Intervention: To be heard…what would you say?

Activity: After exploring the myths and truths about sexual violence each group member will make a message to "the world" of what they want them to know.

Goals: The goal of this intervention is to allow individuals to send a message to the world, or whomever they identify about their feelings or to dispel myths, or judgment. In addition, to allow individuals "space" to put into prospective time and acceptance of feelings since the incident.

Materials: 8 ½ x 11 inch, 12 x 18 inch poster board and color construction paper, pencils, rulers, permanent color markers, scissors, tape, glue sticks, glitter glue sticks, and color masking tape.

Directive: Use the poster board to create a message with words and illustrations of what you would like someone or the world to understand about your experience as an adult female victim of sexual violence.

Rationale: Victims of sexual violence are often judged, labeled or misunderstood due to some of their wounds are not external. Family members and friends want them to return to normal. There are many myths on why individuals become victims of sexual violence and there are those who blame the victim. This intervention will allow group members to respond and not feel ignored. The group members will also have the opportunity to decide where in public to display their illustrations, if they choose to do so.

Discussion: Share and discuss each group member's posters/message

How did completing this activity make you feel?

What did you learn about yourself that you did not realize prior to this activity? Discuss with the group if they would like their messages to be displayed anonymously on the agency Facebook page, or website, during sexual violence awareness month in the lobby of the institution or agency.

Session 4

Intervention: Control

Activity: Part 1: Group members are asked to think about things they can control and cannot control in their life and write it down. Together the group will discuss and share what they feel comfortable sharing with the group.

Part 2: Group members will be asked make a tie-dye t-shirt following the directions.

Materials: White t-shirts, fabric dye, rubber gloves, rubber bands, tie-dye t-shirt photo examples with directions, bucket or Rubbermaid shoeboxes, and paper towels

Goals: The goal of this intervention is to gain the experience of success even when someone cannot control everything. Identifying what you can control and controlling that which you can.

Directive: Think about what in your life that you feel you can control and that you cannot control, write down your thoughts, and prepare to share with the group what you feel comfortable sharing.

Rationale: PTSD symptoms can make victims of sexual violence feel as if there is not thing in their life that they can control. Feelings of giving up also occur. This exercise may aid in allowing victims of sexual violence examine situation to identify what they can control. Feeling like you have a choice after being victimized is imperative to the healing process.

Discussion: How did you feel writing down what you could and could not control?

How did you feel sharing with others what you could and could not control?

How did you feel attempting to follow the directions of how to make a tie-dye

t-shirt?

What part of creating a tie-dye t-shirt did you feel could you control?

What part of creating a tie-dye t-shirt did you feel you could not control?

What do you think you could have done differently?

What did you notice about the tie-dye experience that reflects what you wrote down about control at the start of the group?

Session 5

Intervention: Before and After Mask

Activity: Drawing a line down the center of a mask, group member will detail the mask to illustrate how they seen themselves before and after they experienced sexual violence.

Goals: The goal of this intervention is to identify feelings and change as the result of sexual violence. In addition, to allow individuals "space" to put into prospective time and acceptance of feelings since the incident.

Materials: Pre-made mask, glue sticks, paint, markers, scissors, feathers, aluminum foil, construction paper, and color masking tape.

Directive: Using the mask, divide it in half. On one half, detail the mask to illustrate you before the violence and the opposite side to illustrate you now after the violence.

Rationale: Experiencing the power to control and change situations that are negative or uncomfortable.

Discussion: Share and discuss each group member's mask

How did completing this activity make you feel?

What did you learn about yourself that you did not realize prior to this activity?

What do you want to change?

What do you want to keep?

Session 6:

Intervention: Walk in my shoe

Activity: After a group discussion of PTSD symptoms experienced by victims of sexual violence and trauma, each group member will pick a shoe provided by the facilitator that best represents them. Using the media supplied, each member will design the inside and outside of the shoe to represent a day in their life illustrating their PTSD symptoms

Materials: Magazine cutouts, stickers, card stock scraps, glue sticks, tape, scissors, glitter glue sticks, colored pencils, markers, crayons, pastels, tempera paint, and paint brushes

Goals: To explore PTSD symptoms and acknowledgement of their experience and coping skills.

