

ARTICLE

## Play Therapy and Art Therapy for Substance Abuse Clients Who Have a History of Incest Victimization

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**Abstract**—*This article discusses the use of play therapy and art therapy treatment techniques for persons in substance abuse treatment who have a history of incest victimization. While substance abuse treatment focuses on substance abuse, neglecting to address issues related to past incest contact may increase the potential for relapse. This population displays unique characteristics that may prevent them from participating in, or benefiting from, traditional treatment modalities (which are highly dependent upon the verbal interactions between clients and therapists). Play therapy and art therapy are discussed in terms of history, rationale, and benefits to clients. © 1999 Elsevier Science Inc. All rights reserved.*

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### INTRODUCTION

HIGH RECIDIVISM and relapse rates occur among individuals treated for substance abuse. While the Alcoholics Anonymous (AA) model may attribute this phenomenon to persons not having “hit their bottom,” another possible explanation may be that treatment techniques are effective primarily with persons who have “hit bottom.” Failure to recover before this point may be due, in part, to the failure of treatment to effectively intervene at various stages of deterioration and consider the variability among this population’s treatment needs.

One substantial subpopulation among persons enrolled in substance abuse treatment who may have unique treatment needs are persons who also have a history of childhood incest (Glover, Janikowski, & Benshoff, 1996; Janikowski, Bordieri, & Glover, 1997;

Schaefer & Evans, 1985). National statistics indicate that, in the general population, approximately 19% of females will be sexually abused by a family member or relative by the age of 18 years (Kondora, 1993). In a national survey of substance abuse treatment facilities, Glover, Janikowski, and Benshoff (1996) found that 55% of female clients and 29% of male clients in treatment for substance abuse indicated a history of childhood incest.

It appears that the majority of women who are in substance abuse treatment have a history of sexual abuse (Wadsworth, Spampneto, & Halbrook, 1995). Given the strong and lasting impact that childhood sexual victimization has on adult emotional and social functioning, it is not unreasonable to expect victims of incest to turn to alcohol or other drugs to deal with these negative effects as adults (Rohsenow, Corbett, & Devine, 1988). Addictions are common ways of coping with the emotional distress caused by incest because they serve to numb feelings, suppress memories, and reduce pain (Bass & Davis, 1988). When the effects of sexual traumatization are not treated, other problems in social functioning may emerge. These include addictive behaviors, which often develop into serious problems themselves and increase the potential for relapse (Young, 1990).

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Several authors have suggested that a failure to receive treatment for sexual abuse issues may lead to the premature withdrawal from substance abuse treatment (Nielsen, 1984) and relapse (Barnard, 1989; Evans & Schaefer, 1980; Rohsenow et al., 1988). Relapse rates appear higher among persons in substance abuse treatment who have experienced sexual abuse (Brown, 1991; Kasl, 1989; Rohsenow et al., 1988; Rose, 1991). Data reported in Glover, Janikowski, and Benshoff (1996) indicated that while 40% of the clients surveyed made their counselors aware of their past incest abuse; only 15% were receiving counseling specific to the sexual abuse. However, it may be necessary to resolve past sexual abuse issues in order to reduce the risk of relapse (Brown, 1991; Rohsenow et al., 1988; Rose, 1991) because as memories of past sexual abuse surface or persist untreated, relapse potential increases (Harrison, Hoffman, & Edwall, 1989). Miller (1994) reported that clients in treatment who had a history of sexual abuse used alcohol and drugs for the reduction of emotional pain and tension.

Traditional treatment of alcoholics is confrontational and emphasizes the powerlessness of the individual over substances. This treatment, while effective for some within this population, may be contraindicated for persons in treatment who have childhood incest issues. Koch and Rubin (1997) advise against a "one size fits all" tradition and point out the negative connotation that some clients may associate with a lack of power. Adults who were sexually abused as children may continue to have feelings of powerlessness and helplessness (Courtois, 1988). They are, therefore, more likely to benefit from treatment that focuses on empowerment rather than acquiescence.

Traditional treatment also tends to be a primarily verbal process. Due to the stigmatization and secrecy associated with incest, it is possible that very limited cognitive and verbal processing of the incest has occurred on a conscious, cathartic level. This may make it difficult to begin and sustain treatment using "talk therapy." The challenge then is to provide effective treatment in a nonconfrontational, nonthreatening style that allows for emotional and cognitive assimilation of past traumatic events. Such a form of treatment may already exist outside a formal program and yet not be seriously considered for treating this population.

