Group Sandtray Therapy with Adult Survivors of Childhood Sexual Assault: A Single-case Research Design

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GROUP SANDTRAY THERAPY WITH ADULT SURVIVORS OF CHILDHOOD SEXUAL
ASSAULT: A SINGLE-CASE RESEARCH DESIGN

A Dissertation
presented in partial fulfillment of requirements
for the degree of Doctorate of Philosophy
in the Department of Counselor Education and Supervision
The University of Mississippi

by
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May 2021
Childhood sexual assault (CSA) is a growing problem in our society. A child who experiences a sexual assault not only deals with the immediate trauma surrounding this event, but also the aftermath of this event as they progress into adulthood. Trauma and sexual trauma is an umbrella term that incorporates all of the various implications of experiencing a negative event. In the instance of trauma, neurobiological implications have been well researched and established. This knowledge highlights the need for counseling techniques to be developed and studied that target those who have experienced CSA. The aim of this single-case research design study was to observe the relationship between group sandtray therapy in increasing the global well being of adult survivors of childhood sexual assault. The results showing a moderate effect size are discussed as well as ways to further this area of research.

Keywords: childhood sexual assault, group sandtray therapy, single-case research
DEDICATION

This work is dedicated to my past, present, and future clients. Thank you for teaching me what it means to be brave enough to face fears and choose growth.
ACKNOWLEDGMENTS

I would like to thank Dr. Richard S. Balkin for being my chair and mentor during the dissertation process and doctoral program. Your confidence in me helped me overcome my own anxieties and achieve goals I never thought were possible. I would also like to thank my other committee members Dr. Juawice McCormick, Dr. Alexandria Kerwin, Dr. Amanda Winburn, and Dr. Franc Hudspeth for your support, encouragement, and feedback. To Drew and to my family, thank you for not letting me quit on the toughest days and reminding me that I am enough. Penny, thank you for giving me the final drive to finish this degree. I hope you know you can accomplish your dreams.
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PART I
INTRODUCTION

Childhood sexual assault (CSA) is an ongoing problem in society. CSA can cause long lasting issues on the mental, developmental, emotional, and biological health of survivors (Chapman et al., 2004; Johnston, 1997; Leonard & Follette, 2002; Mazza, 2007). The neurobiological impact of trauma is well established (Anda et al., 2006; Chapman et al., 2004; Delima & Vimpani, 2011; Green & Myrick, 2014; Olson-Morrison, 2017; Streeck-Fischer & van der Kolk, 2000; van der Kolk, 2014). Psychopathology as a result of CSA has also been studied (Chapman et al., 2004; Johnston, 1997; Leonard & Follette, 2002; Mazza, 2007). An increasing need for survivors is to develop treatments that not only target the emotional aspect of trauma but the biological implications as well.

Prevalence rates of childhood sexual assault vary. The Rape, Abuse, & Incest National Network (RAINN) reported "one in 9 girls and one in 53 boys under the age of 18 experience sexual abuse or assault at the hands of an adult” (2019, para. 6). The National Center for Victims of Crime (2019) reported “one in 5 girls and one in 20 boys is a victim of child sexual abuse” (para. 2). The Children’s Bureau of the U.S. Department of Health and Human Services (2018) indicated that 58,114 reports of sexual abuse were made to Child Protective Services in the United States in the 2017 fiscal year. There are several reasons as to the differing statistics related to the prevalence of childhood sexual assault. Childhood sexual assault is not always
reported due to survivors fearing the consequences of disclosing these instances of abuse. Additionally, organizations such as the National Center for Victims of Crime reports only instances for individuals over the age of twelve. While there is no consensus to the specific statistics related to childhood sexual assault, these varying sources demonstrate that childhood sexual assault is a widespread problem in the United States.

RAINN (2019) reported lasting problems related to childhood sexual assault saying survivors are “about 4 times more likely to develop symptoms of drug abuse, about 4 times more likely to experience PTSD as adults, and about 3 times more likely to experience a major depressive episode as adults” (para. 8). As there are lasting consequences to childhood sexual assault, interventions to address these problems are needed for the growing amount of adults who have experienced CSA.

One potential intervention to address CSA is sandtray therapy. Sandtray therapy is a separate intervention from Kalff’s Jungian-based sandplay therapy that focuses on the experience and direction of the client (Homeyer & Sweeney, 2017; Kalff, 2003; Lowenfeld, 1999). Sandtray therapy provides a tactile way to process a variety of experiences in counseling (Homeyer & Sweeney, 2017). Adults can specifically benefit from this intervention (Lowenfeld, 1999) as trauma impacts the portion of the brain that is responsible for speech and language (Homeyer & Sweeney, 2017; van der Kolk, 2014). Sandtray therapy is an approach that does not rely on the ability for the client to communicate in words and provides an experiential and sensory element to the counseling process. Developing and communicating a trauma narrative is a threatening and difficult task (Homeyer & Sweeney, 2017; Olson-Morrison, 2017). Sandtray therapy provides a space that is free from pressure to explain because of its lack of emphasis on interpretation (Homeyer & Sweeney, 2017; Olson-Morrison, 2017). Kirk (2007) stated there is a “power of
play to activate the self-healing mechanism of the psyche” (p. 39). This power in the process of play is an overlooked resource that holds a large amount of potential in providing adequate services to a growing population. Due to these valuable contributions that sensory inclusive counseling modalities such as sandtray and sandplay can have on children, the research community should continue to gain knowledge in this intervention with adult survivors of childhood sexual assault. The purpose of the present study is to observe to what degree group sandtray therapy is an effective intervention for increasing the global well-being for adult survivors of childhood sexual assault? Existing research is limited on sandtray therapy, and existing research is even more limited on group sandtray therapy. Group sandtray therapy combines elements of traditional group therapy with the expressive and sensory elements of sandtray therapy. According to Homeyer and Sweeney (2017), sandtray therapy is effective when combined with other theories making group sandtray therapy an appropriate treatment modality for this population. Adult participants in group sandtray therapy can learn from other group members in the group sandtray therapy sessions.

Statement of the Problem

Existing research shows sandtray therapy to be an effective intervention in working with children, yet there is no existing quantitative research studying sandtray therapy with adults. Furthermore, there is little to no quantitative research studying group sandtray therapy with adults. This study addresses the gap in the literature to better understand the potential effectiveness of group sandtray therapy as an intervention for increasing the global well-being for adult survivors of childhood sexual assault.

Purpose of the Study
The purpose of this quantitative single case research study is to observe to what degree is group sandtray therapy an effective intervention for increasing the global well-being for adult survivors of childhood sexual assault? By gaining a better understanding of the effectiveness of sandtray therapy as a therapeutic modality for treating adult clients who experienced sexual assault in childhood using a single case method tracking individual progress, counselors will better understand the contributions of group sandtray therapy. Counselors will also have quantitative research related to a growing therapeutic modality. Counseling researchers who want to continue to study group sandtray therapy will have an example of a study that could be replicated or adapted in their own future research.

**Significance of the Study**

Adult survivors of CSA can continue to experience the impact of trauma long after it has occurred. Results from previous research indicate neurobiological and somatic symptoms persisting into adulthood as a result of childhood trauma. In order to address these neurobiological, somatic symptoms, and other ongoing consequences of childhood sexual assault, sensory inclusive counseling modalities such as sandtray therapy have been used by counselors. The results from this study can provide a better understanding for continued use of sandtray therapy in treating adult survivors of CSA in a group setting.

As there is a lack of empirical research related to the growing therapeutic modality of group sandtray therapy, a benefit of this study is that more needed information will be available. Counselors can better understand the effectiveness of group sandtray therapy. Counselors who are already trained and utilizing sandtray therapy with children can use the results from this
study to expand this modality to use with adult clients who have experienced CSA. Counselors can also expand their knowledge to using sandtray therapy in group settings.

Existing research on sand therapeutic modalities is primarily focused on Dora Kalff’s Jungian based sandplay therapy, but there is little to no quantitative research on contemporary sandtray therapy. Despite this lack of empirical knowledge in working with adult clients, sandtray therapy continues to grow in popularity among counselors. The quantitative design and emphasis on contemporary sandtray therapy provide a new contribution to the literature and knowledge of this topic. Additionally, the results from this study can further expand on the knowledge of group sandtray therapy in treating adults. An increase in research further advocates for counselors who are interested in utilizing expressive arts therapies such as group sandtray therapy.

**Research Question**

The following research questions were derived from a thorough literature review:

To what degree is group sandtray therapy an effective intervention for increasing the global well-being for adult survivors of childhood sexual assault? To what degree is group sandtray therapy an effective intervention for decreasing symptom distress? To what degree is group sandtray therapy an effective intervention for decreasing problems in interpersonal relations? To what degree is group sandtray therapy an effective intervention for decreasing difficulties in social role?

While group sandtray therapy as a modality in counseling has increased in popularity, there is not an adequate number of participants to utilize statistical methods that require large amounts of participants. Using quantitative designs that necessitate large amounts of participants in order to make the study generalizable would be impossible. However, minimal participants are
needed to continue to have robust results in a single-case research design (Lenz, 2015; Ray, 2015; Vannest, 2011). In order to have significant results, at least three participants are needed in a sample size (Lenz, 2015; Ray, 2015; Vannest, 2011). Additionally, single-case research design is an ideal method for this study because of the desire of the researcher to better understand group sandtray therapy. In studies that use a single-case research design, an emphasis is on the relationship between an independent variable and a dependent variable. In this case, group sandtray therapy is the independent variable being studied to see the relationship it has on the overall wellness among adult survivors of childhood sexual assault. The participants in this study as in all single-case research designs will serve as their own controls even though they will participate in group sessions with other members. This increases the robustness of the study in that changes are observed closely in each individual (Lenz, 2015; Ray, 2015; Vannest, 2011).

Assumptions

The investigation is based on the following assumptions:

1. The participants receiving counseling responded to the measures honestly and to the best of their ability.
2. Data was collected responsibly and analyzed accurately.

Delimitations

The following delimitations are imposed on this study:

1. The participants receiving sandtray therapy counseling are delimited to individuals over the age of 18 who experienced at least one sexual assault prior to age 18.