Directive: Using the media supplied, design the inside and outside of the shoe to represent a day in your life illustrating your PTSD symptoms.

Rationale: Acknowledgement of PTSD symptoms can lead to acceptance of sexual violence is not their fault. Often society or victims of sexual violence blame themselves that interfere with healing from their PTSD symptoms and daily coping.

Discussion: Share your shoe with the group.

What coping skills have you used to cope with the symptoms you shared with the group?

How difficult was this activity?

What did you learn about yourself?

What affirmation can you create for yourself to focus on for the next week?

Did you notice any common themes in the shoes that all of the group members used or mentioned?

Session 7

Intervention: Closed box

Activity: Group members will work together to create a box that will be sealed and never opened. The inside will hold the group members' negative thoughts envelopes from the previous weeks, any art they did not want to take with them, and whatever they agree as group to add to the box. The outside of the box will express their collective group art therapy experience that future groups for adult female victims of sexual violence will see.

Materials: Scrap book paper, stickers, glue sticks, tape, scissors, markers, acrylic paint, paintbrushes, mod podge (group members can request other media used in previous sessions).

Goals: The goal of this intervention is to make a container to hold their trauma and negative thoughts to leave behind safely. Allowing you to feel lighter and providing you more space to breath, grieve, and grow.

Directive: Using the materials provided, together decorate the outside of the box to represent your group art therapy experience to share with future groups. On the inside of the box, decorate and fill it with what you do not want to take with you after the group ends next week. Allow this box to hold and protect what you do not want to take with you, and what you do not want to remember.

Rationale: To create a box collectively as a group and leave the box at the agency it will signify that their trauma happened at a specific time and certain aspect are no longer permitted to continue into the present. All the negative thought envelopes from previous sessions will be sealed inside along with whatever the group

members add to it. Art can provide a distance from the trauma in order to work without becoming flooded by the experience. The outside of the box will represent the universality of their group experience to share with future groups.

Discussion: How did the process of putting all of your negative thought and feelings in the box feel?

How does it feel to leave the box here at the agency?

How do you feel about the message and design on the outside of the box?

What surprised you about this process of making one piece of art together?

What did you learn from working together as a group to create art?

Session 8

Intervention: Closure and termination of group

Activity: Certificate of completion, discussion of the group experience and creating a positive symbol that the facilitator will mail a month from the last day of group.

Materials: Gift bags, flowers, light refreshments, surveys, stationary, paper, and pencils

Goals: Allow the clients to feel a sense of accomplishment for completing the group.

Directive: Create a positive symbol that you would want to remind yourself to focus on or that would remind you completed an eight-week group. Each member can initial it to remind you that your are not alone in your healing.

Rationale: The group members will feel a sense of accomplishment from attending group, normalizing their experience and feelings, have a sense of universality and interpersonal learning. “Art therapy provides materials to contain, symbolize, and externalize the felt sense into the art process” (Rappaport, 2010, p.140).

Discussion: What did you learn about yourself in eight weeks?

Is this your first time receiving a certificate of completing from something that was not school or work related?

Future plans of attending other sexual violence support groups.

Chapter V: Discussion

Throughout this research, the DSM's definitions of trauma and commonly used PTSD treatment models for victims were used to gain understanding to the unique symptoms adult female victims of sexual violence experience. Having an understanding of the non-verbal process of art therapy and body and mind's reaction to trauma resulting from sexual violence, some victims may theoretically benefit more from non-verbal therapy, than solely the more traditional verbal methods.

Researchers have predominately studied the treatment and symptoms of trauma among female veterans of war (Herman, 1997), college women (Zinzow, et., al., 2010), and adult female victims of childhood sexual violence (Lev-Wiesel, 1998). There is limited research and services available for adult female victims of sexual violence outside of immediate crisis intervention (Black, et. al., 2010). Research identified that immediate crisis intervention typically has unprompted improvements identified within the first three-months. However, Roth, Dye & Lebowiz (1988) stated that although immediate crisis intervention with adult female victims of sexual violence is widely practiced and often effective, the long-term persistence of symptoms for some "victims warranted further research" (p.83).

