SEXUAL ABUSE INTERVENTION PROGRAM: HEALING THROUGH ART AND PLAY

by

Sandra Elizabeth McCall

BSW, University of Northern British Columbia, 2008

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Sandra McCall

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Dedication

I dedicate my pursuit of further education to my mother, for without her, I would never have reached for the stars and attempted greatness. I miss you more than words can say Mom. I also wish to thank my sister Pam for being the 'wind beneath my wings' and telling me how proud she is of me, I love you. To Cameron - my love, for your humour, encouragement, and love.

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Introduction

My practicum experience was a rich and enlightening experience that went beyond my expectations in developing new ideologies and methodologies toward practice. The professionals who work at Northern Society for Domestic Peace (NSDP) show exceptional passion in the delivery of their programs to the people they serve within the Bulkley Valley. I was welcomed by every staff member with openness, interest, and they expressed a caring attitude toward me each and every day that I was at my practicum. The society offers a variety of programs and is the center stone of community programs offered in the town of Smithers, BC. The agency is located in a single storey building that faces the street. The agency is in the downtown core and allows access to all with an open door policy.

My background is in social work and I have worked for the Ministry of Children and Family Development (MCFD) since I graduated with my Bachelor of Social Work in May 2008. Initially I was hired on the northern float team as a child protection social worker and I worked for 15 months in Quesnel, BC, until I was fully delegated to complete investigations. I then spent seven months in Hazelton, BC, and had the opportunity of working very closely with the First Nation Bands in and around the Hazeltons. I had the opportunity to work with Gixtsan Child and Families, Band Chiefs, people in the community, and conduct Family Group Conferences in my social work role. After Hazelton I spent six months in Dease Lake, BC, and my practice expanded further as I was covering a vast geographical area and was able to use a generalized practice approach, not always used in larger, urban areas, which divide the social workers into specialized teams.

After my time in Dease Lake, BC, I was transferred to Prince Rupert, BC, and six weeks later I was called back to Hazelton, BC, where I remained for the following year.

After my time in Hazelton, BC, I was moved to Smithers, BC, and worked in child protection until I decided to leave the float team and accept a permanent job in Smithers, BC. I became a Child Youth Special Needs social worker in January 2013, and I currently retain this position. I own a house in the town of Smithers, live with my partner Cameron, and have a yellow lab and a white Norweigan Forest cat.

I treasure my time spent doing social work in the Hazeltons because of the relationships I forged with the First Nations people and the respect we found within one another. I found the First Nations people to be very humorous and gentle people; they in turn liked my red hair and obvious Irish background, yet somehow we worked well together – we built a relationship through respect and honesty and shared common goals to heal together. I like remote practice because of the individual strengths that are required of people and the sense of community and understanding of the land and the people.

I began my Masters in Social Work in hopes of fulfilling a dream of becoming a counsellor, a dream that I had since I was a teenager. I consider myself a natural listener, and am genuinely interested in people and their history. I chose to do my practicum instead of writing a thesis, to complete my MSW, in order to acquire practical clinical experience and work with children and youth since I have found an affinity with this age group. It would have been a more natural route to do a practicum at MCFD, but I wanted to learn a more expansive approach than the single practice method implemented by MCFD, that being cognitive-behavioral therapy.

I began this journey six years ago, and during this time I lost my loving Mother and support, and I was injured in a ski accident and broke my upper arm and dislocated my

shoulder and still cannot raise my arm, however I have persevered – it has been a long and winding road.

My practicum at NSDP in the town of Smithers, in the Bulkley Valley of BC, started in September 2014 and was completed in July 2015. I worked closely with my agency mentor each day of my practicum, she taught me about the Sexual Abuse Intervention Program (SAIP), its goals and objectives, and introduced me to therapeutic interventions throughout my practicum. We met with clients in the neighbouring town of Houston, BC, one day a week, held an afterschool group one day a week in Smithers, BC, and I spent one day a week in the Smithers agency with another practicum student and the other professionals at NSDP who were unrelated to the SAIP program.

My practicum goals incorporated learning about child sexual abuse and its historical, cultural, and social effects. My objective was to learn about childhood trauma and develop intervention techniques applied in art therapy, play therapy, and cognitive behavioural therapy. I wanted to educate myself on the practice approach and therapeutic interventions applied at my practicum agency. My learning goals included understanding the history of community services offered by the agency, studying current programs, and becoming familiar with practice and services. My main objective was to develop clinical skills by working directly with individual clients and by facilitating group work with children.

Chapter One: Description of Practicum Setting

The society offers the following supports: assisting women in, or leaving abusive relationships; support for men interested in strengthening relationships; court ordered violence prevention treatment. NSDP provides support for children and youth with three service programs:

1) Child Sexual Abuse Intervention Program;
2) Children Who Witness Domestic Violence Program; and
3) Youth Services Program.

The agency also provides the Pregnancy Outreach Program offering drop in groups and individual counselling, peer support, and resources; Passage House which offers a safe and supportive environment for women and children experiencing domestic violence, abuse, or crisis; and Third Stage Housing – independent, affordable housing for women and their children. NSDP offers Victim assistance which provides support through the criminal justice system providing information and advocacy, and they operate a Caring Companions Program that provides assistance to elders, such as: grocery shopping, cooking meals, banking, driving, and attending appointments, helping seniors with mental or emotional limitations, offering companionship, and non-medical assistance.

NSDP is an integral service in northern British Columbia that improves the lives of their service users. This report details the 10-month journey that I shared with my mentor(s) and reflects on the practice that I discovered, and my personal development as a practicum student. The Sexual Abuse Intervention Program (SAIP) at NSDP is a service provided under the mandate of the British Columbia Ministry of Children and Family Development and delivered by contracted agencies operating independently of the ministry or by ministry staff.

I wrote down the Mission Statement of NSDP on the first day of my practicum:

> The Northern Society for Domestic Peace is dedicated to developing, delivering, and supporting programs that provide opportunities for individuals and families to strengthen their relationships and the quality of their lives by fostering respect, challenging violence and promoting health and self-determination. (June 2002)

My mentor from NSDP has a Master's Degree in Art Therapy, and provided me with daily guidance in my practice of art therapy, play therapy, and work with groups of children between eight and 18 years of age. I had another mentor who I met with via skype, who has a Master's Degree in Social Work; I worked with this second mentor as a requirement of my practicum as she was able to provide a social work perspective during my practicum. My NSDP mentor gently guided me toward adopting new approaches and working with children using the expressive art therapies, which she uses in her practice as a therapist, to help children deal with trauma from sexual abuse.

At the beginning of my practicum journey my mentor immediately included me in therapy sessions, with permission of both the guardian and child, so I could witness relationship building, expression through art therapy, and observe sessions from an objective perspective. As my practicum continued, my tasks expanded and I worked with groups and individuals and learned the practices of play therapy and cognitive behaviour therapy. This report seeks to share my practicum journey, provide supportive literature for the agency methods, and offer a critical analysis of my perspective of the practicum knowledge that I gained at NSDP.

Learning Goals and Objectives

- Learn about sexual abuse and trauma, the historical, cultural, and social effects on children and families;
- Research art and play therapy techniques used as interventions for sexual abuse;

• Follow agency and practicum supervisors' suggestions on expanding learning toward incorporating both clinical and social work approaches;

• Learn the framework used in NSDP agency surrounding ethical standards;

• Learn assessment tools and apply them within NSDP agency framework;

• Develop goals with supervisors to provide a comprehensive framework for my understanding of art and play therapy in conjunction with social work theory.

• Study the history and programs offered by the agency;

• Explore the role of interventionist;

• Under the guidance of my practicum supervisor, I will develop clinical skills and apply techniques with clients, and within agency guidelines;

• Conduct group work with children as required by practicum supervisor.

Activities and Tasks

• Read articles and books on art and play therapy;

• Journal each week about my practicum experience;

• Develop intervention skills and techniques used in Art and Play therapies at agency;

• Attend agency meetings; assist in programs as a co-facilitator if available;

• Observe and shadow my practicum supervisor in her use of clinical skills;

• Carry a limited caseload as a practicum student with supervision;

• Practice treatment planning within agency standards;

• Maintain file management on client files;

• Follow clients from intake to end of service and document;

• Develop effective time management and note keeping skills

Intake Process

The process of intake begins with an intake interview with the parent, or guardian; a phone intake and information gathering can be completed by the parent prior to the initial meeting; referrals come from both school, and MCFD. After intake is established an Informed Consent – Confidentiality form is signed by the client if they are a youth, and parent, or guardian with a witness. The Informed Consent addresses confidentiality, record keeping, and appointments and what is expected of the client, and in return, what can be expected of the therapeutic process for the child or youth. If required, Consent to Obtain/Release Information form is signed by the parent or guardian, giving NSDP permission to consult and obtain information from other sources. Additionally, another form giving Consent for Documentation of Art, Play, and Sandplay Process in Therapy is signed showing that art ownership is the private property of the client and all artwork will be kept for clients on site at NSDP until file closure. Access to file information is available to the child and parent, or guardian, after the file is closed. The file belongs to MCFD and is collected and held by MCFD for 50 years after the child turns 18.

Monitoring and Tracking Progress

The following check list forms are used at NSDP: Student Interview for Suicide Risk Screening (SISRS); Semi structured Teacher Interview; Child Sexual Behaviour Checklist (CSBCL) Second Revision Part I and Part II; Master Art Evaluation form (Malchiodi, 1990); Child Sexual Abuse Assessment Form; Child PTSD Symptom Scale CPSS (7-17 years); Post-Trauma Stress Reaction Self Evaluation; Teen Evaluation of Trauma Reaction; Parent Evaluation of Trauma Reaction.

Tracking client improvement is done by completing a progress review for the SAIP after each individual and group session. Contact notes record the following information: goals of the session, primary themes, verbalizations or expressions, summary of observations and verbalizations, therapeutic approaches applied, clinical understanding, and future recommendations. Summary notes provide documentation showing if therapeutic goals are being met and allow for observations as to which methods are effective and if the child/youth is showing improvement.

Measuring Success

Measuring success is unique to the individual and measured by reaching therapeutic goals. At my practicum agency we set weekly goals for each therapy session. These were unique to the individual and became the focus of the client's therapy. The goals were specific and attainable for each person and measured after each session within the framework set out with the parent/guardian, or in the case of youths, themselves. All sessions were documented as a Session Summary and notes included: therapist response/assessment, and future plans and recommendations. Each session was dated and included the client's name and session number along with observations and verbalizations, primary themes, or expressions witnessed during therapy.

Sexual Abuse Intervention Program (SAIP)

The Sexual Abuse Intervention Program (SAIP) was introduced into the Province of British Columbia in 1990 as a government initiative to enhance services to survivors of sexual abuse and their families. The Ministries of Health, Social Services, Education, and Attorney General agreed that Child and Youth Mental Health (CYMH) would be responsible for developing and implementing SAIP. At that time CYMH was part of the Ministry of

Health. CYMH was transferred to the Ministry of Children and Family Development (MCFD) in 1996 and the SAIP program came under the responsibility of MCFD. Primary funding provided to SAIP comes from MCFD. The existing Standards for SAIP were developed by MCFD in 2008.

There are two places that offer the SAIP program in the northwest of British Columbia, one in Prince Rupert, BC, and the other in Smithers, BC. In the town of Smithers, BC, the service delivery of SAIP is offered through the NSDP agency. It operates as a specialized and unique community-based program providing a range of treatment to children, inclusive of children with disabilities, and all minorities, who have experienced or have been affected by sexual abuse. SAIP offers support to children under the age of 12 who exhibit sexually intrusive behaviours. Support is shown to non-offending parents or guardians and family members of clients. The program provides community education and prevention both at schools and within the community.