Definition of Terms

Childhood Sexual Assault (CSA): “Child sexual abuse is a form of child abuse that includes sexual activity with a minor. A child cannot consent to any form of sexual activity,
period. When a perpetrator engages with a child this way, they are committing a crime that can have lasting effects on the victim for years. Child sexual abuse does not need to include physical contact between a perpetrator and a child. Some forms of child sexual abuse include exhibitionism, or exposing oneself to a minor; fondling; intercourse; 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; sex trafficking; any other sexual conduct that is harmful to a child’s mental, emotional, or physical welfare.” (RAINN, 2019, para. 2)

Group Sandtray Therapy: a method used in therapy combining theoretical frameworks of group therapy and sandray therapy

Miniatures: toys or objects used in sandtray therapy used to create scenes in the sandtrays; objects or figurines used to represent or recreate experiences in a client’s life

Sandplay Therapy: a method used “in therapy both with children and with adults in order to gain access to the contents of the unconscious. As the name suggests, it consists in playing in a specially proportioned sandbox (approximately 19.5 x 28.5 x 2.75 inches; floor and sides painted with water-resistant bright-blue paint). Boxes of dry and moist sand are provided. Clients also have at their disposal a number of small figures with which they give formal realization to their internal worlds. The figures from which they can choose should represent as complete as possible a cross-section of all inanimate and animate beings which we encounter in the external world as well as in the inner imaginative world: trees, plants, stones, marbles, mosaics, wild and domesticated animals, ordinary women and men pursuing various activities, soldiers, fairytale...
figures, religious figures from diverse cultural spheres, houses, fountains, bridges, ships, vehicles, etc.” (Kalff, 1991, para. 9)

Sandtray Therapy: "an expressive and projective mode of psychotherapy involving the unfolding and processing of intra- and interpersonal issues through the use of specific sandtray materials as a nonverbal medium of communication, led by the client(s) and facilitated by a trained therapist" (Homeyer & Sweeney, 1998, p. 6).

Sexual Assault: “The term sexual assault refers to sexual contact or behavior that occurs without explicit consent of the victim. Some forms of sexual assault include attempted rape; fondling or unwanted sexual touching; forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator’s body; penetration of the victim’s body, also known as rape.” (RAINN, 2019, para. 2)
PART 2
A REVIEW OF THE LITERATURE

Sexual assault is prevalent in society. More reports of sexual assault continue to emerge, and still it is believed that abuse is underreported (Green, 2008). Children are among the most vulnerable population to be violated. Due to this increasing problem, there exists an even greater need to treat those who have been victimized, and an increase in services needs to be a priority (Johnston, 1997). Those who are sexually assaulted as children continue to experience residual problems into their adulthood (Chapman et al., 2004; Johnston, 1997; Leonard & Follette, 2002; Mazza, 2007). As there continues to be significant research pointing towards the long-lasting implications of sexual assault in childhood, there also needs to be evidence-based treatments and resources available to address these long-lasting implications. Tactile and sensory therapeutic interventions are beneficial in working with childhood sexual assault survivors (Balfour, 2008; Cockle, 1993; Doyle & Magor-Blatch, 2017; Green, 2008; Homeyer & Sweeney, 2017; Isom, Groves-Radomsk, & McConaha, 2015; Johnston, 1997; Mazza, 2007; Olson-Morrison, 2017; Riviere, 2008; Troudart, 2017). A specific tactile and sensory intervention identified as promising with children is sandtray therapy (Homeyer & Sweeney, 2017). This specific method has been observed in working with children, but there is a lack of observations in working with adults. There is also value in understanding the contributions it can make to adult survivors of childhood sexual assault.
Childhood Sexual Assault

Childhood sexual assault (CSA) is a large concern in the United States. Among experts, there are differing definitions of sexual assault as well as varying reports in the specific numbers related to the frequency of CSA (Chapman et al., 2004; Edwards, Holden, Feletti, & Anda, 2003; Green, 2008; Leonard & Follette, 2002; Paolucci, Genius, & Violato, 2001). Some consider sexual assault to only include the instances in which penetration or sexual intercourse occurred (Paolucci et al., 2001). Others broaden this definition to include instances of inappropriate touching and witnessing a sexual act (Paolucci et al., 2001). RAINN reports "one in 9 girls and one in 53 boys under the age of 18 experience sexual abuse or assault at the hands of an adult" (2019, para. 6). The National Center for Victims of Crime (2019) reports “one in 5 girls and one in 20 boys is a victim of child sexual abuse” (para. 2). For the purposes of this review, sexual assault is considered to be any unwanted sexual contact (Paolucci et al., 2001; Rape, Abuse, and Incest National Network [RAINN], 2018).

The ongoing problems associated with individuals who are survivors of childhood sexual abuse have been researched at length. Specifically, Paolucci, Genius, & Violato (2001) found that post-traumatic stress disorder, depression, and suicidality increased between 20-21% for CSA survivors, noting that these problems are not only present in childhood, but they continue to exist in adolescence and adulthood.

With the awareness of CSA has come the observance of the various ways that CSA can have lasting influences into adulthood. Multiple researchers observe that there is an increased risk for depression (Chapman et al., 2004; Johnston, 1997), anxiety (Johnston, 1997), post-traumatic stress disorder (Leonard & Follette, 2002), and sexual dysfunction (Leonard & Follette, 2002). In addition to these there is also an increase of feelings of guilt (Johnston, 1997),
shame (Mazza, 2007), anger or rage (Johnston, 1997; Leonard & Follette, 2002; Mazza, 2007), fear or terror (Johnston, 1997; Mazza, 2007). Researchers also recognized individuals feeling responsible for the assault (Johnston, 1997) and having thoughts of being betrayed by those he or she trusted (Mazza, 2007). In addition, researchers found that CSA contributes to social issues and relationships. Increased levels of intimate partner, dating, and interpersonal violence are present in those who have experienced CSA (Campbell, Greeson, Bybee, & Raja, 2008; Daigneault, Hebert, & McDuff, 2009; Loh & Gidycz, 2006; McGuigan & Middlemiss, 2005). Difficulties in emotion regulation and interpersonal functioning contribute to survivors of CSA social wellness (Cloitre, Koenen, Cohen, & Han, 2002). Understanding the lasting influences of CSA has been the focus of much research does not extend solely to emotional and social implications that occur in an individual but also biological changes that are a result of CSA (Beach et al., 2013; van der Kolk, 2014). Delima and Vimpani (2011) found that child sexual abuse is among one of two most significant causes of Post-Traumatic Stress Disorder as well as structural brain changes. Neurobiological and developmental functioning were highlighted in other studies to view significant changes among survivors of CSA (Anda et al., 2006; Chapman et al., 2004; Delima & Vimpani, 2011; Green & Myrick, 2014; Olson-Morrison, 2017; Streeck-Fischer & van der Kolk, 2000; van der Kolk, 2014).

**Neurobiological Implications of Trauma**

van der Kolk (2014) found trauma treatments being most successful when treating the brain in the order that it develops: from the bottom-up. van der Kolk explained that before the higher level functioning of speech and language can be targeted by treatments, there is a need to first address the lower functions in our body. These lower functions would include somatic symptoms and reactions within the body itself.
This bottom-up treatment approach stems from development of the brain (van der Kolk, 2014). van der Kolk (2014) outlined brain development in five stages. The first stage discussed is the portion of the brain that begins to develop first and is responsible for driving basic human needs, including eating, sleeping, waking, crying, breathing, and touching. This specific part is known as the primitive, reptilian, or animal brain. The next area of the brain is the limbic system or the mammalian brain and is the seat of our emotions. The limbic system is in charge of emotion, memory, and behavior. The rational brain develops after the limbic system and houses the fight, flight, or freeze response in our body (van der Kolk, 2014). In other words, the rational brain determines the body’s response to incoming stress or threat (van der Kolk, 2014). The next area of the brain that develops is the neocortex including the abstract and symbolic elements of the world (van der Kolk, 2014). An individual whose neocortex is growing is able to reason. Finally, the frontal lobes develop which hold the ability for language and speech.

Trauma can interfere with brain development and brain functioning (Anda et al., 2006; Delima & Vimpani, 2001; Green & Myrick, 2014; Stewart et al., 2016; Streeck-Fischer, 2000; Troudart, 2017; van der Kolk, 2014). Homeyer and Sweeney (2017), along with van der Kolk (2014), discussed the development of the brain to better understand how trauma can impact each of these specific areas. Certain parts of the brain may become deactivated or can be over-activated from working too much (van der Kolk, 2014). The limbic system, as discussed earlier as being the seat of emotions, is often influenced by trauma, and there is an increase of brain activity in this area (van der Kolk, 2014). In contrast, the Broca’s area of the brain, which lies in the frontal cortex and is credited with controlling speech is often deactivated as a result of trauma (Homeyer & Sweeney, 2017; van der Kolk, 2014). In addition to the structural components of the brain, chemicals within the brain can be impacted by repeated exposure to stress or trauma.
(Stewart et al., 2016). There are two distinct hemispheres in the brain: the left hemisphere and the right hemisphere (Homeyer & Sweeney, 2017; Troudart, 2017; van der Kolk, 2014). The left hemisphere is credited with being linear; whereas, the right hemisphere is the nonverbal, creative, and metaphorical portion. Reintegrate both hemispheres when addressing trauma may be necessary (Homeyer & Sweeney, 2017; Troudart, 2017; van der Kolk, 2014). Traditional therapeutic interventions only target the left hemisphere of the brain, whereas contemporary approaches to counseling incorporate the creative or metaphorical aspect of the right brain (Homeyer & Sweeney, 2017; van der Kolk, 2014). Talk therapy is another term for counseling, and this phrase emphasizes the role of speech and language that exists in counseling. Homeyer and Sweeney, as well as van der Kolk among other researchers, see value in following the lead of the brain in healing trauma. As more information is known about the brain and the physical components of trauma, a greater emphasis is needed to find interventions that incorporate this bottom up approach (Homeyer & Sweeney, 2017; van der Kolk, 2014).

**Sandplay and Sandtray Therapies**

Sandplay and sandtray therapies are expressive arts approaches to treating a variety of disorders. The history of sandplay and sandtray therapies is discussed as well as contemporary usages of interventions utilizing sand in therapy. Integrating contemporary sandtray therapy with other modalities has been shown to be successful in treatment (Homeyer & Sweeney, 2017). Combining group therapy with sandtray therapy is an example of this integrative approach. More details related to the histories of sandplay, sandtray, contemporary, integrative, and group sandtray therapy are further highlighted.

