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Claywork in Art Therapy with Survivors of Childhood Sexual Abuse

Capstone Thesis

Lesley University

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Art Therapy

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Abstract

This literature review explores the potential benefits of the claywork modality within art therapy as a treatment for individuals who experienced childhood sexual abuse or trauma. The goals of this literature review are to indicate and define appropriate terms; discuss the forms and prevalence of childhood sexual abuse and trauma; explore traditional treatment models; investigate the benefits of claywork in treatment for survivors of childhood sexual abuse and trauma. The research reviewed included published studies, research analyses, and literature reviews covering the topics of childhood sexual abuse and trauma, group therapy, art therapy for the treatment of trauma, and claywork. The research was chosen and prioritized based on the size of studies, and how recently the research was performed. Two studies were also reviewed: A 1995 study by Anderson involving two groups of five adult female survivors of childhood sexual abuse in the form of incest; and a 2015 study by Haynes consisting of three adult female survivors of childhood sexual abuse in the form of sex trafficking. Both of these studies employ exclusively claywork as the art therapy modality in treatment. The evidence suggests that the lasting negative effects of childhood sexual abuse and trauma are benefitted by the therapeutic factors of clay and the physical and emotional benefits of claywork. The author notes that the vulnerabilities of this review include the lack of claywork-specific studies, the narrow scope of childhood sexual abuse and trauma treatment research, and the lack of diversity in populations studied. Future research should address these vulnerabilities, as well as addressing the stigma faced by different populations of survivors when reporting, and revising the terms used to be more firmly empowering to survivors.

Keywords: childhood sexual abuse, art therapy, claywork, sexual trauma, treatment

Claywork in Art Therapy with Survivors of Childhood Sexual Abuse

The claywork modality utilizes the process and product of working with clay to elicit therapeutic benefits, and these benefits can be especially effective in the treatment of individuals who experienced sexual trauma in childhood. This literature review aims to identify appropriate terminology for discussing childhood sexual trauma, including the forms and prevalence of childhood sexual abuse; examine traditional group therapeutic models for the treatment of such traumatic experiences; highlight the potential benefits of claywork as an art therapy modality for treatment. In the following pages, we will examine the various forms and dynamics of childhood sexual abuse (CSA) to highlight specific populations that lack robust research and to identify effective potential treatment models.

Extensive literature has studied CSA to understand its effects on child and adult survivors and determine effective treatment models. Outcomes of this research reveal how CSA impacts the individual survivor both mentally and somatically (Carozza & Heirsteiner, 1982). Art therapy as a treatment model has been explored and is increasingly used in the treatment of adult CSA survivors, and has continued to yield many benefits for these clients such as reduction of symptomatology associated with childhood sexual trauma (Anderson, 1995).

Research demonstrates that art therapy can be a more effective therapy for survivors of CSA than traditional verbal therapy. Claywork has received less focus and few studies have been conducted to demonstrate its use when working with survivors of CSA, yet its therapeutic benefits in art therapy have been demonstrated. By reviewing and synthesizing the existing literature, this thesis aims to connect the therapeutic benefits of clay and the effective use of

claywork in treatment for those impacted by CSA. As a foundation for this literature review, definitions of terms will be provided to clarify the focus of this literature review and draw awareness of the connotations for the terminology used on this subject. As such, it is crucial to provide precise definitions of the terms used and to be aware of the connotations of each. When using the term "abuse," the action of the offender is brought into focus, whereas "trauma" focuses on the effects of the abuse, and according to Shapiro (2002) is "any event that has a lasting negative effect on the self or psyche" (p. 14). "According to the American Medical Association (1992), 'childhood sexual abuse' consists of contact abuse ranging from fondling to rape and non-contact abuse, such as modeling inappropriate sexual behavior, forced involvement in child pornography, or exhibitionism" (Yuan, et al., 2006, p.2). "'Sexual trauma' is defined as one or multiple sexual violations that invoke significant distress" (Yuan, et al., 2006, p. 2). "Clinical observations have also suggested that sexual trauma may be a less stigmatizing term for some survivors and may promote healing by acknowledging the impact of the violent act on the individual's wellbeing" (Yuan, et al., 2006, p. 2). This review will be using both of these terms with regards to these contexts, when necessary.

Research by the Centers for Disease Control and Prevention [CDC] and the Rape, Abuse, and Incest National Network [RAINN], specify precise definitions of "childhood" in their identification of CSA involving a "minor" or individual "under 18" (Devlin et al., 2019; RAINN, 2020) with other sources using the term "child" to identify the individual who experienced abuse (Hall & Hall, 2011; U.S. Department of Health and Human Services, Children's Bureau [Children's Bureau], n.d.). Use of the precise definition is preferable as it leaves little ambiguity as to what CSA encompasses, by using legal terms such as "minor," and precise ages. Using

imprecise terms such as "child" to define the affected population is problematic since this term can be dependent on society's definition of a child, which is not a definable age or level of competency. The negative impact of this imprecise language can be seen in the treatment of individuals who have been sex trafficked (Jones & Reid, 2011). The average age of individuals who are sex trafficked is 12-14, but they are frequently treated by society and law enforcement as if they are not children despite their ages and the traumatic nature of their CSA (Haynes, 2015, p. 16; Jones & Reid, 2011). When researching "how local law enforcement treated prostituted minors," Halter (2010) found that "60% of the youth in [the] study sample were regarded as victims, and 40% as offenders," despite 100% of the population in question being under the age of 18 (p. 152).

