A New Beginning:
An Exploration of Drama Therapy and the Facilitation of Attachment
Between Mothers with a History of Childhood Sexual Abuse and Their Children

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ABSTRACT

A New Beginning:
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Traumatic events such as childhood sexual abuse have the ability to destroy a person's inner and outer world. Such incidents can shatter the construction of the self that has been formed by the individual as well as the ability to form and sustain relationships with others. One of the most important relationships that can be affected is that of a mother and her child. This research paper explores the potential value of drama therapy as a therapeutic approach for strengthening the attachment between women survivors of childhood sexual abuse and their children. The paper begins with an examination of the current state of knowledge about childhood sexual abuse and the impact upon the women who live through this experience as they grow into adulthood and motherhood. This is followed by a review of attachment theory and the ways in which a mother's history of sexual trauma and her own maladaptive attachment experiences may interfere with the attachment relationship between her and her child. Finally, throughout this exploration of theoretical models, connections will be made establishing the benefits of drama therapy and its employment of the unique aspects of non-verbal media, along with other creative interventions that may be applicable at different stages of treatment for both mother and child individually and in dyadic formation. Ultimately, specific drama therapy interventions will be discussed as advantageous models for the delicate and complex

process of recovery from childhood sexual abuse, as well as for facilitating engagement

and increasing the quality of attachment between mother and child.

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Introduction

Research Methodology

Qualitative research is an approach used to study social phenomena and is essentially "...grounded in the lived experiences of people" (Marshall & Rossman, 2006, p.2). As this paper aspires to guide the reader towards a deepened comprehension of complex social interactions and the human experience, it falls within the qualitative method of inquiry. A significant focus of this paper is to gain greater insight into the unresolved trauma of women who have experienced sexual abuse as children and the burden of carrying that trauma into motherhood. The aim of this focus is to interpret the negative impact trauma places upon the attachment bond between a mother and her child and to illustrate how drama therapy interventions may be effectively used to help heal any damage caused to the relationship.

Theoretical research requires the researcher to pull together the ideas and knowledge behind existing theories and use them to generate new knowledge and theory; to take what is known and synthesize in a new way. The researcher is able to develop a unique perspective from existing thoughts and theory: forming new ideas in the present by building upon those from the past. Subsequently the goal of this research paper is to develop an integrated body of work that is supported through critical analysis and the synthesis of sources, resulting in a more comprehensive and integrated theory that extends the base of knowledge that the researcher's proposed theory has been based on.

With respect to the existing research, how can drama therapy interventions help facilitate secure attachment between a mother with a history of childhood sexual abuse and her child? A historical-documentary methodological approach will allow for a

comprehensive and critical investigation of the relationship between the theory of

childhood sexual trauma and the theory of attachment. This examination will provide an

opportunity to explore the effects of the former upon the latter and the potential benefits

of employing specific drama therapy methods as a basis for treatment. A thorough

inquest into these connections, along with the exploration of the healing potentials of

drama therapy interventions will lead to greater insight into this under-examined area of

study and promote the need for further development of treatment plans geared towards

the specific needs of this population.

The following paper examines research conducted in the areas of childhood

sexual abuse, attachment, and drama therapy. Specific interventions are explored within

the framework of drama therapy which may be the most beneficial for sexually abused

women and their children. The amount of information available within each of the above

areas is extensive and far beyond the limits of this paper; therefore, emphasis has been

placed upon relevant literature and research findings that best delineate the

interrelationship between these subject areas and consequently lead to strong, supported

conclusions and recommendations.

Trauma of Childhood Sexual Abuse

In order to fully comprehend the implications associated with the trauma of

sexual abuse, it is important to begin with an understanding of this traumatic experience

and the devastating lifelong impact that it can have upon the victim. Only once the effects

are understood, is it possible to determine and develop the treatment plans that would be

most beneficial to both the women who have experienced the abuse and their children

who can and do suffer from the long term effects of their mother's unresolved trauma.

Definition

Knowledge and understanding of Childhood Sexual Abuse (CSA) has greatly increased over the years in terms of public awareness as well as in scientific and clinical research; however, there is still quite a long way to go. Although CSA has progressively entered public awareness, its hidden nature and accompanying secrecy makes research concerning frequency and prevalence quite complex (Sanderson, 2006). Another important factor to point out is that despite the information and understanding that exists regarding the act of CSA, there does not exist a universally agreed definition as to what constitutes CSA. According to Sanderson, this difficulty in defining the term stems from the reality that attitudes towards children and sexuality are reflected differently from culture to culture for example: the differing legal age for sexual consent across cultures and the existence of different childrearing practices, which leads to a diverse range of sexual practices involving children. Despite these difficulties however, it is imperative as a researcher and as a clinician to have a working definition in order to gain a deeper understanding of CSA and to form a base when working with adult survivors. For this paper I will be working with the UK's Department of Health (2004) definition of CSA which is as follows:

> forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) and non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material, or watching sexual activities, or encouraging children to behave

in sexually inappropriate ways. (p.9)

Research indicates that the growth and advancement of the various symptoms and difficulties, which can result from CSA, are impacted by conditions such as severity of the abuse, the concomitant experience of other childhood abuses, and the circumstances under which the abuse occurred (Hartman & Burgess, 1993; Sanderson, 2006). Therefore, understanding how CSA has affected the victim will depend on the context of the abuse experienced.

Long Term Effects of Child Sexual Abuse

Most studies indicate that although the consequences of CSA for the child and future adult can vary enormously, it does have a tremendous impact on the child in a number of harmful ways. According to the research, the following factors play a significant role in the varied effects that result from the impact of CSA: age of the child at onset of CSA, duration and frequency of the CSA, type of sexual act(s), use of force or violence, relationship of the child to the abuser, age and gender of the abuser, and effects of disclosure (Bagley & King, 1990; Courtois, 1988; Duncan, 2004; Finkelhor, 1984; Hall & Lloyd, 1989; Mrazek & Mrazek, 1981; Sanderson, 2006). The impact of CSA varies greatly from individual to individual depending on a number of factors; it is therefore, crucial for a therapist to understand the range of experiences when developing a treatment plan. Extensive research and clinical data have established that there are long-term negative effects for a significant portion of mothers with CSA histories; when reviewing the literature produced by this research it becomes evident that there is a broad range of symptoms linked with CSA (Cross, 2001; Trickett & Putnam, 1998). Some of these symptoms may appear during childhood or later during adolescence; others,

however, may remain dormant and not emerge until later adulthood (Bagley & Ramsay, 1986; Hall & Lloyd).

CSA has been found to cause long term affects on many aspects of an individual's life including personality development, interpersonal relating, self-perception, and social functioning (Bagley & King, 1990; Courtois, 1988; Finkelhor & Browne, 1985). Problems in these areas "...create difficulties that disrupt relationships, prevent the development of appropriate ways of expressing affection or other emotions in intimate relationships, and interfere with the development and establishment of a positive identity and self concept" (Duncan, 2004, p. 97). Adult women with a history of CSA are also at greater risk of psychiatric problems such as depression, anxiety, self mutilation, and substance abuse (Cross, 2001; Fromuth, 1986; Greenwald et al., 1990; Stein et al., 1988). Given that CSA can have severe and long-lasting effects upon different levels of self such as interpersonal, intrapersonal, and cognitive functioning, an examination and understanding of the impact and indicators that exist at each of these levels is necessary.

Impact on Cognitive and Psychological Development

On a cognitive level, the trauma endured can be especially destructive when a child is sexually abused, for those years are crucial to the developmental process, and this period is when necessary capacities for identity formation and emotion regulation are being created (Hooper & Koprowska, 2004; Stovall-McClough & Cloitre, 2006). Piaget (1962, 1963) defines assimilation as the application of new experiences into already existing schemas and accommodation as the altering of a child's previous schemas to conform and correct the incongruity between reality and play. When looking at traumatic events such as sexual abuse, Horowitz (1986) defines such traumas as situations that

provide the victim with information that is inconsistent and cannot be assimilated into her existing schemas of herself in relation to the world. Assimilation and accommodation are constantly working together to enable the child to attune to her surroundings and match her schemas to reality, allowing for successful adjustment to occur (van der Kolk, 1987; van der Kolk et al., 2007).

Many studies have established that when a child is sexually abused, the trauma can lead to confusion for the child and result in a failure of her understanding of, and capacity for, play (Pynoos & Nader, 1988; Terr, 1988; van der Kolk et al., 2007). This confusion is created when the child's distinction between play and reality becomes blurred as the normal intimate play of childhood, such as tickling and other playtime games, are distorted by the abuser for his or her own arousal and power (Herman, 1981; Johnson & Forrester, 2004). The result is that the child will stop actively imagining if she has come to believe that what she imagines will end up becoming a reality (Johnson & Forrester).

Psychoanalytic theory's impact upon play has been abundant: "Its emphasis is upon play and a way of mastering and dealing with traumatic experiences and in its influence upon individuals' psychological maturation and development" (Jones, 1996, p.169). Winnicott (1971, 1974) describes play as an area of *potential space* which is of fundamental importance for a child to develop relationships between her inner world and outer experience. It is therefore a space in which a child's personal identity and the outer world are negotiated in terms of meaning and relationship (Cattanach, 1992; Jones; Winnicott). If the child is lead to believe that the interpersonal realities inherent in a sexually abusive relationship are representative of normal intimacy, reality permeates this

playspace; violating it and destroying the safety that was once found within it (Johnson & Forrester, 2004). As the traumatized child's ability to imagine is constricted, a healthy balance of assimilation and accommodation may not be achieved, leading to the unhealthy development of a *playspace* infused with fear and an imbalanced interaction between self and other (Courtois, 1988; Johnson & Forrester; Winnicott).

A main task of childhood that is crucial for development is learning to orchestrate collaborative relationships with other human beings; (Bretherton, 1984; Cattanach, 1992; Garvey, 1990; van der Kolk et al., 2007) however, when a sexually abused child is flooded with pain, fear, and confusion that cannot be assimilated, her ability to accommodate is lost, and sequentially, so is her ability to anticipate, self-correct, and balance the interaction between herself and her environment (Courtois, 1988). The effects of sexual trauma may not be revealed through a child's overt behavior until the demands of the outside world begin to encroach on her, which could be during adolescence, or perhaps not until later adulthood. Although the sexual abuse may have long been ended, the psychological dysfunction and distress remain enveloped in the ambiguity of denial and avoidance (Bagley & Ramsey, 1986; Finkelhor, 1984; Hall & Lloyd, 1989; Herman, 1981). The significant contribution of play to a child's intellectual growth and development of thought processes has been clearly established; therefore, when play is immobilized due to the trauma of sexual abuse the overall result could potentially be that the child misses a critical developmental stage where important skills are acquired, skills that are essential to function competently as an adult (Cattanach; Johnson & Forrester, 2004; van der Kolk et al.).