Structural Framework/Feminist Approach

It took a few working sessions with my MSW practicum supervisor to adopt a framework using a social work perspective. Adopting a social work perspective that fit with what I was learning at my practicum turned out to be difficult, but not impossible. I found that the struggle in comparing where I was in my practicum from a clinical perspective and comparing it to my viewpoint from a structural social work perspective fit the best, yet it took many months to solidify my understanding, and I had many discussions with my MSW mentor to uncover my truth and find which approach suited my perspective. The goals of structural social work, as set out by Mullaly (1997, pp. 107-108) are:

(1) to address and meet the needs that arise as a consequence of the inequities inherent within capitalist based socio-economic structures of society, and

(2) seek the transformation of society to reflect the principles of social justice, equity and equality for all.

The NSDP agency embraces the feminist social work perspective. Observing myself with a critical lens, I understood that my historical social work framework was from the perspective of a government social worker who works within a structural framework. My goal during my practicum was to link my past structural framework of working as a social worker within the governmental structure of MCFD toward adopting a more client centered, clinical feminist approach. Reflectively thinking, I am much more client centered and I adopt both the feminist and structural approaches with equal credibility. I realize how structure impacts the lives of everybody, not just our clients, but also those who are culturally different and marginalized by the structures in society. NSDP meets the needs of their clients individually, and approaches each person as unique, considering both their ethnicity and circumstance from a client-focused perspective. Seymour (1998) describes the aetiology of sexual abuse of children using a feminist perspective, "It is argued that patriarchy provides the social opportunity to abuse: the social construction of masculinity provides the motivation for abuse; and male sexual socialization provides the direction for expression of the motivation" (p. 415). The feminist perspective does not place blame on victims of abuse, the focus is to hold men responsible for their actions rather than blaming the victim (Seymour, 1998).

Silverstone, Greenspan, Silverstone, Sawa, and Linder (2015) studied a comprehensive one-year program at a unique setting that helps victims of sexual abuse. The Be Brave Ranch is a program designed for children between the ages of 8-12. The ranch is a

"camp-like" setting where children, and parents or guardians, stay at the camp for the first four weeks of the program, and attend three more times for two week periods throughout the year, at intervals of three months. During the stay at the ranch the children receive more than 200 hours of therapy, and when not at the ranch, the children and family attend weekly group sessions. The therapeutic interventions used are a combination of trauma-focused cognitive behavioral group therapy and play therapy, art therapy, and animal assisted therapy. Also included are yoga, arts, games, music, animal interactions, and evening programing. The therapeutic goals are to improve symptoms of post-traumatic stress disorder, depression, anxiety, quality-of-life, self-esteem, and attachment (Silverstone et al., 2015). This is a unique approach which fully encompasses a variety of therapeutic approaches for the entire family. The limitation, cited by Silverstone et al., 2015, was that there is no randomized control group; however, the individual methods practised at the camp have been proven as effective as interventions on their own. The study must show the efficacy of operating a ranch due to the cost and time commitment required of the family. Perhaps this is the future of intensive therapy for children and families who have been affected by sexual abuse. The results of the one-year program are not yet published at this date. However, the design is comprehensive, intensive, and appears to be an encouraging look forward at merging therapeutic interventions into a collaborative format.

Strengthening Families Parent Education Program

The agency of NSDP offers a multitude of programs in the community, and I was fortunate enough to participate in the Strengthening Families Program (SFP) as a Family Facilitator. The program was unique in that participants and facilitators came together once a week, ate dinner together, and since this was a family program, both non-offending

parents/guardians and children/youth were attendees. Once the meal was finished the parents/caregivers stayed in one area and the children went into another room. Both groups followed a mandate of exercises from a workbook specifically created for SFP, activities and educational games for the children, and discussion and strength building was provided for parents. After a 90-minute period the families reunited and worked on specific goals with one another. I took part in the group as co-facilitator leading the children's program. As a facilitator I was given an itemized list of what was expected of me, namely:

- Sign NSDP's code of ethics and confidentiality code;
- Submit to a criminal record check;
- Meet with Strengthening Families Coordinator for initial registration and when required;
- Meet with SFP team members regularly
- Prepare lessons for my group;
- Deliver lessons to my group;
- Participate in dinner time conversation
- Be a role model of program learning outcomes;
- Deliver program evaluative tools to program participants;
- Participate in program evaluation;
- Adhere to protective legislation involving children and vulnerable adults, document any reason for concern, and consult SFP coordinator.

As I reflect on my experience as an SFP coordinator I found the experience to be therapeutic for the group. I witnessed a change in the children as the weeks continued, they shared their stories, and worries, opened up about specific problems both at home and at school, and we became a cohesive group working toward solving identifiable issues. I see

both parents and children/youth in the Smithers community and am amazed at how they respond to me with such enthusiasm and thankfulness, sharing how wonderful the program was, and how it helped their family to make effective changes.

Chapter Two: Literature Review

The intent of this review is to show what the literature shares about expressive art therapy, art therapy, play therapy, and cognitive behavioral therapy and their efficacy in working with children and youth who have suffered trauma. Much of the literature shows that art therapy is an effective modality as an intervention technique with children and many studies combine art therapy and play therapy with other therapy approaches such as cognitive behavioral therapy (CBT). However, more studies are required in the art therapy field in order to increase efficacy and validity within evidence-based research arenas. Research shows positive outcomes in practice that combines art therapy and cognitive behavior therapy as therapeutic interventions for trauma from sexual abuse (Pifalo, 2007).

Child Sex Abuse

Child sexual abuse (CSA) is a challenging topic and in many cases it is a taboo subject. The tangible number of cases is unknown as actual reports may not show the true picture since it is unknown how many cases are unreported. Trocme, Fallon, MacLaurin, and Sinha (2011) report on the 1998, 2003, and 2008 cycles of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) which tracked the changes in child welfare investigation practiced over the last 10 years in Canada. The 2003 CIS showed a dramatic increase in investigations from the 1998 study with rates of substantiated investigations more than doubling over a five year period; however, the number of investigations did not change significantly between the 2003 CIS and the 2008 CIS (Trocme et al., 2011). The 2008 CIS is the third nation-wide study to examine the incidence of reported child maltreatment in Canada. Lefebvre, Van Wert, Fallon, and Trocme (2012) respond to the change in rates of maltreatment-related investigations from the first CIS in 1998 to the third CIS in 2008. They state that the changes:

> ...may reflect changes in detection, reporting, and investigation practices rather than an increase in the number of children being abused and neglected. Four changes are particularly important to consider: changes in public and professional awareness of the problem, changes in legislation or in case-management practices, changes in CIS study procedures and definitions, and changes in the actual rate of maltreatment. (p. 1)

It is important to note that the CIS identified up to 22 forms of maltreatment listed under four main categories: physical abuse, sexual abuse, neglect, and emotional maltreatment. There are many variables in the report, such as different provincial reporting techniques, and reporting differences in jurisdictions, as some child welfare jurisdictions have mandates to investigate children under 16, where other children are investigated up to the age of 19. However, the CIS provides a baseline for a national study of child maltreatment cases. Overall, the 1998 CIS reported 61,200 substantiated maltreatment investigations. Sexual abuse accounts for only 10% of cases, with touching and fondling genitals being most frequently noted (Trocme, Tourigny, MacLaurin, & Fallon, 2003).

CSA can be perceived as a forbidden subject and in many cases the abuse is typically enacted in secrecy, a hidden crime. It is difficult to determine the actual rate of abuse since not all crimes are reported, "...potentially making sexual abuse one of the most underreported crimes" (Pifalo, 2002, p. 12). If reports are not made and secrets are kept hidden, the abuse doubles, as the abused will not receive therapy and the abuser may continue their sexual violations. Psychological mistrust and physical interference with a child is one of the most intrusive acts to take place in a child's development (Pifalo, 2002). Children who have been sexually abused may not be able to verbally tell their story and don't have the language to explain or share the abuse. Art therapy can then act as a medium between verbalizing abuse and expressing it through art work.

My mentor at NSDP said the agency definition of sexual abuse is defined as, "Being any intrusive act from witnessing to touching to suggestions on a text message" (personal communication, NSDP mentor, September 11, 2014). The agency provides services to a variety of people whether the abuse was a one-time incident or there has been a history of continued abuse over years. In reading literature on sexual abuse I found a variety of definitions of sexual abuse. However, NSDP uses a specific set of definitions for the SAIP prescribed by MCFD.

Definitions of sexual abuse or sexual exploitation adhere to those developed by MCFD and documented in the BC Handbook for Action on Child Abuse and Neglect (2007 Edition, p. 24) and are adopted at the agency of my practicum:

Child Sexual Abuse

Sexual abuse is when a child is used (or likely to be used) for the sexual gratification of another person. It includes:

- touching or invitation to touch for sexual purposes
- intercourse (vaginal, oral or anal)
- menacing or threatening sexual acts, obscene gestures, obscene communications or stalking
- sexual references to the child's body/behaviour by words/gestures
- requests that the child expose their body for sexual purposes
- deliberate exposure of the child to sexual activity or material, and sexual aspects of organized or ritual abuse.

Sexual Exploitation

Sexual exploitation is a form of sexual abuse that occurs when a child engages in a sexual activity, usually through manipulation or coercion, in exchange for money, drugs, food, shelter, or other considerations. Sexual activity includes:

- performing sexual acts
- sexually explicit activity for entertainment
- involvement with escort or massage parlour services, and appearing in pornographic images.

MacMillan, Tanaka, Duku, Vaillancourt, and Boyle (2013) reported that females are more likely to report sexual abuse than males. The Ontario Child Health Study conducted in 2000-2001 reported that girls reported sexual abuse 22.1% of the time, compared to boys, who reported sexual abuse only 8.3% of the time. Predictors and risk factors for both physical and sexual abuse in childhood include: growing up in an urban area, young maternal age at the time of child's birth, living in poverty, parental adversity. Further, the siblings of those who experienced either physical abuse or sexual abuse in childhood were at an increased risk for the same abuse (MacMillan et al., 2013). It is important that clinicians are aware of significant risk factors when assessing children with regard to treatment intervention, and being alert to whether other siblings live in the home, with the goal of reducing further incidents of abuse.

There are many theories to explain the cause of sexual abuse. Ward and Beech (2006) discuss the three most influential theories of sexual abuse as: Finkelhor's (1984) Precondition Model of child sexual abuse; Marshall and Barbaree's Integrated Theory (1990); and Hall and Hirschman's (1992) Quadripartite Model.

Ward and Siegert (2002, p. 324) listed the underlying factors found in Finkelhor's Precondition Model (1984) to explain the incidence of abuse. These factors are listed as:

(a) Sex with children as emotionally satisfying to the offender (Emotional Congruence);

(b) Men who offend are sexually aroused by a child (Sexual arousal);

(c) Men have sex with children because they are unable to meet their sexual needs in more socially appropriate ways (Blockage); and

(d) These men become disinhibited and behave in ways that they would not normally behave (Disinhibition).

Ward and Siegert (2002) demonstrate that Marshall and Barbaree's Integrated Theory (1990) of sexual offending includes biological, psychological, social, cultural, and situational factors. According to Ward and Siegert (2002) the focus is on, "… resilience and psychological vulnerability and constitutes a real advance on its competitors and clarifies how developmental adversity contributes to sexual offending" (p. 325).