Whether the individual experiencing sex trafficking was given the title of "victim" or "offender" by local law enforcement was decided "based on the youth's level of cooperation, the presence of an identified sex trafficker or exploiter, whether the youth had a prior record, and how the police discovered the youth's involvement in prostitution" (Jones & Reid, 2011, p. 211). These individuals are often referred to as "child/juvenile/teen prostitutes" (Jones & Reid, 2011, p. 211). This research helped to provide support for "textual abuse," a concept referring to language that exploits and objectifies children by minimizing the seriousness of crimes committed against them to spare the reader from fully acknowledging the child's victimization" (Jones & Reid, 2011, p. 209). By using terms inappropriate for children being sex trafficked, such as "child prostitute", the language erases the issue of the survivor's age, and "the sexual abuse and victimization of the child is never acknowledged" (Jones & Reid, 2011, p. 209).

Terms are important to address to discuss this topic in a way that offers empowerment to the population, rather than taking power away or unnecessarily re-traumatizing the individual. For example, when the individual who has experienced sexual abuse is discussed, terms used to describe them include "child sexual assault victim" and "victims of childhood or adolescent sexual abuse" (Finkelhor et al., 2014). When this population has grown past childhood, the terms used in academic texts include "victims of childhood or adolescent sexual abuse" and "individuals who have been sexually abused in their childhood" (Hall & Hall, 2011, p. 1). Though these terms are accurate, they are contributory in taking power away from the population in question (Halter, 2010). The fostering of empowerment amongst participants has been identified as a critical aspect of helping survivors overcome feelings of loss of control or powerlessness in treatment (Haynes, 2015). Through this thesis “survivor of " and “individual who experienced” will be the terms used to identify an affected population. When talking about therapy populations in general, the terms “client” and “participant” will be used in the necessary contexts. Using survivor-centered language promotes the removal of stigma associated with these terms.

Being precise with the language used when discussing potential offenders is important as well because having a clear understanding of who commits these acts is integral to understanding the pervasive but often invisible problem of CSA. Historically, research has shown the offender’s identity to impact the identification of abuse, sometimes more than the identity of the individual who experienced the abuse (Halter, 2010). For example, sexual abuse by a sibling or older child was not always considered as damaging or outside of natural development as abuse by an adult (Collin-Vézina, et al., 2014). Further research has clearly shown that this narrow

definition of abuse is not effective or useful and that sexual abuse by a sibling child impacts not only the individual but all members of the family system, with damaging effects on the family dynamic (Collin-Vézina, et al., 2014). Abuse by a sibling is the most common form of familial abuse and has been shown to carry a similarly damaging impact as abuse perpetrated by an adult caregiver (Krienert & Walsh, 2011). More recent definitions are careful to be precise in stating that sexual abuse between children has occurred when an older child obtains participation in sexual acts by a younger child "through seduction or coercion" (Hall & Hall, 2011, p.p. 1-2).

The Scope of Childhood Sexual Abuse

CSA can occur across populations and within many different variables of age, duration, severity, and perpetrator population. This literature review found a range of statistics when investigating the prevalence of CSA. There are several possible reasons for this lack of cohesion in the statistics, including the chronic under-reporting of abuse as well as the wide variables of who and what is included in the statistics (Krienert & Walsh, 2011). For example, as noted above, sibling abuse is also the most common form of familial abuse but often goes unreported or disclosure does not occur until adulthood (Krienert & Walsh, 2011). Sexual abuse that does not include touch and other non-penetrative types of sexual abuse are reported less often, which means the number of individuals sexually abused in childhood may be greater than the reported numbers (Hall & Hall, 2011). These factors can contribute to statistics varying between sources.

The most recent statistics from RAINN indicate that “1 in 9 girls and 1 in 53 boys under the age of 18 experience sexual abuse or assault at the hands of an adult” (Finkelhor et all., 2014; RAINN, 2020). The CDC reported a much higher prevalence in a widely published study from 2014: 1 in every 4 girls and 1 in every 6 males will be the victim of sexual abuse before the age

of 18 (Devlin et al., 2019). The prevalence of this problem is undeniable, and the research continues to return increasingly troubling statistics as this form of abuse becomes more widely understood and studied.

As with most abuse, CSA can take many forms, and it contributes many lasting effects. The U.S. Department of Health and Human Services' Child Welfare Bureau defines the sexual behaviors that constitute CSA as "fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography" (Children's Bureau, n.d.). RAINN (2020) further elaborates including, "masturbation in the presence of a minor or forcing the minor to masturbate; obscene phone calls, text messages, or digital interaction; producing, owning, or sharing pornographic images or movies of children; sex of any kind with a minor, including vaginal, oral, or anal; and sex trafficking." The definition used by RAINN "also includes any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare" (RAINN, 2020). This broad definition is focused on the offender's actions against the child. These actions are consistently informed by the imbalance of power that exists in these relationships. An aspect of domination and exploitation inherently exists in CSA by an adult or older child. Therefore, ethical therapy and research aim to avoid unnecessary re-traumatization by acknowledging the survivor's autonomy to inform what constitutes abuse (Hall & Hall, 2011).

The Psychophysiological Impact of Childhood Sexual Abuse

The harm from childhood sexual trauma often manifests mentally and somatically, pervasively impacting the individual's mental and physical health with long-lasting effects (RAINN, 2020.; Carozza, & Heirsteiner, 1982). Individuals may also exhibit symptoms

associated with Post-Traumatic Stress Disorder (PTSD), anxiety, eating disorders, as well as depression. “Self-mutilation is also common among adolescents who have been, or continue to be, sexually abused” (Devlin et al., 2019, p. 361). According to Shapiro, “because the present is perceived through the lens of the past, unprocessed traumatic memories can stimulate arous- al corresponding to fears of abandonment, fear of failure, loss of love, and anxiety about survival” (Tripp, 2007, p. 177). When abuse occurs in childhood, the high levels of stress that accompany this abuse have been shown to negatively impact brain function. When a traumatic experience is recalled, Broca's area-- a neural center for speech - is shut down and the amygdala - an area of the brain implicated in emotional response and expression-- is aroused (Rausch et al., 1996). This combination of shut down and arousal impairs the executive functioning of the brain, providing a neural and physiological basis for the strong emotional response individuals experience and the inability to explain it (van der Kolk, 2003). "This phenomenon seems to account for the 'speechless terror' that traumatized individuals face when attempting to verbalize what they are experiencing" (Tripp, 2007, p. 177). Repeated or prolonged dysregulation in the brain can lead to the death of neuronal cells in the limbic system of the brain which "can be evident in a variety of symptoms including impaired self-regulation, somatization, aggression against the self and others, character pathology, and dissociation" (Tripp, 2006, p.177; van der Kolk et al., 2005). It can also affect biological processes such as temperature control, memory systems, and neurotransmitter regulation (van der Kolk, 2003).