The purpose of this article is to examine the unique problems and characteristics of persons in treatment for substance abuse who also have a history of incest and to consider alternative approaches that are process-focused (emotive-visual to cognitive-verbal) and include play therapy and art therapy techniques. These techniques of essentially nonverbal therapy assist in cognitive and verbal processing of the incest experience, which may be a necessary predicate to lasting substance abuse treatment. Currently play therapy and art therapy are used primarily with children in order to access their feelings and allow those feelings to be worked through and processed in a

nonconfrontational and frequently in a spontaneous, non-directive manner. It is often assumed that adults in treatment have already verbally processed information and need only be willing participants to make progress in treatment. In fact, due to dissociation from the trauma of the incest experience, adult clients may be *unable* to proceed immediately into talk therapy.

### LONG-TERM EFFECTS OF INCEST

The long-term effects of incest include a host of negative behaviors, emotional reactions, self-perceptions, interpersonal relations, and social interactions. Emotional reactions consist of pervasive feelings of fear and anxiety, which may manifest as sleep disturbances, anxiety attacks, and phobias (Courtois, 1988). Depression is a widely recognized consequence of incest (Kondora, 1993). Feelings of grief and loss associated with the void of a lost childhood may also be experienced (Courtois, 1988).

Negative self-perceptions include feelings of shame, self-blame, worthlessness, and isolation. Among persons in treatment for substance abuse, Glover et al. (1995) found a significantly lower self-esteem rating among persons who reported histories of incest victimization. Interpersonal and social problems within this group consist of difficulty with intimacy, commitment, and authority figures. These difficulties may burgeon into isolation, rebellion against structured authority, various antisocial behaviors, and difficulty in trusting others and developing interpersonal relationships (Courtois, 1988).

Emotional withdrawal and dissociation are used as coping mechanisms and serve to avoid painful feelings. When the mind cannot accept the pain of a traumatic event it responds by shutting out the experience from consciousness (Miller, 1994). "When that situation is one of child abuse, especially incest, the victim is additionally doomed to silence, sometimes by fiat, always by shame . . . the role of repression is typically one of partial amnesia with occasional flashes of visual, auditory, or somatic memory" (Shapiro, 1988, p. 4). Dissociation ranges from an emotional numbing to complete amnesia of traumatic events. When memories threaten to reduce the "protective barrier," these mechanisms are employed to distance the memories.

The adult survivor, wishing to recreate this experience of escape, searches for other avenues to this state of oblivion. In a strangely paradoxical way, chemical abuse provides pleasurable sensations of excitement and at the same time induces numbness and a sense of being outside one's own mind and body. (Miller, 1994, p. 49).

### PLAY AS THERAPY

The differences between adult verbal thinking and a child's thought process probably underlie the development of play therapy. Therapists have long been aware of

the therapeutic qualities of play. Margaret Lowenfeld's research of the diagnosis and treatment of troubled children began in the early 1900s and focused on "the insufficiency of words to express those aspects of childhood thought and feeling which interested her most . . . her rejection of words as a medium of communication, unless they are supplemented by visible, manipulatable forms" (Lowenfeld, 1979, p. vii–viii).

A child does not think in a linear fashion as do many adults. A child's feelings, thoughts, and memories are not in a linear, chronological timeline or necessarily logically connected but are nonetheless intricately interwoven in a distinct pattern. Thinking takes place on multiple planes simultaneously. Children may think in pictures that may not be converted into words because pictures or actions may embody the idea more. Feelings themselves are not truly accessible at a verbal level due to undeveloped cognitive and verbal abilities. For a child, play is a natural way of "thinking," unlike using verbal means to express emotional concerns. Play therapy can utilize play itself to bridge the gap between child thinking and adult thinking (Landreth, 1993; Lowenfeld, 1939). Play therapy might also be used to facilitate verbal processing if this gap remains for the adult due to dissociation at the time of the sexual trauma.