**History of Sandplay and Sandtray Therapies**
The use of sandtray in working with clients began with Margaret Lowenfeld in her work with children in 1929 (Cockle, 1993; Doyle & Magor-Blatch, 2017; Homeyer & Sweeney, 2017; Isom et al., 2015; Kirk, 2007; Lowenfeld, 1999; Sangganjanavanich & Magnuson, 2011). She observed that sand trays along with miniature figures and toys aided the child in communicating his or her inner world (Lowenfeld, 1999). This in turn aided understanding of the child’s inner world on the part of the counselor (Lowenfeld, 1999). Lowenfeld (1999) developed a specific technique known as the World Technique because of the emphasis on the child’s internal world.

From working with and learning from Lowenfeld, as well as Carl Jung, Dora Kalff adapted the use of sand trays and developed Jungian-based sandplay therapy. Kalff suggested that themes could shift as children progressed in therapy (Cockle, 1993; Doyle & Magor-Blatch, 2017; Homeyer & Sweeney, 2017; Isom et al., 2015; Kalff, 2003; Kirk, 2007; Sangganjanavanich & Magnuson, 2011). Sandplay therapy emphasizes a more projective nature and focuses on the unconscious in the client (Kalff, 2003). Kalff viewed sandplay as possessing symbolism from which the counselor can draw conclusions about the client (Kalff, 2003). Kirk (2007) explained Kalff’s view of the sand reflecting the projective nature of the mind when noting, “sandplay is a modality of psychotherapy that evokes the earth, yet it’s not of solid ground….sand shifts and changes shape, just as the content of our minds shift and change” (p. 40). Troudart (2017) spoke to the power of sandplay in that it provides “a gradual unfolding of the traumatic contents” of a client’s story (p. 52). Even though emphasis is placed heavily on interpretation, Green (2008) identified that Jungian-based interventions highlight creativity and also place importance on the strength of the therapeutic relationship. Clinicians must be trained in the specific techniques and interpretations in order to utilize Kalff’s Jungian-based sandplay therapy.
Kalff’s Jungian-based Sandplay Therapy

A significant amount of research was conducted in relation to Kalff’s Jungian-based sandplay therapy. Numerous studies provide evidence for Kalff’s Jungian-based sandplay therapy with individuals who are survivors of CSA (Balfour, 2008; Doyle & Magor-Blatch, 2017; Riviere, 2008; Troudart, 2017). Practitioners of Kalff’s sandplay therapy wrote case studies of clients outlining this technique. Specifically, Troudart (2017) described a client in one case study being unable to use words yet utilizing sandplay therapy. Kirk (2007), another practitioner of Kalff’s sandplay therapy, highlighted the value of this modality in saying “the conscious and the unconscious are bridged through sandplay” (p. 39).

Contemporary Sandtray Therapy and Integrated Models

In addition to Kalff’s Jungian-based sandplay therapy, contemporary sandtray therapy is an extension of Lowenfeld’s World technique (Homeyer & Sweeney, 2017). Sandtray is unlike sandplay in that there is not an emphasis on interpretation (Homeyer & Sweeney, 2017; Isom et al., 2015). The counselor’s role is seen as an observer and someone who is accompanying the client on a journey (Homeyer & Sweeney, 2017; Isom et al., 2015). There is a specific reason why sandtray counselors refrain from making interpretations (Homeyer & Sweeney, 2017; Isom et al., 2015). Counselors could impose their own values and goals in interpreting on the behalf of the client (Homeyer & Sweeney, 2017; Isom et al., 2015). This could overshadow the needs of the client and what the client is attempting to communicate (Homeyer & Sweeney, 2017; Isom et al., 2015). Even though sandtray therapy refrains from focusing on interpretation there is still a responsibility for counselors to receive official training in utilizing these techniques as to protect the client (Homeyer & Sweeney, 2017; Isom et al., 2015).
Contemporary sandtray is not linked to one specific theoretical framework, but sandtray was adapted to use within the context of other traditional counseling theories (Homeyer & Sweeney, 2017). This is further described by sandtray counselors such as Homeyer and Sweeney (2017), as they use an integrative model of sandtray. The focus is placed on the client and the client’s insights that come from utilizing the sand trays and the miniature figurines (Homeyer & Sweeney, 2017; Lowenfeld, 1999). Clients are given freedom to express their pasts, presents, and futures (Homeyer & Sweeney, 2017). This opportunity to engage with their own world empowers clients (Homeyer & Sweeney, 2017). The counselor engages with the clients as clients create their scene in the sand (Homeyer & Sweeney, 2017; Lowenfeld, 1999). The counselor pays attention to the details that occur within the tray and within the client as the scene is being built (Homeyer & Sweeney, 2017; Lowenfeld, 1999). The counselor with the permission of the client can ask questions and facilitate processing of the experience in building the scene (Homeyer & Sweeney, 2017).

**Group Sandtray Therapy**

Sangganjanavanich and Magnuson (2011) and Homeyer and Sweeney (2017) noted that the use of sand tray is often integrated with other approaches. One example of integrating sandtray with other approaches is group sandtray therapy. Group therapy has long been a modality of therapy in a variety of settings. Group therapy is useful in providing resources to more people at one time making it a cost effective and practical solution to barriers of treatment. Group therapy has been well researched, and there are various adaptations of group therapy with multiple psychotherapy theories. Homeyer and Sweeney (2017) provide further evidence for the benefits of combining sandtray therapy with group therapy. Homeyer and Sweeney (2017) note that group participants can encourage each other to participate, can learn from one another, can
provide and receive feedback from others besides the counselor, and can feel less isolated in treatment.

This review focuses on the specific use of integrative sandtray therapy as described by Homeyer and Sweeney (2017), which preserves the techniques developed by Margaret Lowenfeld (1999) combined with the components of a traditional group therapy framework in that one or more counselor provides treatment to several clients at one time (Corey, 2009; Yalom, 2005). In this approach, as described by both Homeyer and Sweeney (2017), a variety of tray and sand types are used. Sangganjanavanich and Magnuson (2011) explained how the miniature figures can have different meanings for each client. This can produce a language and a meaning between client, other group participants, and counselor that assists in greater communication (Homeyer & Sweeney, 2017). The group format will provide an opportunity for participants to interact not only with the counselor or group facilitator but also with one another allowing the group itself to serve as a mechanism for growth and development (Corey, 2009; Homeyer & Sweeney, 2017; Yalom, 2005).

**Sandtray Therapy with Adult Clients**

As previously described, neurobiology established the need for interventions that do not rely solely on language for communication in all ages of those who have experienced trauma. In the study of sandtray therapy, usually the focus has been using this with children. In the literature related to the history of sandtray therapy Lowenfeld (1999) recognized that sandtray “has proved as valuable in psychotherapeutic work with adults as with children and is welcomed by adult patients as an aid to their understanding of themselves and to communication with their therapist (p. 5). However, there is not as much literature and research for sandtray therapy with adults who have experienced trauma. Lowenfeld (1999) noted that play can benefit a child and recognizes it
as a form of communication. This seems to be a natural aspect of counseling children due to developmental knowledge (Lowenfeld, 1999). However, sandtray therapy, because of its adaptive properties, may be beneficial for the treatment of adults (Sangganjanavanich & Magnuson, 2011). Johnston (1997) emphasized the differences in children and adult communication in saying, “The world of a child is vastly different from that of an adult. An adult’s world is often filled with abstract, theoretical, intangible realities which are easily understood from the adult’s verbal perspective” (p. 102). As detailed earlier, the brain of a traumatized individual no matter the age can experience neurobiological changes that directly inhibit speech and language (Homeyer & Sweeney, 2017; van der Kolk, 2014). Due to the fact that this ability is inhibited adults who have experienced trauma will function in a more childlike or primitive way (Homeyer & Sweeney, 2017). Therefore, as sandtray therapy has provided a greater ability to communicate for children it can also aid an adult who is struggling to create a trauma narrative.

Streeck-Fischer and van der Kolk (2000) identified the benefits of early intervention for children who experienced trauma. However, there are many children who are unable to receive treatment immediately following the traumatic event, especially if it is recurring. This can be for multiple reasons including socioeconomic reasons, lack of resources in the area, or nondisclosure of the event on the part of the child. These reasons along with others contribute to a large population of adults who experienced abuse as a child but never received treatment.

**Sandtray Therapy with Adult Survivors of Childhood Sexual Assault**

The cognitive, social, and physical aspects of an individual can be directly affected by trauma (Steeck-Fischer & van der Kolk, 2000). Therefore, interventions designed to address a combination of these areas could be helpful. Gazza (2007) and Homeyer and Sweeney (2017)
acknowledged that trauma is an experience that the body feels. As evidenced by the work of many researchers, neuroscience continues to establish a need for utilizing treatments that can target trauma from a bottom-up approach (Olson-Morrison, 2017; van der Kolk, 2014). Specifically, Olson-Morrison (2017) noted that neuroscience shows the benefit in using play and expressive techniques to merge this mind and body connection. For this reason, sandtray therapy could be an appropriate intervention in working with survivors of CSA. Sandtray therapy could provide clients with a safe space in which to express trauma (Cockle, 1993; Doyle & Magor-Blatch, 2017; Isom et al., 2015; Olson-Morrison, 2017; Troudart, 2017).

Individuals who have experienced CSA may find it difficult to talk about what happened or to create a narrative of the events (Homeyer & Sweeney, 2017; Stewart, Field, & Etcherling, 2016; van der Kolk, 2014). The Broca’s area of the brain, which controls speech and language, can be directly impacted as a result of trauma contributing to the difficulty to address the trauma through talk therapy alone (Homeyer & Sweeney, 2017; van der Kolk, 2014). Sandtray therapy can address this difficulty in communication as Streeck-Fischer and van der Kolk (2000) described how trauma victims “tend to communicate the nature of their traumatic past by repeating it in the form of interpersonal enactments: in their play and actions” (p. 905).

