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Suitability of a community-based creative arts therapy intervention for abused children in South Africa: challenges and dilemmas

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Abstract

This article reports on the suitability of implementing a trauma-focused creative arts therapy intervention for children who have been abused in South Africa. The study aimed to explore implementation processes and outcomes associated with the delivery of this therapy. The intervention was implemented in a child trauma clinic situated within communities in and around Johannesburg, South Africa. While the intervention was found to be effective in reducing posttraumatic stress symptoms, the challenges of implementing and evaluating a new intervention programme within routine clinical practice in a developing context have been significant. We therefore outlined three major challenges referring to retention rates, the facilitator's skills and commitment, and the suitability of the evaluation methods used. Finally, we discuss how these challenges can inform us about the suitability of community-based and trauma-focused treatment in a developing context and make recommendations based on pivotal lessons learned.

Key words: creative arts therapy, child abuse, maltreatment, South Africa, suitability study

Introduction

Archbishop Desmond Tutu called South Africa a 'rainbow nation'[i], referring to a country characterized by diversity across socio-economic, cultural, ethnic, language and religious realms. According to the World Bank, South Africa is considered an upper-middle-income economy.[ii] The country has an unequal divide of socio-economic resources causing numerous people to live in extreme poverty. Currently, over 50% of South Africans live below the poverty line and poverty numbers are rising (Stats SA, 2017). There is a stark divide in the health care system between the public and private sector, with 80% of the population (about 40 million people) relying on public facilities, with only 30% of doctors and specialists serving this sector (Keeton, 2010). Many South Africans in rural areas still follow traditional explanatory models of health and seek health care through traditional healing rituals (Campbell-Hall et al., 2010).

The country has a history of violence. During Apartheid up to 1994, people were subjected to various violations of human rights, such as suppression, detention without trial and torture (Truth and Reconciliation Commission, 1998). This violent history is still leaving its mark upon contemporary society; post-Apartheid South Africa is characterized by increased hostility and interpersonal violence. Death rates caused by interpersonal violence are four and a half times the global average (Seedat, van Niekerk, Jewkes, Suffla, & Ratele, 2009). Violence against women and children is particularly prominent; the rate of homicide of women by intimate partners is six times the global average, and it has been reported that up to 39% of girls have undergone some form of sexual violence before the age of 18 years (Seedat et al., 2009).

This article reports on the suitability of implementing a trauma-focused creative arts therapy intervention for abused children in South Africa. The study aimed to explore implementation processes as well as outcomes associated with this intervention that was implemented in communities in and around Johannesburg. The significant challenges and dilemmas of implementing and evaluating such a new intervention programme within routine clinical practice in a developing context is the topic of this article.

Child maltreatment

Child abuse or maltreatment includes 'all forms of physical and emotional ill-treatment, sexual abuse, neglect and negligent treatment, emotional abuse, and exploitation that results in actual or potential harm to the child's health, development or dignity' (WHO, 2017, para 1). Child sexual abuse prevalence rates in South Africa have been reported to be around 35%, or one in every three children (Optimus Study, 2016). Moreover, a study among rural South African youth self-reported physical abuse rates of 89.3% for girls and 94.4% for boys, emotional abuse rates of 54.7% (girls) and 56.4% (boys), and emotional neglect at 41.6% for girls and 39.6% for boys (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010).

Studies in South Africa have reported that child abuse increases the risk of HIV/AIDS, other sexually transmitted infections and unwanted pregnancies (Garwood, Gerassi, Jonson-Reid, Plax, & Drake, 2015; Jewkes et al., 2010), as well as substance abuse (Jewkes et al., 2010), and common mental disorders such as post-traumatic stress disorder, depression and suicide (Fincham, Altes, Stein, & Seedat, 2009; Jewkes et al., 2010). Exposure to violence and neglect in childhood can also have severe consequences later in life. For instance, girls exposed to sexual abuse are at increased risk of physical and/or sexual violence later in life and adult sexual assault (Dunkle et al., 2004), and boys who have been abused in childhood are at increased risk of later becoming perpetrators, resulting in an intergenerational cycle of violence (Jewkes et al., 2006; Seedat et al., 2009).