Ward and Siegert (2002) discuss Hall and Hirschman's Quadripartite Model (1992) of sexual aggression against children, based on four components: physiological sexual arousal, cognitions justifying sexual aggression, affective dyscontrol, and personality problems. Ward and Siegert (2002) note that, "The focus on multiple factors is a major strength as is the suggestion that sexual offending may be the product of converging causal pathways" (p. 326). The Hall and Hirschman's Quadripartite Model (1992) focused on the offender and subsequent treatment was found to be innovative in offering a different viewpoint to therapists to provide intervention with a theory based model.

Although these have been prominent theories, they do come with their limitations. Finkelhor (1984) theorizes that there are four factors that explain the incidence of child

sexual abuse which require that all four preconditions must be met. Marshall and Barabee's (1990) Integrated Theory (as cited in Ward and Beech, 2006) states:

> Specifically, this theory suggests that individuals experiencing developmentally adverse events (e.g., poor parenting, inconsistent and harsh discipline, physical and sexual abuse) are likely to exhibit distorted internal working models of relationships, particularly, with respect to sex and aggression, resulting in poor social and self -regulation skills from an early age. (p. 59)

Hall and Hirschman (1992) suggest that child sexual abuse is based on four components which are "dependent on state and traits" which result in "affective disturbance and/or distorted thinking" of the child molester.

The Pathways Model of Child Sexual Abuse (Ward & Siegert, 2002) also has its four requirements to be met involving sexual offenses by the perpetrator. This theory differs from the previous three concepts in that all factors must be involved: intimacy and social skill deficits; distorted sexual scripts; emotional dysregulation; and cognitive distortions. Ward and Beech's (2006) Integrated Theory of Sexual Offending offers a more comprehensive explanation asserting that sexual abuse is the result of many interrelated factors from a biopsychosocial perspective. It is important to note that these theories focus exclusively on males, excluding female perpetrators of sexual abuse.

Clarifying the underlying causes of sexual offending can help therapists to develop appropriate treatment programs for offenders, and thereby lowering the possibility of individuals reoffending. Likewise, understanding the causes of sexual offending helps improve intervention techniques resulting in effective therapeutic programs for children who have been abused. Developing therapeutic interventions and goals with children and youth who have faced sexual abuse is complex, Habigzang, Damasio, and Koller (2013, p. 174) look at factors to consider:

(a) The characteristics of the violence, such as its duration, comorbidity with other maltreatment types, and aggressor proximity;

(b) Risk factors and protection within the family, including the caretakers' belief in what the child says and their emotional and protective support; and

(c) Symptoms and changes in the child's or adolescent's cognition, behavior, and emotions.

The environment and support network that is immediately around the victim must be considered in developing the most relevant intervention modality to provide safety and protection during the healing process.

Defining Trauma

Trauma-and Stressor-Related Disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); American Psychiatric Association (2013), include disorders where exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion: reactive attachment disorder, disinhibited social engagement disorder, post-traumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders.

In recent studies, researchers define traumatic memories as a distinctive kind of memory that can be experienced by flashes of vivid fragments of sights, sounds, smells, and physical sensations (Sarid & Huss, 2010). Complex trauma in children and adolescents has been defined by Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, and Van der Kolk (2005) as being:

> Immediate and long-term consequences of children's exposure to maltreatment and other traumatic experiences are multifaceted. Emotional abuse and neglect, sexual abuse, and physical abuse, as well as witnessing domestic violence, ethnic cleansing, or war, can interfere with the development of a secure attachment within the caregiving system. (p. 390)

Exposure to complex trauma can form and extend trauma symptoms into adulthood and length of exposure increases risk for further trauma exposure. The effects from complex trauma can spill over into other aspects of impairments for the trauma victim, (eg., psychiatric and addictive disorders; chronic medical illness; legal, vocation, and family problems) (Van der Kolk, as cited in Cook et al., 2005). Complex trauma has been described as, "...the result of exposure to multiple traumatic events that have been prolonged and repeated, as often is the case with child sexual abuse, other abuse or neglect, and family violence" (Herman, 1992; Kezelman & Stavropoulos, 2012; King-West & Hass-Cohen, 2008, as cited in Stace, 2014, p. 12).

Traumatic events can be actual or perceived by an individual through death, injury, or physical integrity of self or others and the response is felt as intense fear, helplessness, or shock. Clinical interventions demonstrate that research has shown that harmful effects of trauma on brain systems can be reversed or blocked in the immediate aftermath of trauma before memories become stabilized through a time-dependent process. Exposure to trauma and the experiences are individual and not all children or youth who have been exposed will have the same reaction. Racco and Vis (2015) note the impact on age of trauma:

> The child or youth's developmental stage, the perception of the incident, the interpretation, the ability to express self linguistically and organize memories are quite different from an adult; influencing the responses and symptoms of trauma exposure...the identification of child and youth PTSD is complicated. (p. 122)

Age sensitivity, developmental stages, length of trauma all effect how a child or youth will react and exhibit symptoms, or if those symptoms will manifest into post-traumatic stress disorder. Perry, Pollard, Blakley, Baker, and Vigilante (1995) on childhood trauma and the neurobiology of adaptation, summarize trauma:

> Trauma is an experience. Ultimately, it is the human brain that processes and internalizes traumatic (and therapeutic) experiences. It is the brain that mediates all emotional, cognitive, behavioral, social, and physiological functioning. Understanding the organization, function, and development of the human brain, and brain-mediated response to threat, provides the keys to understanding the traumatized child. (p. 273)

The complexity of the brain and the injury of trauma exhibit variable effects in the traumatized child. Learning and understanding the function of the physiological side of trauma can help practitioners in designing effective intervention strategies.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) was described by my NSDP mentor as "prolonged experiences of a trauma". However, not all people who suffer trauma experience PTSD. There are varying factors to consider, some people will develop PTSD, and others will have different responses within PTSD or outside PTSD. If after one month the symptoms of PSTD, such as flashbacks, are still happening then it is time to look at PTSD and ways to deal with the trauma from that lens. (personal communication, NSDP mentor, September 11, 2014)

Historically, when the DSM-I was released in 1952 there was a diagnosis called "Gross Stress Reaction" which was a response to soldiers from WW1 who came home with psychological symptoms from the war. Gross Stress Reaction was included in the DSM-I as a response to experiences faced in battle, also known as "shell shock". The DSM-II was published in 1968 during the Vietnam War and Gross Stress Reaction was removed from the DSM-II due to the news that military and mental health professionals solved the psychological reaction to war because of the reduction of troops who were sent home for psychological reasons. However, the veterans of Vietnam did present psychological ramifications when they returned home from war.

It was hoped that Gross Stress Reaction would be returned to the DSM-III due to the many reports about the mental suffering experienced from the Vietnam War veterans. The DSM-III was published in 1980 with, "Post-Traumatic Stress Disorder to take into account those who were exposed to traumatic situations and experience strong emotional reactions afterward that are related to the event" (Scott, 1990, p. 2). The current diagnostic statistical manual in use by both MCFD and my practicum agency is the DSM-IV-TR, published in 2000.

PTSD is described by Collie, Backos, Malchiodi, and Spiegel (2006) as, "...an anxiety disorder that can develop after exposure to a terrifying event or series of events... characterized by three groups of symptoms: intrusive re-experiencing, avoidance of reminders and triggers, and hyperarousal including hypervigilance and exaggerated startle response" (p. 157). Trauma impact experienced through long term childhood sexual abuse or a single traumatic event can impact a child with unforeseen outcomes. PTSD is described by Javidi and Yadollahie (2012) as:

> Important traumatic events include war, violent personal assault (e.g. sexual assault, and physical attack), being taken hostage or kidnapped, confinements a prisoner of war, torture, terrorist attack, severe car accidents, and natural disasters. In childhood age sexual abuse or witnessing serious injuries or unexpected death of beloved one are among important traumatic events. (p. 1)

Prolonged trauma develops into PTSD due to length and severity of symptoms and can be categorized as - acute or chronic. When traumatic symptoms persist for less than three months, the term 'acute' is prescribed. Symptomology longer than three months is considered 'chronic PTSD.' (Javidi & Yadollahie, 2012)

Major symptoms of PTSD include re-experiencing the event through intrusive memories and recurrent nightmares (Ducrocq, Vaiva, Cottencin, Molenda, & Bailly, 2001)

and avoidance of stimuli associated with the traumatic event. Emotional numbing is an indicator of PTSD diagnosis. Additional risk factors unrelated to the actual traumatic event are indicators for developing PTSD, and include, "...younger age at the time of the trauma, female gender, lower social economic status, lack of social support, premorbid personality characteristics and pre-existing anxiety or depressive disorders increase the risk of PTSD" (Auxéméry, 2012, p. 373). When a diagnosis of PTSD is established, intervention is required with modalities of therapy that demonstrate effectiveness, namely cognitive behavioural therapy, art and play therapy to work with children specifically. Pifalo (2007) conducted a study by applying both art therapy and cognitive behavior therapy with sexually abused children, and reasoned that since many sexually abused children carry a diagnosis of PTSD, the goals of effective interventions for sexual abuse must use the most effective tools available to reduce trauma-related symptoms. The latest version of the Diagnostic and Statistical Manual of Mental Disorders—5th edition (DSM-5) on PTSD have highlights of changes from DSM-IV-TR to DSM-5 as summarized below by the American Psychiatric Association (2013):

(a) Criterion A the stressor criterion is more explicit with regard to individual experienced "traumatic events;

(b) Criterion A2 the subjective reaction has been eliminated;

(c) Three major symptom clusters in DSM-IV are now four symptoms clusters in DSM-5 avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood;

(d) Most of the DSM-IV numbing symptoms include new or reconceptualised symptoms, such as persistent negative emotional states;

(e) Final cluster – alternations in arousal and reactivity retain most of the DSM-IV arousal symptoms, including irritable or aggressive behavior and reckless or self-destructive behavior;

(f) PTSD is developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents; separate criteria have been added for children age six years or younger with this disorder. (p. 9)

It is important to note that the definition for PTSD in the latest DSM-5 has not yet been adapted or applied by MCFD. The criterion listed for PTSD in the DSM-IV manual is the current definition used at MCFD.

Creative Arts Therapies

Creative arts therapies were researched over a time span of 12 years in a paper by Westrhenen and Fritz (2014). The authors looked at techniques, used theoretical frameworks with focus and attention given to the reliability, validity and trustworthiness of their findings. Their recommendation was to link therapist with researcher, the goal was to have researchers work closely with art therapists, and to make art therapies less of an 'outlier' in the therapeutic approaches for traumatized children. The literature shows that art therapy is often coupled with other therapies as an adjunct therapy and not studied solely as an individual intervention. Westrhene and Fritz (2014) state in their findings:

> As long as the therapy goals, concepts and process followed are clearly defined, we believe that a qualitative or quantitative study can be conducted. The reason behind the lack of quality studies in this area may be that many art therapists find themselves working as practitioners in the field and not necessarily in the world of academia, and hence researching their practice and publishing articles of secondary importance to them. (p. 532)

Collaboration between academia and creative art therapists could lead to solidifying the benefits of art therapy and promote the sharing and exchanging of ideologies about practical

modalities used with children and youth in the area of trauma. Further research is required in the field of art therapy within the confines required by the scientific community to prove qualitative or quantifiable evidence as to its efficacy. The process of art therapy, in its essence, involves the unfolding and discovery of what a client might be feeling and thinking. The timing and duration of this process varies from client to client, and may not be readily forced into a clean, controlled, time-constrained experimental design (Eaton, Doherty, & Widrick, 2007).