Individuals who have been exposed to chronic trauma have a lack of awareness about their inner world, as well as the external world (Streeck-Fischer & van der Kolk, 2000). An individual’s inner world relates to the thoughts, feelings, emotions one might have towards an event or of themselves. The external world relates to the world outside of the individual’s experiences. Sandtray therapy is rooted as described earlier in the desire for Lowenfeld to find a resource that would help child clients construct their inner world through means that do not rely on speech and
language. As traumatized adults’ speech and language can be impacted, sandtray therapy is a tool that could help bring about the awareness of both their inner world and their external world.

Trauma includes a sensory element (Homeyer & Sweeney, 2017; Mazza, 2007). Thus, Homeyer and Sweeney (2017) and Mazza (2007) identified that any intervention that is targeting trauma should include a tactile or sensory element. Sandtray therapy can provide this element. Homeyer and Sweeney (2017) explained that being forced to talk about trauma can often lead to re-traumatization. Therefore, sandtray therapy can provide a therapeutic approach to clients who have been traumatized in a non-threatening and relational way (Homeyer & Sweeney, 2017). Homeyer and Sweeney explained that the main goals of sandtray therapy are to provide a safe and relational space, return control to the clients, and help clients develop a sense of mastery.

Likewise, Olson-Morrison (2017) found in studying integrative play therapy with adults that this modality was specifically helpful in “repairing a sense of self, regulating sensory and emotional systems, and improving social awareness and social skills” (p. 174). Olson-Morrison (2017) highlighted the goals of this modality being safety, stabilization and affect regulation, and trauma processing. Integrative play therapy was beneficial in meeting each of these goals (Olson-Morrison, 2017). Expressive arts therapies, such as sandtray therapy, empower clients to take control and for the counselor to follow their lead (Homeyer & Sweeney, 2017; Olson-Morrison, 2017). Olson-Morrison (2017) emphasized the “adult client is allowed the freedom to choose” (p. 176). This return of freedom in a non-threatening and accepting environment ultimately creates a space where the adult client can have the resources to approach elements of his or her trauma. This space focuses on a non-directive style of communication in order to bring about healing and congruence within the client.
**Current Literature on Group Sandtray Therapy**

Existing research on group sandtray therapy is limited with the majority of the studies being descriptive or exploratory in nature (Homeyer & Sweeney, 2017). Swank and Lenes (2013) conducted an exploratory study of sandtray group experiences with adolescent females in an alternative school and found five themes being self-expression, development of insight, growth opportunities, hope, and group dynamics. Hughes (2004) in a dissertation study observed 14 adults between the ages of 30 and 65 after one, two-hour group sandtray therapy session and found evidence to suggest that the group experience led to shared experiences among the participants relating to culture. Another dissertation study focusing on adult clients in group sandtray therapy was completed by McCormick (2019). McCormick (2019) studied the impact of sandtray therapy on group climate and therapeutic factors in residential substance abuse treatment and found that the participants in the sandtray groups scored higher on the Group Climate Questionnaire-Short (GCQ-S) and the Therapeutic Factors Inventory-19 (TFI-19) than those in the cognitive-behavioral treatment groups.

Group sandtray therapy has also been researched in working with adolescents. Shen and Armstrong (2008) studied the impact of group sandtray therapy on the self-esteem of 37 young adolescent girls and found statistically significant differences in five of the six sub scales of the Self-Perception Profile for Children. Flahive and Ray (2007) studied the effectiveness of group sandtray therapy with 56 preadolescents with behavioral difficulties and found that those who received group sandtray therapy had statistically significant differences as rated by teachers but showed no statistically significant differences in self-reports.

While the existing research on group sandtray therapy provides promising results, there is still a need for more quantitative research studying adults engaging in group sandtray therapy.
Current Literature on Sandtray with Adult Clients

In studies focused on contemporary sandtray therapy being used with adults, the populations of adults vary. Adult sandtray therapy was used in short-term psychiatric facilities (Schadler & De Domenico, 2012), long-term psychiatric facilities (Schadler & De Domenico, 2012), and outpatient facilities used for treating diverse issues. One example of outpatient sandtray therapy treatment is using it in working with adults for career counseling (Sangganjanavanich & Magnuson, 2011). Within the counseling profession, sandtray therapy has been researched in relation to emerging counselors in the supervision process (Anekstein, Hoskins, Astramovich, Garner, & Terry, 2014; Perryman, Moss, & Anderson, 2016). There is research dedicated to studying the way sandtray therapy can be used as a counseling professional in development but also in self-care (Garrett, 2015).

In relation to research studying sandplay therapy being used with individuals who have experienced CSA, there are multiple articles that include case studies. Doyle and Magor-Blatch (2017) explained their experiences of using Kalff’s Jungian-based sandplay therapy with one adult survivor of CSA and found a reduction in depression symptoms and stress. They (Doyle & Magor-Blatch, 2017) found an increase in symptoms of post-traumatic stress disorder and anxiety symptoms. In addition, they (Doyle & Magor-Blatch, 2017) outlined four themes: inadequacy of word, externalizing issues, enormity of suffering, and feeling change (Doyle & Magor-Blatch, 2017). Riviere (2008) shared experiences in working with a 43-year-old woman who was sexually abused as a child by detailing ten pictures of sandplay sessions with this client to show the process of sandplay therapy. Balfour (2008) documented experience in utilizing Kalff’s Jungian-based sandplay therapy with a 36-year-old woman who was a survivor of CSA.
and found that the client was successful in recovering from depression and healing from her repressed experiences of abuse. Troudart (2017) documented working with a female client in her early twenties who was a survivor of CSA and found sandplay therapy to help the client “strengthen her ego” (p. 1) as well as target dissociations.

In each of these publications, the authors utilized Kalff’s Jungian-based sandplay therapy in working with these clients. Sandplay therapy possesses qualities that are beneficial, but sandtray therapy emphasizes the independence and self-direction of the client (Homeyer & Sweeney, 2017; Lowenfeld, 1999). This empowerment of the client and the lack of focus on the counselor makes sandtray therapy a modality that requires further study. Giving control to adult clients is a necessary step in healing (Homeyer & Sweeney, 2017; Olson-Morrison, 2017). At this time, there is a lack of research and writing related to using sandtray therapy with adult survivors of CSA.

**Conclusion**

Childhood sexual assault is an ongoing problem in our society. As evidenced by significant research, CSA can cause long lasting issues on the mental, developmental, emotional, and biological health of survivors (Chapman et al., 2004; Johnston, 1997; Leonard & Follette, 2002; Mazza, 2007). Adequate research was conducted to establish the neurobiological impact of trauma (Anda et al., 2006; Chapman et al., 2004; Delima & Vimpani, 2011; Green & Myrick, 2014; Olson-Morrison, 2017; Streeck-Fischer & van der Kolk, 2000; van der Kolk, 2014). Psychopathology as a result of CSA has also been studied (Chapman et al., 2004; Johnston, 1997; Leonard & Follette, 2002; Mazza, 2007). With an increase in the understanding of the factors that can be influenced by trauma, there is a need to develop treatments for survivors. Sandtray therapy is a separate intervention from Kalff’s Jungian-based sandplay therapy in that it
focuses on the experience and direction of the client (Homeyer & Sweeney, 2017; Lowenfeld, 1999). This empowerment of the client is essential in providing a safe, therapeutic environment where elements of the trauma can emerge and be confronted (Homeyer & Sweeney, 2017; Lowenfeld, 1999). Sandtray therapy is beneficial in activating physical sensations in the body (Homeyer & Sweeney, 2017). Adults can specifically benefit from this intervention (Lowenfeld, 1999) as trauma impacts the portion of the brain that is responsible for speech and language (Homeyer & Sweeney, 2017; van der Kolk, 2014). Sandtray therapy is an approach that does not rely on the ability for the client to communicate in words. Developing and communicating a trauma narrative is a threatening and difficult task (Homeyer & Sweeney, 2017; Olson-Morrison, 2017). Sandtray therapy provides a space that is free from pressure to explain because of its lack of emphasis on interpretation (Homeyer & Sweeney, 2017; Olson-Morrison, 2017). Kirk (2007) indicated there is a “power of play to activate the self-healing mechanism of the psyche” (p. 39). This power in the process of play is an overlooked resource that holds a large amount of potential in providing adequate services to a growing population. Group therapy is also a well-researched and developed counseling modality that is also beneficial when combined with sandtray therapy (Homeyer & Sweeney, 2017). The combination of these two modalities gives the clients opportunities to benefit from the unique characteristics of sandtray therapy and group therapy. Due to these valuable contributions that sandtray can have on children, the research community should continue to gain knowledge in this intervention with adult survivors of childhood sexual assault in a group therapy setting.
PART III

METHODOLOGY

Method

Single Case Research Design

Single-case research design (SCRD) is a quantitative research method that is beneficial to use in counseling research (Lenz, 2015; Ray, 2015). According to Lenz (2015), “when counselors use SCRDs, they are implanting a scientifically rigorous, yet flexible approach for estimating the benefit of interventions that can be evaluated across counseling settings” (p. 389). The benefits of utilizing a single-case research design is that it tracks individual participant progress throughout the duration of the study resulting in data to show change overtime. Another benefit of SCRDs is that it reduces the likelihood that change comes from something other than the treatment (Kazdin, 2018) aiding in the process of establishing evidence-based practices (Horner et. al, 2005). Vannest and Ninci (2015) noted SCRDs provide immediate data that can inform counselors on course of treatment for clients. The use of single-case research designs in the counseling profession has grown significantly and is beneficial in validating treatment modalities that have been difficult to research (Lenz, 2015). Research can become increasingly difficult when there is a lack of sufficient sample sizes to perform statistical procedures that require large sample sizes. Research can also be difficult when there is a lack of resources making it difficult to accommodate a large sampling. Additionally, some treatment modalities are newer and have not had as much research completed in order to do replication studies. These
reasons make a single-case research design most appropriate for this dissertation study. Ray (2015) discussed some of the challenges in utilizing single-case research design in that the highest level of rigor is often not attainable. Therefore, the researcher needs to make design decisions “that allows for the highest level of rigor in the context of practical limitations” (Ray, 2015, p. 399). One design decision made to have the highest level of rigor is in utilizing a multiple baseline.

**Research Questions**

To what degree is group sandtray therapy an effective intervention for increasing the global well-being for adult survivors of childhood sexual assault?

To what degree is group sandtray therapy an effective intervention for decreasing symptom distress?