Engaging in research about the how traumatic experiences are imprinted in the brain and not easily accessed can help clinicians engage in addressing the symptoms that adult female victims of sexual violence may experience with or without immediate crisis intervention (Talwar, 2007; Roth, Dye, & Lebowiz, 1988). Talwar's (2007) research identified how traumatic memories do not reside in the verbal analytical areas of the brain, but more often recorded in implicit memory. Researching the cognitive effects of sexual violence highlighted the interpersonal violation characteristic of sexual violence, making it is reasonable to anticipate that

victims often are unable to talk about their experience. The research concluded that the non-verbal feature of art therapy allows adult female victims of sexual violence the innocuous opportunity to express through images their inner thoughts, feelings, perceptions, and flashbacks.

Group therapy approaches have been identified as appealing to victims of sexual violence because of the extra advantages afforded by the presence of other victims (Roth, Dye, & Lebowitz,1988). As art therapists engage in group art therapy with adult female victims of sexual violence it is important to establish safety and trust within the group, which in turn enables the group members to experience a common bond which serves to normalize their experience (Yalom, 1995; Wadeson,1987). Researchers consider that the common bond allows for identification of issues, coping methods, insight, and a sense of hope (Spring, 2004; Foy, Erickson, & Trice, 2001; Roth Dye, &Lebowitz, 1988).

Art therapy interventions used in group therapy with adult victims of sexual violence that address the loss of control, safety, and trust; and feelings of hopelessness, guilt, and isolation will assist the client in developing coping skills, empowerment, self-esteem, and control. The art image produced in an art therapy session becomes substantial in cultivating a verbal exchange between the client and the therapist and in achieving insight. Furthermore, communicating relevant information to the therapist from the client helps “resolve conflicts, solve problems, and formulate new perceptions that in turn lead to positive changes, growth, and healing” (Malchiodi, 2007, p. 6). The art becomes part of the client’s record documenting his or her therapeutic progress. According to Wadeson (2010) by reviewing the art product with the client, new insights may develop, patterns may emerge, and he or she may recall feelings that were present during the creation process that are no longer present. This process allows for both the art

therapist and the client “to derive a sense of the ongoing development that occurs in the therapeutic process” (p.12).

Chapter VI: Conclusions and Recommendations

Forty years of research on sexual violence is not a long time, violence in American culture is increasing, and it is not a challenge to understand why more research is required. Adult female victims of sexual violence not only struggle with changes to their personality and relationships, but also experience sensory, physiological, and cognitive shifts. In the wake of the society we live in sexual violence will not likely diminish. As adult female victims continue to seek help for their symptoms it seems necessary that agencies become willing to hire more art therapists, address the unique symptoms of victims, collect data to help research identify the different aspects of their traumatic experience that differ from other forms of violence and trauma, and validate the effectiveness of art therapy. The purpose of this literature review was to bring attention to the need for more research on adult female victims of sexual violence; the need to recognize the varying differences in the PTSD symptoms of sexual violence; the brain, and the body's response to trauma, the necessity to identify effective ways of treating the trauma beyond immediate care; and the potential of group art therapy with adult female victims of sexual violence.

It is crucial that a master's level art therapist facilitates group art therapy with adult female victims of sexual violence. An art therapists' training in art and psychotherapy endorses their understanding of the ETC framework. Art therapists have knowledge of the myriad therapeutic uses art expression provides. Art therapists, unlike other mental health professionals, have been trained to understand the ETC, a structure that organizes media interactions and developmental sequence of information processing and image formation.

In conclusion, adult female victims of sexual violence need services that address their unique symptoms. Sexual violence is a highly interpersonal and relationally based traumatic

experience with significant physiological, cognitive, and emotional consequences. There is no certainty as to which intervention is superior in addressing PTSD symptoms of adult female victims of sexual violence. If more agencies are willing to implement sexual violence group art therapy services with a registered art therapist (ATR) it could further future research studies to identify and address the unique symptoms of adult female victims of sexual violence.

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