In addition to verbal facilitation, several additional therapeutic benefits have been realized through the use of play therapy with children. Amster (1982) described several therapeutic advantages to using play therapy with children including: (a) the development of a working relationship with the therapist because it allows for non-threatening interaction using the familiar medium of play, (b) breaking down of personal defenses, (c) facilitation of verbalization because it allows for a distancing from the emotional event, and (d) cathartic release by allowing a child a safe avenue for the release of highly emotional material (Bow, 1993).

Free expression in a nonthreatening environment would seem a necessary prerequisite when working with adults who may be plagued by feelings of guilt and shame, fear and anxiety. Play is a natural occurrence and allows children to express themselves openly, allowing a release from strict self-control so that attitudes toward self, environment, and life can be expressed genuinely (Davis, 1952). It is an inherently satisfying activity whose motivation is simply to elicit pleasure. "The therapist uses play with children because play is the child's symbolic language of self-expression, and for children to 'play out' their experiences, and attitudes, is the most natural dynamic and self-healing process in which children can engage." (Landreth, 1993, p. 51). Once a child has allowed the feelings to surface and faced the feelings, he/she can choose to either control or abandon them (Axline, 1947). The player is allowed the freedom of expression without punitive consequences (Jack, 1987) and becomes more self-aware regarding personal preferences and dislikes (Arieti, 1976). Play is essential to children's

emotional, social, and cognitive development because it provides the opportunity for experimentation and exploration in communication, decision making, social skills and interactions, and feelings. "Play is the most complete form of self-expression developed by humans" (Landreth, 1993, p. 42). Play allows the child to immerse himself totally into an activity (Moustakas, 1981) and is distinguishable from other activities in that the motivation is not goal-oriented, but process-oriented.

Play within the context of counseling has similar implications in that it provides a place for the exploration of actions and consequences in a safe environment (without social consequences) while strengthening one's ability to cope in life (Liebmann, 1986). Further, play allows a child the option of distancing herself from her feelings when the content becomes too emotionally threatening (Eaker, 1986). A child can act out feelings and resolve internal conflicts because the child has a feeling of control while letting go (Landreth, 1991). Specifically, play can assist persons in rapport building, understanding relationships, and understanding problematic situations (Thompson & Rudolph, 1988). It has been suggested that free play, like free association, be utilized initially with clients until the therapist has a sense of the problems (Eaker, 1986).

Allan and Brown (1993), who take a Jungian approach in school counseling, suggest that once a therapeutic alliance has been established, children will play out their struggles in order to self-heal and move toward growth and wholeness. Axline (1969) noted that free play allowed children to express attitudes, desires, and feelings. Play allows for the release of tension and anxiety, along with laughter and relief from everyday stressors, while gaining a sense of self-control and personal confidence. Experienced as a group, cohesion and trust may be increased.

Play, when used in group treatment, permits clients to interact with one another and form nonthreatening, less defensive positions. Play allows for the free expression of one's self without consequences or external rules. It can provide healing and relief from anxieties. However, free play is as natural to adults as balancing a checkbook is to children. But, like children, as adults become more comfortable in a therapeutic setting, they tend to become more open to playfulness. Sometimes however, the playfulness elicited seems to be used as a vehicle to disguise rather than play out internal struggles. Thus play therapy for adults may require more therapeutic direction.

Some form of catharsis has been a goal of therapeutic treatment since Freud. Piaget (1962) noticed that as a child becomes comfortable in the play setting, play may take the form of re-enactments of the environment or develop into expressions of feelings about his environment. He proposed that the primary motivation of play is the mastery over conflict.

Anna Freud (1955) believed that negative and maladaptive behaviors were likely to result from traumatic

events if the individual did not express the emotions associated with the traumatic occurrence. Treatment for adults included the expression of the repressed emotions in order to assist in release from those emotions. Likewise, Nichols and Efran (1985) believe that catharsis is a way of defining emotions that may otherwise block persons from effective functioning because negative emotions may build up internal tensions that block personal goals. By releasing the interfering emotions, the client is better able to work toward personal mastery. Play therapy can provide a nonthreatening atmosphere for such a catharsis to occur, specific play therapy techniques can provide a protective shield of sorts.