Severe sexual abuse can cause children to resort to many different psychological

defenses (Herman, 1997). The fourth edition of the Diagnostic and Statistical Manual of

Mental Disorders (DSM-IV; American Psychiatric Association, 1994) defines

dissociation as "a disruption in the usually integrated functions of consciousness, memory,

identity, or perception of the environment" (p.477). Research has revealed an alliance

between dissociation and a history of trauma, most specifically childhood abuse (Putnam

et al., 1995; Sanderson, 2006). While various childhood abuses have been found to be

associated with dissociation, CSA survivors have been indicated as having the highest

potential for dissociative disturbances (Sanderson; Zlotnick et al., 1996). Research has

also established that CSA can impact all aspects of both the child and later adult survivor,

creating various and all-encompassing physical, biological, and neurobiological

disturbances (Courtois, 1988; Glaser, 2000; Herman 1981, 1997; Teicher, 2002; van der

Kolk et al., 2007). Later research has suggested that the early onset of CSA is a common

indicator of later dissociative disturbance, more than likely due to the neurological and

cognitive immaturity and underdeveloped sense of identity of the abused child (Chu,

1999; Kirby, Chiu & Dill, 1993; Waldinger et al., 1994).

Dissociation has been found to serve many purposes and therefore exists on a

continuum (Courtois, 1988; Price, 1987); it can allow the child to alter his or her reality

as a way to cope with the abuse by minimizing or avoiding the reality of the traumatic

experience (Hartman & Burgess, 1993; Herman, 1997; Ludwig, 1983; Putnam, 1993; van

der Kolk, 1987), becoming both a defense adaptation as well as a key principle of

personality organization. Whether a child contends with abuse by dissociating can be

determined by the frequency, intensity, and length of the abuse (Egeland & Susman-

Stillman, 1996; Hartman & Burgess). If a child is experiencing ongoing sexual trauma,

research has established that dissociation can be an effective way to continue to function; however, if it continues to be implemented after the abuse has ceased, dissociation can become an impediment to everyday living (Polusny & Follette, 1995; van der Kolk et al., 2007).

According to MacLean (1985, 1990), the limbic system is thought to be the part of the central nervous system that codes incoming information as it sustains and directs the emotions and behavior necessary for self-preservation and survival. During most occurrences of CSA the limbic system becomes overwhelmed by the information it is receiving and provides an alerting response as a result (MacLean). If this response fails to manage and respond to the incoming information, it is possible that it can be transformed into a survival response, specifically that of dissociation (Hartman & Burgess, 1993). This can be a significant factor when looking at the unresolved trauma of a mother's history of sexual abuse and its impact upon the relationship with her own child, as the output of the limbic system influences different basic regulatory processes, including attachment (Hartman & Burgess).

Draijer and Langeland (1999) postulate that maternal dysfunction is established as an additional factor in dissociation: "Maternal dysfunction, neglect, and perceived emotional unavailability can impact on the quality of attachment between a parent and child" (Sanderson, 2006, p.184). Research also indicates that severe dissociation has been correlated with certain attachment styles, specifically fearful-avoidant and disorganized (Anderson & Alexander, 1996; Liotti, 1992, 2004; Stovall-McClough & Cloitre, 2006). The detrimental consequences of dissociation as a coping strategy could therefore be an important factor when assessing the long lasting effects of CSA and their impact on the

mother-child relationship. While it is important to note that not all adult survivors of CSA experience or develop dissociative disorders, the paradigm that dissociation is a structured detachment of mental processes which are normally integrated within the individual, such as emotions, feelings, thoughts and desires,(Allen, 2001; Spiegel & Cardena, 1991) can be a significant factor when trying to understand how the inner experience of the mother contributes to attachment difficulties within mother-child dyads.

The effects of sexual abuse can be tremendously overwhelming and dissociation can provide a level of protective detachment; however, it also has the potential to result in a sense of disconnection from others (Herman, 1997; van der Kolk, 1987; van der Kolk et al., 2007.). This disconnection can exist in various relationships, but for the scope of this paper, the focus is on the disconnection that can result between a mother with a history of CSA and her own child. Dissociation has also been proven to play a role in the transmission of abuse across generations and can be a crucial element in understanding the relationship between mother and child (Baker, 2001; Egeland & Susman-Stillman, 1996).

These various defenses that a child uses to adapt to an environment of chronic abuse provide her with the ability to survive within it; yet, despite the fact that the child may grow up with the ability to ignore or repress the years of pain endured and reach adulthood with her secrets unrevealed, there is a good chance that the defensive structure created will eventually begin to break down. This can result in increasingly maladaptive relationships, especially with her children. According to Roth and Newman (1991), if the chronic effects of sexual trauma are constantly avoided and left untreated, the individual will unconsciously continue the pattern of maladaptive behavior within relationships.

Effects on Intrapersonal Development

As mentioned above, dissociation can provide a way for survivors of CSA trauma to cope with the stress of their experiences; however, the use of this coping mechanism makes the ability to describe, identify, and consciously utilize emotional responses difficult, as they have detached themselves from their emotions (Baker, 2001). For a female survivor of CSA this *numbing* response can provide emotional constriction that can be understood as a way of fending off constant invasive recollections of the trauma, allowing her to gain some sense of arbitrary control by rejecting emotional involvement (Duncan, 2004; Herman, 1997; van der Kolk, 1987; van der Kolk et al., 2007). However, avoidance of emotional involvement can often lead to an avoidance or rejection of intimate relationships, which not only results in a disconnection from one's own sense of self, but can also lead to empty relationships where responses to others become seemingly cold and distant (Duncan). If a mother is unable to feel and express herself to her own child, it is essentially the child who will begin to suffer from the residual effects of his or her mother's history of abuse.

For some abused children it is impossible to avoid the reality of the abuse through dissociation and therefore they need to find a way to justify it. Herman (1997) contends that this justification occurs through self blame where the child concludes that she is "bad", and that this innate "badness" is the cause of the abuse. The child will conclude this in order to preserve her primary attachment to the abuser, to the trusted caregiver upon whom she relies and could not believe capable of doing something harmful. Eventually this overwhelming sense of "badness" that develops will follow the child into adulthood, as the foundation around which the child's identity is formed (Herman). The

contradiction of how the abused child chooses to see the glorified aspects of the abusing parent and the actual real experience of the abusive parent takes away the child's ability to form a secure sense of independence, because she is unable to develop inner representations of a safe and dependable caretaker. Normal self regulation within the child is prevented, resulting in the development of a fragmented identity (Herman).

Another major consequence of CSA is the potential inability of the child to develop a sense of self, or a shattering of the child's formed sense of self if the abuse took place at a later developmental age (Sanderson, 2006; Wilson, 2006). From an attachment framework a child must develop a relation to others, a connection in which she experiences positive mirroring in order to begin establishing a sense of self (Fonagy et al., 2002; Winnicott, 1974). "Failure in early attachment and deficits in internal self-structures also lead to detachment, a loss of bonding capacity, an external locus of control and impaired socialization" (Sanderson, p.302). Impaired attachment can lead to various long term effects that have the potential to continually impact the individual's own self-structure and, for those survivors who have children of their own, can lead to anxieties and distortions within the parenting role (Alexander, 1992; DiLillo & Damashek, 2003; Sanderson).

Understanding the complex dynamics that underlie the development of a cohesive and coherent sense of self is crucial when working with women survivors of CSA. A therapeutic framework that focuses on a corrective emotional experience would be appropriate so that the loss experienced in early childhood from lack of positive mirroring and empathy could be counteracted. Establishing treatment approaches that focus upon women survivors' ability to reconnect with themselves would hopefully lead them to also

reconnect with others, specifically their own children.

Another fairly consistent finding is that the self-perceptions of CSA survivors are frequently negative. Low self-esteem is a result of the extreme sense of guilt and shame about the sexual abuse and their inability to stop it (Courtois, 1988; Hall & Lloyd, 1989). Mollon (2002) relates this generation of shame that manifests as a result of CSA to what he terms *psychic murder syndrome*, where the abused individual's authentic self is so permeated by shame that the development of other healthy self structures is prevented. The constant guilt and shame that women survivors of CSA can feel makes it difficult for them to appreciate and accept themselves and as a result believe that others could accept and care about them (Duncan, 2004; Hall & Lloyd). Feelings of helplessness and powerlessness as well as a lack of assertiveness are all consequences of low self-esteem and self-worth. The impact of these consequences can follow a woman into motherhood and sabotage her competence and confidence in her parenting abilities, leading her to neglect her own child as she may be unaware of or unable to meet her child's emotional needs (DiLillo & Damashek, 2003; Hall & Lloyd).

Effects on Interpersonal Development

Adult survivors of CSA can struggle with their ability to relate to and trust others (Briere, 1988; Burgess et al., 1987; Finkelhor & Browne, 1985; Gold, 1986; Nadelson et al., 1982; Roth & Newman, 1991; van der Kolk et al., 2007); loneliness and isolation are also common with survivors of CSA due to the danger that is often associated with closeness to others. Other levels of social functioning can also develop from the trauma of CSA, such as rebellion, antisocial behavior, and compulsive social interaction (Courtois, 1988; Sanderson, 2006). Cole and Putnam (1992) suggest that the ability for a

child to experience trust and safety with people in her life who are emotionally substantial to her is weakened when she is sexually abused, which can then lead to mistrust and insecurity in her adult relationships.

In an article by Davis and Petretic-Jackson (2000) titled *The Impact of Child Sexual Abuse on Adult Interpersonal Functioning*, various empirical findings concerning the interpersonal distress that CSA survivors experience in their intimate relationships are compiled. Within the article, several different theoretical models of CSA that address its association with adult survivor interpersonal functioning are explored.

One of the most comprehensive models that aims to specify which factors make the trauma of CSA distinct from other childhood traumas, was designed by Finkelhor and Browne (1986). The model proposes that the experience of CSA can be examined in reference to four trauma-causing factors, which are thought to be the cause of the unique effects of this trauma. These factors, termed *traumagenic dynamics*, are: traumatic sexualization, stigmatization, betrayal, and powerlessness. While these dynamics are experienced by survivors of other traumatic circumstances, it is their occurrence in combination that makes the trauma of sexual abuse specific (Finkelhor & Browne). "These dynamics, when present, alter the child's cognitive and emotional orientation to the world, and create trauma by distorting a child's self-concept, worldview, and affective capacities" (p.181). Gaining an understanding of these traumagenics can be beneficial for helping to explain the effects of CSA and thus help facilitate assessment. Consequently the most appropriate treatment plan to offer a client at her starting point for recovery may be determined.