Sexual abuse during childhood and adolescence is shown to impact the individual's neurodevelopment, resulting in impacts on cognitive and socioemotional abilities that impede their relationship and educational outcomes (Devlin et al., 2019). It can also affect their ability to

regulate emotions, healthily handle stress, and process new experiences and memories (Tripp, 2007). During childhood and adolescence, survivors of this trauma tend to struggle more academically and are at higher risk of not graduating high school or seeking higher education (Devlin et al., 2019). These disadvantages in development increase health risk behaviors and predict poorer health outcomes in adulthood (Devlin et al., 2019). Individuals who have experienced sexual abuse as children are "about four times more likely to develop symptoms of drug abuse," and are at a "greater risk of problem alcohol use later in life" (Hall & Hall, 2011, p. 3; Yuan et al., 2006, p. 3). They are also more likely to exhibit self-destructive behaviors and suicidal ideations (Hall & Hall, 2011).

The lasting effects and symptoms of this childhood sexual trauma also carry through into adulthood (Devlin et al., 2019). In adulthood, an individual is likely to experience depression, lower self-esteem, and disruption of trust in relationships and sexual activity (Devlin et al., 2019). Self-blame, guilt, and shame from CSA contribute to the increased risk of suicide in women who have been abused (Devlin et al., 2019). Sexual abuse in childhood often manifests years of feeling down, having negative self-thoughts, and feelings of worthlessness in survivors which can further contribute to depression (Hall & Hall, 2011).

Variables That Impact the Effects of Childhood Sexual Abuse

Many variables impact the effects of CSA, including the extent of the abuse, "nature and severity of the sexual act," the number of experiences, and the age at which the abuse first occurred (Hall & Hall, 2011, p. 2). Other influences such as the individual's perspective, their internal resources, and the level of support they have access to will also impact the way symptoms manifest over time (Hall & Hall, 2011). When interfamilial abuse-- the most common

of sexual abuse-- occurs, survivors may display what is known as “betrayal trauma” which stems from the realization that the people who are meant to love and care for children are the ones who hurt them (Devlin et al., 2019, p. 361). They may begin to realize that they are objects of lust instead of children loved by their families, which can disrupt familial bonds and family dynamics, causing further relationship and support problems (Devlin et al., 2009). Sibling abuse, a prevalent form of abuse, has been demonstrated to result in “psychosocial/ psychosexual dysfunction” but remains less researched than other forms of intrafamilial abuse (Krienert & Walsh, 2011, p. 353). A 2011 study reported that women survivors of incest-- the most common form of CSA-- reported higher current levels of depression than those who survived non-familial abuse (Hall & Hall, 2011). Anderson (1995)defined incest as “repeated physical contact of a sexual nature between an adult who has violated a position of trust or authority or a caretaking role (regardless of kinship) and a child” (p. 413). The three most common diagnoses given to survivors of CSA are PTSD, anxiety, and depression (Devlin et al., 2019). “PTSD allows the individual to relive the experience countless times, anxiety calls for the mistrust of many individuals over numerous social situations, and depression permits the victim to feel negative emotions about their previous experiences" (Devlin et al., 2019, p. 361). Depression is one of the most common long-term symptoms reported among adult survivors of CSA (Hall & Hall, 2011). Depression in survivors is linked to a higher risk of self-destructive behaviors, suicidal ideations, and suicide (Hall & Hall, 2011). Like any trauma, how childhood sexual trauma affects survivors is subjective and highly individualized. Further research into more varying and diverse populations is needed to understand how all of these variables can affect survivors over time.

Though this abuse can deeply affect the individual, it also can significantly impact the family unit involved, especially in the case of incest (Baker, et al., 2001). There is little research on the impact of CSA for non-abused, non-offending siblings (Schreier, et al., 2016). These secondary victim populations, who are nevertheless impacted by the abuse environment while escaping the direct sexual abuse, can also exhibit trauma symptoms and maladaptive behaviors brought on by the abuse environment (Schreier, et al., 2016). There is little evidence on treating these non-abused, non-offending siblings, even in the context of treating the damaged family dynamics, despite these non-abused individuals having shown to exhibit similar trauma symptoms as their abused siblings (Schreier et al., 2016). This lack of research is despite ample evidence that treating damaged family dynamics can greatly impact an individual's recovery from trauma (Baker, et al., 2001). Despite the complexity of the CSA problem, and its wide-ranging impacts, little research has been done examining these differing victim populations, and to date, only two published papers focus on the populations of non-abused, non-offending siblings (Schreier et al., 2016).

Treatment modalities

Traditional treatments for addressing sexual trauma include group therapy, eye movement desensitization, and reprocessing (EMDR), cognitive-behavioral therapy (CBT), and psychotherapy (Adeniyi, 2014). This literature review will focus primarily on group therapy as the traditional therapy model in question, as it lends itself naturally to, and has demonstrated its effectiveness in, art therapy practices, as well as combining techniques from the other therapies.