The process of play then may be logically extended to adults who have experienced sexual abuse because it can provide some of the same cathartic benefits. That is, it may allow for free expression of feelings and events without the consequence of societal stigmatization. It can provide the opportunity for adults to release the feelings of shame associated with the past abuse. Adults may also find play a vehicle for internal conflict resolution. Play therapy can be used to safely work through "emotional memories," thus revealing anxieties and fears because play is a stabilizing experience, offering the comfort of a nonthreatening environment (Eaker, 1986).

One form of play therapy is the use of psychodrama or play-acting. Forward and Buck (1972) outlined treatment goals for adults molested as children and applied these in group treatment plans using these psychodrama techniques:

1. Externalize repressed feelings
2. Place the responsibility with the parents
3. Encourage the victim to direct the energy used for self-destructive behavior toward self-fulfilling behaviors.

In this way, treatment benefits parallel those of free-play for children in that attitudes, desires, and feelings are expressed as experiences that are played out. Blame is appropriately placed with perpetrators and responsible adults and a sense of self-control is established through the victim's direction of energy toward positive behaviors.

Another traditional play-therapy technique is the use of puppets with children. One of the first reported uses of puppets occurred in 1940. Woltman (1940) found that puppets allowed children to express their feelings regarding interpersonal relationships onto the puppets. They can also be used to verbalize impressions that cannot be easily stated (Frey, 1993). Puppets also provide a "misdirection" in that the focus of attention is directed at the puppet rather than the therapist. The child may feel more at ease speaking to or from the puppet. This was especially valuable in gathering information on sensitive topics, such as sexual abuse (Bow, 1993). By attributing the feelings, fears, fantasies, and guilt to a puppet or other objects, children maintain a safe psychological distance from traumatic experiences (Landreth, 1993), but are

able to develop courage and freedom through the expressions and move toward healthy living (Conn, 1989). Essentially, play therapy uses symbolic representation to establish a sense of self-control (Landreth, 1993).

In adults, psychodrama and puppets may be used to form a kind of protective barrier for the client. As with children, it may be easier for clients to attribute feelings, attitudes, and past experiences to the puppet or to "pretend." It may be more comfortable for clients to talk about themselves or others with such a distance. Through the use of these play techniques, adults may be able to express experience in a nonthreatening environment, experience cathartic release, and maintain a safe emotional distance.

Similar techniques may include bringing pets or toys into therapy. Children who bring their own toys into session have an established love connection with the pet or object (Lieberman, 1979) and may, therefore, be able to talk through the object with more ease and insight. A modification for adults in treatment might be the use of a saved love object from childhood (teddy bear) or a recreated lost love object.

## ART AS THERAPY

An artist's thought process may be closer to a child's thought process because of the reliance on visualization. In describing the qualities of an artist's thought process, Arnheim (1966) discussed the reliance upon the senses for thinking, calling this process *visual thinking*. It is the process of drawing from the feelings the thoughts that will allow for expression into a final art product. This permits the addition of feeling to cognitive thought that is expressed through the art form.

Jung believed that creativity could assist with healing and incorporated art making and writing into the therapeutic process (Allan & Brown, 1993). In their work with children using "art counseling," Allen and Clark (1984) observed that children progressed through chaos and struggle before coming to self-resolution and closure through art. Like children, artists do not think in a linear fashion, rather, the artwork produced is a dynamic interaction between feelings, thoughts, and the medium itself. Art is able to prompt deep and personal emotional reactions in the viewer because it beckons for a further connection between the viewer, the artist, and the art work; yet the art work itself allows the viewer safety from the emotional intensity it provokes (Peloquin, 1996).

There are two general approaches to art therapy. Emphasis can be placed upon the end product itself with secondary focus given to client interpretation or emphasis. It is usually offered in conjunction with other types of therapy. The therapist is interested in the end-product as a means of expression. The second approach places emphasis upon client free-associations and interpretations as the primary goal. This approach may be used because verbal expression is blocked and the approach may allow

for personal expression (Singer, 1993). Rubin (1987) concludes that art can be used to help children uncover imagery, examine and express feelings, facilitate communication, and overcome defenses. Erikson (1950) found art to be a way for the child to recreate difficult situations or experiences in order to gain mastery by reducing anxiety and gaining pleasure in finding resolve.