The consequences of child maltreatment are a serious public health concern world-wide. It is a cross-disciplinary challenge that impacts on all different levels of society (Mathews & Collin-Vézina, 2016), including public health, social justice, gender equality, human rights (Reading et al., 2009), as well as the economy (Fang, Brown, Florence, & Mercy, 2012). All these facts stress the importance and urgency of sufficient intervention programmes for children after abuse.

Therapy after child abuse

Current resources in South Africa are insufficient to provide sufficient mental health care for the extreme high number of victims of child maltreatment (Optimus Study, 2016). Moreover, most psychological treatments are based on Western health care models developed in first world countries that are not only expensive and thus inaccessible for disadvantaged communities, but also foreign and disconnected to indigenous and multicultural traditions (Campbell-Hall et al., 2010). Creative arts therapy could be a suitable mental health treatment in this context, considering that creative expression is inherent to most South African cultures as reflected in rituals that include narrations, song, dance, beading and painting. Foreign concepts of 'Western' therapy could be introduced in combination with more familiar forms of expression including dance, arts, music and drama. Although scientific research is limited compared to other trauma therapy forms (Van Westrhenen & Fritz, 2014), creative arts therapy has been suggested to have specific benefits for individuals who have experienced trauma in the sense that it could help to process sensory experiences of trauma that are otherwise difficult to express verbally (Levine, 2010) and that it could facilitate reflection and externalizing thoughts in a non-threatening environment (Cassidy, Turnbull, & Gumley, 2014). Furthermore, in a country with eleven official languages such as South Africa, a therapy that does not rely on speech is appropriate, because it avoids possible language barriers between therapist and client.

Although studies on evidence-based interventions for children after trauma have been documented in scientific literature (Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2013), most interventions are based on Western health care principles, and have only been tested in high-income countries. As Tol and colleagues (2011) pointed out in a review, there is a serious gap between research and practice when it comes to interventions in low- and middle-income countries, and the most commonly used interventions (e.g. counselling and community-based support programmes) are noted to have the least rigorous research and evidence. In order to address these gaps, we designed, implemented and evaluated a creative arts therapy intervention programme for children who have experienced maltreatment in South Africa (van Westrhenen, Fritz, Oosthuizen, Lemont, Vermeer, & Kleber, 2017).

In the course of this project, however, we came to struggle with various dilemmas, such as barriers to accessibility, complications concerning language and cultural barriers, managing high volumes of clients, and empowering semi-skilled professionals. The challenges in this project turned out to be substantial. Therefore, the aim of this paper is to discuss the challenges experienced and lessons learned, in the hope that this knowledge will be helpful to others facing similar circumstances.

Methods

Over a period of three years, 125 children participated in the study: 74 children were in the treatment condition, and 51 children were in the control condition, receiving a low-level supportive programme without treatment. Participants were considered eligible for the intervention study if they experienced one or multiple events of abuse (physical, sexual, emotional or neglect) between three months and twelve months ago and were in the age between 8 and 12 years at the time of enrolment. Participants were recruited at a local child abuse clinic in Johannesburg, South Africa.

The creative arts therapy protocol

The creative arts therapy programme is a structured, group-based therapy for children after trauma, aiming to enhance psychological wellbeing and strengthen coping strategies (van Westrhenen et al., 2017). The programme combines psychotherapy principles with creative arts activities in order to facilitate healing through three different stages of a trauma recovery model (Herman, 1992). The first phase (session 1-3) focuses on establishing safety, in which activities aim to create trust among group members, facilitate psycho-education, and practising self-care through relaxation techniques. In the second phase (session 4-6) disclosure was encouraged in an indirect manner through creative activities, anxiety is reduced through relaxation techniques, and emotional identification and emotional regulation is practised. The third phase (session 7-10) focused on preparing the children to go back to their communities, with emphasis on resilience and coping strategies. The programme is facilitated in groups of 6-8 children by a trained professional healthcare worker.