Support for more studies could increase.and expand the application of art therapy and give it the support in the scientific community as being an evidence-based intervention for trauma-based therapy. As the literature shows in Eaton et al. (2007) studies support the efficacy of art therapy in combination with other therapies, namely, cognitive behavioral therapy, however, if art therapists desire quantifiable research to support their practice, art therapy research needs its' own measureable instruments and standardization to receive individual distinction, separate and apart from combined therapy with other modalities of intervention.

Further research and more rigorous designs to reflect scientific standards are required to prove the efficacy of all creative therapies. The call for stringent testing showing consistent results for interventions with children is ongoing. More valid research is needed to support creative art therapies as an effective and suitable intervention with children. Homeyer and Morrison (2008) support scientific rigor:

> Quality research-such as between-group design experiments, random assignment of subjects, use of treatment manuals and protocols, clearly defined client samples (gender, age, race, and other) and appropriate analyses of data are required, as are single-case designs that meet rigorous research standards. All such research must meet current standards. (p. 222)

Art therapies and play therapies need to meet stringent requirements providing evidence that their therapeutic interventions are effective. Measuring instruments need to be standardized to allow replication with any individual or group of children who are being treated with creative therapies.

Effects of Art Therapy

The models of therapy practiced at the agency of my practicum in the Sexual Abuse Intervention Program (SAIP) combined both expressive art therapy and play therapy with variable therapeutic goals. Session summaries showed materials, activities, and therapeutic tools used in each session including observations and verbalizations. Themes of the session were monitored and placed into categories of play, art and verbalizations. Therapeutic responses were tracked and indicated in summary and clinical understandings and recommendations of the counselor were provided.

Eaton et al. (2007) conducted a review of research and methods used to establish art therapy as an effective treatment method for traumatized children and found that art therapy was used successfully in a variety of contexts as treatment for traumatized children. Eaton et al. (2007) state, "Art therapy uses creative expression to provide individuals with a safe outlet for expressing thoughts and emotions to successfully facilitate recovery from psychological distress" (p. 256). The study also addressed the lack of research in art therapy and the obstacles in measuring variable outcomes. The reasons for the lack of research were addressed by Tibbetts (1995) and pointed to a lack of art therapists trained in experimental research methods, and Wadeson (as cited in Tibbetts, 1995) referred to a historical lack of doctoral-level clinical psychologists trained in art therapy. Other art therapists share that studies do not measure by empirical methods (e.g. self-actualization) and these are the results

of interest to them, and other measures tend to be abstract psychological constructs (Wadeson, 1994; Wolf, 1995, as cited in Tibbetts, 1995). Eaton et al. (2007) describe the difference of art therapy:

> The process of art therapy, in its essence, involves the unfolding and discovery of what a client might be feeling and thinking. The timing and duration of this process varies from client to client, and may not be readily forced into a clean, controlled, time-constrained experimental design. (p. 260)

Tibbetts (1995) suggests that qualitative outcomes of studies done with art therapy somehow appear to be scientifically inferior to quantitative outcomes, and the methods used in art therapy do not lend themselves to quantitative measures, and this promotes a view that art therapy is unscientific. More studies are required in the art therapy field in order to increase efficacy and validity within evidence-based research arenas.

Art therapy has proven to be effective with a variety of symptoms in children and youth other than trauma. A 10-week study on the effects of art therapy on anger and self-esteem in aggressive children was conducted by alavinezhad, Mousavi, and Sohrabi (2014) that showed significant reduction of anger and greater improvement of self-esteem in participant children from the ages of 7 to 11 years. The authors stated that anger is an emotion that can often be experienced but if it is not controlled or is extended it can create emotional difficulties. If anger is not treated or dealt with in a constructive manner, "…childhood behavioral problems characterized by anger and aggression can lead to high rates of school dropout, juvenile delinquency, substance abuse, and poor peer relationships in adolescence" (alavinezhad et al., 2014, p. 111). Applying art therapy techniques with 30 children over a two-month period showed that art therapy was seen as a less threatening approach than verbal communication for aggressive children.

Talwar (2007) proposed an art therapy protocol designed to address the non-verbal core of traumatic memory. Van der Kolk (2002, as cited in Talwar, 2007) states that, "Recent developments in neurobiology have shown that memory is an active and constructive process, and that the mind constantly re-assembles old impressions and attaches them to new information" (p.22). Further, McNamee (2005) supports, "The goal is to engage both the left and the right brain in the process of art therapy" (p. 546). Integrating both left and right brain functions through the expression of art therapy allows experienced trauma to be released at an emotional and non-verbal core level. Van der Kolk (2006, as cited in Racco & Vis, 2015) describes the biological process of exposure to trauma:

> Subjects had cerebral blood flow increases in the right medial orbitofrontal cortex, insula, amygdala, and anterior temporal pole, and in a relative deactivation in the left anterior prefrontal cortex, specifically Broca's area, the expressive speech center in the brain, and area necessary to communicate what one is thinking and feeling. (p. 278)

This shows how brain functioning is affected when there is exposure to a traumatic event, and intensifying neural responses when multiple traumas are experienced. Accordingly, Racco and Vis (2015) concluded that re-experiencing trauma activates the brain structures responsible for intense emotion and emotion regulation and communication is deactivated. Several aspects of brain functioning are affected during exposure to traumatic events. It has been proposed by Feldman and Vengrober (2011) that younger children who are non-verbal, or who have little speech, will perceive trauma differently than older children, youth, and adults. Racco and Vis (2015) report that, "…traumatic events can cause disruptions in the child's developmental progression, physical advancement, interpersonal effectiveness and behavioral difficulties" (p. 122). Acknowledging the complexity of the physiological effects of trauma is valuable to both therapist and children working toward therapeutic goals.

Art therapy works toward improving self-esteem by allowing children to learn new coping skills and to alter cognitions through their own self-work and discovery of emotions through their art work (Argyle & Bolton, 2005; Franklin, 1999, as cited in alavinezhad et al., 2014, p. 112). Consistent results show that art therapy is effective when working with children as confirmed by Liebmann (2008, as cited in alvinezhad et al., 2014, p. 112), "Art therapy has substantial credentials as an effective way of working with children (and adults) who are often (for complex reasons, including fear, shame, and lack of adequate language) unable to verbalize their experience." The study combined a cognitive-behavioral approach with art therapy to increase self-esteem and reduce anger and the combination proved effective.

Expressive therapies allow for a multitude of selections in art material, creative approaches, and therapeutic tools that can be chosen by the counselor or the client. Themes are noted and the focus of each session is based on the client and their uniqueness, not a prescribed or rigid goal of the counselor. Goals are individual and client centered and the counselor acts as a guide to support the healing process.

Art therapy has been proven successful in addressing other symptoms such as coping and lowering anxiety. The influence of art on anxiety was studied by Sandmire, Gorham, Rankin, and Grimm (2012) with a sample of 57 undergraduate students. The measurement used was a State-Trait Anxiety Inventory before and after partaking in the study. The college students painted, colored pre-designed mandalas, painted freely, made collages, drew still life drawings, and modeled with clay. The findings showed a significant reduction of anxiety post participation, implying that art therapy is a model used to help lower stress and anxiety with proven success. However, the study did not know whether the results were long-lasting

as the measurement of the State-Trait Anxiety Inventory was conducted immediately after the art therapy session with no follow up after a period of time.

Studies showing improvement of symptoms associated with sexual abuse provide further evidence that art therapy is effective. Positive results create building blocks toward increasing further proof of art therapy as an effective intervention.

Expressive Art Therapy

A report conducted at a large urban hospital trauma center provides evidence those children who received art therapy as an intervention modality experienced a reduction in acute stress symptoms. Chapman, Morabito, Ladakakos, Schreier, and Knudson (2001) observed traumatized children in a hospital setting with behaviours consistent with the DSM-IV definition of PTSD. Those symptoms include re-experiencing phenomena observed in post-traumatic play, psychobiological reactions, recurrent intrusive images, avoidance symptoms, withdrawal, dissociative episodes, apathy toward primary caregivers, refusal to comply with treatment plans, and regressed developmental skills. Symptoms of increased arousal were observed in nightmares and sleep disturbances, irritability, new aggressive behaviors, exaggerated startle responses, and anxious attachment (Chapman et al., 2001, p. 100). The intervention was conducted over a 10-year time period with hundreds of pediatric trauma patients under a controlled study. The Children's Post-Traumatic Stress Disorder Index designed and validated by Robert Pynoos, MD (1997, as cited in Chapman et al., 2001, p. 101) was used to measure the outcome. An early analysis did not show a statistically significant reduction in lowering PTSD symptoms; however, there was a reduction in the measurement of acute stress symptoms. The group who did not receive art therapy did not show any improvement of exhibited symptoms.

O'Brien (2004) explored the hypothesis that artwork created during therapy sessions activates neurological structures in the brain, allowing non-verbal experiences to be known. O'Brien (2004) studied the theory that artwork therapy can reach early emotional trauma, and through art expression, healing takes place as an activity of the right brain. Accessing emotional trauma which has been caused by early abuse or neglect allows children to work through their emotions by creating free-form, and messy art. In studying attachment, trauma, and the brain, O'Brien (2004) witnesses that, "Many children with emotional difficulties produce well-organised artwork in their art therapy sessions, but where early infant relational trauma exists, especially if in conjunction with sexual abuse, there is often abundant mess and confusion" (p. 2). The study showed that messy art work allows children to reconnect neural pathways by activating parts of the brain that retrieves emotional experiences and making order out of past trauma. Klorer (2005, as cited in Gerteisen, 2008) on expressive therapy indicated:

> ...early trauma may lead to deficient hemispheric integration and traumatic memories may be stored in the right hemisphere. Since these traumatic experiences are processed and stored in the right part of the brain that is nonverbal, it makes sense to pay more attention to nonverbal methods of treatment. (p. 91)

Art therapy allows for the child to be creative in a safe environment, and provides them space to create and explore their individual self-expression, as a sensory experience, and not solely communicating from a cognitive perspective.

Expressive art therapy is on the rise in popularity, especially with young children who are unable to use their words to explain and articulate their feelings and experiences. The creative use of variable forms of art allows children to express their anger, sadness, and fear in a concrete and simple manner. Davis (2010) presented a study using music and the

expressive arts with children after surviving a tornado which destroyed homes and community, and closed their school for a week. Prior to the children returning to their classes, the children in grades three through five were brought into three separate classrooms with 20 children each from a variety of different ethnic backgrounds. At the center of the classroom was a variety of instruments and the children were encouraged to try what they liked and choose one. Then they were each given a card with a feeling written on it and given 20 minutes to compose a musical piece that represented their word. Once finished all groups were brought together and a maestro conducted each group and combined performances and feelings together. Afterward a discussion and questions were asked about their experience and processing of their feelings. Once the feelings were expressed they were acknowledged in a supportive manner and the children learned how to process feelings in a healthy and healing way. The parents were involved in the activity and this helped them feel better about moving forward once they were able to share their feelings around their trauma. The study concluded that the therapeutic activity of expression was essential for children after a traumatic event and can be done with a variety of objects (Davis, 2010).

Waller (1992, as cited in Pifalo, 2002) explains why art therapy is preferable to verbal therapy as he notes:

> Some victims of sexual abuse may have been lied to, threatened, or misled with words by their abusers or other adults whom they trusted. Words have become misleading and mistrusted; therefore, strictly verbal approaches to therapy may meet with more resistance. (p. 12)

Expressive arts therapy is defined in a variety of ways. Natalie Rogers, (as cited in Davis, 2010) a pioneer of creative and expressive arts, and daughter of Carl Rogers, defined expressive art therapy as, "...the use of various arts-movement, drawing, painting, sculpting, music, writing, sound and improvisation in a supportive setting to facilitate growth and

healing. It is a process of discovering ourselves through any art form that comes from an emotional depth" (p. 126). The end product is not analyzed; it is the expression of the internal feelings and emotions that need support and therapeutic intervention. It is about exploring the inner domain and expressing feelings through various means of expression and supporting the therapeutic processes of creation. Children require a modality that they relate to and are familiar with such as play and making art. Younger children are limited in their cognitive ability which prevents them from understanding adult therapies that rely on the ability to think and express thoughts and feelings through verbalization (Reyes & Asbrand, 2005). Expressive therapies bridge the gap between verbal expression and cognitive awareness when normal development has been inhibited through sexual abuse and trauma.