Traumatic sexualization pertains to "...a process in which a child's sexuality

(including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of the sexual abuse" (Finkelhor & Browne, 1986, p.181). The authors claim that sexualization can result from a variety of circumstances which depend on the manner in which the abuse is committed. Examples of this include the child's sexual performance being rewarded by the abuser, the child receiving gifts or affection from the abuser in exchange for sexual acts, as well as misconceptions about sexual behavior that the child develops as they are transferred to her from the abuser. The impact of traumatic sexualization will differ depending on specific factors which can play a part in the event such as whether the child was persuaded by the abuser or forced, the child's awareness or understanding of the experience, and the child's level of cognitive functioning.

The second traumagenic dynamic is betrayal and due to the fact that survivors of CSA struggle with trust, it would seem that this dynamic could be the most significant in regards to impact on adult interpersonal functioning. When a child is sexually abused, the level of trust and safety felt in the presence of the abuser is shattered; leaving the child to feel a sense of betrayal as she comes to the realization that she has been manipulated and harmed by someone she loved and depended on. The child can also experience betrayal with family members who were not the abusers, but who were unable or unwilling to prevent the abuse and provide the child with protection and security. Betrayal can further be experienced by the child if a non-abusing family member in whom the child trusts fails to believe the child when she discloses the abuse, exacerbated by the possibility of the child being blamed or ostracized for the revelation.

Powerlessness is the third traumagenic dynamic within Finkelhor and Browne's

(1986) model, referring to "the process in which the child's will, desires, and sense of efficacy are continually contravened" (p.183). It is indicated by the authors that this dynamic can have many contributing factors based on the sexual abuse experience of the child. Control and power are completely ripped from the child through the continuous invasion of the child's body and personal space. This violation is reinforced by the abuser's manipulation process; the various ways in which the child is enticed and coerced into the abuse. Powerlessness is also experienced when the attempts made by the child to stop the abuse are thwarted, and this dynamic is then increased by fear as the child comes to realize that she is trapped in the abusive situation. Factors such as use of force or threat by the perpetrator, disclosure of the abuse by the child, the child being believed after disclosure, and the child's success in putting a stop to the abuse, will all determine the degree of powerlessness that is felt by the child and may subsequently prevent adult survivors from becoming assertive in future relationships due to the residual effects of fear and anxiety (Bagley & Ramsay, 1986; Finkelhor & Browne).

The fourth and final traumagenic dynamic is stigmatization, which refers to "the negative connotations - for example: badness, shame, and guilt - that are communicated to the child about the experiences and that then become incorporated into the child's self-image" (Finkelhor & Browne, 1986, p.184). Finkelhor and Browne indicate that this dynamic may develop from the perpetrator's consistent belittling of the child, from the perpetrator's insistence for secrecy about the abuse which communicates a sense of shame and guilt, the response received by the child from family or others after disclosure or uncovering of the abuse, or it could also evolve from the child's own understanding about the perverse nature of the activity which can reinforce the stigmatization if the

child ends up being blamed for what happened. When women survivors of CSA engage in self-damaging behavior it is often due to the significant shame and guilt that continues to plague their lives; therefore, the shame linked with stigmatization can potentially lead to isolation, as a sense of connection with others may feel unattainable (Duncan, 2004; Finkelhor & Browne; Hall & Lloyd, 1989; Sanderson, 2006).

Another model by Briere (1992) theorizes that interpersonal difficulties evolve from CSA from two sources: the first is based around the cognitive and conditioned responses resulting from the abuse, such as low self-esteem, anxieties regarding abandonment, and distrust in others, which the survivor carries into the future; the second is an accommodation response that occurs as a result of the ongoing abuse, such as sexualization, passivity, or avoidance. What Briere proposes is that these different reactions are the result of the unresolved trauma and follow the abused into adulthood, impeding healthy interpersonal functioning. When a child is sexually abused she is engaging in an interaction with another person; an unhealthy, violating, and potentially damaging interaction where the perpetrator is abusing his or her greater power over the child. How the meaning of this interactive, abusive experience is formulated by the child can then have significant long term effects on her interactions with others.

Another theoretical model devised to explain survivors' responses and the long term effects of CSA was developed by Polusny and Follette (1995). The main focus of this model is the impact of different coping behaviors used by CSA survivors on future interpersonal functioning. Within the model, Polusny and Follette acknowledge the subjective relief that can be provided by various coping behaviors such as dissociation, self-mutilation, and avoidance of intimate relationships, as they allow survivors of CSA

to disconnect from their emotions in order to cope with the stress of their experience; what the authors suggest, however, is that the relief gained by those coping behaviors is short-lived. Emotional avoidance, over time, can potentially result in feelings of social isolation and a sense of disconnection from others.

In addition to the interpersonal effects discussed in the three models above, CSA survivors also struggle with difficulties regarding boundaries, which is not surprising given that in childhood their boundaries were consistently invaded by their abusers. Boundary issues can manifest in very different ways during adulthood, depending on the child's experience. Some individuals may have more difficulty establishing boundaries of self and one's own body, some may grapple with their ability to set and maintain boundary limits with others, and some may experience complications in each of these areas (Sanderson, 2006). The constant invasion the child suffers at the hands of her abuser can lead to difficulties in the development of a sense of self, resulting in the adult survivor feeling as though the only way she can function is connected to another person. This lack of autonomy and need for enmeshment can also prevent the individual from attuning to her own needs; therefore, finding it difficult to say to no to others and potentially leading herself into other abusive relationships (Sanderson). Inversely, the boundaries of CSA survivors may also be so distorted that they fear dependency on others, since it may lead to feelings of vulnerability that could once again be exploited, like they were as a child. This fear can cause the survivor to withdraw from social contact and consequently result in isolation and loneliness. Establishing a clear sense of personal boundaries is necessary for survivors of CSA in order to neutralize the impact that this traumatic experience has had upon their lives.

Research surrounding the impact of CSA on adult interpersonal functioning has established that, in many ways, CSA can and does disturb the normal developmental path in children, consequently leading to problems surrounding the development of sexual identity and self concept as well as shattering the ability to establish safety and trust within future relationships (Cole & Putnam, 1992; Trickett & Putnam, 1993). DiLillo (2001) indicates the importance of remedying these experiences, since "...these developmental deficits can set the stage for adult interpersonal dysfunction in the form of poor couple and peer relationships, strained family interactions, and difficulties in the parenting role" (p.568). According to research, attachment issues play a significant role in the reported long-term interpersonal effects of CSA (Alexander, 1992; DiLillo; Sanderson, 2006), and understanding the connection between the two will be imperative for determining how a mother's experience of CSA can impact the connection with her child and lead to struggles within the role of the parent.

Effects of Mothers CSA History on Mother-Child Relationship
Theoretical Formulations

Accumulative research based on clinical observations of mothers who were victims of CSA has indicated several different areas of difficulty that are often experienced in the maternal role. Gaining insight into the experiences and behaviors of women CSA survivors in this parental role is imperative, for it expands our understanding of CSA in relation to the complex facet of adult functioning, provides crucial information as to how the impact of long-term correlates of CSA on a mother can extend into the relationship she has with her child and interfere with her ability to parent, and finally allows us to gain a more comprehensive understanding of the possible

implications of early CSA on the intergenerational transmission of abuse. An increased

knowledge base surrounding the parenting characteristics and mother-child relationships

of CSA survivors will also help illuminate appropriate avenues for therapeutic

intervention, aimed to help mothers heal from their past traumatic experience and cope

with parenting difficulties associated with these experiences.

The relationship between CSA and later parenting difficulties can be explained

through several different theoretical perspectives. Research in both clinical and non-

clinical settings has repeatedly documented that the distress and dysfunction survivors

can experience as a result of the maternal psychopathology affiliated with a history of

CSA, may potentially interfere with their abilities to function as parents (Courtois, 1988;

Cross, 2001; DiLillo & Damanshek, 2003; Seifer & Dickstein, 1993). One theoretical

perspective that discusses the association between CSA and parenting problems is a

social learning paradigm. From this point of view, when children grow up in a family

environment plagued with intense levels of dysfunction resulting from sexual abuse

(Carson et al., 1990, Dadds et al., 1991; Harter et al., 1988; Madonna et al., 1991), they

probably do not have healthy, competent parental role models to watch and learn from.

Without this exposure to models of able and efficacious caregiving and without the

opportunity to witness and internalize successful parenting skills, a woman's own

parenting has the potential to be inadequate and maladaptive (Armsworth & Stronck,

1999; DiLillo & Damashek).

The developmental psychopathology perspective that examines the evolution of

psychological disturbances in the context of development (Cole & Putnam, 1992; Sroufe

& Rutter, 1984) also helps to explain the various parenting difficulties that can emerge

from a history of CSA. "Self and social development are inextricably bound together, and dysfunction in the self domain would inevitably have it's counterpart in the social domain" (Cole & Putnam, p.176). As discussed, CSA interferes with typical self and social development which can increase the risk of serious psychopathology in later adult functioning (Cicchetti & Toth, 2000; Cole & Putnam; Trickett & Putnam, 1993). This pathology around the establishment and maintenance of healthy attachment relationships that CSA survivors experience, can be an impediment to their ability to parent their own children (Davis & Petretic-Jackson, 2000; Fitzgerald et al., 2005; Rumstein-McKean & Hunsely, 2001).

Finally, attachment theorists have also attempted to explain the relationship between CSA and subsequent parenting difficulties. The value of childhood attachment relationships was described by Bowlby (1969, 1988), who maintained that children develop *internal working models* of parent-child roles and relationships. It has been documented that these mental constructions affect and predict a person's feelings and behavior in relation to attachment experiences and subsequently influence one's own parenting beliefs and behaviors in adulthood (Bretherton et al., 1990; George & Solomon, 1996; Main & Cassidy, 1988). Evidence has continued to support the idea that parents' internal working models of relationships can impact their ability to engage with their children in a gentle and supportive way (Fonagy et al., 1993; Fonagy, Steele, & Steele, 1991; George & Solomon; Main, 1995; Main & Goldwyn, 1984). Due to the distorted and dysfunctional relationship that can form between a child and attachment figure as a result of CSA, survivors may specifically be at risk of forming distorted internal working models of parent-child relationships (Bolen, 2000; Crowell & Feldman, 1988; Fitzgerald

et.al., 2005; Ricks, 1987). Consequently, these distorted working models may form the

groundwork for the development of maladaptive parent-child roles. An in depth

examination of attachment theory and its application to the study of CSA will be

conducted later in this paper.