Outcome measures

In order to evaluate the effect of the programme, an embedded-mixed methods design using a non-randomized controlled trial was used. Quantitative data were the main source of information and the effect of the therapy was measured with regard to posttraumatic stress symptoms, posttraumatic growth and behaviour problems, comprising three questionnaires; the Child PTSD Checklist (C-PTSD-C) (Amaya-Jackson, McCarthy, Chemey, & Newman, 1995) and the Posttraumatic Growth Inventory for Children- Revised (PTGI-C-R) (Kilmer et al., 2009), administered with the children, and the Child Behaviour Checklist (CBCL; Achenbach, 1991) administered with the parents or primary caregivers of the children. Qualitative data comprised semi-structured interviews with the parents and social workers

facilitating the therapy as well as observations during therapy, aiming to support the quantitative findings and provide further insights into the therapy process. Furthermore, researchers involved in the project made constant field notes, as constant monitoring and evaluation was an integral part of the project, allowing for continuous improvement and development of the programme.

Procedure

At the start of the project, a partnership was established between the trauma clinic and the first researcher. After approval by the board of the trauma clinic, a team of local social workers, staff members, and researchers both from in- and outside South Africa got involved in the project. Ethical clearance for this study was provided by the Department of Psychology at the University of Johannesburg. Funding for the project was raised through crowdfunding initiatives, although costs were aimed to remain low in order to increase sustainability. The first step of the project was to assess needs through qualitative research. This phase included interviews with local social workers and observations done by the primary researcher volunteering in the clinic for a year (conducting intakes with clients and co-facilitating therapy groups) in order to assess the possibilities for implementing the programme. In the second step, the creative arts therapy intervention protocol was developed in collaboration with local psychologists and creative arts therapists. Subsequently, training and supervision were organized for the social workers of the clinic. In total, four social workers were trained in the first year, and due to high staff turnover, training was repeated annually. In the final step, children were referred to the programme, information was provided to the participating families beforehand in their home language and parents signed consent indicating commitment. The programme was facilitated by social workers, and programme evaluation took place according to the previously mentioned outcome measures.

Results

First, we will briefly mention the results concerning the treatment outcomes. Detailed reporting of the evaluation results, however, are beyond the focus of this current article (e.g., Van Westrhenen, Fritz, Vermeer & Kleber. 2017; Van Westrhenen, Fritz, Vermeer, Boelen, & Kleber, 2019). After reporting the treatment outcomes, we will highlight three major challenges that were identified based on systematic documentation of information and experiences of all researchers and social workers involved. These three challenges concerned recruitment and retention, facilitator’s skills and commitment, and the evaluation design.

Treatment outcomes

From the 125 children referred to the project, 62.4% dropped out. Based on a final sample of 47 participants (23 in the treatment condition, 24 in the control condition), quantitative results showed that both hyperarousal and avoidance posttraumatic stress symptoms decreased

significantly more in the treatment group compared to the control group (van Westrhenen et al., 2019). Behaviour problems reduced and posttraumatic growth increased, but this was not found to be significantly different from the control group. In the interviews and informal conversations, the parents reported improvement in the child's behaviour at home, for instance they showed less aggressive behaviour (e.g. less fighting with other children), they played more with other children and they reported less nightmares. Social workers were positive about the therapy, saying that the children moved from a point of being a victim to being survivors.

Challenge 1: Recruitment and Retention

The first major challenge encountered was the difficulty in acquiring sufficient respondents for our study. Despite the high prevalence of child abuse and neglect in South Africa and although the clinic (located in Johannesburg, a city with approximately 5 million inhabitants) supported many children who have experienced maltreatment, there was a high dropout rate. Of the 125 children referred to the project over three years, 62.4% dropped out during the course of the programme, in both the experimental group and the control group. Furthermore, more than 50% of the children in the experimental group only attended one or two sessions out of the prescribed ten, resulting in three out of the nine therapy groups being terminated prematurely due to low and inconsistent turnout. Another constraint was that parents and children that did show up could easily be one to two hours early or late, complicating adherence to session routines and structure of the creative arts therapy intervention protocol. The high dropout results were obtained despite the fact that the clinic in which the therapy was run was located within the communities, the services were provided free of charge, and where possible transport or transport money was provided to the families. Also, in an attempt to facilitate commitment, weekly reminders were sent to the parents via SMS, and food and beverages were regularly made available in the sessions.