To what degree is group sandtray therapy an effective intervention for decreasing problems in interpersonal relations?

To what degree is group sandtray therapy an effective intervention for decreasing difficulties in social role?

**Sampling**

The researcher utilized random sampling to recruit participants. In order to participate in the study, individuals were required to be over the age 18 and must have experienced at least one instance of sexual assault as defined by RAINN prior to 18 years of age. An email was sent to a group of college aged students at a local university twice to call for participants. No incentives were provided for participant participation.

Originally, seven participants contacted the researcher following this call. Due to the COVID-19 pandemic, the study was put on hold for several months. At that time, necessary
alterations in the study were made to account for safe social distancing and health procedures and three participants remained in the study. Additionally, the IRB set forth new guidelines accounting for the increased risk to COVID-19. After evaluating the space for the study and the need for three participants to have statistical significance in a single-case research design, three participants plus the researcher were agreed upon by the IRB.

**Recruitment and Data Collection Procedures**

Prior to the beginning of the study, the researcher met individually with each participant to discuss consent procedures, group sandtray therapy, and to determine if the participant was fit for the study. Participants completed the OQ-45.2 (Lambert et al., 1996) for the first time to determine if they had any clinically severe symptoms that would make them high risk to participate in this study. In this individual meeting, the researcher shared a link to a secure Box account so that participants could upload their weekly completed OQ-45.2 (Lambert et al., 1996) in the baseline phase of this study.

These participants were randomly assigned to two groups using a coin toss. The first group consisting of 2 subjects completed the OQ-45.2 (Lambert et al., 1996) five times during the baseline phase and participated in six, group sandtray therapy sessions for the treatment phase. The second group consisted of 1 subject and completed the OQ-45.2 (Lambert et al., 1996) four times during the baseline phase and participated in five, group sandtray therapy sessions for the treatment phase. During the treatment phase, participants completed the OQ-45.2 (Lambert et al., 1996) in person and left the completed measures with the researcher who kept them secure.
Participants

Three participants participated in this study and ranged in age and diverse backgrounds. Individual demographic information and relevant details disclosed in the screening form are discussed below.

Participant 1

Participant 1, a self-identified African-American female in her mid-twenties, experienced multiple sexual assaults in her childhood. She disclosed she was three years old at the time of her first sexual assault. Participant 1 did not receive any prior counseling to address any sexual assault she experienced. She completed four baseline measures and five treatment measures in this study.

Participant 2

Participant 2, a self-identified African-American female in her early twenties, experienced one sexual assault in her childhood at the age of fifteen. She did not receive any prior counseling to address this sexual assault. Participant 2 completed five baseline measures and six treatment measures.

Participant 3

Participant 3, a self-identified Caucasian female in her early thirties, experienced multiple sexual assaults in her childhood. She disclosed she was two years old at the time of her first sexual assault. Participant 3 did receive multiple counseling experiences in response to these assaults in adulthood but not in childhood. She completed five baseline measures and six treatment measures.

Context of the Study
Participants participated in non-directive, non-interpretive sandtray therapy for 5 or 6 group counseling sessions led by this researcher. These counseling sessions occurred in an outpatient clinical mental health care setting in Oxford, Mississippi. Prior to beginning these sessions, participants were randomly assigned to two groups. The first group completed the OQ-45.2 four times to establish a baseline measurement and participated in five group counseling sessions. The second group completed the OQ-45.2 five times to establish a baseline measurement and participated in six group counseling sessions. Utilizing two groups achieved having a multiple baseline measure design, which contributes to the reliability of the baseline scores (Lenz, 2015; Ray, 2015). Participants completed the OQ-45.2 prior to each group sandtray therapy session to track individual changes throughout the duration of the study. following each of the group sandtray therapy sessions.

Measures

The OQ-45.2 Outcome Questionnaire (OQ-45.2) is designed for repeated measurement of client progress throughout therapy and following termination through self-report (Lambert et al., 2014). According to Hanson, Merker, & Pfeiffer (2005), the OQ-45.2 includes 45 items using a Likert like scale and has a total score and three subscale scores. The subscale scores are symptom distress, interpersonal relations, and social role. The items were selected by the authors of the measure through “reviews of relevant literature, fit with DSM criteria, and interitem correlations” (Hanson, Merker, & Pfeiffer, 2005, para. 3). The OQ-45.2 is appropriate for use with individuals ages 17-80. The standard error of measurement (SEM) is reported to be .93 for the OQ-45.2 (manual). “Test score sensitivity, the extent to which a score accurately detects the presence of a condition/phenomenon (e.g., subjective distress), is reported to be .84” (Hanson, Merker, & Pfeiffer, 2005, para. 5). The OQ-45.2 is “widely considered the gold standard adult
outcome questionnaire across the global psychology research community” (Lambert et al., 2004).

Boswell, White, Sims, Harrist, & Romans (2013) sampled 220 clients in a midwestern counseling center to determine the reliability and validity of the OQ-45.2 and found “strong support for the validity of the OQ-45.2 total score and the symptoms distress subscale” (p. 1). Additionally, “weaker support was found for the interpersonal relations and social role subscales” (Boswell et al., p. 1). Lambert et al., (2004) found internal consistency of the OQ 45-2 to be high with scores ranging from .70 to .93. Test-retest reliability scores were found to range from .78 to .84 (Lambert et al., 2004).

The OQ-45.2 was utilized throughout each phase of the study and was administered at the same interval of time in order to increase strength of study. The OQ-45.2 was given prior to the group sandtray therapy sessions to establish reliable baselines in each participant. The OQ-45.2 was then administered at each of the treatment group sandtray therapy sessions.

**Intervention**

At the time of this study, there were no manualized group sandtray therapy treatments and existing research has not contributed to a set format for implementing group sandtray therapy. As Homeyer and Sweeney (2017) identified, sandtray therapy is able to be combined with other counseling theories and theoretical treatments while no procedures currently exist. Group sandtray therapy is popular in practice, but specific formats to the delivery of this treatment is largely dependent on the theoretical framework of the counselor. My counseling theoretical framework is integrative, yet I strongly align with the theories presented by Carl Rogers. In my counseling practice, I utilize child-centered play therapy as developed by Garry Landreth. The principles of child-centered play therapy are also based on a humanistic approach from Carl Rogers. Therefore, the group sandtray therapy sessions in this study were non-
directive and followed the sandtray therapy modality developed by Margaret Lowenfeld in that it was non-interpretive. The group and the sandtray served as vehicles to further process the experiences of the participants who are survivors of childhood sexual assault. I developed a structure and flow for each group sandtray therapy session while also allowing for the participants to direct the course of each session. Each group sandtray therapy session included a large sandtray and individual sandtrays. Participants were prompted to “check-in” to each group by placing one or more miniatures into the large sandtray that was shared with other group members. Following the placement of the miniatures, each group member was able to share further details with the group about the miniatures placed in the large sandtray. At this time, participants were asked “in looking at the miniatures you placed in the large sandtray, did anyone bring anything to the group today that they would like to go deeper into?” After a group member identified an area to go deeper in processing, participants were prompted to construct an individual sandtray as it related to the issue brought forth by the group members. Further processing of the individual trays occurred as group members choose to share details of their individual sandtrays. Following the processing of the small sandtrays, group participants had option to make any changes in the larger shared sandtray to reflect any changes in the group member through the progression of the session. This style of group sandtray therapy came from my own experience in practice as a counselor in combining group therapy with sandtray therapy and was reviewed by several experienced sandtray therapists in the field.

**Evaluation of Fidelity**

In order to ensure that group sandtray therapy is the intervention being utilized in each session, the group sandtray therapy sessions were videotaped. The researcher reviewed each session videotape and completed a fidelity checklist.
The group sandtray fidelity checklist included the following items:

1. Turned on video recorder

2. Prompted participants to begin group sandtray session with a “check-in” in the large sandtray. Welcome to the sandtray group. You can take as much time as you need to find a miniature or group of miniatures that represent your presence in the group today. When you are ready, place these in the large sandtray.”

3. Allowed each participant to share details around the miniatures placed in the large sandtray. Each person describe what they placed in the sandtray and share details with the group about these miniatures.”

4. Utilized non-directive techniques in allowing group participants to identify areas to process further with the group. In looking at the miniatures you placed in the large sandtray, did anyone bring anything to the group today that they would like to go deeper into?”

5. Prompted participants to construct an individual sandtray in the small sandtray as it relates to the group

6. Allowed each participant to share more details about their individual sandtray as it relates to the group

7. Utilized non-directive techniques in allowing group participants to identify areas in the individual trays to process further with the group

8. Prompted participants to make any changes to the larger sandtray after group process of individual trays

9. Turned off video recorder

10. Verified that each participant completed the OQ-45.2
**Data Analysis**

In single-case research, there are a variety of ways to analyze data. Primarily, data was analyzed visually by charting individual OQ-45.2 scores throughout the duration of the study for each participant. In order to determine effect size, there are several different choices for analysis. These are percentage of nonoverlapping data (PND), percentage exceeding the median (PEM), improvement rate difference (IRD), and nonoverlap of pairs (NAP) (Barrio Minton & Lenz, 2019; Vannest & Ninci, 2015). Tau-U is another data analysis approach in single-case research design and can correct for a baseline trend (Vannest & Ninci, 2015). Following the receipt of baseline scores from the participants, a decision was made by the researcher to determine which analysis is most appropriate. TAU-U was utilized to identify effect size for overall global scores of the OQ-45.2. Additionally, NAP was selected because this statistical analysis takes into account any sensitive changes in scores (Parker & Vannest, 2009). Data was analyzed both visually and statistically to show participants’ response to treatment throughout the study, and both were reported in the results of the study.
PART IV
RESULTS