The available medium for personal expression is limited only by the imagination. The manipulation of clay has been suggested as a means to reduce anxiety and increase relaxation (Campbell, 1993). In their treatment of preadolescents and adolescents with histories of incest, Carozza and Heirsteiner (1982) noted that clay offered the participants an outlet for feelings of fear, anger, and anxiety. Schaefer (1981) found that the therapist must also be willing and able to access the child within himself in order to be in sync with the client and understand the spontaneity and playful nature of children so that it can be used advantageously. If the adult therapist relies solely on adult thinking, interpretation and understanding of the artwork is hampered.

To get any value out of the material, the user must find his way to an understanding of the possibilities of the material and gradually come to "find himself" in the medium, if it is to yield a really rich harvest. Careful record, therefore, of exactly what is done by each child at each use of the world material is very important, and this record must contain the maker's own description of it and his reaction to it, both in detail and as a whole. . . . As soon as the observer sets out to make such a record, an immediate difficulty arises. Words used in their ordinary grammatical sense and construction do not always express what has been created, something new is needed. . . . It is essential for the proper understanding of the nature and use of this technique that no interpretation be given by the therapist to the child. The purpose is to explore the as yet insignificantly known aspects of a child's inner experience. (Lowenfeld, 1979, p. 6)

There may be a significant overlay between art therapy with children as applied to adults, because the composite of the adult's experience is superimposed upon memories and attitudes of the child within. For some adults, art may be the vehicle that permits a release of unacceptable feelings and past events as well as a means of exploring recovery.

### LIMITATIONS

It may be unrealistic to presume that sufficient trust can be established to facilitate truly effective treatment within the time allotted for treatment by such external restraints as insurance coverage for publicly funded programs. This may explain the tendency by counselors to avoid opening a Pandora's box by staying with the limited treatment for the symptoms of substance abuse only and avoiding addressing the sexual abuse. It stands to reason that partial treatment can lead to a relapse cycle and the revolving door in the treatment facility because it leaves the client without necessary resources and sup-

ports to deal with both issues. Therefore, strong inter-agency ties are essential for long-term recovery. Referrals to community treatment groups for survivors (which are often free of charge) following treatment in the substance abuse treatment may also be beneficial.

Riszt (1979) noted that "a dearth of treatment reports on incest exists, and research to guide practitioners in appropriate therapeutic intervention with incest participants is needed or it is likely that treatment efforts will continue to be confined to symptom control" (p. 690).

Therapeutically, these disturbances need to be recognized as consequences of the untreated original effects of the abuse. Treatment must therefore be directed towards addressing the original trauma as well as its initial and chronic aftereffects. (Courtois, 1988, p. 117)

The effectiveness of play and art therapy has not been well documented or researched. Clients who may wish to simply enjoy the play or art, rather than push themselves toward resolution, may have a misconception of the counseling process. Looking for immediate results, they may not have the patience to work through art or play and may prematurely drop out of treatment. Further, if a client is ready to talk, they may not need this treatment mode (Gladding, 1993). However, the efficacy of play and art therapy for this population should not be dismissed within the traditional therapeutic setting because counselors who treat substance abuse may have little training or experience in the area of incest victimization. Counselor training in this area would broaden the knowledge and capabilities of counselors as well as assist counselors with proper referral decisions.

### DISCUSSION

It is becoming increasingly clear that the substance abuse treatment needs of clients cannot be accommodated fully by applying universal treatment techniques. Clients in treatment may use substances for a variety of reasons and purposes. It appears that a substantial number of clients in treatment for substance abuse also have a history of incest that may require specific, highly individualized treatment. Shame, self-blame, feelings of worthlessness, stigma, low self-esteem, and a lack of trust in others may stand as barriers to entering into therapy that is highly focused upon verbal interactions between clients and therapists. Furthermore, talk therapy may not be the most effective form of treatment because, due to dissociation, the client may not have previously verbally processed the experience and associated emotions. These memories may exist primarily as visual and emotive memories similar to those of a child. By utilizing therapy that is focused on play or visualization through art therapy, the adult client may process and work toward resolution.

In an atmosphere that allows one to draw upon childhood memories, haunting secrets and repressed feelings may at last surface so that the client may at last come to

terms with the past and be empowered to make positive changes (Eaker, 1986). Similar to childhood cognitive processing, traumatic events are frequently re-experienced in fragmented and multidimensional forms. A therapy that allows an individual access to all of those dimensions is more holistic and effective than merely treating the symptoms of substance abuse.