Group Therapy

Group therapy has been identified as beneficial for survivors of CSA by several studies (Anderson, 1995; Carozza, & Heirsteiner, 1982). A 2015 study by Haynes examined the efficacy of claywork in a group setting as a treatment modality for individuals who experienced childhood sexual trauma. One of the major benefits group therapy offers this population is the opportunity for individuals to build community with others who can relate to their experiences. The opportunity "to feel a sense of universality and normalcy" is likely behind this benefit (Haynes, 2015, p. 18). Group therapy has often been identified as the treatment of choice among survivors of sexual abuse (Haynes, 2015). This is likely in part because of group therapy's ability to transition individuals from a state of isolation to a state of rejoining others in relationship and intimacy (Anderson, 1995). This contributes to an overall feeling that the client is not alone in dealing with the trauma of their past (Haynes, 2015). The "sense of safety through social support" allows the individual to feel understood when expressing deep emotions of "shame, guilt, rage, self-blame and uncleanliness" (Haynes, 2015, p. 11). Participants in the Haynes (2015) study emphasized the benefits of the group therapeutic model in their exit interview statements. The three participants in that study emphasized that they were "not the only ones" and hearing the other participants' stories helped build the understanding that they were not alone in the abuse and trauma they had experienced. During the study's exit interview, participants emphasized that being able to relate helped them feel like they were not alone, that someone else understood the trauma that they endured. The participants greatly benefited from knowing that their experience was understood and similar to others around them (Haynes, 2015). The group also provides a space of safety where individuals can begin to learn from each other and gain

skills and insights through these interactions (Sholt & Gavron, 2006). The individual who has received reassurance and acceptance from the group is then able to engage in self-exploration to restore a sense of self and identity (Anderson, 1995). The group setting can also impact an individual's self-value by demonstrating how they positively impact others in the group (Sholt & Gavron, 2006). Group therapy has demonstrated the ability to boost positive self-perception and self-esteem in participants (Haynes, 2015). In the Haynes (2015) study, one participant stated that they were "learning to love" themselves (p. 67). The interviews concluding the study showed that the claywork modality helped facilitate the participants having a new acceptance of themselves. Haynes (2015) found that as the women found more positive worth in their pots, they paralleled more positive regard for themselves, verbalizing more positive self-thoughts toward the end of therapy. A participant emphasized this when stating: "Before this, I had no idea they'd been through what I'd been through. I thought I was the only one" (Haynes, 2015, p. 79).

These positive impacts are particularly helpful for survivors of CSA, because of the particularly unempowering dynamic that exists at the time of traumatization. By giving individuals who feel they have lost control of their power a platform in which to assert themselves, group therapy encourages healing and growth (Sholt & Gavron, 2006). Haynes (2015) states that one participant "felt empowered when the group verified her decisions in the art-making process, making her more confident in herself" (p. 68). Communicating about the trauma in this safe environment with other survivors empowered the women to speak the truths of their own experiences and have them validated by a group of people uniquely empathetic to the experience (Haynes, 2015). “These moments of empowerment appeared to increase the

women's self-confidence, self-esteem, self-efficacy, autonomy, and freedom. They viewed themselves less as powerless victims and more as empowered creators and artists" (Haynes, 2015, p. 68). "The healing aspects of art making come from the act of trying, failing, experimenting, and succeeding together with others" (Allen, 2008, p.11). The process of art therapy has demonstrated the ability to decrease trauma symptoms while promoting community, empowerment and life skills amongst survivors of CSA (Hardy et al., 2013). Additional research continues to explore how working through trauma in creation through art therapy, can also empower the survivor to further regain their power to "create" their truth about their own experience.

Art Therapy

Art therapy is a mental health modality that combines "active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship" (American Art Therapy Association, 2017). Clinical art therapy has the advantage of being able to adapt different theories and methods of therapy within the art therapy practice, which makes it effective and beneficial (Adeniyi, 2014). Combining cognitive-behavioral therapy (CBT) and art therapy with survivors of CSA demonstrated "a statistically significant reduction in symptomatology scores on nine of the ten clinical subscales (Anxiety, Depression, Anger, Posttraumatic [sic] Stress, Dissociation, Dissociation-Overt, Sexual Concerns, Sexual Preoccupation, and Sexual Distress) in the direction of reduced pathology" (Pifalo, 2006, p. 182). For art therapy to be effective, certain flexibility on the therapist's behalf is essential to ensure each client's individual needs are met. Similarly, the practice, mediums, and forms of art-making

that take place in treatment will vary with each art therapist. This flexibility and range of benefits have made art therapy a very effective tool when treating survivors of CSA.

Art therapy has been increasingly used in the treatment of adult survivors of CSA and has continued to yield many benefits for these clients (Anderson, 1995). There has been considerable attention paid to the subject of CSA, its effects on child and adult survivors, and effective treatment methods (Anderson, 1995). There is even research that shows art therapy is a more effective therapy for survivors than traditional verbal therapy, "because verbal psychotherapy tends to permit the client to remain in the intellectual realm and may even reinforce the split that most survivors have between thinking and feeling" (Anderson, 1995, p. 413). The power of art media to evoke emotional rather than intellectual responses is at the core of the basis of the usefulness of art as a therapeutic medium (Anderson, 1995). The nature of childhood sexual trauma makes it difficult for victims to express themselves verbally when recounting their abuse (Tripp, 2007). By encouraging nonverbal expression, art therapy further empowers survivors to define and express their experience using a form of communication that may be less activating to their trauma. Clay was shown to bring back memories and one participant remarked that "bad memories outweighed the good" (Haynes, 2015, p.p. 76-77). Haynes (2015) observed that the clay allowed this participant to process their memories in a way that was "less intrusive" than processing verbally and reported that "the qualitative data from discussions, observations, and interviews supports that the women were beginning to process their trauma" (p.p. 76-77). This can give the power of defining and controlling the narrative back to the survivor, thus encouraging more healing and growth (Anderson, 1995). In group therapy, research has found that "empowering the patient-artists as decision makers and creators increased their sense of

belonging and responsibility" (McNiff, 2004, p. 18). Encouraging individuals who have been previously put into the role of "victim" to inhabit an empowered role that gives them the choice to express, to make, and to act of their own volition, can lead to healing of damaged self-perception and self-esteem (Moon 2004; Haynes, 2015). Art therapy has also shown to counter the depression that survivors of CSA often report by offering benefits that counter depressive thoughts, such as increased optimism and ego resilience (Haynes, 2015; Meekums, 1999). For these reasons, art therapy has shown real promise when used in the treatment of childhood sexual trauma.