Challenge 2: Facilitators' skills and commitment

A second challenge included the wide variety in skill levels, professionalism and commitment of the facilitators; some social workers were highly involved, dedicated, and collaborated with the researchers, others were overwhelmed by their workload or reported feeling aggrieved. There were instances of problematic administration; the client files contained missing or inaccurate information, resulting in incorrect referrals of children who did not meet the therapy inclusion criteria, and therapy progress notes that went missing. There were challenges with punctuality; facilitators did not always adhere to the creative arts therapy manual, changed activities, changed session times and structures, or cancelled sessions last-minute, impacting on routine and retention. Another concern was the elevated levels of resentment and frustration amongst a part of the clinic staff towards the project, resulting in a breakdown in communication. Although a major aim of the research was to benefit the clinic and the children attending the clinic directly, social workers at times had the impression that it was the researchers who were going to gain the most from the

collaboration. Also, some managers at the clinic did not allocate sufficient time to the social workers for the project. This added pressure to the social workers who had high caseloads whilst working in a minimally paid capacity. When the social workers facilitated the creative arts therapy programme a number of times, they reported experiencing the benefits of the therapy, they started feeling more confident in their own abilities, and they were more likely to maintain their positive contributions in the programme. Lastly, the staff turnover at the clinic was high, in the first year 50% of those that were trained and supervised in creative arts therapy protocol left the clinic, the second year this was 66%. Due to this very high staff turnover, investments in terms of training and supervision that were made did not last, and training and supervision had to be repeated.

Challenge 3: Evaluation design

The researchers experienced challenges in the evaluation of the creative arts therapy programme. Attendance was low and inconsistent, and due to the low literacy rates and language barriers, understanding of questionnaires was problematic. It was initially noticed that the young participants struggled to understand the Likert scales, and the attention span for children as well as the parents was relatively short. When working with orphans it was at times hard to find someone who could report on the emotional and behavioural history of the child, due to a high staff turnover at orphanages. In response to the language challenges, further translation in the various South African languages were made available. Moreover, visual cues were introduced to indicate the Likert-scale answers options of the questionnaires. Even considering these adaptations, reliability of the questionnaires in this context in our opinion remained questionable. Considering that this study was pioneering in this field and therefore explorative in nature, reliability and validity of instruments could be optimized in future research.

Discussion

Previous studies have outlined the urgent need for more community-based trauma interventions and evidence-based studies in developing countries (e.g. Tol et al., 2011). Although the implemented creative arts therapy intervention aimed to respond to this need whilst addressing previously reported barriers by following specific recommendations, such as decentralization of services, capacity-building through training, and incorporating a culturally congruent and low-cost approach (Saraceno et al., 2007; Tol et al., 2011, 2014), implementation of the programme into routine practice in South Africa encountered significant challenges. Below we will discuss the suitability of the intervention programme by reflecting on the challenges experienced.

Exploring barriers to access to treatment

Several reasons for the problems with recruitment and retention in this study can be distinguished. The clinic was not as decentralized or well-established in the community as initially thought, as turnout reflected little interest in or accessibility to the psychological services offered. One explanation for this could be rather practical: although services were free of charge, parents reported not being able to pay for transport to travel to and from the clinic. However, because transport costs for some groups were fully funded and still attrition was high, it was unlikely that this was the main reason for non-attendance. Moreover, problems with accessibility may be strongly influenced by a mismatch between the offered services and the acceptability of services based on health literacy and cultural norms and values. Traditional explanatory models of health in South Africa often refer to spiritual causes of ill health such as ancestors, for which patients seek the help of a traditional healer instead of a medical professional (Campbell-Hall et al., 2010). It is not uncommon that traditional communities favour existing (more traditional) practices over new interventions, as they are more in line with cultural beliefs and traditions about ill health and how it should be treated (Tol et al., 2014). Although the creative arts therapy tried addressing the gap between the western and more traditional practises, by using creative mediums, the concept of therapy may still have been too foreign for the community and more education is needed in this area.