The purpose of this study was to examine the effectiveness of group sandtray therapy in increasing the global well-being of adult survivors of childhood sexual assault. The project was aimed at contributing to the quantitative research of sandtray therapy with adults. In this section, the findings of the study are discussed. A total of four research questions were included in the research project. Each question will be addressed separately. In order to determine effect size, there are several different choices for analysis in single-case research design. These are percentage of nonoverlapping data (PND), percentage exceeding the median (PEM), improvement rate difference (IRD), and nonoverlap of pairs (NAP) (Barrio Minton & Lenz, 2019; Vannest & Ninci, 2015). Tau-U is another data analysis approach in single-case research design and can correct for a baseline trend (Vannest & Ninci, 2015). Following the receipt of baseline scores from the participants, a decision was made by the researcher to determine that the TAU-U was the most appropriate. Due to the outlier data in the baseline scores, TAU-U was determined to be the best fit to reduce the potential for Type 1 or Type 2 error. Data was be analyzed both visually and statistically to show participants’ responses to treatment throughout the study. Both are reported below. Additionally, split-middle line of progress (Cooper, Heron, & Howard, 2007) was utilized in the visual representation of the results to aid in statistical analysis of treatment results. Celeration lines are discussed for each figure including the baseline and treatment phases.
**Research Question 1: Global Well-being**

The first research question examined each participant’s global well-being score using the OQ-45.2 (Lambert et al., 1996). Using the TAU-U calculator (Vannest et al., 2016), p=.71 indicating a moderate effect size for the overall scores of the OQ-45.2 showing global well-being. Figure 1 shows the visual data of progression for each participant throughout both the baseline and treatment phases of this study. In addition to the TAU-U score, the researcher calculated the NAP ES (nonoverlap of all pairs effect size) scores for each participant’s global well-being. NAP was selected because this statistical analysis takes into account any sensitive changes in scores (Parker & Vannest, 2009). Additionally, NAP “compares each data point in Phase A with each data point in Phase B (Vannest & Ninci, 2015, p. 406). Participant 1’s NAP ES=.95 indicating a significant effect size for global well-being. Participant 2’s global well-being scores indicated a low effect size for global well-being scores with NAP ES=.10. Participant 3 had a moderate effect size with NAP ES=.50. Split-middle line of progress shows participant 1 deceleration line is descending in both the baseline and treatment phases. Participant 2 has a decelerating celebration line in the baseline phase but an accelerating line in the treatment phase indicating no effect. Participant 3 indicated an accelerating line in the baseline phase and a descending line in the treatment phase indicating a moderate effect.

**Research Question 2: Symptom Distress**

The second research question focused on the symptom distress subscale within the OQ-45.2. The NAP ES for Participant 1=1 showing a very significant effect. Participant 2’s NAP ES=.20 showing no effect. Participant 3’s NAP ES=.30 showing no effect. Figure 2 shows the visual data of progression for each participant throughout both the baseline and treatment phases of this study. Split-middle line of progress shows participant 1 with decelerating lines in both the
baseline and treatment phases indicating a significant effect. Participant 2 showed therapeutically neutral celeration lines in both the baseline and treatment phases indicating no effect. Participant 3 had an accelerating line in the baseline phase and a decelerating line in the treatment phase indicating a therapeutic benefit.

**Research Question 3: Interpersonal Relations**

The third research question focused on the interpersonal relations subscale within the OQ-45.2. Using NAP (Parker & Vannest, 2009) Participant 1 had a very significant effect with NAP ES=.95. Participants 2 and 3 had no effect with Participant 2 NAP ES=.20 and Participant 3 NAP ES=.30. Figure 3 shows the visual data of progression for each participant throughout both the baseline and treatment phases of this study. Split-middle line of progress shows participant 1 with decelerating lines in both the baseline and treatment phases indicating a therapeutically beneficial effect. Participant 2 had accelerating lines in both the baseline and treatment phases indicating no therapeutically beneficial effect. Participant 3 had an accelerating celeration line in the baseline phase but a decelerating line in the treatment phase showing a therapeutic benefit.

**Research 4: Social Role**

The fourth research question focused on the social role subscale within the OQ-45.2. Using NAP (Parker & Vannest, 2009) Participant 1 and Participant 3 had very significant effect size with NAP ES=.90 for both participants. Participant 2 had no effect with NAP ES=.10. Figure 4 show the visual data of progression for each participant throughout both the baseline and treatment phases of this study. Split-middle line of progress shows participant 1 with an accelerating line in the baseline phase but a decelerating line in the treatment phase indicating a significant effect. Participant 2 had decelerating lines in both the baseline and treatment phases
indicating no effect. Participant 3 had an accelerating line in the baseline phase and a decelerating line in the treatment phase indicating a therapeutic benefit.
Figure 1

Global Well-being Scores

Note: Vertical line shows change from baseline phase to treatment phase.

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Figure 2

Symptom Distress Scores

Note: Vertical line shows change from baseline phase to treatment phase.
Figure 3

Interpersonal Relations Scores

Note: Vertical line shows change from baseline phase to treatment phase.
Figure 4

Social Role Scores

Note: Vertical line shows change from baseline phase to treatment phase.
The results from this study contribute to the necessary research of sensory inclusive and creative counseling techniques in working with clients who have experienced sexual trauma in childhood due to the small amount of existing statistical knowledge on the topic. The results show group sandtray therapy to be beneficial for some adult survivors of childhood sexual assault but not all, and this knowledge can be helpful for counselors in choosing creative counseling techniques in practice with this population. Group sandtray therapy had a moderate effect on increasing the global well-being for adult survivors of childhood sexual assault. However, once evaluating the data using NAP (Parker & Vannest, 2009) more information was given to describe the specific experiences of each participant. Existing research on group sandtray therapy is limited with the majority of the studies being descriptive or exploratory in nature (Homeyer & Sweeney, 2017). In relation to research studying sandplay therapy being used with individuals who have experienced CSA, there are multiple articles that include case studies. Doyle and Magor-Blatch (2017) explained their experiences of using Kalff’s Jungian-based sandplay therapy with one adult survivor of CSA and found a reduction in depression symptoms and stress. Riviere (2008) shared experiences in working with a 43-year-old woman who was sexually abused as a child by detailing ten pictures of sandplay sessions with this client to show the process of sandplay therapy. Balfour (2008) documented experience in utilizing Kalff’s Jungian-based sandplay therapy with a 36-year-old woman who was a survivor of CSA.
and found that the client was successful in recovering from depression and healing from her repressed experiences of abuse. Troudart (2017) documented working with a female client in her early twenties who was a survivor of CSA and found sandplay therapy to help the client “strengthen her ego” (p. 1) as well as target dissociations. In each of these publications, the authors utilized Kalff’s Jungian-based sandplay therapy in working with these clients. However, at the time of this study there are no existing quantitative research studies of group sandtray therapy with adult survivors of childhood sexual assault.

**Reflection of Results for Each Participant**

Participant 1 had very significant effect sizes in global well-being, symptom distress, interpersonal relations, and social role. It is evident from the visual analysis to see that Participant 1’s scores show that she benefitted from group sandtray therapy in each subscale and overall score of the OQ. 45.2.

Participant 2 had no improvement or effect in any of the four scales. The scores show and visual figures support that participant 3 did not benefit from this intervention. The highest effect size participant 3 had out of each scores was the interpersonal relations subscale was NAP ES= .30.

Participant 3 had a moderate effect size in the global well-being scale, and visually the scores do not change dramatically. The subscale scores for participant 3 vary. Participant 3 showed the greatest benefit being in the social role subscale. Participant 3, however, did not show any improvement in both the symptom distress subscale and the interpersonal relations subscale.
In evaluation each of the participant’s subscale scores and overall scores with NAP (Parker & Vannest, 2009), participant 1 benefitted more from this intervention; participant 2 did not benefit from this intervention; and participant 3 somewhat benefitted from this intervention. This further informs the TAU-U score showing a moderate effect size for the results as a whole. While results varied for each participant, the results from this study and the utilization of group sandtray therapy have implications for survivors, counselors, and researchers.

**Implications for Counseling**

As evidenced by various research, childhood sexual assault is prevalent and contributes to an individual’s cognitive, social, and physical health (Steeck-Fischer & van der Kolk, 2000). Streeck-Fischer and van der Kolk (2000) identified the benefits of early intervention for children who experienced trauma. However, there are many children who are unable to receive treatment immediately following the traumatic event, especially if it is recurring. This can be for multiple reasons including socioeconomic reasons, lack of resources in the area, or nondisclosure of the event on the part of the child. These reasons along with others contribute to a large population of adults who experienced abuse as a child but never received treatment.

Additionally, individuals who have experienced CSA may find it difficult to talk about what happened or to create a narrative of the events (Homeyer & Sweeney, 2017; Stewart, Field, & Etcherling, 2016; van der Kolk, 2014). The findings in this research study are promising for adults who experienced childhood sexual assault yet never received treatment or feel that they did not receive as much treatment as they would have preferred. This research points to the success of group sandtray therapy, an intervention that does not rely on talking or creating a trauma narrative. Adult survivors of childhood sexual assault can have more confidence in trying group sandtray therapy as a modality for treatment.
Counselors’ interest in creative therapeutic interventions is growing (Gladding, 2016). In evaluating continued education opportunities over the past several years and in following an online forum for play therapists, counselors and play therapists often have questions about utilizing sandtray therapy with adult clients and are eager to learn more about doing so to optimize client treatment outcomes. Those who are trained in and are providing sandtray therapy can use the results in this study to inform expansion of this modality to use with adult survivors of childhood sexual assault. This research study can provide an example of how to utilize a popular technique among children with adults in a group setting.

Researchers in the counseling profession can use the findings of this study to inform future studies in quantitative research of group sandtray therapy. Additionally, the information in this study contributes to the necessary literature surrounding adult survivors of childhood sexual assault and the literature for sandtray therapy. More research needs to be done to study sandtray therapy with adults who present with a variety of issues, and this study can serve as a stepping stone to replicate or adapt similar studies across more clinical populations. This study should be replicated with more participants when the COVID-19 restrictions are no longer in place to expand the knowledge of this topic and to continue to understand the relationship between group sandtray therapy with adult survivors of childhood sexual assault.

**Limitations of the Study**

There are several limitations of this study one being the sample size. While three participants in single-case research is acceptable, it was the goal of the researcher to have ten participants to include more data. More participants would have contributed to a clearer understanding of the relationship between global well-being, symptom distress, interpersonal relations, and social role among adult survivors of childhood sexual assault participating in group
sandtray therapy. Also, the COVID-19 protocols directly impacted the ability to have a larger sample size. If the research were replicated with multiple groups to increase sample size, this would have been difficult considering the increased cost of equipment including cleaning products, separate individual trays for each participant, and new sand for each session. In conducting this research during COVID-19, sickness and group attendance is another factor that impacted this study. Originally, Participant 1 was going to complete three baseline measures and participate in all six group sandtray sessions. Due to contracting COVID during the baseline data collection phase, a change was made to allow for adequate quarantine procedures resulting in an extra baseline measure and one less treatment phase. Finally, a limitation of this study is the lack of previous studies or results to use for comparison or as a reference in designing this study.