Claywork

Claywork is a modality of art therapy that, although researched and discussed with various populations, has received less research attention in the treatment of CSA. This thesis will attempt to provide support for increased research into and use of claywork modality in art therapy to help in the treatment of survivors of CSA by first examining the benefits of claywork as a therapeutic tool, and then addressing how these benefits could best serve the population of survivors of CSA. Sholt and Gavron (2006) define claywork as the "process of handling, manipulating, and sculpting clay, and the products of these activities" (p. 66). Haynes (2015) further defined claywork in the specific context of art therapy as a "therapeutic art intervention that utilizes clay as the primary medium throughout treatment" (p. 4). Claywork as an art therapy modality combines the process of working with the clay with the product of the clay art piece that is created to elicit an emotional response. Claywork, like many modalities, operates through the knowledge that insight, inspiration and metaphors will develop during the process of creating (Meekums, 1999). A wide range of books and studies discuss the claywork modality in an art

therapy practice. Although research on claywork as a treatment for CSA is limited, the therapeutic qualities of clay have been adequately evaluated and presented (Sholt & Gavron, 2006). Sholt & Gavron (2006) conducted a review of 35 clinical reports to identify the 6 major therapeutic factors of clay. Carozza et al. (1983) reported that clay was often chosen as the preferred art medium in groups of girls aged 9 to 17.

Literature Review

The focus on process and product in claywork will "foster significant psychological processes, revealing meaningful information about the creators' inner world" (Sholt & Gavron, 2006, p. 1). Similar to clay itself, the process of healing from CSA is messy, and progress is not linear. By continuing to expand the research into this topic, therapists can help use the benefits of claywork to encourage this progress. This thesis will examine in-depth two studies that show the beneficial effects of claywork in the treatment of trauma. These studies address the use of claywork to treat various specific populations and symptomatology. As previously discussed, the survivor populations, the nature of trauma, and the short- and long-term effects of CSA are widely varied, and the treatment of CSA would benefit from research that informs individualized treatment. However, there is much overlap in the treatment goals of these studies and the therapeutic benefits of clay, demonstrating its appropriateness and efficacy in treatment for survivors of CSA.

The study conducted by Anderson in 1995 is one of the few studies that review claywork being used as the main art therapy modality in the treatment of survivors of CSA. Its goals revolved around helping clients feel safe and cared for to achieve effective therapy, encouraging group communication, and community building, addressing damaged family dynamics and

perpetrator communication, and creating art that allows for emotional release (Anderson, 1995). This study, though very well-focused for this thesis, has several critical flaws, including a small number of participants, as well as the participants being of the most heavily-researched populations of CSA. By contrast, the meta-analysis conducted by Sholt and Gavron in 2006 instead focused on the qualities of claywork for therapeutic benefit which lends its research more adequately to multiple populations. By comparing these two studies, this thesis will attempt to offer greater context for both studies, and form an argument for further research into the use of claywork as a treatment for survivors of CSA and childhood sexual trauma.

The method in Anderson's 1995 study utilizes both process and product. Anderson facilitated two pilot studies consisting of five females each, all participants had experienced CSA in the form of incest. The clients participated in weekly group sessions which involved a claywork intervention followed by weekly journaling to respond to specific questions (Anderson, 1995). The clients were provided with an environment where they would "feel safe enough to share their own rage and pain" in order to encourage "work[ing] through their outrage" (Anderson, 1995, p.p. 416-417). The process of becoming comfortable within the environment facilitated the client's other journeys of learning the new medium of claywork, creating community within the group, and communicating and working through their own trauma. One of the goals of the Anderson (1995) study was "to help the client develop mastery in clay, which in turn would enhance her self-esteem" (p.p. 416- 417). This process of learning and practicing claywork and the process of integrating into group therapy are both helping facilitate healing and are equally important to the therapy process as the final product of the art-making, or the final product of a supportive community. Sholt and Gavron (2006) explain that

> The importance of both product and process is based on the conception that an art expression is not merely the final product but is also the process by which the product has been developed, and that both product and process foster significant psychological processes, revealing meaningful information about the creators' inner world. (p. 66)

Sholt and Gavron's Six Therapeutic Factors

Through the review of 35 clinical trials, Sholt and Gavron identified six therapeutic factors of clay-work used in art therapy and psychotherapy (Sholt & Gavron, 2006). This naming of the specific therapeutic qualities attributed to clay emerged as common as the authors performed an "integrative review regarding the therapeutic factors of clay-work...and examination of its importance in applied theory" (Sholt, 2006, p. 66). Several of the goals of Anderson's (1995) study match up with the therapeutic factors of claywork identified by Sholt and Gavron. While Anderson's (1995) goals are an expression of what the therapist hopes the client will achieve during therapy, the therapeutic factors of claywork are framed around what the medium of clay can elicit from a client during therapy (Sholt & Gavron, 2006). These therapeutic factors of claywork are

> (1) facilitating emotion of expression (2) facilitating catharsis (3) revealing unconscious materials (4) facilitating rich and deep expressions (5) facilitating verbal communication (6) concretization and symbolization: the embodiment of the inner representations in visual images. (Sholt & Gavron, 2006, p. 70)

By comparing the goals from the Sholt and Gavron (2006) study with Anderson's (1995) goals for the client, this thesis will show the effects of these therapeutic factors as they manifest in survivors of CSA engaging with claywork.