Another possible explanation for the low acceptability of treatment relates to research that shows that poor health is usually associated with low income and poverty, not only in developing countries (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). The relationship between socio-economic status and wellbeing is influenced by locus of control, or the subjective sense of control over particular life circumstances (Marmot, 2004). People with a low socio-economic status in the society who have a low sense of control may be less likely to seek help from health care professionals, or do not see the benefits of such help, compared to those who have a higher status. Additionally, the stigma around mental health illnesses and HIV/AIDS (an overwhelming problem in South Africa) of which the child is at risk after sexual abuse, also effects help-seeking behaviour (Jewkes, 2010).

The difficulty to reach patients and the dropout of mental health treatment are well-known issues in cross-cultural studies (Bruwer et al., 2011). They are considered serious and difficult to handle problems, especially among people who have low income, lack insurance, are from different ethnic backgrounds and have negative or ambivalent attitudes towards mental health care. The social workers, although black, were not necessarily culturally aligned to the participants, keeping in mind that there are various ethnic groups amongst the black population. Specific interventions targeting these groups are needed to increase the proportion of patients who complete an adequate course of treatment.

Improving practitioner's practice

The lack of commitment by some of the social workers could be attributed to their high caseload, in combination with a lack of training, supervision and management. It is considered a key barrier in low- and middle-income countries that health care workers are generally overburdened with multiple tasks and patient loads (Saraceno et al., 2007), and even though the group approach in the creative arts therapy protocol was aimed to address this barrier (by enabling to help more people at once), the initial buy-in and commitment from the clinic staff was lacking to make it work. Furthermore, this lack of commitment is a rather frequently occurring problem in cross-cultural research (Knipscheer & Kleber, 2005). Researchers are often confronted with suspicion and reluctance.

Ethical considerations for community-based research in a developing context

The selected questionnaires for this study were used before in previous studies in comparable settings in South Africa, and reliability and validity measures were published. Based on our experiences with the administration of these questionnaires, we were surprised not to find any reports on the limitations of administering these questionnaires in this context. Although it is quite common to use standardized questionnaires developed in the western world in non-western settings, there is serious doubt about their cross-cultural validity and reliability in settings that are characterized by abuse and poverty (Bolton, 2001). The interplay between qualitative and quantitative forms of research should be utilized better and more frequently.

Furthermore, the effectiveness of trauma-focused treatment in a context of ongoing adversity, such as in the case of chronic poverty, community violence and war, has been questioned. For instance, psychological treatments are not always effective when someone experiences ongoing stress and compounded trauma (Nickerson, Bryant, Silove, & Steel, 2011; Tol et al., 2014a). It can be debated whether introducing trauma-focused treatment in such settings without also addressing psychosocial problems is sustainable (Miller & Rasmussen, 2010). Daily stressors have substantial impact on mental health outcomes (e.g. Miller, Omidan, Rasmussen, Yaqubi & Daudzai, 2008), yet psychosocial interventions that exclusively target these daily stressors risk overlooking the need for more specialized trauma treatment.

Ethical dilemmas such as having to choose between investing in a psychosocial intervention or trauma-focused treatment although moral obligations would suggest adopting both, (e.g. Beauchamp & Childress, 2001), increase the risk of compromising the reliability and validity of a research study. Although in our study the main aim was to provide trauma-focused treatment, we were concerned about the physical health of the children (mostly living in vast townships of South Africa) when they were continuously reporting being hungry and therefore struggled to concentrate on the therapeutic activities. We quickly realized that it was impossible to treat the traumatic stress symptoms in isolation of psychosocial challenges, but struggled to find the right balance between trauma-treatment and psychosocial support, in our capacity as psychologists and researchers.