Parenting Behaviors and Attitudes

Various clinical reports and empirical studies examining the association between

a maternal history of CSA and parenting, as well as the myriad of literature on the

extensive long-term consequences of CSA, have established that childhood trauma can

affect a woman's maternal practices in a number of ways. One of the parenting behaviors

of women CSA survivors that emerges frequently within the literature is that of *role*

reversal, also referred to as *parentification*, in which "... mothers who have been sexually

abused may become overly dependent on children to meet their own emotional needs"

(DiLillo & Damashek, 2003, p.323). In an observational study comparing sexually

abused mothers' interactions with their children with those of nonabused mothers,

Burkett (1991) found that mothers who reported a history of sexual abuse were more self-

focused when interacting with their children and were more likely to engage with their

children in a manner they would a close friend. The study also reveals that CSA survivors

relied more fervently on their children for emotional caretaking and companionship

(Burkett). As mentioned previously, parenting difficulties may evolve from the victims

own experience of poor parenting as a child; therefore, role reversal could then result

from the survivor having witnessed or experienced boundary distortions in her own

family (Alexander et al., 2000). However, Alexander, Teti, and Anderson purport that a

mother's ability to competently cope with her own emotional needs, as well as the

challenging demands of parenting, may be impaired by the sheer trauma of the sexual

abuse in addition to the modeling of unsuccessful parenting. Role reversal then can also

occur when a mother's own attachment related anxieties are activated by her unresolved

CSA, and she responds by turning towards her child for solace (Ainsworth & Eichberg,

1991; Alexander et al.; Liotti, 1992).

Research also suggests that women with a history of sexual abuse may engage in

more permissive parenting (Cole et al., 1992; DiLillo & Damashek, 2003; Kreklewetz &

Piotrowski, 1998; Ruscio, 2001). One theory explaining this behavior suggests that, as

child victims, women experienced an abuse of power at the hands of another that may

prevent them from implementing their own parental authority (Ruscio). Another

explanation provided for permissive parenting is that mothers may feel as though they are

less competent or efficacious in the parental role, which results in their inability to set

suitable limits with their children (Banyard, 1997; Cohen, 1995; Cole & Woolger, 1989;

Cole et al., 1992, Fitzgerald et al., 2005; Herman, 1981). In a handful of studies,

overprotecting parenting has also been found to be a parenting behavior of women CSA

survivors (Cohen; Duncan, 2004; Hall & Lloyd, 1989; Kreklewetz & Piotrowski; Rucio;

Sanderson, 2006; Westerlund, 1992). In these various studies, mothers have expressed

that they want to be a better parent than their own, to be the "perfect mother", which can

then lead to this over-protective, overly nurturing behavior. Other specific parenting

attitudes and behaviors that women CSA survivors hold, which may compromise their

parenting abilities, are: difficulty maintaining a balance of discipline and affection

(Gelinas, 1983), use of excessively harsh discipline techniques with their children

(DiLillo et al. 2000; Dubowitz et al., 2001, Hall et al., 1998; Spieker et al., 1996; Zuravin

et al., 1996), difficulty with developing and maintaining consistent boundaries for their children (Alexander et al., 2000; Banyard; Burkett, 1991), lack of engagement with their infants (Lyons-Ruth & Block, 1996), feeling more stressed and less emotionally controlled in child rearing (Cohen; Cole et al; Cole & Woolger; Douglas, 2000), usage of more negative communication styles with their children (Burkett), difficulty showing physical affection towards their children (Douglas; Duncan; Hall & Lloyd), difficulty showing emotional affection towards their children (Duncan; Gelinas; Goodwin et al., 1981; Hall & Lloyd; James & Nasjleti, 1983), and setting standards and expectations for themselves that are unrealistic, making it difficult for them to feel fulfilled in the maternal role (Butler, 1978; Herman; Herman & Hirschman, 1981).

In summarizing these findings, it is important to remember that this is a young area research; therefore, few studies have actually been conducted which explore any solitary facet of parental functioning among women CSA survivors. Although the emerging status of the literature makes it difficult at this time to come to any solid conclusions, the merging of data from an array of sources supplies some evidence that certain aspects of parenting may be impacted for a mother who has a history of CSA.

Intergenerational Transmission of Abuse

Not all women who were sexually abused as children grow up to abuse their own children (Burkett, 1991; Egeland et al., 1988; Egeland & Susman-Stillman, 1996; Main & Goldwyn 1984). There has been a significant amount of research addressing the intergenerational transmission of *physical* abuse, with most results supporting the supposition that individuals with a history of abuse in childhood are at an increased risk of abusing their own children (Herrenkohl et al., 1983; Straus et al., 1980; Widom, 2000).

Throughout the literature, there has been some speculation about how and why the process of intergenerational transmission of sexual abuse may occur; however, the empirical data that does exist is both sparse and conflicting. Unlike physical maltreatment where the abuse is often transferred directly from parent to child, the infrequent incidence of females perpetrating sexual abuse suggests that intergenerational transmission in the second generation will occur by someone other than the adult victim herself (Finkelhor, 1979; Russell, 1983). Certain research has found that mothers with CSA histories use more physical punishment and have a higher potential for physically abusing their children than mothers who were not sexually abused as children (Banyard, 1997; Egeland, et al., 1987; Goodwin et al., 1981; Hall et al., 1998; Spieker et al., 1996). It is important to identify that these studies only refer to the possible transmission of physical and not sexual abuse.

One speculation about the intergenerational process suggests that parents who were sexually abused themselves may fail to protect their children, as the traumatic past results in mothers who are emotionally distant and removed from their children, increasing the potential for them to be victimized by someone else (DiLillo & Damashek, 2003; Gelinas, 1983; Goodwin, et al., 1981; Hooper & Koprowska, 2004). Another speculation suggests that mothers with a history of CSA may become romantically involved with men who are similar to their past abusive models of masculinity, and they fail to perceive that they have put their own children at risk (Faller, 1989). Others have suggested that, within the intergenerational pattern, a majority of abusers are identified as family members, with a significant amount being members of the mother's family of origin (McClosky & Bailey, 2000). This indicates that children who are in contact with

their mother's abuser are at an increased risk of being sexually abused by this individual, and thus, the abuse across generations may be perpetrated by the same person. Finally, other research indicates that women who have been sexually abused may develop unrealistic expectations for their children based on distorted perceptions that have evolved as a result of their own unresolved trauma (Herzog et al., 1992; Lyons-Ruth & Block, 1996). The intergenerational pattern of abuse that may then be generated and transmitted by mothers with CSA histories could be neglect or rejection of their children as opposed to physical or sexual abuse.

The literature and empirical data that exists regarding the intergenerational transmission of sexual abuse is both deficient and demonstrates significant methodological problems such as lack of standardized measures, inadequate control groups, and varying cultural backgrounds of participants (Cross, 2001; DiLillo & Damashek, 2003). However, the existing literature does show that women who have experienced childhood CSA are at risk for passing on a pattern of abuse to their own children which may continue if the mother's trauma is left unresolved (Kreklewetz & Piotrowski, 1998).

There has been substantial research exploring the mothering experiences of sexually abused women, trying to determine why some women are more capable of nurturing, empathic relationships with their own children and why some are not, thus passing on their abusive experience. However, only a few studies have used observational techniques to study the ways in which CSA survivor mothers relate with their children. Lyons- Ruth and Block (1996) describe their longitudinal study in which they examine the interplay between women CSA survivors and their children, specifically researching

the potential alliance between the intensity of the mothers' past childhood trauma and current adult care-giving behaviors, in 45 low- income mothers and their 18-month-old infants. The findings in this study reveal that a history of sexual abuse is associated with diminished maternal engagement with the infant (e.g., warmth, verbal communication, comforting touching, sensitivity), and an increased level of restricted maternal affect. Along with increased risk for unresponsive, detached, hostile, or emotionally withdrawn caregiving behavior, the findings indicate that disorganized attachment relationships are also a potential outcome of childhood trauma (Lyons-Ruth & Block). Furthermore, the data collected within the study provides empirical support for other research that describes two different modes of adaptation used by abused mothers with their infants. The first is a more hostile stance, clinically termed *identifying with the aggressor*, where the child structures the self around the bad and unlovable aspects of the abuser. This defense mechanism can help CSA survivors deal with their anxiety, for it allows them to bypass empathy for themselves in order to not be reminded of their own helplessness (Terr, 1991; van der Kolk, 2007). Lyons-Ruth and Block state that this hostile stance is more strongly associated with a history of physical abuse rather than sexual abuse. The second mode of adaptation described in the study is the withdrawing stance. This adaptation is based on more emotional and physical withdrawal from the infant and has been shown to be more associated with sexual abuse (Lyons-Ruth & Block). The trickle down effect ends up being that the mother who was sexually abused as a child develops unhealthy adaptation modes, which lead to the problems she experiences with her own children, and the consequences of sexual abuse reverberate to the next generation.

In an exploratory study, Herzog, Gara, and Rosenberg (1992) investigate how a

mother's history of abuse is connected to the structure of interpersonal and self

perceptions, as well as how these relationships can impact the quality of interactions a

mother has with her child. In the study, the utility of free response methods as developed

in social psychology are used to examine the participants' *implicit personality theory*

(IPT), a non-academic theory that explores how an individual perceives his or her own

personality as well as the personalities of others (Bruner & Tagiuri, 1954; Herzog et al.,).

Once each individual's IPT is ascertained and analyzed, they are grouped in order to

determine patterns among specific populations of subjects. It is then proposed that the

identified patterns may give insight into how an abused mother's past experiences, along

with her perceptions of those experiences, are connected to her behavior and

understanding of being a mother in the present. The participants in the study are five

mothers, three of whom had a history of abuse in their childhoods and two who did not.

These women were seen in their homes and given two separate interviews which

provided the researchers with descriptions of how each woman sees aspects of herself and

of other important people in her life. The authors found that the three women with

histories of abuse had difficulty forming selves that "...reflect integration of both

acceptable and unacceptable past and present experiences" (Herzog et al., p.96). The

findings also demonstrated that mothers with poorly integrated selves had distorted

perceptions of their own infants (Herzog, et al.).

Larrence and Twentyman (1983) propose a four-stage developmental model as a

means of helping determine the way in which a parent's traumatic history of CSA

construes his or her parental approach. Process of the model begins by parents

maintaining unrealistic expectations for the child. When the child does not act in the way

expected by the parent, which is the second stage, the parent misconstrues the child's

actions (stage three), and sees them as intentional ways of being annoying or spiteful.

Then in the final stage, the parent overreacts and the child is unreasonably punished

(Larrence & Twentyman). According to Herzog, Gara, and Rosenberg (1992), clinical

studies have described this pattern as one in which an insecure, emotionally needy person

looks unsuccessfully to her infant for the love, comfort, and personal validation that she

never received from her own parents. Many researchers have explained these distorted

expectations and behaviors that a mother has in reaction to her child, as a result of her

inability to integrate her own abusive childhood experiences into her present sense of self

(Baker, 2001; Egeland & Susman-Stillman, 1996; Herzog et al.; Leifer & Smith, 1990;

Main & Goldwyn, 1984). As described, Larrence and Twentyman's model begins with a

parent's unrealistic expectations, and as those expectations continue to not be met, the

mother's history of abuse guides her to treat her child in the same abusive or rejecting

manner that she experienced as a child. Therefore, the mother's internal working model

of parent-child relationships that developed from her own maltreatment or rejection as a

child has influenced the quality of parenting into the next generation (Bowlby, 1980;

Bretherton & Munholland, 1999; Fitzgerald et al., 2005; van IJzendoorn, 1995).