**Conclusion**

The researcher sought to better understand the degree to which group sandtray therapy is an effective intervention for increasing the global well-being of adult survivors of childhood sexual assault. Finding effective treatment methods that incorporate the specific needs of adult survivors of CSA is an important expansion of the counseling profession. Adult survivors of CSA need options that are proven to be helpful in addressing a wide variety of concerns, and overall the findings show that group sandtray therapy is a promising treatment method for this population. According to the results, group sandtray therapy is a moderately effective treatment modality for working with adult survivors of childhood sexual assault and is sufficient evidence to justify continuing research and further understanding of this modality. These findings contribute to the conversation among play therapists and counselors who utilize sandtray therapy in their clinical practice as both counselors and researchers seek to benefit the treatment outcomes for clients.
REFERENCES
LIST OF REFERENCES


APPENDIX A: CONSENT TO PARTICIPATE
Consent to Participate in Research

Study Title: Group Sandtray Therapy with Adult Survivors of Childhood Sexual Assault

Investigator
Jana E. Frankum, M.S., LPC, NCC, CCMHC

Faculty Sponsor
Richard S. Balkin, Ph.D., LPC, NCC

Key Information for You to Consider

- **Voluntary Consent.** You are being asked to volunteer for a research study. It is up to you whether you choose to participate or not. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or discontinue participation.

- **Purpose.** The purpose of this research is to better understand to what degree sandtray therapy is an effective intervention for increasing the global well-being of adult survivors of childhood sexual assault.

- **Duration.** It is expected that your participation will last between 9-12 weeks.

- **Procedures and Activities.** You will be asked to complete a series of measures for several weeks prior to group sandtray therapy sessions and upload your completed measures to a UMBox folder created by the researcher. You will be asked to attend six 60-minute group sandtray therapy sessions and complete the same measure following each group session.

- **Risks.** Some of the foreseeable risks or discomforts of your participation include the potential for treatment to make you initially feel worse. Group therapy sessions can trigger unwanted thoughts or emotions that are distressing to you. While you will participate in six sessions, you may need further counseling or treatment after the conclusion of the study. Additionally, group sandtray therapy sessions may not be effective. Another risk is due to the group therapy model, there is no guarantee of total confidentiality (See Confidentiality paragraph below).

- **Benefits.** Some of the benefits that may be expected include an increase in overall well-being, healing from traumatic events, and the ability to form relationships with other individuals who have experienced similar experiences to you. Additionally, you will receive six free group sandtray therapy sessions.

- **Alternatives.** As an alternative to participation, you could find that individual therapy might be a better course of treatment.
By checking this box I certify that I am 18 years of age or older.

**What you will do for this study**

If you choose to participate in this study, you will complete a survey asking about your demographic information, any previous counseling experience, and history of childhood sexual assault. Some examples of questions you will be asked are: how old were you when you were sexually assaulted? “Was this abuse a one-time occurrence?” “Have you ever received any counseling services because of any sexual assault you experienced in your childhood?” You will be asked to complete a 45-item questionnaire (OQ-45.2) once a week for either 3 or 5 weeks. You will upload a completed OQ-45.2 to a UMBox Folder created by the researcher. Upon agreeing to participate in this study, you will come to the Wellness Center of Oxford (202 Enterprise Drive Oxford, MS 38655) to meet with the researcher to review consent, complete a screening form, complete the first OQ-45.2 measure, be trained in accessing the UMBox link and uploading completed measures, and sign consent forms. You will then be randomly assigned to a group and be asked to complete the OQ-45.2 for either 2 or 4 additional weeks. Upon completion of the measure you will upload this to the UMBox Folder link previously provided to you in the initial meeting with the researcher. Following completion of the measures, you will come to the Wellness Center of Oxford (202 Enterprise Drive Oxford, MS 38655) once a week for 6 weeks. At that time you will participate in a 60-minute group sandtray therapy session. Groups will consist of you, 4-5 other participants, and the researcher. Depending on the number of participants there may be one or two groups that will receive the same intervention. Your assignment to a group may be decided randomly (e.g. flipping a coin), but the content of the group will be the same. During group sandtray therapy you will (a) explore your experiences, thoughts, and feelings related to childhood sexual abuse utilizing sandtray therapy as a medium (b) be prompted to “check-in” to the group by placing a miniature in a large sandtray (c) be allowed to share details around this miniature (d) be allowed to identify areas to process further with the group (e) be prompted to construct an individual sandtray in a small sandtray (f) be allowed to share more details about your individual sandtray as it relates to the group (g) be allowed to identify more details about your individual sandtray to process further with the group (h) be prompted to make any changes to the larger sandtray after group process of individual trays as a “check out.” Group sandtray therapy sessions will be facilitated by the researcher who is also a provisionally licensed professional counselor in the state of Mississippi. After each group sandtray therapy session you will complete the same 45-item questionnaire. Anticipated circumstances under which a subject’s participation may be terminated by the researcher is if the researcher identifies any extreme scores on the OQ-45.2 such as suicidality. You will be contacted individually, evaluated for safety, and referred to services.

The researcher and facilitator of the group is a licensed professional counselor in the state of Mississippi (License No. 2578) and has been in clinical practice since 2015. The researcher has a Master’s of Science in Clinical Mental Health counseling with specific training in play therapy.
and expressive arts including receiving training in childhood trauma and expressive arts. The researcher is a doctoral candidate in the department of Leadership and Counselor Education at The University of Mississippi, serves as a graduate assistant supervisor at the Clinic for Outreach and Personal Enrichment, and is a counselor in a private practice in Oxford, Mississippi. The researcher has specific training in QPR Mental Health First Aid, is a National Certified Counselor, and a Certified Clinical Mental Health Counselor.

Videotaping / Audiotaping
You will be videotaped while you participate in the group sandtray therapy sessions so that the researcher can complete a checklist to verify that sandtray therapy procedures were faithfully applied.

Time required for this study
This study will take about 15 minutes to complete the 45-item questionnaire each time and 1 hour for each group sandtray therapy session — for a total of 7.5 hours.

Possible risks from your participation
Answering questions related to your history of sexual assault may be stressful. Additionally, participating in group sandtray therapy sessions may produce unwanted thoughts or emotions that are distressing to you. While you will participate in six sessions, you may need further counseling or treatment after the conclusion of the study. Additionally, group sandtray therapy sessions may not be effective. Another risk due to the group therapy model is no guarantee of total confidentiality on the part of other participants in this study. The researcher will emphasize confidentiality on the part of other participants but compliance is not guaranteed. In the event that you are triggered, I may request to speak with you individually following the conclusion of group. During this time, you will be evaluated for safety and referred to additional counseling services. Additionally, these procedures may involve risks to subjects that are currently unforeseeable.

Benefits from your participation
You should not expect benefits from participating in this study. However, you might experience satisfaction from contributing to scientific knowledge. Also, answering the survey questions might make you more aware of habits you’d like to change – sometimes this can help lead to improved habits. Participating in group therapy sessions can make you more aware of areas you would like to continue to process in ongoing therapy (individual or group).

Confidentiality
Research team members will have access to your records. We will protect confidentiality by coding your records and removing any identifying information. These records will be kept under a two-lock system and will only be accessible by the research team. Video recordings will allow the researcher to validate that sessions were in fact group sandtray therapy sessions. Video recordings will be kept on an encrypted, password protected hard drive that will also be stored under a two-lock system. Video recordings, screening and consent forms, and completed OQ-45.2 measures will be destroyed after the end of the study — which is expected to be December 2020
a. Under Mississippi State law, an exception to confidentiality is in incidents of child abuse or neglect. If I have reasonable cause to suspect a child may be neglected or abused, I am required by law to immediately make a report to the Mississippi Department of Child Protection Services.

b. I am bound by law and by the American Counseling Association’s Code of Ethics to maintain confidentiality unless a group member discloses any suicidality, homicidality, or exposure of a minor to an abuser as it relates to safety of group participants and minors. Group members are bound by honor to keep what is said in the group in the group. I realize that you may want to share what you are learning about yourself in group with a significant other. This is fine as long as you remember not to talk about how events unfold in group or in any other way compromise the confidentiality of other group members. As potentially sensitive information is disclosed each of you should avoid posting on social media your experiences in this group and experiences of other members. I also encourage each of you to use pseudonyms with respect to a name for an abuser.

c. Members of the Institutional Review Board (IRB) – the committee responsible for reviewing the ethics of, approving, and monitoring all research with humans – have authority to access all records. However, the IRB will request identifiers only when necessary. We will not release identifiable results of the study to anyone else without your written consent unless required by law.

**Right to Withdraw**
You do not have to volunteer for this study, and there is no penalty if you refuse. If you start the study and decide that you do not want to finish, just tell the researcher. Whether or not you participate or withdraw will not affect your current or future relationship with the Department of Leadership & Counselor Education, or with the University, and it will not cause you to lose any benefits to which you are entitled.

**Identifiable Private Information**
Identifiable private information is any personal information which identifies you in some way. The data collected in this study includes: demographic information, history of previous counseling, history of childhood sexual assault(s), results of weekly questionnaires. A decision to participate in this research means that you agree to the use of your health information for the study described in this form. This information will not be released beyond the purposes of conducting this study. The information collected for this study will be kept until the study is complete which is projected to be December 2020. While this study is ongoing you may not have access to the research information, but you may request it after the research is completed. In the event that the researcher discovers significant new findings developed during the course of the research that may relate to your willingness to continue, this will be provided to you. You may request a copy of the visual results from this study after the research is completed, and you may consult with the researcher to discuss your individual results.

**IRB Approval**
This study has been reviewed by The University of Mississippi’s Institutional Review Board (IRB). The IRB has determined that this study fulfills the human research subject protections obligations required by state and federal law and University policies. If you have any questions or concerns regarding your rights as a research participant, please contact the IRB at (662) 915-7482 or irb@olemiss.edu.
Please ask the researcher if there is anything that is not clear or if you need more information. When all your questions have been answered, then decide if you want to be in the study or not.