Conclusions

Based on the challenges discussed above, we formulated a number of recommendations for future studies in a comparable context.

- Considering our methodological challenges and concerns using questionnaires in a complex multicultural context and to ensure cultural validity, we recommend that future studies consist of a mixed design (Boeije, Slagt, & van Wesel, 2013), including methods such as clinical interviews, focus groups, semi-structured interviews, and observations, in combination with developing and administering cross-culturally validated questionnaires.
- In order to decrease geographical barriers to access of mental health care, providing clinical services inside schools, churches, or other well-established organisations within the community could possibly help.
- More education should be provided to the communities on the possible benefits of (creative arts) therapy to eliminate existing barriers on acceptability. This should be a primary focus of future studies and could be done by for instance social workers, teachers and spiritual leaders.
- Considering the complexity and cross-disciplinary nature (e.g. anthropology, economy, law, psychiatry, psychology, sociology) of the challenges we encountered, we recommend interdisciplinary research initiatives working on scientific and clinical practice issues related to child maltreatment (Freyd et al., 2005) and community-based mental health interventions. This would have helped us to get a more holistic understanding of the context we were working in, and possibly would have eliminated some of the experienced challenges in this context from the beginning.
- In order to implement successful interventions in this context, the health care workers executing treatments require more organisational leadership support. This can be achieved when for instance specialist staff primarily takes on the role of managers and supervisors (Saraceno et al., 2007), and social workers are supported and receive continuous professional development. Involvement of different people from different levels in the organization and community, such as is the case in participatory action research, can help project commitment and possibly reduce cultural and attitudinal barriers between researchers, staff, and clients (Saraceno et al., 2007).
- Based on feedback and observations from social workers, we learned that success was related to the social workers' feelings of self-efficacy (Bandura, 1977), experience in facilitating groups, and hours of training and supervision. Therefore, it is crucial to set good examples within an organization and share success stories. This will stimulate participation and interest in the facilitation of therapy programmes amongst staff members and ultimately affect the success of a programme.

- Considering the ethical dilemma we faced between providing psychosocial support vs psychological therapy, we find merit in developing an ethical problem solving model for research with at-risk population groups in developing countries. Such a model could provide a framework to examine complex situations considering multi parties interests', using a systemic multi-step approach to guide decision making. Using a foundation such as the ethical decision making model by Koocher and Keith-Spiegel (2008), research can be conducted into developing such a framework.
- Finally, we see merit in introducing creative arts therapy in the South African context, because it incorporates creative mediums that connect with the community's traditional ways of emotional expression. Despite the major challenges experienced implementing and evaluating this study, our results suggested a positive effect of the therapy on reducing posttraumatic stress symptoms. More research though should be conducted to create a stronger evidence-base in this field.

We hope that our insights with regard to research in poor communities in South Africa can guide similar studies into how we can best support the high numbers of children who have been abused in developing countries. We specifically experienced challenges around recruitment and retention, facilitators' skills and commitment, and the evaluation design. We recommend further research on help-seeking behaviour in impoverished and multicultural communities, and the close collaboration between researchers, health care professionals, also including patients/clients from the communities in decision making and implementation of treatment protocols. Due to the multi-faceted nature of the problem of child maltreatment, different interdisciplinary pools of knowledge are required to effectively address the problem. Increasing training and supervision of qualified health care professionals and the inclusion of mixed research designs are possible strategies to improve evidence-based mental health care for the large number of traumatized children who need psychological help. Lastly, we acknowledged the ethical dilemmas researchers face between providing trauma-focused and psychosocial support in a context of ongoing stress and trauma, and we recommend the development of an ethical problem-solving model to guide decision making.

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[i] http://southafrica.co.za/desmond-tutu.html
[ii] https://data.worldbank.org/country/south-africa