We separate ourselves from children in our roles, our relaxation, our diets, our dreams, and nearly every activity we engage in, as if that part of ourselves does not remain with us, and was never a part of us. Sometimes only in playing with our own children do we regain a glimpse of that lost world. Yet, there may be much lost in putting away our childhood things.

## REFERENCES

- Allan, A., & Brown, K. (1993). Jungian play therapy in elementary schools. *Elementary School Guidance and Counseling*, **28**, 30–41.
- Allen, J., & Clark, M. (1984). Directed art counseling. *Elementary School Guidance and Counseling*, **19**, 116–124.
- Amster, F. (1982). Differential uses of play in treatment of young children. In G.L. Landreth (Ed.), *Play therapy: Dynamics of the process of counseling with children* (pp. 33–42). Springfield, IL: Charles C Thomas.
- Arieti, S. (1976). *Creativity*. New York: Basic Books.
- Arnheim, R. (1966). Growth. In E.W. Eisner & D.W. Ecker (Eds.), *Readings and art education* (pp. 85–96). Waltham, MA: Blaisdell.
- Axline, V. (1947). *Play therapy: The inner dynamics of childhood*. Cambridge, MA: Houghton Mifflin.
- Axline, V. (1969). *Play therapy*. New York: Ballantine Books.
- Barnard, C.P. (1989). Alcoholism and sex abuse in the family: Incest and marital rape. *Journal of Chemical Dependency Treatment*, **3**, 131–144.
- Bass, E., & Davis, L. (1988). *The courage to heal*. New York: Harper & Row.
- Bow, J.N. (1993). Overcoming resistance. In C. Schaefer (Ed.), *The therapeutic powers of play* (pp. 17–39). Northvale, NJ: Jason Aronson Inc.
- Brown, H.M. (1991). Shame and relapse issues with the chemically dependent client. *Alcoholism Treatment Quarterly*, **8**, 77–82.
- Campbell, C.A. (1993). Play, the fabric of elementary school counseling programs. *Elementary School Guidance and Counseling*, **28**, 10–15.
- Carozza, P.M., & Heirsteiner, C.L. (1982). Young female incest victims in treatment: Stages of growth seen with a group art therapy model. *Clinical Social Work*, **10**, 165–175.
- Conn, J.H. (1989). Play interview therapy: Its history, theory and practice—A fifty year retrospective. *Child Psychiatry and Human Development*, **20**, 3–13.
- Courtois, C.A. (1988). *Healing the incest wound*. New York: W.W. Norton & Co.
- Davis, J.E. (1952). *Clinical applications of recreational therapy*. Springfield, IL: Charles C Thomas.
- Eaker, B. (1986). Unlocking the family secret in family play therapy. *Child and Adolescent Social Work*, **3**, 235–253.
- Erikson, E. (1950). *Childhood and society*. New York: Norton
- Evans, S., & Schaefer, S. (1980). Why women's sexuality is important to address in chemical dependency treatment programs. *Grassroots*, **37**, 37–40.
- Forward, S., & Buck, C. (1972). *Betrayal and innocence: Incest and its devastation*. Los Angeles: J.P. Tarcher, Inc.
- Freud, A. (1955). *The psycho-analytical treatment of children*. New York: International Universities Press.
- Frey, D.E. (1993). Learning by metaphor. In C. Schaefer (Ed.), *The therapeutic powers of play* (pp. 223–240). Northvale, NJ: Jason Aronson Inc.
- Gladding, S. (1993). The therapeutic use of play in counseling: An overview. *The Journal of Humanistic Education and Development*, **31**, 106–115.
- Glover, N.M., Janikowski, T.P., & Benshoff, J.J. (1995). The incidence of incest histories among clients receiving substance abuse treatment. *Journal of Counseling and Development*, **73**, 475–480.
- Glover, N.M., Janikowski, T.P., & Benshoff, J.J. (1996). Substance abuse and past incest contact: A national perspective. *Journal of Substance Abuse Treatment*, **13**, 185–193.