Facilitating Emotion of Expression

Clay is especially helpful in facilitating the expression of emotions, especially those emotions that are not easily expressed verbally, both because of the way it dictates the use of the body, and because of its material aspects (Hinz, 2009). The tactility of claywork is an inherently useful quality when working with expressing emotions nonverbally since "touch was identified as one of the first sensory responses to develop in humans" (Sholt & Gavron, 2006, p. 67*).* As children, the sense of touch is one way of interacting with the world that is not taught but rather develops instinctually. Working with clay "taps into primary modes of communication and expression (e.g. through touch) and is thereby linked to actual past memories and feelings that were encoded through touch and movement" rather than through verbal encoding (Sholt & Gavron, 2006, p. 67). The connection between emotions and communication can become damaged by trauma during childhood, causing problems with verbal communication and clear expression. "Adolescents coming from abusive situations often lack the stability to accurately express their thoughts verbally" (Devlin et al., 2019, p. 361). By encouraging the client to tap into touch, an early pre-verbal form of communication and expression, the claywork facilitates healing of this connection and encourages more open communication about the client's experiences and emotions (Sholt & Gavron, 2006). In this way, claywork helps to facilitate Anderson's goal, which is to help the client to integrate affect and intellect" (Anderson, 1995, p.p. 416-417). Claywork's inherent physicality and tactility allow for a greater expression of emotions and can be helpful when dealing with traumas that have affected verbal expression such as CSA.

Facilitating Catharsis

Achieving catharsis is an important and often final step in allowing the client access to traumatic memories without the accompanying emotional and behavioral response. Anderson (1995) stated that "once some of the affect could be vented, clients could begin to move past the abusive experience(s) toward an integration of affect and intellect and toward recovery" (p. 415). One goal of Anderson's (1995) study was "to provide the environment for the clients to work through their outrage" (p.p. 416-417). To achieve this recovery through venting both emotional distance through acceptance and growth and "making it real" in the form of concretization have to happen so "both catharsis and empowerment [can] occur" (Anderson, 1995, p. 416). The safe environment that comes with an art therapy group as evidenced in Anderson's (1995) study, allows the client to engage with their experiences from a safe distance, filtered through both a physical art medium and a group of supportive peers. This group art therapy can also help concretization by fulfilling one of the goals of Anderson's (1995) study: "to make the clients feel they are not alone, others have had similar experiences (i.e., to help clients cohere into a group so that group process can facilitate healing" (p.p. 416-417).

This healing often comes in the form of catharsis. Catharsis lets the client release, and thus gain relief from, the intense emotions that were stored as a result of childhood trauma. The concept of catharsis, according to Aristotle, "embodies several concepts… a cleansing/purging, a rebirth, and a reorganization of one's worldviews" (Anderson, 1995, p. 416). This "new state" can be a place from which clients gain a new perspective and understanding of their past experiences, and begin to heal (Anderson, 1995, p. 416). Without this perspective shift, the trauma holder is not able to re-process their memories effectively and is in effect "stuck" with the

experience of their trauma as it was initially recorded in the brain at the time of abuse (Shapiro, 2002). When a client can achieve catharsis through therapy, "the shock of the emotional arousal and purgation helps to rearrange perceptions and so leads to a modification of the audience's self-concept and world view" (Anderson, 1995, p. 416). Blending the client's past and present worldviews into a new perspective requires the client to engage in a concrete expression of their experiences, and symbolic expression of the parts of the experiences that cannot be expressed verbally (Sholt & Gavron, 2006). The goal of intense trauma therapy is "[to work] through the process of changing the intrusive reliving of the traumatic events so that the client can deal with these memories without the accompanying intense affect," thereby "integrat[ing] affect and intellect" (Anderson, 1995, p. 414). Catharsis offers the client an “emotional cleansing” when the trauma of sexual abuse is reexperienced in the “structured, safe and controlled situation” of the group therapy session facilitated by the therapist and their ability to move the client through this (Anderson, 1995, p. 416).

Another benefit of the group setting is that not only does the individual experience catharsis, but others within the group experience catharsis through observation (Anderson,1995). This was demonstrated in Anderson's (1995) study when the participants discussed witnessing another member's cathartic experience and were then allowed to discuss how they felt during the other participants' "emotional outburst" (p. 422). This group benefit further emphasizes how helpful it is for the families and support systems of survivors of CSA to engage in group therapy. Not only does the experience help facilitate healing in the traumatized individual, but the group itself experiences both their healing and the secondhand experience of catharsis and healing felt by other group members (Anderson, 1995).

Revealing Unconscious Materials

The third therapeutic factor of claywork that Sholt and Gavron (2006) identified is that claywork facilitates revealing unconscious materials. Sholt and Gavron (2006) state that "clay-work could function as a central window to... unconscious, nonverbal representations and may be especially helpful with people who find it hard to express themselves verbally or who are very defensive" (p. 70). This literature review has already explored how these nonverbal representations can be expressed through the physicality and tactility of the clay, as well as the way group therapy can help encourage more open communication of emotions that are difficult to express. The unconscious expressions made through the clay "can evoke direct expression that is not filtered through the client's mind" (Sholt & Gavron, 2006, p. 70). This means that expressions and emotions that might otherwise be filtered by the client, whether conscious or unconscious, can be revealed through the use of clay. When working with memories that occurred in childhood, the primitive or primary modes of communication are sometimes more accessible than modes of communication that may have been learned or refined after the initial trauma (Tripp, 2007). Using these modes of communication may allow the client to access memories that are either not normally accessed or that have never been revisited (Tripp, 2007). The clay's ability to bypass an individual's intellect and evoke direct expression was demonstrated in Anderson's 1995 study when a participant stated that "clay in the hands is the window into one's soul" (p. 422). These opportunities of re-awakening and re-discovery can help survivors of childhood sexual trauma to examine their experiences in a safe environment, to work through conscious and unconscious emotions, and to encourage healing through self-knowing and self-acceptance (Haynes, 2015). A participant in the Haynes (2015) study

"described that the working with her hands put her 'into deeper thought' " and allowed them to revisit memories with details that had not been noticed" (p. 55).