A significant piece of literature points to the statistically significant evidence-based research that supports art therapy in addressing sexual trauma. Pifalo (2002) conducted a study with art therapy and groups that is effective in addressing the long and short term effects of sexual abuse. The study used the Trauma Symptom Child Checklist (TSCC) (Briere, 1995, as cited in Pifalo, 2002) to measure symptoms, before and after participating in a 10-week group program. The results proved that there was a reduction in symptoms with childhood sexual abuse survivors at the end of the art therapy intervention program. The symptoms measured were anxiety, depression, post-traumatic stress, anger, dissociation, and sexual preoccupation and distress. The TSCC is an important tool used in the field of child abuse and protection (Ralston, 2001, as cited in Pifalo, 2002) which allows comparison of the outcome of this study to others using the same instrument. Pifalo's (2002) study showed that a 10-week group session offering a different art therapy activity each week produced an overall reduction of symptoms across all scales when pre and post test scores of symptoms

were compared. The results were positive and showed that the creative process of art therapy can be a vehicle toward addressing sexual trauma. In particular, the TSCC instrument showed a statistically significant difference in anxiety, post-traumatic stress, and dissociation on the Post-test scores.

Exploring the efficacy of group art therapy was continued in a study by Pretorius and Pfeifer (2010). The study observed group art therapy as an intervention for sexually abused girls to demonstrate that art therapy programmes improve symptoms of depression and anxiety. Pretorius and Pfeifer (2010) focussed their study on exploring art therapy as an intervention toward reducing depression, anxiety, sexual trauma, and low self-esteem. The focus group consisted of 25 sexually abused girls between the ages of 8-11 years of age, in South Africa. The measurement used was the Trauma Symptom Checklist for Children (TSCC). Each child was provided with eight sessions consisting of four themes: establishing group cohesion and fostering trust; exploring feelings associated with the abuse; sexual behaviour and prevention of re-victimisation; group separation – which provided the children opportunity to paint, draw or sculpt their feelings about what they liked and disliked about the program and how they felt about leaving the group. Results indicated a decrease in depression and anxiety but the programme was not effective at increasing self-esteem. Criticism of the study was its small sample size, which lowered the significance of the study; it was argued that the validity of the results was sound.

Cumulative Trauma

Ogawa, 2004, addresses exposure to trauma and suggests that it is important to look at a child with a history of more than one trauma. Ogawa states, "This is important, since multiple experiences of trauma affect a child's sense of control, and, as a consequence,

increase the child's vulnerability and hopelessness" (p.20). Addressing historical traumatic events is essential when developing interventions for children who have experienced more than one trauma.

Interpersonal traumas are personal events and can occur more than once, a series of traumatic events, are considered cumulative. However, if someone goes through a single external trauma that is not personal in nature, it does not imply that they will experience another. Nevertheless, if someone experiences interpersonal trauma there is a link to additional traumas in adulthood. Studies show those who have experienced childhood abuse are at a higher risk of further abuse. Classen et al., (2002) and Tjaden and Thoennes (2000), (as cited in Briere & Scott, 2006) elaborate:

> …a number of studies demonstrate that victims of interpersonal traumas are at statistically greater risk of additional interpersonal traumas. This is especially true in what is known as re-victimization: those who have experienced childhood abuse are considerably more likely to be victimized again as adults. (p. 10)

Further trauma occurs as a result of the effects of the traumas themselves, and how a child is able to adapt and cope with the trauma is crucially sensitive to the healing process, as trauma reactions are complex. Briere and Scott (2006) explain that childhood and adult traumas can produce psychological symptoms in adult survivors and may signify:

> (1) the effects of childhood trauma that have lasted into adulthood, (2) the effects of more recent sexual or physical assaults, (3) the additive effects of childhood trauma and adult assaults (for example, flashbacks to both childhood and adult victimization experiences), and (4) the exacerbating interaction of childhood trauma and adult assault, such as especially severe, regressed, dissociated, or self-destructive responses to the adult trauma. (p. 10)

Realizing cumulative trauma is complicated, knowledge of cumulative or multiple traumas must be considered in treatment interventions to fully treat the whole individual, and not

limit therapy to a singular occurrence. Understanding exhibited trauma symptoms allow therapists to understand the complexity of trauma and adapt cumulative trauma focused therapy accordingly.

A qualitative study by Naff (2014) focused on art therapy treatment for cumulative trauma from the therapist perspective. Samuels-Dennis, Ford-Gilboe, Wilk, Avison, and Ray (as cited in Naff, 2014) describe cumulative trauma as being, "...the experience of two or more different types of trauma occurring in one's lifetime" (p. 79). A small-scale qualitative study was used to provide detailed data on how art therapists are currently addressing the effects of cumulative trauma in their practice. The sample included three clinicians who were interviewed individually for 45-50 minutes. The findings revealed that each practitioner found that cumulative trauma is complex and can present initially with varying behavioral problems in children at first presentation. The most commonly chosen therapy was trauma-focused cognitive behavioral therapy (TF-CBT). The clinicians also valued art making as a more:

> ...accurate reflection of the client's inner emotional process with minimal distortion... art in session often diffused tension because it allowed the client to remove the focus from the self...clients learn to exert control over the intensity of their trauma-focused work in a way that appropriately meets their needs. (Naff, 2014, p. 82)

The findings show that art therapists adjust themselves to their client's individual levels of distress throughout assessment and the course of treatment. The clinicians also agreed that the creative process was an integral part of treating cumulative trauma as it allows for bringing out the unique and individual client experiences in a creative and expressive manner. The uniqueness of this study stems from observing perspectives from the clinician

viewpoint, rather than basing success on results or the viewpoint of the client after the intervention process has terminated.

Play Therapy

During my practicum sessions we practiced non-directive play therapy allowing the child to choose what they want to play, and to be guided by their own imagination. The child initiates play and you follow and gently repeat what they are doing, using no suggestions, or no questions. Summary notes were also completed at the end of a session which included assessment and therapeutic goals for each session. When my mentor and I worked with groups, we approached the session using client centered play therapy, and allowed the participants to move from one activity to another. When I met with one youth, in his late teens, each week we focused on addressing uncomfortable issues and applied creative thinking in how to cope and lessen tension by using cognitive behavioral therapy (CBT). The youth could verbalize issues, reflect and was cognisant of his thoughts and self-talk. Talk therapy was a better option than art therapy, and his willingness to want to verbalize his feelings, allowed progress to happen in his therapy. The approach was definitely more solution focused and we concentrated on thoughts, using CBT to attain specific, weekly goals. I found that working with youth, CBT was a more practical approach as play therapy was more applicable to the children I worked with that were under 12. Play therapy is an effective therapeutic modality to use with children. Youth are more reluctant to use play as a therapeutic tool as it may not be age-appropriate or engaging as CBT.

Ogawa (2004) examined the impact of trauma witnessed and experienced by children and adopted the use of play therapy as being the, "...child's universal language and that working with younger children under the age of 48 months presents limitations as children

often possess limited cognitive, abstract thinking, and expressive language skills" (p. 20). The nature of the trauma will affect the healing process, and play therapy is a proven intervention in helping children work through their trauma.

A study looking at the trauma suffered in children who were placed in foster care showed that long term play therapy showed effective, empirical results. Clausen, Ruff, Von Wiederhold, and Heineman (2012) concluded:

> Using relationship-based, psychoanalytic play therapy to change mental health and functional outcomes for individual children in foster care has the likely potential to change long-term outcomes for these children, and, ultimately, for the next generation of children who will be born to these former foster youth. (p. 51)

Play therapy allows the children to express themselves through the use of play and share their feelings and thoughts in the process. The therapist creates a safe place to allow the children to explore in a nurturing environment so that the children can communicate and connect with their feelings through play (Clausen et al., 2012). Play therapy has an abundance of studies in the literature which supports its efficacy with children and trauma.

Coholic, Lougheed, and Cadell (2009) explored the helpfulness of arts-based methods with children living in foster care, their trauma, and post-traumatic growth. The research was qualitative in design and looked carefully at how arts-based methods can help children's self-esteem develop coping skills without direct dialogue and work through their traumatic life events. The term "arts-based method" was described as art therapy techniques administered by mental health professionals or social workers and certified child and youth care workers. The group focus was to teach methods on how to, "...pay attention, use imagination, understand and practice mindfulness-based techniques, explore feelings, thoughts, and behaviours and develop strengths" (Coholic et al., 2009, p. 66). The group consisted of children in foster care between the ages of 8 and 15, each session lasted two hours and the

program ran for six weeks. The children who attended the group were in care due to sexual abuse, transient parents, parental drug abuse, domestic violence, and parental mental health problems. The six sessions were not enough and the children in the group wanted to continue the process so they moved to a 12 week model. The findings from 17 six-week groups of 38 children, 20 foster parents and child care workers were tremendously positive. When asked what could be improved the children could not answer. They responded by talking about how much better they felt in all aspects, including improved self-esteem and better relationships at home and in school because of the techniques they learned. Coholic et al. (2009) concluded that, "Arts-based methods offer a fun and creative way to engage children, and preliminary research findings indicate that these methods can assist children to develop coping skills, self-awareness, and aspects of self-esteem" (p. 69). In summary, the arts-based program provided methods that helped to develop self-esteem, social skills, and psychosocial functioning. The study produced positive results through the children's individual self-reports at the end of the 12 weeks of group therapy.

Sand play therapy is another technique used in play therapy as a therapeutic approach to healing trauma. Mahalle, Zakaria, and Nawi (2014) discussed sand therapy as an additional technique or approach in counseling. Based on the Personality Theory by Carl Jung, sand therapy was introduced by Dora Marie Kalff (as cited in Mahalle et al., 2014) who, "…believed that the interpretation of stories slowly can provide space for a client to experience intense transformation in psyche" (p. 78). Sand play uses dry or wet sand and the therapist sits quietly while the child talks about their life or what comes to them, or they create a story with their imagination using toys or colours or mold the sand with their hands. The imagination of the child is needed and the therapist allows for the child's play to unfold

in a series of pictures or creations (Mahalle et al., 2014). Throughout my practicum, I discovered that when in a session in the play therapy room, all children, without exception, were attracted to, and played in the sand, even with a large variety of other toys or objects in the room to choose from. The sand play method brought forth many expressions of emotions and it was a huge release for the children to play out their individual trauma and talk about troubles, or share their stories by drawing in the sand.

Cognitive Behavioral Therapy

In their study of very young children between the ages of three and six, Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2011), examined the efficacy and feasibility of trauma-focused cognitive behavioral therapy (TF-CBT) for treatment of PTSD and other varied types of traumas. Their findings showed a significant improvement on symptoms of PTSD, but not with depression, separation anxiety, and oppositional defiant or attention deficit hyperactivity disorders. The question was whether young children were developed enough to possess skills in connecting with cognitive reasoning that is a required aspect of CBT, and if they are able to self-reflect, have the language capability, and memory. The study allowed for modifications, based on an earlier treatment manual by March, Amaya-Jackson, and Murray (1998), and used cartoons to describe the tasks in the study. Forty-six children participated in the study and the findings showed that 83.5% of the children understood and completed the tasks asked of them. The younger the child the more difficulty was found in doing the tasks. For example, the three year old child had more difficulty than the six year old, but when given more time was able to complete the requested tasks. The study showed support for the efficacy and viability of a structured treatment program for very young children with post-traumatic stress symptoms.