**Statement of Consent**

I have been informed of the researcher’s role as a mandated reporter in the event that I disclose that minors are currently exposed to abusers. I have read the above information. I have been given an unsigned copy of this form. I have had an opportunity to ask questions, and I have received answers. I consent to participate in the study.

Furthermore, I also affirm that the experimenter explained the study to me and told me about the study’s risks as well as my right to refuse to participate and to withdraw.

<table>
<thead>
<tr>
<th>Signature of Participant</th>
<th>Date</th>
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<td>_________________________</td>
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______________________________
Printed name of Participant
Appendix B: COVID CONSENT FORM
The University of Mississippi
COVID-19 Compliance, Liability Waiver, and Assumption of the Risk

The novel coronavirus, COVID-19, is a highly infectious, life-threatening disease declared by the World Health Organization to be a global pandemic. There is no current vaccine for COVID-19. COVID-19’s highly contagious nature means that contact with others, or contact with surfaces that have been exposed to the virus, can lead to infection. Additionally, individuals who may have been infected with COVID-19 may be asymptomatic for a period of time, or may never become symptomatic at all. Because of its highly contagious and sometimes “hidden” nature, it is currently very difficult to control the spread of COVID-19 or to determine whether, where, or how a specific individual may have been exposed to the disease.

I understand that the research investigator, [name], has put in place safety procedures in order to mitigate the spread of COVID-19, which may be updated at any time, in accordance with University policies and procedures. I understand that these procedures may or may not be effective in mitigating the spread of COVID-19. I agree to comply with all safety procedures, which may include, but are not limited to, symptom screening, mask wearing, hand washing, hand sanitizing, and social distancing. I understand that failing to comply with these procedures may result in my being removed from the study.

I agree that if I am exhibiting symptoms or if, to my knowledge, I have been in contact with anyone diagnosed with COVID-19 or is exhibiting symptoms of respiratory illness, a fever of 100.4°F or higher, or signs of a fever within the last 14 days, I will notify the research investigator. I understand that I may be asked to withdraw from the study if I am exhibiting any of the symptoms mentioned previously or for my failure to report such symptoms to the research investigator.

By signing this agreement, I acknowledge the contagious nature of COVID-19, the fact that it can be difficult to identify in another, and the inherent risks of exposure in the research setting to those who may be infected with COVID-19. I knowingly and voluntarily assume the risk that I may be exposed to or infected with COVID-19 by volunteering to participate in this research and that such exposure or infection, as well as the use of any protective equipment, including face masks, provided to me, may result in personal injury, illness, permanent disability, and/or even death. I knowingly and voluntarily waive and release UM from all present and future claims of any type for any harm or loss, including economic loss, personal injury, death, or property damage suffered by me and arising out of my participation in this research. I agree to indemnify, hold harmless, and covenant not to sue UM for any damages, personal injury, death, medical expenses, disability, lost wages, loss of capacity, property damage, court costs, attorney’s fees, or any other loss of any kind.
I acknowledge that I have asked for and/or been given any information that I may need to determine the risks associated with volunteering to participate in this research and to make an informed assumption of those risks. **Aware of the foregoing, I am knowingly and voluntarily participating in this research.**

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I AM AWARE THAT BY SIGNING THIS AGREEMENT I MAY BE WAIVING CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE. THIS AGREEMENT SHALL BE BINDING UPON ME AND MY HEIRS, LEGAL REPRESENTATIVES, AND ASSIGNS, AND SHALL INURE TO THE BENEFIT OF THE UNIVERSITY AND THEIR SUCCESSORS AND ASSIGNS.

My signature below indicates that I am at least eighteen years of age and that I have read and understand the above statements and intend to be bound legally by its terms.

PARTICIPANT SIGNATURE

DATE:

RESEARCHER SIGNATURE

DATE:
Appendix C: Screening Form
Group Sandtray with Adult Survivors of Childhood Sexual Assault Screening Form

Name:______________________________________

Age:__________       Sex:__________

How old were you when you were sexually assaulted? __________

Was this abuse a one-time occurrence?_______________

Have you ever received any counseling services because of any sexual assault you experienced in your childhood? _________________
Appendix D: OQ-45.2
### Outcome Questionnaire (OQ®-45.2)

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

<table>
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<tr>
<th>Session #</th>
<th>Date</th>
<th>Name</th>
<th>Age (yrs.)</th>
<th>Sex (M/F)</th>
<th>ID#</th>
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<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
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<tbody>
<tr>
<td>1. I get along well with others.</td>
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<td>2. I tire quickly.</td>
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<td>3. I feel no interest in things.</td>
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<td>4. I feel stressed at work/school.</td>
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<td>5. I blame myself for things.</td>
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<td>6. I feel irritated.</td>
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<td>7. I feel unhappy in my marriage/significant relationship.</td>
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<td>8. I have thoughts of ending my life.</td>
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<td>9. I feel weak.</td>
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<td>10. I feel fearful.</td>
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<td>11. After heavy drinking, I need a drink the next morning to get going.</td>
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<td>12. I find my work/school satisfying.</td>
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<td>13. I am a happy person.</td>
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<td>14. I work/study too much.</td>
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<td>15. I feel worthless.</td>
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<td>16. I am concerned about family troubles.</td>
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<td>17. I have an unfulfilling sex life.</td>
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<td>18. I feel lonely.</td>
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<td>19. I have frequent arguments.</td>
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<td>20. I feel loved and wanted.</td>
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<td>21. I enjoy my spare time.</td>
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<td>22. I have difficulty concentrating.</td>
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<td>23. I feel hopeless about the future.</td>
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<td>24. I like myself.</td>
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<td>25. Disturbing thoughts come into my mind that I cannot get rid of.</td>
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**Therapist's Guide to Positive Psychological Interventions**

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26. I feel annoyed by people who criticize my drinking (or drug use).[4 = never] 0 1 2 3 4
(If not applicable, mark "never")
27. I have an upset stomach. 0 1 2 3 4
28. I am not working/studying as well as I used to. 0 1 2 3 4
29. My heart pounds too much. 0 1 2 3 4
30. I have trouble getting along with friends and close acquaintances. 0 1 2 3 4
31. I am satisfied with my life. 4 3 2 1 0
32. I have trouble at work/school because of drinking or drug use. 0 1 2 3 4
(If not applicable, mark "never")
33. I feel that something bad is going to happen. 0 1 2 3 4
34. I have sore muscles. 0 1 2 3 4
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth. 0 1 2 3 4
36. I feel nervous. 0 1 2 3 4
37. I feel my love relationships are full and complete. 4 3 2 1 0
38. I feel that I am not doing well at work/school. 0 1 2 3 4
39. I have too many disagreements at work/school. 0 1 2 3 4
40. I feel something is wrong with my mind. 0 1 2 3 4
41. I have trouble falling asleep or staying asleep. 0 1 2 3 4
42. I feel blue. 0 1 2 3 4
43. I am satisfied with my relationships with others. 4 3 2 1 0
44. I feel angry enough at work/school to do something I might regret. 0 1 2 3 4
45. I have headaches. 0 1 2 3 4

Total:

+ +
VITA

Jana E. Scott

PROFESSIONAL DEVELOPMENT:
American Counseling Association National Conference April 2018
Mississippi Counseling Association State Conference November 2017
Sandplay Therapy 101: Basics for the Play Therapist March 2017
Presented by Linda Homeyer, Ph. D. at the Center for Play Therapy and Expressive Arts Conference
Psychological First Aid (PFA)-Helping People Cope During Disasters & Public Health Emergencies June 2016
Assessing & Managing Suicide Risk (AMSR): Core Competencies Behavioral Health Professionals June 2016
Presented by Andrea Mills, LPC at Lipscomb University Counseling Center
Columbia-Suicide Severity Rating Scale (C-SSRS) Training February 2016
Trauma and the Twelve Steps March 2015
Presented by Jamie Marich, Ph.D., LPCC-S, LICDC-CS at the Nashville Area Association of Christian Counselors
Child Parent Relationship Therapy February 2015
Presented by Garry L. Landreth, Ed.D., LPC, RPT-S at the Center for Play Therapy and Expressive Arts Conference

PROFESSIONAL EXPERIENCE & ADVOCACY:
Mississippi Journal of Counseling Research and Practice October 2018-April 2020
Assistant to the Editors
Clinic for Outreach and Personal Enrichment May 2018-April 2020
Doctoral Graduate Assistant
Counselor
Supervisor
University Counseling Center August 2017-December 2018
Doctoral Graduate Assistant
Counselor
CPCE Exam Study Session December 2018
Taught the group counseling review session for the 2nd year Master’s students
Lipscomb University Counseling Center January 2016-December 2016
Counseling Intern
Breaking the Silence: A Community Conversation about Suicide Prevention September 2016
Co-counseled teens, parents, and those who interact with teens (coaches, teachers, etc.) on suicide prevention
REAL Dialogue: Race, Equity, and Leadership Discussion September 2016
Volunteer Crisis Counselor for participants of a community conversation led by Nashville mayor
Jana E. Scott

You’re Not Alone (Student Led Organization)  August 2016-December 2016
Co-Founder of Chapter & Vice President for this student led organization dedicated to ending the stigmas surrounding mental health on Lipscomb University’s campus

Camp Cope  June 2016
Served as a counselor at a summer therapy camp for children of incarcerated parents

 PROFESSIONAL CONFERENCE PRESENTATIONS:
Lost in Loss: How Counselor Educators Experience Grief within Their Programs  October 2018
and Professional Roles
Poster presentation at the Southern Association for Counselor Educators and Supervisors
When the Tongue Fails: Directive Techniques in Play Therapy  February 2018
Co-presented at the Mississippi Association for Play Therapy Conference
American Gladiators: The NFL, Head Trauma, and Mental Health  April 2015
Co-presented at the Middle Tennessee Counseling Association Conference

TEACHING EXPERIENCE:
eLearning Training Course (eTC)  Fall 2018
The University of Mississippi: Training for certification to teach online/eLearning courses
Counseling Practicum  Fall 2018
Co-taught with Dr. Jennifer Austen-Main
Substance Abuse  Summer 2018
Guest lecturer
Professional Ethics  Summer 2018
Guest lecturer