Facilitating Rich and Deep Expressions

The fourth therapeutic factor of claywork that Sholt and Gavron (2006) identified is that claywork facilitates rich and deep expressions. The physical malleability of the clay, and the way it encourages nonverbal expressions, as well as, the way it uses the whole body, encourages the client to “feel” their emotions before “saying” or “reacting” to their emotions. Sholt and Gavron (2006) point out that “the many opportunities of modeling in clay furnish countless ways in which anger can be expressed or ventilated, such as scratching, clasping, stabbing, throwing, smashing, and so on” (p. 70). The client can feel open to expressing emotions in their natural form, without feeling pressured to verbalize or rationalize them immediately (Tripp, 2007). The process of working with clay invites expression of emotion even before a complete art product is made (Sholt & Gavron, 2006). It encourages the sincere expression of emotion without the added pressure of having to verbally communicate these emotions. Sholt and Gavron (2006) state, "these emotional expressions are made through the most primal and procedural mode of communication, through tactile contact and on a somatic level. Hence there is a greater likelihood that they will be authentic with regard to affect" (p. 67).

Though many art therapy materials offer the possibility of this emotional expression, clay is especially effective in containing the strong emotions that trauma survivors often express during therapy because “clay as a material resists some of [the client’s] manipulations and is not easily breakable or ruined or destroyed in its plastic state (unlike painting), the client can engage in these aggressive actions without fear of negative outcomes to the material” (Sholt & Gavron,

2006, p. 70). The malleability and robustness of the clay and the way that it readily accepts the emotions of the client and encourages physicality encourages the client to work through emotions during the process of working with the clay, as well as identifying and communicating emotions that arise from the finished clay product.

It is not only the making of the art or only the communication about the art that is beneficial to the client's therapy. Rather, these processes blend with and build upon the client's inner language, and can be used to uncover sources of discord or reasons for thinking or feeling that may otherwise be difficult to express (Sholt & Gavron, 2006). It is especially helpful to build bridges between a client's inner and outer world when working with childhood trauma because the trauma happened when the client's verbal communication skills, and understanding of the world, were in the early stages of development (Tripp, 2007). Adult survivors of CSA may find it difficult to relate to, understand, or communicate the feelings that their childhood-self experienced (Shapiro, 2002). Though these feelings can be hard to verbalize, they affect the client deeply and, therefore, need to be expressed to be understood (Devlin et al., 2019).

By incorporating both art product and process into the therapy model, the therapist allows the client to blend their developed “adult” thinking, which may be more rooted in rational and verbal processes, with their “child” thinking, which may be more rooted in emotional and nonverbal processes (Devlin et al., 2019). When patients brought their clay products to their therapeutic sessions, the presence of these symbolic figures often facilitated the patients’ verbal associations: ‘Thus verbal communication often became easier and the patients’ possibility of emotional experience and insight increased in the therapy-situation” (Jorstad, 1965; Sholt & Gavron, 2006, p. 70). This process blends the client’s initial, often unprocessed or nonverbal,

perspective of the situation with their post-processing perspective and facilitates a greater understanding that can lead to healing. This incorporation can also lead to an increase in and improvement of verbal communication (Devlin et al., 2019).

Facilitating Verbal Communication

The fifth therapeutic factor of claywork that Sholt and Gavron (2006) identified is the way that claywork facilitates verbal communication. When CSA occurs, it is a child's brain that processes the trauma.

> ...memories contain the perceptions that were encoded at the time of the event-- images, thoughts and sounds, emotions, physical sensations, and the metaperceptions or self beliefs may be encoded with fundamentally unaltered childhood perceptions, regardless of the current age of the client (Shapiro, 2002, p. 10).

A child's brain and worldview are not fully developed and the child has not yet developed the comprehension or communication skills to accurately and understandably express the trauma (Tripp, 2007). Therefore, the child is often not able to fully process the trauma when it occurs, nor are they able to store the trauma memories in a way that is clear to an adult brain (Shapiro, 2002). Often, these memories can be felt emotionally, or even physically, but not expressed verbally (Devlin et al., 2019). The trauma memories are filed in the brain in a way that makes sense to the victim's brain at the time of the trauma (Shapiro, 2002). "Finding a therapeutic style where adolescent clients can express themselves by other mediums when emotions and words fail is crucial to true recovery" (Devlin et al, 2019, p. 361).

For healing to occur, the survivor of the trauma needs to re-process these trauma memories in a way that enables the client to understand the experience from the perspective of a

post-trauma survivor rather than as someone currently experiencing the trauma. A participant in Anderson's (1995) study emphasized that the reason it was "so much easier in the art therapy group to talk and to connect than in the verbal therapy group that she attended" was because of the clay (p. 424). By using this method of nonverbal expression, claywork naturally encourages a much broader range of communication possibilities. Being able to talk about an experience is one of the easiest ways to effectively communicate it both internally and externally and, therefore, effectively work through the trauma of the experience. When experience can be communicated, whether verbally or nonverbally, it can be "made real," therefore, validating the experience of the holder while giving them the option to understand and treat the effects of the experience.

Concretization and Symbolization

The final therapeutic factor of claywork that Sholt and Gavron (2006) identified is the way claywork facilitates concretization and symbolization. "'Concretization' refers to "the process in which thoughts, feelings, fantasies, and conflicts are embodied in concrete objects," and 'symbolization' refers to the way these concrete objects can then become symbols for things that are not easily expressed verbally (Sholt & Gavron, 2006, p. 70).

Verbal communication is the easiest way to concretize an experience, emotion, or memory because it allows the client to communicate and describe what is happening in their minds and bodies in a way that the therapist and support group can understand. However, as this thesis has explored, CSA can damage a client's ability to effectively use verbal communication about their traumatic childhood experiences (Tripp, 2007). When concretization is unable to

occur through verbal means, because the client cannot or will not verbalize their feelings, nonverbal communication and symbolization are beneficial.