- Harrison, P.A., Hoffman, N.G., & Edwall, G.E. (1989). Sexual abuse correlates: Similarities between male and female adolescents in chemical dependency treatment. *Journal of Adolescent Research*, **4**, 385–399.
- Jack, W. (1987). Using play in psychiatric rehabilitation. *Journal of Psychosocial Nursing*, **25**(7), 17–20.
- Janikowski, T.P., Bordieri, J.E., & Glover, N.M. (1997). Perceptions of incest and substance abuse. *Addictive Behaviors*, **4**, 447–459.
- Kasl, C.D. (1989). *Women, sex, and addiction*. New York: Harper and Row.
- Koch, D.S., & Rubin, S.E. (1997). Challenges faced by rehabilitation counselors working with alcohol and other drug abuse in a "One size fits all" treatment tradition. *Journal of Applied Rehabilitation Counseling*, **28**, 31–35.
- Kondora, L.L. (1993). A Heideggerian hermeneutical analysis of survivors of incest. *IMAGE: Journal of Nursing Scholarship*, **25**, 11–16.
- Landreth, G.L. (1991). *Play therapy: The art of the relationship*. Muncie, IN: Accelerated Development.
- Landreth, G.L. (1993). Self-expressive communication. In C. Schaefer (Ed.), *The therapeutic powers of play* (pp. 41–64). Northvale, NJ: Jason Aronson Inc.
- Lieberman, F. (1979). *Social work with children*. New York: Human Sciences Press.
- Liebmann, M. (1986). *Art therapy for groups*. Cambridge, MA: Brookline.
- Lowenfeld, M. (1939). The world of pictures. *British Journal of Medicine and Psychology*, **18**, 65–101
- Lowenfeld, M. (1979). *The world technique*. London: George Allen & Unwin.
- Miller, D. (1994). *Women who hurt themselves*. New York: Basic Books.
- Moustakas, C. (1981). *Children in play therapy*. New York: Jason Aronson.
- Nichols, M.P., & Efran, J.S. (1985). Catharsis in psychotherapy: A new perspective. *Psychotherapy*, **22**, 46–58.
- Nielsen, L.A. (1984). Sexual abuse and chemical dependency: Assessing the risk for women alcoholics and adult children. *Focus on Family*, **7**(6), 6, 10, 11, 37.
- Peloquin, S.M. (1996). Art: An occupation with promise for developing empathy. *The American Journal of Occupational Therapy*, **50**, 655–661.
- Piaget, J. (1962). *Play, dreams, and imitation in childhood*. New York: Norton.
- Risz, K. (1979). Incest: Theoretical and clinical views. *American Journal of Orthopsychiatry*, **49**, 680–691.
- Rohsenow, D.J., Corbett, R., & Devine, D. (1988). Molested as children: A hidden contribution to substance abuse. *Journal of substance abuse treatment*, **5**, 13–18.
- Rose, S.M. (1991). Acknowledging abuse backgrounds of intensive case management clients. *Community Mental Health Journal*, **27**, 255–263.
- Rubin, J.A. (1987). *Approaches to art therapy: Theory and technique*. New York: Brunner/Mazel.
- Schaefer, C.E. (1981). *The therapeutic use of child's play*. New York: Jason Aronson.
- Schaefer, S., & Evans S. (1985). Women's sexuality and the process of recovery. *Journal of Chemical Dependency Treatment*, **1**, 91–120.
- Shapiro, M.K. (1988). Hypno-play therapy with adults: Theory, method, and practice. *American Journal of Clinical Hypnosis*, **31**, 1–11.
- Singer, D.G. (1993). Fantasy and visualization. In C.E. Schaefer (Ed.),

- The therapeutic powers of play* (pp. 189–222). Northvale, NJ: Jason Aronson Inc.
- Thompson, C.I., & Rudolph, I.B. (1988). *Counseling children*. Pacific Grove, CA: Brooks/Cole.
- Wadsworth, R., Spampneto, A.M., & Halbrosk, B.M. (1995). The role of sexual trauma in the treatment of chemically dependent women: Addressing the relapse issue. *Journal of Counseling and Development*, **73**, 401–406.
- Woltman, A.G. (1940). The use of puppetry in understanding children. *Mental Hygiene*, **24**, 445–448.
- Young, E. (1990). The Role of incest in relapse. *Journal of Psychoactive Drugs*, **22**, 249–258.