As a trauma therapist, Johnson (2009) provides an examination of the underlying similarities between creative art therapy (CAT) and CBT and reaches for further understanding between the two approaches. Johnson (2009) willingly admits that CBT is the dominant paradigm used in the current medical field, founded on evidence-based research that provides support for its efficacy. The study provides the art therapist perspective and presents the viewpoint that the CBT approach does not need to be adopted by the CAT, and furthermore, creative art therapy doesn't need to fit into CBT formats. Johnson (2009) discusses five articles questioning the need felt by CAT researchers to adapt to more stringent, quantitative studies and suggests that creative art therapies create some of the basis to which cognitive behaviour therapy has adapted. Johnson (2009) argues that CAT is a neuroscience model that has been accepted by mainstream science in the trauma field and is recognized as an evidenced-based approach.

The trio of Hall, Schaefer, and Kaduson (2002) researched 15 play therapy techniques that are operative, pleasurable, economical, and simple to construct. Their research included a broad range of play approaches that addressed: anxiety, depression, impulsivity, distractibility, and noncompliance. The goal was to find clinically useful play therapy techniques. Their therapeutic rationale for games states:

> Often children have difficulty verbalizing their feelings when directly questioned, either because they are guarded or they do not connect with those feelings they find most threatening. When involved in playing a game, children's defenses are reduced, and they are more likely to talk about their feelings. (p. 515)

They chose 15 methods of play with a rationale, description, and application, namely: Color-Your-Life, The Pick-Up-Sticks Game, Balloons of Anger, The Mad Game, Beat the Clock, The Slow Motion Game, Relaxation Training: Bubble Breaths, Worry Can, Party Hats on

Monsters, Weights and Balloons, The Power Animal Technique, Internalizing a Positive Symbol of Strength, Using a Puppet to Create a Symbolic Client, Broadcast News, and The Spy and the Sneak (Hall, Schaefer, & Kaduson, 2002).

Hall et al. (2002) concluded that there is a vast array of hidden creative potential for play therapists to apply to their practice. Their suggestion is that the greater the number of applications in a therapist's toolbox, the more likely that success will be met when selecting the correct tool for healing specific symptoms.

Child-Centred Play Therapy

A more recent meta-analytic review by Lin and Bratton (2015) explored 52 controlled outcome studies between 1995 and 2010 on child-centered play therapy (CCPT) approaches. There is abundant research support for CCPT and the authors share that its' inception comes from Carl Roger's (1951, as cited in Lin & Bratton, 2015) Person-Centered Theory. CCPT is different from other theoretical models by the determined belief that children inherently strive toward personal growth and maturity, as well as having capacity for self-directed healing (Lin & Bratton, 2015). This meta-analytic review included ethnicity as a part of the study characteristics. It is difficult to find studies on child ethnicity because of the limited numbers of studies targeting specific ethnic groups other than Caucasian. Lin and Bratton (2015) divided the 52 studies into four categories:

(a) Caucasian (more than 60% of child participants were Caucasian),

(b) non-Caucasian (more than 60% of child participants were non-Caucasian),

(c) mixed groups (none of the represented ethnic groups were more than 60% of total child participants), and

(d) not stated.

The findings showed that the mean effect size of .76 for non-Caucasian studies were statistically significantly higher than the mean effect size of .33 for Caucasian studies. This supports a positive outcome of CCPT and its outcome on diverse populations of children, especially when seeking culturally sensitive counselling treatment models that are effective with children. Therapy research is evolving in play therapy and a span of time between earlier methodological applications and more recent applied methods can be assessed to deliver the most appropriate method to meet current scientific criteria.

Using methodological rigor proposed by Nathan and Gorman (2002) in determining scientific evidence Phillips (2010) described Type I studies as, "...randomized, prospectively designed, clinical trials using randomly assigned comparison groups, blind assessments, clear inclusion/exclusion criteria, state-of the art diagnosis, measurement of treatment fidelity, and adequate sample sizes to power clearly described statistical analyses" (p. 14). In a critique of play therapy research Phillips (2010) pointed to Bonner, Walker, and Berliner (1993, 1999) as a group that worked with a clear and empirically defined sample of young children with sexual problem behaviours. The study examined two groups over 12 sessions comparing cognitive behavioral intervention and client centered play therapy; both groups included structured collateral parent groups. The treatment showed statistically significant reductions in parent-reported sexual behaviors for children in both treatment groups. The study concluded that both interventions showed statistical effectiveness in reducing sexual behaviours among children after a 10-year follow up with the entire sample groups.

Culturally Responsive Practice

Current methods of cultural awareness are adapted at the agency where I completed my practicum with most of the staff regularly attending cultural awareness training programs

to augment their practice. Working in the north, and particularly in areas where agencies serve culturally diverse communities, it is good practice to include methods that are all-inclusive or specific to varying ethnicities. This is true for clinicians working with First Nations as well as other diverse cultures, especially as the diversity of people in the north expands.

It is important for clinicians to be culturally aware of diverse populations, especially those who service areas that are ethnically, culturally, and economically different. Consideration of barriers to service, socioeconomic factors, and impediments to treatment are discussed by Misurell and Springer (2013). Their study focused on a culturally congruent Game-Based Cognitive-Behavioral Group Therapy (GB-CBT) model for child sexual abuse used in a center that services mostly urban, economically disadvantaged, African-American and Latino families. GB-CBT was developed at Newark Beth Israel Medical Center's Metropolitan Regional Child Abuse Diagnostic and Treatment Center as a culturally congruent intervention. Their study showed culturally congruent elements that should be applied in professional development to increase cultural responsiveness, namely: emphasis on collectivism; centrality of the family; strength-based approach; active style and present focused orientation; importance of genuineness for African-American families; and importance of simpatia (pleasant socialization) for Latino families (Misurell & Springer, 2013). The center offering cultural awareness was intent on knowing their client base, and allowing for integration of cultural and ethnic variations to be addressed and dominate practice. Culturally based research in the literature is limited; however, an increase of culturally responsive evidence-based practice is on the rise (Misurrell & Springer, 2013).

The literature shows that much of the research done on culturally adapted evidence-based practice is limited in sample size, lacks statistical power, and doesn't address acculturation. Bernal, Jimenez-Chafey, and Domenech-Rodriquez (2009) address evidence-based therapy (EBT) research, "Because most research supporting EBTs has been conducted with White, middleclass patients, the external validity of these treatments is unknown; they may not generalize to other groups" (p. 363). The literature requires more definitive research with wider sample size inclusive of ethnic diversity. Further studies addressing culturally responsive interventions will widen ethnically diversified practice. However, Bernal et al. (2009) make an argument that cultural adaptation is not feasible. They argue that this is a new field, and the variety of testing instruments with evidence-based practice engaging in cultural adaptation field tests and efficacy trials is too cumbersome. Gathering evidence, conducting efficacy tests by ethnicity and race for all ethno cultural groups would be a task too large without resources for such studies (Bernal et al., 2009). There is a demand for cultural inclusion in treatment and practice, which can happen through personal education by practitioners, agencies, and government, to understand cultural identities and practice with ethnic diversity.

Clinicians also must be aware of their own cultural background and their worldview relative to the values and views of their clients. Self-awareness leads to bridging differences between clinicians and clients to recognize personal biases and awareness of racial identities to increase cultural competence (Stuart 2004). Identifying multicultural competence as suggested by Stuart (2004, p. 6):

1. Develop skill in discovering each person's unique cultural outlook.

2. Acknowledge and control personal biases by articulating your worldview and evaluating its sources and validity.
3. Develop sensitivity to cultural differences without overemphasizing them.
4. Uncouple theory from culture.
5. Develop a sufficiently complex set of cultural categories.
6. Critically evaluate the methods used to collect culturally relevant data before applying the findings in psychological services.
7. Develop a means of determining a person's acceptance of relevant cultural themes.
8. Develop a means of determining the salience of ethnic identity for each client.
9. Match any psychological tests to client characteristics.
10. Contextualize all assessments.
11. Consider clients' ethnic and worldviews in selecting therapists, intervention goals, and methods.
12. Respect clients' beliefs, but attempt to change them when necessary.

Therapists need to be aware of their clients' perspective, their history, cultural and ethnic background, and to be aware of their own perceptions and biases to understand the influence they have on their clients.

Therapeutic Relationships

Measuring the experience of play is best described from the child's point of view. Carroll (2002) listened to the opinions of the children about their play therapy experience. Describing the experience and allowing children to define their play experience produced a variety of responses through the research project. Considering the views of the children is essential to the process. As a play therapist Carroll (2002), gives the children a voice and

presents significant elements of the therapeutic process. Carroll (2002) was led to develop her research based on the Armstrong and Galloway (as cited in Carroll, 2002) study assessing children's special educational needs where the views of children were taken into consideration. This led into translating the children's opinions into adult language and learning what is best for them from their viewpoint. The findings of Carroll's (2002) project showed that, "...four aspects stand out: the importance of the therapeutic relationship, the termination of this relationship, the children's attitude to talking, and the importance of having fun" (p. 185). The children's relationship with their play therapists was at the centre of how the children felt if play therapy had been helpful. Some of the children were able to acknowledge the process on a deeper level and understand the value of exploring difficult feelings through play therapy. Additionally, the children found that play was fun, and Carroll (2002) supported the association of fun as, "...when truly shared, is in itself, a therapeutic process" (p. 186). The client-therapist relationship is an integral part of fostering a safe vehicle toward forming a therapeutic bond (Eaton et al., 2007).

A meta-analysis study by Asay and Lambert (1999) has shown that, "...the client-therapist relationship is one of the most important predictors of client outcomes. On average, 30% of the variance in client outcomes has been attributed to the client-therapist relationship, which translates to a 65% success rate" (Asay & Lambert, 1999, as cited in Eaton et al., 2007, p. 261). The Kazdin, Whitley, and Marciano (2006) study depicts the importance of a positive therapeutic alliance with both client and parent and therapist, and the key findings presented:

1. the child-therapist and the parent-therapist alliances were related to therapeutic changes in the children. The better the quality of these alliances during treatment, the greater the therapeutic changes among the children; and
2. the parent-therapist alliance was related to improvements in parenting skills and interactions at home. (p. 443)

The bond between client and therapist is made during the first few visits, as I experienced at my practicum, and this is where trust and agreements are formed with parent and child. In actuality, when a parent initiates contact with the agency, that is the beginning of the therapeutic relationship. Specific characteristics of the therapist come into play, from the client perspective, if the therapeutic experience is positive or negative.

The Allnock, Hynes, and Archibald (2013) study found key characteristics of a positive relationship between child and therapist. Positive relationships include a therapist and child bond developed by the therapist through listening, showing empathy, and being genuine. Important components in building a strong alliance include: trustworthiness, experience, confidence, easy communication, and truthful interpretation. Positive results such as, "…improved coping skills, improvements in how to deal with new life situations, development of practical day-to-day skills and finding new methods of expressing and managing overwhelming feelings" (Allnock, Hynes, & Archibald, 2013, p. 124) were relative to having positive therapeutic support.

The characteristics of the therapist that were liked and appreciated were: listening, showing respect, and providing attention. Therapists were liked because they were, "…friendly, nice and/or down to earth, warm, calm and relaxed, non-judgemental and non-patronising and provided validation of children's abuse experiences…open and accepting,

funny and humorous, happy and positive, trustworthy and non-pressuring" (Allnock, Hynes, & Archibald, 2013, p. 125).