Expressive and nonverbal communication is especially useful when working with clients whose trauma occurred in childhood. A participant in Anderson's (1995) study stated "the clay was what made things real and concrete, and it was the claywork done as a part of the art therapy group that made it easier to deal with the incest issue" (p. 424). Anderson (1995) observed that claywork empowered the clients to communicate nonverbally, and that claywork could "contain the client outrage, make what happened to the clients real, and yet provide some psychic distance at the same time" (p. 416). The clay offers a malleable material that can be physically controlled and manipulated by the client to symbolically mold a reality that can be managed and understood by the psyche. Sholt and Gavron (2006) found that

> since through claywork one can make real-like things, clay sculptures can also function as symbolic play objects, and thus afford a much wider potential space for manifestations of fantasy and the inner world, such as fears, anxieties, wishes, and so on (p. 68).

Being able to communicate this inner world encourages the integration of a person's emotions, experiences, and affect. This integration is one of the primary goals of Anderson's (1995) study as it is fundamental to healing from CSA. In Anderson's (1995) study the participants' experiences of sexual abuse were concretized, sometimes for the first time, when they created clay symbols of their perpetrators (p. 420). One of the goals of Anderson's (1995) study was "to address [and/or] confront perpetrators symbolically" (p.p. 416-417). Creating a three-dimensional form required the participant to "confront" the sexual abuse they had experienced and the image of the offender. Since many individuals struggle with self-doubt and

lingering questions about their memories, the creation of clay symbols gives them a tangible form that is easier to see, feel, and experience in their outer world. The clay also provides enough psychic distance from the offender that the participant can think of the offender without being confronted by their image directly. The participants in Anderson's 1995 study could tangibly witness in the others' clay symbols "a community of survivors" (p. 420). A group therapy dynamic provides a positive environment for healing, as it reminds the client that they are not alone and that others have had similar experiences (Anderson, 1995).

This process concretized participants' experiences while also providing an opportunity for catharsis: most participants had smashed the clay figures within six months of completing the art therapy group. For future groups, participants were provided with a safe space to smash their figures with a rubber mallet. This allowed for more discussion on the experience of smashing and observing (Anderson, 1995). A participant was able to concretize their dissociation symptoms when they created an image of their memory immediately after being sexually abused (Anderson, 1995). The participant depicts "her father standing in front of her as she lies on her bed. She just vomited and the puddle is in the lower left. She "watches" from outside her window" (Anderson, 1995, p. 423). By first using the clay to symbolize this experience, she was able to verbally communicate the memory from the safe distance of describing her claywork. This extra layer of symbolization and concretization encouraged deeper, more meaningful therapy.

Discussion

This literature review has explored the populations affected by CSA and the many ways in which CSA impacts an individual throughout their life. Despite the research indicating that CSA is a widespread problem that affects many different populations, some populations have received very little attention in research. Studies that use the claywork modality in treatment with survivors of CSA are sparse. Claywork is incorporated in art therapy practices treating survivors but is used sparingly and with many other modalities, making it difficult to directly evaluate the impact of the claywork. Anderson's (1995) review of the literature identified 18 studies on art therapy and incest survivors. These 18 reports are already limited in scope because the research was conducted with a narrow survivor population of only adult female participants (Anderson, 1995). Of these 18 studies, only two were identified that exclusively used claywork in treatment with survivors of CSA. The larger study of 5 adult female survivors of incest perpetrated by a father (Anderson, 1995). The only other study exclusively using claywork in the treatment of CSA was conducted as a graduate thesis in 2015 by Haynes and included only three adult women who had been sex trafficked. The Anderson (1995) and Sholt & Gavron (2006) studies indicated numerous benefits to using claywork with survivors of CSA. However, their small size and narrow population demographics limit their usefulness, as they cannot demonstrate claywork effectiveness beyond that of the populations and dynamics directly involved in the research. The lack of research into different populations of survivors and different dynamics between survivor and offenders suggests a need for further and more varied research.

Conclusion

In synthesizing the scant literature available, claywork appears to be an effective potential treatment modality for treating the symptoms of CSA and childhood sexual trauma, and when combined with other traditional therapies it appears particularly suited to help this population of clients due to the six therapeutic factors of claywork identified by Sholt & Gavron (2006). Research shows that art therapy can be more effective for survivors of CSA than traditional verbal therapy because it can help survivors express their emotions more clearly and effectively. The research connecting the benefits of the use of claywork to positive treatment results for those impacted by CSA suggests a correlation supporting claywork as an effective treatment method. When combined with the positive social support and the individual impact that comes from group therapy, claywork showed a marked difference in individuals' sense of self and positive communications.

To clarify differential findings and dismiss any ambiguity, this literature review disambiguates terms to identify those impacted by sexual trauma that aim to empower, rather than re-victimize. It also clarified the definition of CSA and who can be affected by it and defined "childhood" precisely in legal terms. This clarification of terms is in response to research showing that the terms used when discussing CSA can greatly affect the way survivors are treated, and the level of empowerment they feel over their own life. In carefully adhering to person-centered, unambiguous terms in research and discussion, researchers and practitioners can facilitate more positive outcomes for survivors of CSA.

This review and other research to follow will contribute to the knowledge of claywork as an effective treatment modality for CSA and childhood sexual trauma. Many untapped

opportunities for investigation exist; the lack of diversity in the populations being researched, the small size of the claywork-specific studies, and the challenges of gathering research from a vulnerable population suggest that there is much more opportunity for research into both the claywork modality and treatment of CSA as a whole. More academic attention also needs to be paid to addressing the stigma faced by different populations when reporting, and the terms used need to be more firmly empowering to survivors of CSA. The historical approach to CSA treatment as a monolith, despite research showing that the populations, dynamics, and symptomatology can vary greatly between individuals, provides many opportunities for further clarification and research into CSA and its possible treatments.

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