    A mother with a history of sexual abuse has a variety of psychological

mechanisms to guard against the re-experiencing of the negative emotions associated

with the trauma, such as fear, helplessness, and rage (Lyons-Ruth & Block, 1996). These

mechanisms are a result of the mother's distorted beliefs, which continue to prevent

access to the self and to a secure relationship with her child (DeOliveira et al., 2004). For

this imperative integration of self and emotions to occur, the abused mother needs to find

empathy for herself as an abused child, as well as some realistic perspective of her past

abusers. Herzog, Gara, and Rosenberg (1992) claim that this empathy comes with the

mother's ability to not only remember the act of the abuse, but more importantly, to gain

access to the pain associated with it. Similarly, if she acts as if she has nothing in

common with her abusers because they are simply monsters, she will be ill-equipped for

the real trials of parenting (Leifer & Smith, 1990; Main & Goldwyn, 1984). This lack of

empathy for others, the dissociation of feelings from memories, and the inflexible attitude

towards self and others are characteristic of many abusive mothers, and as the literature

has demonstrated, these characteristics are what allow the mother to self perpetuate her

own destiny for abusive behavior and disconnection from her child.

Factors Involved with Breaking the Cycle of Abuse

It has been established that despite the popularity of the intergenerational

hypothesis, there has been little written evidence explaining why transmission does occur

across generations; however, there is perhaps a more important question that may provide

answers that could have practical and crucial implications for treatment interventions and

prevention of child mistreatment. It may also provide a further understanding of the

process involved in the transmission of abuse. If not all victims of childhood abuse

become abusive parents to their own children, then how are these victims able to break

the cycle of abuse, and how do they differ from parents who do pass on the abusive

pattern?

One factor that has been identified in different investigations as a fundamental

component in assisting individuals in breaking the abuse cycle is the involvement of an

emotionally supportive partner in their lives (Bowlby, 1973; Egeland, et al., 1988;

Egeland & Susman-Stillman, 1996; Leifer & Smith, 1990). Another significant factor

believed to be related to mothers who were able to break the cycle of abuse was the

availability of an emotionally supportive relationship that existed alongside the abusive

relationship during the mother's early childhood (Bowlby; Conte & Shuerman, 1987;

Gold, 1986; van der Kolk et al., 2007). It is postulated that these experiences would

provide a foundation of support and allow CSA survivors to transform their perspective

on relationships, thus enabling a mother to foster a nurturing relationship with her child,

irrespective of her traumatic past. Finally, one of the more researched factors that has

been found to impact the transmission of abuse from mother to child, and may

consequently determine the level of connection that she develops with her child, is the

mother's ability to both remember and integrate the emotions and feelings that she

experienced as a result of her childhood abuse (Baker, 2001; Egeland & Susman-

Stillman; Fraiberg et al., 1975; Herzog et al., 1992; Leifer & Smith; Leon et al., 2004;

Main & Goldwyn, 1984; Roth & Newman, 1991).

A mechanism that has been recognized within the literature as preventing this

integration from occurring and therefore considered to be a perpetrating force of

maltreatment across generations is the process of dissociation (Egeland, 1993; Egeland &

Susman-Stillman, 1996). In different follow-up studies of victims of sexual abuse, links

have been discovered between the abuse and dissociative phenomena (Chu & Dill, 1990;

Lindberg & Distad, 1985; Terr, 1991; van der Kolk, 1987). When dissociation is

experienced, the normal structured psychological processes which usually occur within

an individual, such as memory, emotions, thoughts, and identity, become separated and

certain information for a period of time is no longer integrated with other information

(Putnam, 1993; Spiegel & Cardena, 1991). When dissociation causes a problem with memory where certain events cannot be recalled, certain experiences become compartmentalized and fail to be connected into a coherent perception of self. Consequently, when dissociation is used as a coping mechanism from the traumatic experience of sexual abuse, the disturbance that it can cause in memory may result in a "...fundamental disruption in the integration of experience" (Hartman & Burgess, 1993, p.50). Egeland and Susman-Stillman (1996) found that mothers who were abused in childhood and became abusive themselves, exhibit more dissociative symptomology and processes in comparison to mothers who were able to break the cycle of abuse. The study indicates that mothers who broke the cycle were able to communicate their childhood experiences in a way that demonstrated they understood the events of their past and that the experience happened to them. The participants reflected their experience in a way that established they had moved forward in their lives. Another important element regarding how they spoke of their experience was that their recollection suggested they had integrated the abuse as part of their identity. This indicates that they were aware of the pain they endured as a child and had therefore made a conscious effort not to repeat this with their own children (Egeland & Susman-Stillman).

As mentioned earlier, not all victims of abuse dissociate. Hartman and Burgess (1993) suggest that factors such as frequency, duration, and intensity of the abuse may be important indicators as to whether or not dissociation will be used as a coping tool by an abused child. The developmental level of the child, as well as whom the perpetrator is, may also be contributing factors that determine whether dissociation occurs (Egeland & Susman-Stillman, 1996). Crucially, these findings demonstrate how a mother's

dissociation from her own feelings and memories surrounding her past abuse can increase

the possibility of her abusing or neglecting her own child, as she may be unable to access

feelings of pain or empathy.

Research has therefore indicated that recovering factual aspects of the abusive

events that occurred in childhood can not only help prevent the transmission of abuse

from mother to child but also help mothers develop more nurturing and empathic

relationships with their children. However, further studies have indicated that with

remembering only facts about the events the individual may still repress the painful

feelings connected to these memories (Leifer & Smith, 1990; Main & Goldwyn, 1984). If

this occurs, the individual is still at risk of identifying with the aggressor, which has been

established as a defense process that pertains to the intergenerational cycle.

In an article by Selma Fraiberg (1975) titled *Ghosts in the Nursery*, she too

discusses the notion that history is not necessarily destiny. According to Fraiberg's case

studies, the mothers studied did not lack the ability to remember the events of their

childhood abuse, but were unable to remember the terror and the hopelessness that those

experiences brought them. It is then indicated that it is the mental representations which

are formed by the mother through the experiences rather than the experiences alone that

lead the mother to the compulsion to repeat those malignant experiences (Fraiberg et al.).

Through remembering and identifying with the injured child (the childhood self), a

maltreated parent then begins to develop a powerful deterrent against identification with

the aggressor and can be sufficiently released of her morbid experiences so to discontinue

the repetition of them. Therefore, the key to this process of parents releasing the "ghosts"

of their past, of coming to the realization of their own pain resulting in the ability to say

"I will not allow my child to suffer as I have", is the recovery of the associated affect experience (Fraiberg et al.).

In another study that explores factors which contribute to the abused-abusing intergenerational cycle, Main and Goldwyn (1984) found in their examination of thirty Berkeley Adult Attachment Interviews that a mother's apparent experience of her own mother as rejecting is systematically related to her rejection of her own infant, as well as to systematic distortions in her own cognitive processes. The mother's distortions are then found to also be related to the rejection of her own infant which may consequently play a significant role in the perpetuation of abuse. An examination by the authors of the mothers' representations of their own attachment experiences indicates that respective facets of a mother's failure to integrate her past experiences are significantly associated with her own infant's avoidance. If the mother was unable to remember her childhood or idealized her rejecting mother in some way, it was likely that her infant would avoid her. However, if during the interview she was able to connect with her own feelings regarding attachment and express her enmity and anger towards her mother, it was unlikely that her infant would avoid her (Main & Goldwyn). Therefore, as a result of the conducted Adult Attachment Interviews, positive relationships were found between a woman's depiction of her own mother as rejecting, her rejection of her own infant, and specific distortions in her cognitive processes. These findings appear to support Fraiberg's (1975) conclusions that access to childhood pain becomes a strong preventive force against repetition of abuse in parenting.

Roth and Newman (1991) present a conceptual system that they believe marks the coping process of recovery from sexual trauma. When describing the ideal case of coping,

Roth & Newman suggest that the individual gradually integrate manageable amounts of emotional material. The process is explained as "...she would be trying to come to an emotional and cognitive understanding of the meaning of trauma, and the impact it has had, a process which involves a re-experiencing of the affect associated with the trauma in the context of painful memories" (Roth & Newman, p.281). This process is also congruent with Fraiberg (1975) and Main and Goldwyn (1984), suggesting that memory of affect is crucial in order for an individual to break free of past abuse. However, the process of remembering and resolving such trauma may not be possible without the help and guidance of a therapist, and therefore the theories that have been postulated here, however incomplete, have practical therapeutic implications for both mothers and their children who continue to endure the "ghosts" of a mother's past.

The respective findings referenced above suggest that a greater understanding of the intergenerational transmission of abuse and other various parenting behaviors could be acquired by continued systematic research into the potential ways a mother's interactive behavior with her child is related to self perception and her perception of others. A consistent finding throughout various research studies is that mothers who have experienced considerable abuse as a child, and have failed to resolve and integrate these experiences, are likely to have difficulty understanding and regulating their own emotions, and this then results in profound difficultly in responding appropriately to their children's emotions.

Attachment

A significant number of researchers have examined the continuity of attachment patterns from childhood into adulthood and established their connection to parenting

behavior, as well as other behavior patterns and symptoms which are theoretically

homogeneous with an attachment paradigm (Ainsworth, 1989; Bartholomew & Horowitz,

1991; Bowlby, 1980; Bretherton & Waters, 1985; Fonagy, Steele, & Steele, 1996; Haft &

Slade, 1989; Main & Cassidy, 1988; Main & Goldwyn, 1984; Ward & Carlson, 1995;

Weiss, 1982). Attachment theory can thus supply a valuable conceptual framework for

understanding a mother's preceding family experience as well as the long term

consequences of her abuse. The following section will explore the foundation of

attachment theory, looking specifically at the pattern of attachment that is likely to form

between a mother with an unresolved history of childhood sexual abuse and her child.

This understanding of how a mother's own negative attachment experiences may be

intergenerationally transmitted may provide crucial information as to how a therapist may

begin the process of helping to rehabilitate the mother-child dyad in their present

interaction.

History of Attachment Theory

Attachment theory, as it currently exists, is a model based on the collective work

of John Bowlby and Mary Ainsworth. By combining existing concepts from ethology,

cybernetics, psychoanalysis, and developmental psychology, John Bowlby formulated the

primary framework of attachment theory as a way to provide an advanced perspective of

the bond connecting infant to mother, along with its disturbance resulting from maternal

deprivation and separation (Bretherton, 1991). Bowlby's work with children throughout

his years after graduation from university had led to his belief that emotional disturbance

within the child is a result of family experiences (Holmes, 1993). In working with these

children, Bowlby found that when the quality of maternal care received by the children

was recognized, the behavioral and emotional problems expressed by the children could then be linked to their caregiving experiences (Bretherton, 1992). Bowlby claimed that maternal care could be sensibly explained through understanding of the experiences the mother had within her own family, her views on parenting, as well as aspects of her personality. In an early theoretical paper, Bowlby (1940) began demonstrating his interest in the intergenerational transmission of attachment relations and its implications. From this point of view, Bowlby proposed that a parent's own attachment experiences are frequently transmitted to her children, which can be the cause of emotional disturbances and psychologically maladaptive behaviors.