Trauma Informed Practice

In addition to my other learning goals, I was introduced to trauma informed practice at my practicum and include it in this report as it has become an important part of my current practice at MCFD, and was also addressed in my practicum education. Trauma-informed practice is delivering service with the knowledge and appreciation of personal violence and victimization that have impacted a client. Having an understanding of how trauma has impacted the lives of service users provides awareness and respect for the recovery process of the client. Lacking the knowledge of trauma is equal to denying the existence and impact of the trauma (Elliott, Bjelajac, Fallor, Markoff, & Reed, 2005).

The 10 principles of trauma-informed services that recognize the impact of violence and victimization on development and coping strategies, provided by Elliott et al., (2005) are:

> Identify recovery from trauma as a primary goal; employ an empowerment model; strive to maximize a woman's choices and control over her recovery; are based in a relational collaboration; create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance; emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology; minimize the possibilities of re-traumatization; strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background; agencies solicit consumer input and involve consumers in designing and evaluating services. (pp. 465-469)

Practice consideration for trauma-informed practice must encompass the entirety of services offered to clients and not be limited in any area of delivery. Social workers must focus on being sensitive to current therapeutic issues of clients along with the understanding that there may be past trauma (Knight, 2015). The ability to validate past trauma, but not dwell on it, is emphasized in trauma-informed social work practice. Focus is placed on presenting issues with the knowledge that clients may have past trauma. The practitioner does not assume that

the client has experienced past trauma, it is only to understand that past trauma may have occurred and may be a part of the client's history. Conversely, not using trauma-informed practice can produce unwanted reactions. Knight (2015) states, "Specifically, survivors reported as unhelpful clinicians, those who: avoided addressing the trauma at all, asked for too much detail and encouraged expression of feelings when it wasn't appropriate, and minimized the significance of the trauma in the client's current life" (p. 27). The clinician is obliged to be well-informed about childhood trauma and its association to the client's present difficulties to meet the standards of trauma-informed practice.

Disclosure

A report of 311 cases in a study conducted by Essabar, Khalqallah, and Dakhama (2015) highlighted the need for a multidisciplinary approach toward prevention and management of child sexual abuse. The study looked at the harmful impact on victims and discussed the epidemiology of sexual abuse. The study was conducted over a 20-year period from January 1993 to March 2014. It was found that children seldom divulge sexual abuse immediately after the abuse has taken place. When children are ready to disclose it can be delayed up to 24 months and discussion comes after a physical complaint or a change in behaviour is addressed (Frasier, 2002, as cited in Essabar et al., 2015).

When a child discloses sexual abuse the consequences create upheaval within the family and within the child who discloses. Without proper support and intervention, healing will not take place. The response to the disclosure can be vital in the recovery of the child and family. Pifalo, 2009, states that, "Disclosure of sexual abuse places the family on a terrifying journey into uncharted, unknown territory; nothing may be more frightening than to embark without direction or guidance" (p. 12). A child may fear that disclosure will lead

to potential dissolution of their family yet if a positive response is given to the child it can lead to intervention and stop the abuse. Hershkowitz, Lanes, and Lamb (2007) explored disclosure of sexual abuse of children, and found that children's willingness to divulge abuse to their parents decreased when they believe their disclosure will be met with negative responses, especially when the abuse is more severe. Fear of family rejection and parental reaction, especially maternal, is key to safe disclosure from the child. Paine and Hansen (2002) state, "A child's self-disclosure of sexual abuse is a critical component in initiating intervention to halt the abuse, address its immediate effects, and decrease the likelihood of negative long-term outcome" (p. 271). Once a child begins receiving therapy there can be involvement from other supporters in the child's life.

Involving the non-offending parent in therapy can help to support a positive outcome. Assessment for self-blame and trauma symptoms during the medical evaluation of suspected sexual abuse was studied by Melville, Kellog, Perez, and Lukefahr (2014) and they concluded that parents need to have the knowledge of how vital it is to believe their child when abuse is disclosed, and that their response has an enormous impact on the child's emotional reaction to the abuse. Inviting parental involvement into therapy shows it may be an acceptable type of service delivery for both parents and children.

In a study designed to include non-offending parents/caregivers and children, Springer and Misurell (2012) provided a case sample showing the clinical application of Game-Based CBT to treat child sexual abuse. Springer and Misurell (2012) confirm the inception of GB-CBT, "The GB-CBT approach emerged through an integration of two treatment approaches that have shown to be effective for treating childhood trauma: CBT and Play Therapy" (p. 189). Delivery covers (Springer & Misurell, 2012)

"...developmentally appropriate games, play therapy, social skills building, psychoeducation about child sexual abuse, personal safety skills training and exposure treatment with play therapy interventions" (p. 188). These techniques are intended to allow children to process their trauma with the support of a non-offending parent or caregiver and acquire skills to protect themselves and increase their safety in a safe, fun, and engaging format.

Salloum, Dorsey, Swaidan, and Storch (2015) examined parents' and children's perception of parent-led trauma focused cognitive behavioral therapy. The three main treatment components of trauma-focused cognitive behavioral therapy (TF-CBT) set out by Mannarino et al., 2012, (as cited in Salloum et al., 2015, p. 12) are:

1. Skill-building techniques for the child and parent;
2. Trauma narrative (i.e., child describes and cognitively processes his/her trauma);
3. Treatment closure (i.e., conjoint parent-child sessions and safety plans.

The ages of the children were between 8 and 12 years and both parents and children completed step one of the stepped care trauma-focused cognitive behavioral therapy program. The study results were positive and conditions improved significantly over time for the children; both parents and children liked the treatment and found it supportive. The children indicated that the relaxation exercises were the most liked and helpful component (62.5%) followed by trauma narrative activities (56.3%). Some of the children (18.8%) did not like or found the least helpful component the trauma narrative activity because they didn't like thinking or talking about the trauma. Parents indicated that the parent-child meetings were the most liked/helpful (82.4%); parents (23.5%) felt that the workbook seemed too repetitive and some parents (17.6%) were uncertain if they were leading the parent-child meetings the best way (Salloum et al., 2015).

Including parents and guardians in therapy was studied by Salloum and Storch (2011) to challenge barriers to treatment and support alternative service delivery approaches using a stepped care model. Salloum and Storch (2011) observed that due to the prevalence of childhood post-traumatic stress disorder, alternative paths to interventions such as parent-lead, therapist-assisted, and trauma-focused cognitive behavioral therapy could aid in lifting the barriers to service. Salloum (2010) defines the approach:

> Therapist-assisted, versus therapist-directed, interventions take less therapist time which allows therapists to spend more time with patients who "step up" to receive more intensive care. A minimal therapist-assisted CBT intervention could be provided first and children who do not respond would then be stepped up to receive a therapist-directed evidence-based practice for that specific anxiety disorder. (p. 44)

The stepped care approach takes into consideration that not all clients need face-to-face intervention with a therapist on a weekly basis and there may be multiple benefits from applying alternative approaches to therapy, namely no wait-lists for service. Stepped care approaches may work in geographic regions such as northern and remote areas that have barriers such as transportation issues, lack of services, and fewer qualified therapists.

Long Term Consequences

Adult survivors of trauma and child sex abuse can experience long-term consequences, and the literature provides detailed accounts of outcomes of those who have survived child abuse. Studying the benefits and downsides of interventions can assist therapists to uncover what is effective, and what works or is harmful, with adult survivors. Walker-Williams and Fouche (2015) evaluated the benefits of a strengths-based group intervention for women who experienced child sexual abuse to facilitate post-traumatic growth in survivors. Six group sessions with 10 purposively selected women were chosen; qualitative data was collected using drawings, narratives, and transcriptions, resulting in

positive outcomes in personal narrative, personal strength, emotional awareness, and decisive action. Long term consequences of child sexual abuse include:

> ...mental health disorders (such as depression, anxiety, post-traumatic stress, substance abuse, and personality disorders), sexual maladjustment (such as high-risk sexual behavior), and interpersonal problems (such as, poor self-esteem, difficulty in trusting others, and a tendency toward re-victimization). (Walker-Williams & Fouche, 2015, p. 1)

Knowing the pervasiveness of long-term consequences and problems in adult survivors of CSA, and understanding the significance of effective treatment in facilitating healing and recovery cannot be underrated. There is strong support for group therapy with adult survivors, Brown, Reyes, Brown, and Gonzenbach (2013) argue that in group therapy, "...members might be able to better deal with issues relating to CSA such as guilt, shame, and isolation in the presence of it being shared with others" (p. 145). Group therapy can help survivors deal with isolation and stigma that can be attached to being a survivor. A strengths-based approach can have positive effects on group therapy participants; however, there can be a drawback to solely concentrating on a person's strengths leaving the impression that their past experiences are irrelevant. A fine balance must be maintained in a group setting, and as a therapist, you want to avoid disempowering and focus on only negative symptoms, you want to encourage a well-balanced approach (Orbke and Smith, 2013).

Chapter Three: The Practicum Learning Experience

Development of Clinical Social Work Skills

The first day of my practicum began with sitting in a session to watch my mentor during a therapy session she held in Houston, BC, a community just outside of Smithers, BC. During the first two weeks at my practicum I read the ethical standards outlined in the NSDP agency manual and read about agency programs, Code of Conduct, Code of Ethics, Understanding and Agreement Respecting Confidentiality, and the Policy Manual. The principles at NSDP include: strength-based, child rights, culturally relevant, respectful, collaborative, responsive, permanency, holistic, fairness, and accountable. The standards show what must be done and require a high level of service from assessment to treatment planning and interventions.

During my 560 practicum hours I completed 120 hours of direct-client contact. About 60% of the clients I worked with were male and 40% were female. First Nations clients comprised 30% of my caseload. Most of the clients I worked with were between the ages of 6-18 during my direct-client hours; however, I spent 10% of my time with female adults. Preparation work by way of research involved approximately 280 hours of practicum time. This included locating articles and manuals on art therapy and play therapy techniques, as well as studies on cognitive behavioural interventions. An additional 60 hours of research and preparation involved time spent viewing videos of therapy sessions. The remaining 100 hours of my practicum time was spent directly observing other therapists, recording contact information, and receiving supervision from my agency-based supervisor and my mentor. Following is a list of activities that I undertook during the practicum:

- Developed intervention skills and techniques used in Art and Play therapies at agency by listening and observing during therapy sessions;

- Observed and shadowed my practicum supervisor in her use of clinical skills;
- Carried a limited caseload as a practicum student with supervision;
- Followed clients from intake to end of service and document;
- Practiced treatment planning within agency standards;
- Maintain file management on client files

I met with clients on a weekly basis, a group on every Monday after school, a full day each Wednesday in another community, and a full day at NSDP in Smithers, BC on Fridays. Treatment plans, goals, and objectives were always discussed with my practicum supervisor, prior to, and after each meeting outlining individual therapeutic goals and techniques. I maintained all documentation and therapy session notes on each child that I worked with. I developed effective time management and note keeping skills with feedback from my practicum supervisor.

I was able to engage some clients from intake to the end of service, employing skills of creating therapeutic relationship, and closing service with client. In some cases, I joined therapeutic sessions in process. My introduction into ongoing therapeutic sessions was established through my practicum supervisor, who invited me to sit in on sessions. This enabled the client and I to become familiar and comfortable with one another prior to continuing the sessions on my own.