In light of the research that Bowlby conducted in the late 1940's, he received and accepted a request from the World Health Organization to write a report on the mental health condition of homeless children in post-war Europe, which was published in 1951 and entitled *Maternal Care and Mental Health* (Holmes, 1993). Through the process of writing this report, Bowlby arrived at the inference that in order for children to develop healthy emotional functioning they need to experience "...a close and continuous caregiving relationship" (Bretherton, 1992, p.762), and this proposition needed a theoretical basis. It was from here that Bowlby began to draw heavily on ethological concepts in order to help guide him towards original means of thinking about infant-mother attachment (Bowlby, 1988). As Bowlby's research continued over the years, he adopted this ethological framework, which, combined with applied concepts of developmental psychology, led to his first formal statement of attachment theory and subsequently five classic papers considered to represent "...the first basic blueprint of attachment theory" (Bretherton, 1992, p.762).

According to Bowlby (1969), attachment is the biologically based bond with a caregiver; a biologically based desire for proximity. His ethological approach to understanding this bond led Bowlby to determine various behaviors that increase this proximity and serve to mediate the relationship. Bowlby (1988) states:

> Attachment behavior is any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving. (p.26-27)

Some attachment behaviors, such as vocalizing or smiling, are signaling behaviors, which means they inform the mother of the child's want for interaction and function to bring her to her child. The other category of behavior is approach behaviors, which are any form of active behavior that will move the child towards the mother (Bowlby, 1969). These behaviors are then organized into what Bowlby proposed as an *attachment behavioral system*, another concept borrowed from ethology which allows the variety of behaviors within the child to be organized in such a way where they are available to be chosen in the moment they are most useful. In other words, if the goal of the child is to reach her mother, her behavioral system will allow her to utilize whichever behaviors necessary to reach that goal. As these attachment behaviors assure proximity to the caregiver, they are subsequently serving the function of protection, for when the system allows the attached child to feel at ease by using the parent as a secure base, the child is then able to engage in play, explore her environment, as well as other social behaviors (Bowlby 1988, Bretherton & Munholland, 1999). The attachment experiences and pattern

of interaction formed through these behaviors gave rise to the concept of the *internal working model*, an important aspect of Bowlby's theory. This model, its significance within attachment theory, and the impact that CSA can have upon the formation, functioning, and intergenerational transmission of the model from mother to child, will be discussed in a later section.

Mary Ainsworth is the other significant pioneer in the development of attachment theory. Ainsworth completed her graduate studies at the University of Toronto just before World War II, and it was here that she was introduced to the paradigm of security theory; a concept that maintains one of it's principal beliefs to be that "...infants and young children need to develop a secure dependence on parents before launching out into unfamiliar situations where they must cope on their own" (Bretherton, 1991, p.12). Security theory became the focus of Ainsworth's dissertation, which alongside her collaboration with William Blatz, the man who developed the theory, made an outstanding impact on her future contribution to attachment theory.

Ainsworth was considered to be an extremely effective researcher, and her work not only provided a foundation for the continued measuring and assessment of parent-infant interaction, but also supplied the primary empirical support for Bowlby's proposed theory regarding both attachment theory and the understanding of infant behavior. In establishing the attachment bond as being separate from attachment behavior, Ainsworth (1969) was able to indicate the critical experiences of attachment security pertaining to child development. Like Bowlby, Ainsworth's theoretical contributions along with her exhaustive empirical work are extensive and far beyond the scope of this paper; however, one of her most significant contributions pertinent to this discussion is her concept of the

caregiver as a *secure base*. According to Ainsworth (1973; Ainsworth et al., 1978), at the

center of attachment theory is the role the child's caregiver plays in providing a *secure*

base. A *secure* relationship is considered established if the mother, as this base, is able to

meet the child's need for security and comfort as well as encourage his or her exploration

of the physical and social environment. However, if balance is not established between

these components, or if one exists without the other, the child's relationship is considered

to be *insecure* (Ainsworth et al; Bowlby, 1969).

In order to explore and assess an infant's pattern and style of attachment to a

caregiver, Ainsworth (1978) along with her colleagues developed the well known Strange

Situation Procedure, a protocol that is still used today. In this procedure, conducted

within a laboratory setting, the child is observed playing for twenty minutes while

caregivers and strangers enter and exit the room, recreating the flow of the familiar and

the unfamiliar presence in the child's life. The child's response behaviors towards the

caregiver's departure and return are observed and categorized into one of three categories

which were devised by Ainsworth (1967) as a result of her comprehensive mother-infant

observational studies undertaken in Africa, Scotland, and the United States. The three

patterns are secure, anxious-avoidant, and anxious-ambivalent, with each of these groups

reflecting a different kind of attachment relationship with the caregiver (Ainsworth et al.,

1978; Main & Cassidy, 1988; Main & Solomon, 1990). The Strange Situation Procedure

also allowed for exploration of the correlation between the observed infant behavior and

specific characteristics of maternal sensitivity when it was conducted within the family's

home. The next section provides a brief description of each category of attachment

adapted from Ainsworth et al. (1978) along with the communication styles of attachment

figures that correlate with the behavior patterns of children within each category.

Categories of Attachment Patterns

Secure Attachment (Group B)

Children who are securely attached to their mothers will freely explore various toys along with the strange environment they are in during preparation episodes as the mother is experienced as a secure base. When the mother departs from the room, the attached child may become visibly upset or distressed, but if that is the case, the child will actively seek contact following the separation and quickly feel soothed and comforted upon the mother's return. The child will then be able to return to further exploration or interactive play with the mother. Although securely attached children will usually prefer to interact with their mothers rather than a stranger, their behavior is found to typically be friendly towards unfamiliar adults. The attachment figure of securely attached children usually responds quickly and consistently to both the physical and emotional needs of the child.

Insecure-Avoidant Attachment (Group A)

Children with an insecure-avoidant style of attachment will avoid or ignore their mothers, showing little emotion or distress when she leaves the room or when she returns. The insecure-avoidant child usually makes little or no effort to interact or seek contact with the mother throughout the Strange Situation process and may spend the time engrossed with exploration of the toys or the room. Avoidant behaviors may include moving or turning away from the mother when she returns, resistance to being held or picked up by the mother but often expressed without affect, avoiding eye contact, or not responding to communication attempts made by the mother. Strangers are usually reacted

to with similar indifference; however, in some instances the child may even display more amicability towards the stranger than the mother. Findings have demonstrated that mothers of avoidant children show little response to their children when they are distressed.

Insecure-Ambivalent Attachment (Group C)

Children who are classified with an insecure-ambivalent style of attachment will demonstrate the simultaneous desire for proximity and contact with the mother once she returns along with resistance towards it. These children do not seem to experience security in the mother's presence and often refuse to or are unable to be soothed, causing them to appear consistently unsettled. When the mother departs the child usually becomes extremely distressed and then ambivalent towards her when she returns. Insecure-ambivalent children may seek some sense of comfort from their mothers; however, they also demonstrate a great deal of separation anxiety and are not confident in their parent's responsiveness. The inconsistent behavior of the ambivalent child has been found to result from the inconsistent caregiving provided by the attachment figure. There may be times when the mother appropriately meets the needs of her child but at other times she may be neglectful and less responsive, consequently preventing her child from utilizing her as a secure base.

For many years following the development of Ainsworth's Strange Situation Procedure, investigators who worked with parent-infant dyads had typically placed infants into the best-fitting A, B, or C attachment classification; however, Main and Solomon (1986) described the Strange-Situation behavior of fifty-five infants whose response to their parent's departure and return had neglected to meet either A, B, or C

classification criteria. What they found was that the infants who did not fit these

classifications did not resemble each other in any coherent or organized way, but rather

they appeared to share odd sequences of behavior which seemed to lack an observable

goal or intention (Main & Solomon). Main and Solomon then selected the term

disorganized/disorganized to delineate these diverse behavior patterns, which became a

fourth pattern of attachment, also referred to as Type D. Main and Solomon (1990)

described the behavior of infants who fall into the Type D category as exhibiting one or

more of seven following features: (1) sequential display of contradictory behavior

patterns; (2) simultaneous display of contradictory behavior patterns; (3) undirected,

misdirected, incomplete, and interrupted movements and expressions; (4) stereotypies,

asymmetrical movements, mistimed movements, and anomalous postures; (5) freezing,

stilling, and slowed movements and expressions; (6) direct indices of apprehension

regarding the parent; and (7) direct indices of disorganization or disorientation (p.135).

Since the identification of the disorganized/disoriented attachment pattern, various

studies have been conducted investigating this category's implications for attachment as

well as if and how this category could be associated with any specific experience the

parent or infant may have gone through or been subjected to (Main & Solomon, 1990).

One of the major emerging theories has been that infant disorganized/disoriented status is

found to be strongly associated with the parent's maladaptive behavior which is due to

her own unresolved trauma (Ainsworth & Eichberg, 1991; Carlson, 1998; Carlson et al.,

1989a, 1989b; Lyons-Ruth et al., 1997; Main & Cassidy, 1988; Main & Hesse, 1990).

The following section will then focus on how the unresolved trauma of a mother's CSA

can lead to an insecure disorganized/disoriented attachment pattern with her child, in

hopes of ascertaining how drama therapy models may then be used as a reparative

therapeutic approach for both mother and child.

Impact of CSA on Attachment

Internal Working Models

As mentioned previously, a significant facet of Bowlby's attachment theory is his

concept of the *internal working model*, internal mental constructions that "...allow an

individual to interpret and predict the attachment partner's behavior and to plan

immediate and future response" (Bretherton, Ridgeway & Cassidy, 1990, p.274). Bowlby

(1973) suggested that infants construct models of their caregiver's expected behavior,

how they themselves are supposed to behave, and how the parent-infant roles interact

together. Therefore, as a result of early experiences and recurrent interactions with a

significant caregiver and other important attachment figures, the infant formulates mental

representations of self, attachment figures, and the social world, which then forms the

foundation of his or her personality (Alexander, 1992; Bowlby, 1980; Bretherton, 1985;

Klohnen & John, 1998) As an example, if an infant experiences a primary attachment

figure as rejecting, she is likely to form an internal working model of self that is

unworthy or unlovable and a model of caregiver as uncaring or unreliable (Bretherton;

Bretherton & Munholland, 1999; Bretherton, Ridgeway & Cassidy). Conversely, if the

infant experiences the attachment figure as supportive, caring, and consistently able to

meet her emotional needs, the infant is likely to view the self as competent and worthy of

being loved and cared for. Therefore, the main function of the internal working model is

to guide adaptive behavior and "...provide an adequate representation of self, attachment

relationships, and the environment" (Bretherton, Ridgeway & Cassidy, p.275). And while

these internal models may change with the internalizing of new experiences, they have a tendency to remain stable and continue throughout an individual's life (Bowlby, 1980; Crittenden, 1990).

Based on the foundation of Bowlby's idea of the internal working model, attachments to parents is understood to carry on into adulthood and play a significant role in the intergenerational transmission of attachment patterns and subsequent parenting behavior (Ainsworth, 1989; Bowlby, 1973; Crowell & Feldman, 1988; Leifer & Smith, 1990; Main & Goldwyn, 1984; Main, Kaplan & Cassidy, 1985). Subsequently, the internalized representation that a woman has experienced of her own mother provides her with knowledge of the maternal role, and as a mother herself she may replicate that experience with her own child (Belsky & Fearon, 2002; Stroufe & Fleeson, 1986). According to Bowlby (1973, 1980), it is probable that traumatic events such as CSA experienced at the hands of attachment figures may overwhelm and disrupt the developing attachment behavioral system, potentially leading to future difficulties in parenting (Alexander, 1992; Crowell & Feldman; D'Oliveira et al., 2004; Jacobvitz et al., 2006; Liotti, 1992; Lyons-Ruth & Block, 1996; Main & Hesse, 1990). The internalized working model of attachment for a parent who has been sexually abused may govern how that parent behaves as an attachment figure, becoming a significant indicator or causal factor for emotional disturbance in the child (Bowlby, 1969, 1973; Egeland, 1988).

One of the most important paradigms that has been used to study the relationship between caregiving by a parent and the derived internal working model of the parent with regard to her own attachment history is the Adult Attachment Inventory interview (AAI) (Main & Goldwyn, 1984). During the interview the parent provides descriptions of her

own attachment relationships and her responses are then analyzed in order to determine

how her experiences may impact her own parenting (Main & Hesse, 1990). Based on her

scoring, the parent is placed in one of the four following classification categories: (1)

Secure/autonomous, (2) Insecure/dismissing, (3) Preoccupied, or (4)

Unresolved/disorganized. Empirical findings through the use of AAI's have determined

that a strong correlation exists between the parent's classified attachment style and the

quality of attachment with her own child (Ainsworth & Eichberg, 1991; Carlson, 1990;

Crowell & Feldman, 1988; Fonagy, Steele, & Steele, 1991; Grossman et al., 1988; Main

& Goldwyn; Main, Kaplan & Cassidy, 1985). An important finding within these studies,

which have measured parents' internal working models of relationships and attachment

classifications through AAI's, is that insecure attachment patterns with caregivers that are

developed in childhood increase the chance of insecure attachment patterns with one's

own children (Main & Cassidy, 1988; van IJzendoorn, 1995).

Disorganized/Disoriented Attachment and Unresolved Trauma of CSA

There is significant evidence that the internal working models of parent-child

relationships have an effect upon the caliber of parenting across generations (Bretherton

& Munholland, 1999; van IJzendoorn, 1995), and, although it has been established

through research that the physical act of abuse is not always transmitted, sexual abuse is

often linked with the intergenerational transmission of insecure attachment (Ainsworth &

Eichberg, 1991; Hooper & Koprowska, 2004; Main & Hesse, 1990).

In recent years, there has been a growing number of researchers within the field of

parent-child attachment who have studied disorganized/disoriented attachment behavior

and have come to acknowledge the value of a thorough understanding regarding the

precursors and consequences of this attachment relationship. Infants who are classified as disorganized/disoriented will often engage in patterns of behavior that are odd or conflicting when they are in contact with their caregiver (Main & Solomon, 1986, 1990; Main & Hesse, 1990). Examples of certain contradictory behaviors they may engage in are: reaching out towards the parent yet at the same time turning away from her; standing near the door screaming for the parent when she leaves, and then silently moving away when she returns; rocking on hands and knees when an approach towards the parent is unsuccessful; getting up to greet the parent when she returns but then purposefully falling to the ground; and lastly, moving towards a wall, away from the parent when seemingly frightened by the stranger (Main & Hesse, p. 164). The behavior patterns that occur within a disorganized attachment classification are not as easily recognized as Ainsworth's A, B, and C classifications; therefore, it is indicated as a category that occurs as a response to extremely stressful conditions (Main & Solomon, 1990). This inference has been found to make sense, for a correlation has been discovered between attachment-related traumas experienced by the parent such as CSA and infant disorganization (Carlson et al., 1989; Main & Hesse).

By carefully exploring how parental attitudes may be linked to disorganized attachment in the child, Main and Hesse (1992) found the main feature that differentiates parents of disorganized infants from parents of A, B, or C infants is related to traumas of past abuse that have not been successfully resolved. Main and Hesse (1990) have emphasized the prospective impact of childhood trauma on the caregiving system by hypothesizing that a parent's unresolved trauma plays an influential role in the development of disorganized infant attachment behaviors. Main and Hesse continued to

expand their hypothesis, taking into consideration the fears stemming from traumatic events which took place in the parent's childhood and how those fears are thought to interfere directly with their caregiving (Ainsworth & Eichberg, 1991; Hesse & Main, 2000). When the parent remains traumatized and reacts to memories or thoughts surrounding the trauma, it has been proposed that she may temporarily become frightened and impulsively react in ways that frighten the infant (Main & Hesse, 1990). According to Main and Hesse, it is also possible that frightened/frightening behavior could be brought on unconsciously in response to aspects of the environment that serve as a reminder of the trauma in some way. The paradox of responses felt by the parent is reflected to the infant and the infant then faces her own irresolvable paradox of wanting to seek comfort from the caregiver but also feeling the contradictory need to get away (Main & Hesse; Hesse & Main, 2000). What results is a breakdown of behavioral strategies leading to an array of disorganized behaviors (Jacobvitz, Leon & Hazen, 2006). Consequently, it is crucial to gain an understanding of why parents engage in frightened/frightening behavior, as it has been empirically related to infant attachment disorganization (Abrams et al., 2006; Lyons-Ruth et al., 1999; Schuengel et al., 1999), and disorganized attachment has successively been connected to various emotional and behavioral problems later in childhood (Main & Cassidy, 1988).

Lyons-Ruth, Bronfman, and Atwood (1999) take maternal frightened/frightening behavior into a broader context, revealing that the severity of the trauma experienced by a mother in her childhood plays a significant role in relation to her interactive behaviors with her child, subsequently determining whether her child will develop disorganized attachment as a result of her unresolved fear. The authors argue that a mother's ability to

monitor and respond appropriately to her infant's distress is diminished when she is unable to integrate her traumatic experiences; however, they also inferred that for the infant to be left with disorganization as the only alternative due to such a pattern of interaction, as hypothesized by Main and Hesse (1990), the mother's frightened/frightening behavior must be either chronic or include events that are extremely traumatic (Lyon-Ruth et al.).

Stimulated by Main and Hesse's (1990) model of disorganization, Jacobvitz, Leon, and Hazen (2006) studied the origins of maternal frightening behavior and explored the conditions under which unresolved mothers are more likely to display frightened and/or frightening behaviors in the presence of their infant. In a longitudinal study, they administered the Adult Attachment interview to 116 pregnant women and then later observed these women at home for 30-40 minutes interacting with their first born 8 month old infants. The authors' findings indicate that mothers who are classified as unresolved as a result of analyzed AAI's are likely to engage in frightened/frightening behavior when their infants are 8 months old. Distinct associations have been made in previous research between mothers unresolved/disorganized attachment status on their AAI's and their infant's classification of disorganized attachment (Benoit & Parker, 1994; Steele, Steele, & Fonagy, 1996; Ward & Carlson, 1995), as well as perceivable connections between frightened/frightening behavior and disorganized infant attachment. Therefore, the authors in this study aimed to gain a deeper understanding of why mothers who have experienced abuse engage in frightened and/or frightening behavior with their children (Jacobvitz, Leon, & Hazen, 2006). The study examined the extent to which a mother's severity of abuse increases the likelihood that she will be classified as

unresolved and engage in frightened/frightening behavior and it was found that mothers who received the classification of unresolved scored significantly higher than not-unresolved on their AAI's in respect to severity of sexual abuse experienced (Jacobvitz, Leon, & Hazen). These findings contribute to the growing understanding of the impact a mother's unresolved trauma has on the relationship with her child. Severity of abuse has once again been indicated as a significant component in the development of the disorganized attachment pattern in children, which may be an essential determining factor for building appropriate therapeutic programs aimed at preventing the further development of impaired mother-child interactions.

Research has continued over the years surrounding the genesis of the disorganized attachment relationship in early mother-infant interaction, and a significant number of studies have stemmed from the pioneering work of Main and Hesse (1990). DeOliveira, Bailey, Moran and Pederson (2004) developed a framework based on two theories of emotion socialization: Gergely and Watson's (1996) Social Biofeedback Theory and Gianino and Tronick's (1992) Mutual Regulation Model, and used this framework to hypothesize that dysfunctional emotional processes and maladaptive emotion socialization in early mother-infant interaction plays a role in the development of disorganized attachment as a result of the mother's unresolved trauma.

Studies of women survivors of CSA have indicated that these women experience emotional difficulties that continue on into adulthood and also experience difficulty reflecting on their own feelings and those of others (Steele et al., 1996; van der Kolk & Fisler, 1994). Furthermore, chronic CSA has also been associated with a breakdown in a mother's ability to regulate emotions such as anger and fear (Briere, 1992; Terr, 1991;

van der Kolk, 2007). In response to these difficulties, DeOliveira, Bailey, Moran and Pederson (2004) propose that individuals who are unable to integrate their traumatic experiences of abuse remain unresolved and are therefore more likely to experience greater "...trauma-related symptomology and greater emotion regulatory difficulties than those who are not Unresolved" (p. 458). As a result of the mother's inability to regulate her own emotions, the authors also propose that she will have difficulty providing open and flexible responses to her own children's emotions. According to DeOliveira, Bailey, Moran and Pederson, emotion regulation can be part of an infant's accommodative strategy which provides the function of helping to preserve the relationship with the attachment figure; therefore, they suggest that the behaviors demonstrated by infants with disorganized attachment may be seen as representing a dysfunction in that emotion regulation.

As an end result, the authors developed a framework that aims to understand and explore how disorganization develops within the mother-infant relationship, and through that framework proposed a developmental process through which "...the mother's own experience of childhood abuse impacts her likelihood to encounter systematic and critical difficulties in emotional availability and responsiveness in her interactions with her own child, contributing towards the development of a Disorganized attachment relationship" (DeOliveira et al., 2004, p.461).