I did not attend agency meetings, and would have liked to have done so to watch how the diversity of the agency programs worked collectively. I assisted in Strengthening Families as a co-facilitator prior to and during my practicum. I hope to continue this work as it is very satisfying and strengthens my relationship with both the families and community

members involved in the program. These are the steps that I began with as I entered into my practicum setting during therapeutic sessions:

1. I sat quietly on a chair and watched my practicum mentor work with the children, sometimes it would be art, sometimes it would be play, sometimes movement;
2. I joined in if I was asked to by my mentor, usually immediately if there was body movement involved, that way all of us could share the space the same way;
3. I observed, listened, and when the session was over I immediately wrote down in my journal the session goals, applied therapeutic approach, the child/youth reactions;
4. Between sessions I asked questions about different approaches, and learned that every child/youth was unique and if I felt stuck to ask the child what they want, and listen.

I found out that children are very welcoming when they know that you want to help them, and in most instances they welcomed me into their sessions with my mentor, and then without my mentor. It was a steep learning curve, and I wasn't sure if I could go on my own, but when I did I felt comfortable and at ease because of all the observing, listening, and learning that I experienced.

I explored the role of interventionist by watching, and contributing in my role as a practicum student, and eventually took on the role of the interventionist. My practicum supervisor guided me, watched me, coached me, and when I was ready to be on my own, she provided me with the tools and assistance to move forward as an interventionist. I developed clinical skills and applied the techniques that I was taught by my supervisor. My practicum supervisor and I conducted group work with children, each week we made a new goal and explored varying therapeutic interventions.

Chapter Four: Summary of Learning Achievements

The focus of this chapter is to discuss my practicum learning goals and objectives that I set out to complete at the start of my practicum. My initial learning goals and objectives were to learn about sexual abuse and its effects on children and families. I learned about the childhood effects of sexual abuse, and also had the experience of working with adults who were affected by the long-term consequences of childhood abuse. I also researched art and play therapy studies and explored techniques used as interventions for childhood trauma. I learned about cognitive behavioral therapy and practiced this technique with youth at my practicum. I set out learning goals and objectives at the outset of my practicum, and learned more as I followed the lead of my practicum supervisor and expanded those goals and objectives.

NSDP provides a comprehensive range of programs and the history and legacy of the agency is extensive. I was unaware of the full array of programs, and as a social worker in the community, I was pleased to learn the extensive range of programs offered to the community.

NSDP is an agency that provides counselling services to children and youth who have gone through trauma, and my goal was to enhance my skills in counselling by observing and learning new skills. I accomplished my goal by learning different modalities of therapy, such as: expressive art, play and cognitive therapeutic interventions. I benefitted from applying my social work skills that I learned during my MSW program and from working in my current role at MCFD. I learned different social work approaches in comparison to therapeutic approaches by learning that NSDP embraces the feminist perspective. The ethical standards that I work with as a social worker were not dissimilar to ethical standards held by therapists. I found that therapists provide direct therapeutic interventions, social workers do

case management and referrals, and this has been my experience until my practicum allowed me to use clinical interventions.

I was involved in learning a variety of activities that enhanced the development of my clinical social work skills. I developed successful implementation of skills in the following areas: facilitation of the intake process, developed treatment plans, researched and planned therapy sessions. I conducted therapy sessions with both individuals, and groups of children, youth and adults. I was consistent in applying observation and interviewing skills, incorporated awareness of social and structural issues that impact child, youth, and family mental health, and the effective use of community and other resources. I was able to link structural social work with understanding clinical interventions. When I met with my MSW mentor we discussed integrating structural social work into my practicum learning and its relevance to good practice. Gil (2006) states, "…interpersonal acts of child abuse and neglect occur within a larger context that can include additional stressors, such as drug abuse, domestic violence, or environmental stressors (poverty, social oppression, etc.)" (p. 6). It is vital to understand the historical, cultural, and social effects sexual abuse has on clients and their families.

I learned assessment tools, and applied, and maintained confidential records during my practicum. I also wrote a journal that I updated every day of my practicum over the 10-month period. I studied the history and programs offered by the agency. I conducted group work with children, met with individual clients, both children, youth, and sometimes adults who walked in with immediate trauma issues. Due to specific days of my practicum I did not attend agency meetings, however I felt included and my practicum mentor made me feel a part of the team.

I learned to summarize what I learned and where I was at in reaching my practicum goals and objectives by regularly revisiting my list that I made at the beginning of my practicum. I attended to the list by researching and reading as many articles I could on art and play therapy. Each day of my practicum I wrote in a journal about my practicum experience, reflected on my perceptions about the information that I was reading, and on the knowledge that I was acquiring. I continually challenged and scrutinized my perspective as a working social worker, and as a practicum student studying new concepts and intervention techniques. I was aware that I brought historical knowledge with me into the practicum setting from both my work as a social worker and the foundation of social work courses. Through my studies and work as a social worker I was acutely aware of the historical, social, and cultural effects that children and their families experience around trauma, especially those who are marginalized. The agency workers know their client base, and embrace practice with the knowledge and understanding of historical, cultural, and social impacts that trauma has on clients and their families.

Chapter Five: Conclusion

Summary of the Practicum Learning Experience

I completed a 10-month, 560 hour practicum at Northern Society for Domestic Peace to fulfill the practicum requirements for the Master of Social Work program at the University of Northern British Columbia. At the beginning of my practicum I was nervous and excited, and as time went on, and I felt more prepared and comfortable, I looked forward to my practicum days. I didn't want the experience to end. As I tried to prepare myself for letting go, I thought of my time with the clients, their effect upon me, and mine on them. I was always cognizant of the realisation that I was a practicum student, and that my involvement with families would come to an end and my therapeutic relationships would cease. I would not get the opportunity to learn about client outcomes because of my practicum ending. This was important to me as I realized that every interaction I had with a client might be the last time that I get to see them, and I needed to be mindful of the impression I left with them. I also had to be mindful of the impact of my presence as a temporary counsellor in their lives. It was important not to minimize the effect I had on clients.

My interest in counselling and group work has increased as a result of my practicum and I look forward to future opportunities of practice in this area. I will hopefully continue to expand my knowledge around interventions and explore methodologies to become a more practiced therapist, as I believe this will be an essential element toward having a future in working with children and youth.

My learning objectives were met during my practicum placement. I wanted to challenge myself as a social worker through exposure to new practice situations and experiences, and feel that my direct involvement with the SAIP and the goals and objectives enabled me to complete the objectives that I set out to accomplish. The people who work at

the agency were very supportive of my learning and I appreciated the continued professional development that was offered to me by the agency through personal supervision. I found the feedback was a critical component of my learning as it provided the opportunity to receive feedback about client cases in a non-judgmental environment. The diverse backgrounds, experiences, and concerns of clientele provided me with many opportunities to broaden my knowledge of what it is like to come from a place of child and youth with special needs social worker into a position of creative art therapist. My learning curve in relation to formal individual counselling was steep and my prior knowledge of theory and the counselling process was definitely broadened as a result of my clinical interactions with both individual and group work. Furthermore, NSDP operates from a feminist perspective and recognizes the role of oppressive environmental factors on individuals. They endorse the idea of the feminist perspective of understanding the power imbalance in relationships between men and women, and children and their abusers. The society also understands the inequalities due to racial and cultural factors as well.

Social work education teaches social workers to engage in discourse about understanding social effects, and both history and culture of service users. It is essential to self-reflect and have self-awareness as a social worker to bridge differences and build relationships through understanding personal biases. During my practicum it was acknowledged that I came with an understanding of cultural inclusion and historical knowledge of First Nations peoples. Gil (1995, as cited in Purvis and Ward, 2006) proposed:

> Cultural issues are relevant to child sexual abuse in three major ways: how cultural beliefs or attitudes contribute to family climates in which children can be abused; how cultural organization prohibits or hinders disclosure; and how

> culture plays a role in seeking or accepting social service or mental health assistance. (p. 300)

Practicing with ethnically diverse people was expected and displaying empathetic treatment methods during the intervention process included understanding the link between trauma, history, culture, and social effects. My solid foundation of social work courses ensured that I carried this requirement with me into my practicum setting.

Northern Society for Domestic Peace is an agency in downtown Smithers, BC, extending services throughout the Bulkley Valley, and offering a variety of services that extend beyond the reach of all other services provided in the area. I was privileged to have had such an extremely intelligent and giving mentor who took me under her wing and showed me her counselling skills in art and play therapies and cognitive behavioral therapy. My 10-month practicum allowed me to find the methods and approach that I would like to use as a clinician. Play therapy was a fit for me because I was able to connect with the children and use my skills as a social worker to create a trusting atmosphere. Connecting with children and youth is a true passion and I feel fortunate to have found this method of practice that I will add to my current work as a Child Youth Special Needs social worker. My hope is that I have been able to provide the evidence of effectiveness on the success of art and play therapy within the context of this paper; I know that I have had the advantage of empirically witnessing the results from a personal perspective through the children and youth that I had the privilege to work with.

Recommendations

During my practicum I was critically aware of my interpersonal experience and I realized that I went in with a pre-conceived idea of thinking that my experience would provide me with a large toolkit that would take me directly into a clinician position in mental

health at the Ministry of Children and Family Development. I realize that my practicum gave me a solid foundation toward becoming a clinical therapist and provided me a broad-based perspective into what I would experience as a therapist in an agency setting.

I learned that the ability to prove the efficacy of introducing expressive art therapies is a challenge. More evidence-based studies are needed in the area of art therapy to increase the opportunity for agencies and governmental bodies to include these approaches as proven intervention techniques in healing sexual abuse. I observed changes in the clients that I worked with, witnessed the effectiveness of art therapy and play therapy, and saw the positive changes that came with these interventions in relationships with siblings, family, and friends. I look forward to using expressive art therapies as a method of intervention in the future of my career.

Living in the north entails isolation and lack of resources in comparison to southern regions that have greater populations, more agencies, and access to a larger number of practitioners. The agencies in the north are critical to reaching out to remote regions and the people they service. My practicum agency is largely funded by government and as a result, there are limitations resulting from the funding contract. However, my recommendations to improve service delivery for NSDP would be:

(a) increase office space to employ more therapists;

(b) increase funding to allow for increased outreach services;

(c) begin a training program to mentor social workers and therapists who want to stay in the north; and

(d) provide transportation in the north to help resolve isolation issues.

The Northern Society for Domestic Peace receives funding from the Ministry of Children and Family Development and boosts their presence in the community and resource pool by creating fund-raisers and accepting donations. I recommend greater resources from the province to recognize and maintain the critical support that NSDP offers to their community, the people within it, and the service users. More support would lower wait lists, employ more professionals, expand their reach of services, and benefit the families who rely on this agency.

The SAIP program is unique in that it is not offered in many communities and this limitation needs to be addressed. NSDP creates and offers programs in the community, and requires funding from the government, and it is imperative for continued service that funding be consistent and reliable. NSDP encourages and supports continued professional development, and the employer provides funding, and time off from work to pursue individual educational goals. The mutual respect within the agency between employer and employees has not been surpassed in my history of working as a social worker in northern British Columbia. I reflect on these words that demonstrate the genius that I observed in watching my NSDP mentor share her art:

> Watching my supervisor was the most beneficial learning experience that I've had in any environment. She's a very centered, balanced person who knows what she's doing. She was able to convey that, to teach by example and not by being directive, with staff, parents, kids, me… When I was dealing with certain circumstances, I would think about her and draw on her. (Barretti, 2009, p. 245, as cited in Williamson, Hostetter, Byers, & Huggins, 2010)

As I watched, I listened, and absorbed myself in the practicum process and gleaned all I could from the gifted people at NSDP, and was enriched by those who are driven to help children heal from trauma.

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