Much of the existing research that has been conducted surrounding the connection between unresolved trauma and the onset of disorganized attachment has focused on the trauma of loss much more than physical or sexual abuse, and despite the increasing research interest in the long-term sequelae of CSA, empirical support regarding the

parental functions of mothers with CSA histories, and the potential impact this traumatic experience may have on the attachment relationship with her child, is lacking. However, research that has replicated and extended Main and Hesse's (1990) findings support the notion that a mother with unresolved trauma due to CSA may engage in frightened/frightening behavior, which is linked to the memories of her past traumatic experience. Her infant's struggle to understand the source of her actions then heightens the infants own fear resulting in disorganized/disoriented behavior (Hesse & Main, 1999; Main & Hesse). Further research focused on the exploration of how mothers' are triggered by their frightening memories may also be beneficial for determining therapeutic interventions.

Impact of Trauma of CSA on Mentalization and Attachment

It is also important to look at the role of mentalization within attachment in hopes of trying to determine how attachment links to an infant's mental state in herself and others. Within that frame, it is essential to look at how trauma such as sexual abuse can affect this level of functioning so that it can be determined how drama therapy may be most beneficial. Fonagy (1998), states that the child uses what is termed the *reflective function* as a way to look beyond her present experience and try to determine the caregiver's mental state, which may be forming the basis for the behavior observed by the child. This function is used as protection in the sense that it allows the child to understand that negative behavior demonstrated by the caregiver is a result from events separate from the child and not as a response to anything the child has done (Fonagy). Fonagy, Steele, Steele, and Target, (1997), focus on the quality of reflective functioning using AAI narratives and the results suggest that attachment security develops in the child when the

parent has the capacity to observe and respond to the infant's intentional state, and this

secure attachment makes the infant receptive to mentalistic thinking (Fonagy). However,

in the absence of this bond, where the child's experience includes the experience of

traumatic abuse, there is a deactivation of the reflective function as a defense. Trauma

within the context of an attachment relationship activates the internal working model,

which loses its mentalizing qualities as a result of this defense. According to Fonagy, an

intergenerational element exists within reflective function strategy, and he along with his

colleagues have demonstrated that mentalizing in the child is determined by both the

child's and parent's existing and past attachment classification (Fonagy, Redfern, &

Charman, 1997). A mother whose AAI narratives have classified her as unresolved due to

past trauma of CSA will likely also have a history of disorganized attachment, as sexual

abuse is often associated with this pattern (Carlson et al., 1989a, 1989b). Therefore, if a

mother maintains an inadequate understanding of mental functioning as a result of her

own past attachment experience, her infant's capacity to mentalize may also be impaired.

Individuals who have experienced trauma within the context of their family

environment become vulnerable in terms of the continuous dysfunctional effect of their

response to the trauma and of their diminished capability to cope with it (Fonagy et al.,

2002). It is then suggested by Fonagy, Gergely, Jurist, and Target that "the predominantly

nonmentalizing stance adopted in such situations therefore further impairs the individual

and, in the extreme, their nonmentalizing approach will come to dominate all intimate

interpersonal relationships" (p.64).

Based on the information that has been provided, it can be inferred that applying

attachment theory to the understanding of the lasting traumatic effects of CSA provides

crucial insight into the potential damage it can cause to the mother's sense of self, to her child's development, and to their relationship, if left unresolved. However, studies have found that the damage is not necessarily permanent and that therapeutic interventions, specifically the use of models within drama therapy, play therapy, and psychodrama can assist in the reparative process of reversing negative patterns; helping both mother and child to heal and reconnect.

The Use of Creative Arts Therapies as Treatment Modalities for CSA Trauma

The foundation of treatment, especially involving traumatic experience, is the safety developed within the therapeutic relationship (van der Kolk et al., 2007; Rogers, 1957). As mentioned earlier, simply uncovering memories is not sufficient; they need to be altered, transformed, and reconstructed in a safe and personally meaningful fashion (van der Kolk et al.). The essence of the trauma that the victim must face is the painful, unacceptable reality that they have avoided for so long, and so the individual must find a comfortable and safe way in which she can eventually confront her hidden secrets. One of the central goals for therapy with unresolved trauma is to explore the personal meaning of the trauma. The past cannot be changed, so by giving past experiences meaning, the victim can begin to heal (Herman, 1997).

> The long term effects of child sexual abuse can be so pervasive that it's sometimes hard to pinpoint exactly how the abuse affected you. It permeates everything: your sense of self, your intimate relationships, your sexuality, your parenting, your work life, even your sanity. Everywhere you look, you see its effects. (Bass & Davis, 1988, p.33)

Due to the damage that has been done at the hands of abusive authority figures, it would

seem appropriate that therapists employ a non-directive approach when working with women survivors of CSA as a way to give the client a feeling of control over the direction and pace of the therapeutic process. Briere (1989) claims that sexual abuse places the victim in a powerless position. Two key factors are therefore crucial within the therapy experience in order for it to be a safe and effective process for the client: (1) a therapist who is not only empathic and caring but also extremely reliable, as trust may easily be broken, and (2) a therapeutic environment that will nurture the client and enable her to develop self-acceptance, self-awareness, and a strong facility to stand on her own.

According to Johnson (1987), the treatment of victims who have suffered psychological trauma happens in a three part process. In the first stage, the patient must gain access to the trauma in a way that is safe and contained (Johnson). Due to possible psychological defenses such as dissociation of memories or Alexithymia, a condition where an individual is unable to describe emotions in words, a CSA survivor may experience great difficulty accessing past traumatic events. The focus of this stage is for the individual to overcome denial of their experiences in order to move closer towards healing. Throughout the second stage of treatment, the patient slowly works through the trauma, which requires a process of acknowledgment and re-examination in order to transform trauma into a memory that does not intrude on the patient's every day life (Johnson). Finally, within the third stage of the process, the client needs to take the transformation that has occurred, integrate it through forgiveness, and go on with her life (Johnson). There are a variety of techniques within the modality of drama therapy that can be applied to this process in order to allow for healing to occur within a traumatized mother and between her and her child. "The use of drama as therapy fosters liberation,

expansion, and perspective. Drama therapy invites us to uncover and integrate dormant aspects of ourselves, to stretch our conception of who we are, and experience our intrinsic connection with others" (Emunah, 1994, xvii).

It is apparent within the literature that various treatment modalities may be beneficial to adult survivors of CSA. What is difficult to determine is their effectiveness for the long term in addition to the short term, as well as which individuals' will benefit from which approach, for the severity of abuse varies from person to person (Bannister, 2003). Bannister suggests that such a measurement of severity is next to impossible, since each abused child is affected differently by other factors (e.g., living environment, subsequent support systems, and variables of the abuse itself). This implies that a flexible approach to treatment may in fact be most suitable for this population; a model that is grounded in theory yet that is adaptable in order to address the specific needs of each client and not push that client too far too fast.

The use of the creative arts therapies with adult survivors of CSA has been given some theoretical justification within the existing literature. Simonds' (1994) multi-modal therapy approach to working with CSA survivors is described in significant detail with great emphasis placed upon the utilization of both movement and art modalities in combination with verbal psychotherapy. Simonds suggests that, in order for trauma to be resolved, the traumatic memories need to be retrieved, along with an expression of affect. The employment of combined creative modalities, according to Simonds, provides the adult survivor with the ability to revisit her trauma in a safe and contained framework using exploration and expression as a means to realign her view of not only herself and others, but also of the world.

Mackay, Gold, and Gold (1987) present a pilot study with five girls aged 12-18 who attended eight weekly drama therapy sessions, with each session running between four to five hours. The authors hypothesized that a drama therapy program would be a useful process for reducing depression and increasing interpersonal trust and self esteem in adolescent girls who have been sexually abused. What they found was that after the eight week drama therapy process the participants reported less depression, hostility, and decreased psychotic thinking. This research study is one of the few that has used drama therapy with CSA survivors.

Anderson (1995) describes an evaluation of a nine-week clay therapy group program. The main treatment goal was providing a safe place where some of the fear and rage that survivors feel as a result of their sexual abuse could be re-experienced, allowing for some of that emotional baggage to be released and resolved. It was hoped that the clay could provide simultaneous containment and distance in order for both catharsis and empowerment to occur. Anderson reveals that nine weeks is too short of a framework and that the individual therapy all clients received outside of the group provided additional support, which potentially maximized the effects of the group therapy. However, Anderson also indicates that all clients were polled at both three and six months after the completion of the group and all reported that positive progress was ongoing and positive feelings about themselves continued as a result of their participation within the group.

Meekums (1999, 2000) presents a model of recovery for women survivors of CSA, which was developed during her doctoral research. The research included the participation of fourteen women with each taking part in one of four twenty-session multi-modal arts therapy groups for CSA survivors in a mental health setting. The groups

were run and co-facilitated by two creative arts therapists, each being trained in either drama therapy, dance movement therapy, or art therapy. Meekums (1999) model is presented as a four part creative process that she wishes to be viewed as "...an oversimplification of a very complex process" (p.252). Meekums makes this statement as she suggests the process of recovery cannot be assumed to follow a neat and predictable series of events, but is rather a complex, overlapping phenomena. Recovery from CSA can be a long, painful, and unpredictable journey that may result in an ebb and flow of breakthroughs and setbacks; therefore, Meekums (1999) suggests that her model of recovery be viewed as a spiral, as certain elements and material will be revisited with a future goal of integration and shaping of the self. Meekums (2000) indicates that her research provides evidence that the creative arts therapies are powerful therapeutic approaches which have the ability to assist the survivor of CSA in recovery. Results from Meekums' (1999) research include a reduction in self-harming, an increased sense of the future, an increased sense of self-worth, an increased ability to behave assertively, an increased tendency to place blame with the abuser, and a reduction in intrusive imagery.

Through the development of her model and results attained from her research, Meekums (1999, 2000) suggests four ways in which the creative arts therapies may be useful in treatment planning for survivors of CSA: (1) their ability to unearth unconscious material; (2) their containing and distancing properties, when treatment is planned with this in mind; (3) the potential for generating an image, which can be faced, witnessed, and appraised; and (4) the sense that the creation "speaks for" the survivor, either without the need for the more familiar use of language as discourse, or facilitating this (p.111). However, like any other treatment approach, the use of the creative arts as therapy may

not necessarily be the most appropriate method, and used without the necessary sense of

safety could prove to be more harmful than helpful. So while it is clear that the creative

arts can be powerful tools for assisting in the recovery of sexual abuse, caution must be

used when determining treatment plans.

Treatment Implications for Sexual Trauma

In order for healing to begin between an insecure mother-child dyad, the

implementation of a three step process may be considered. First, if the long term effects

of a mother's CSA have not been resolved and consequently manifested as a barrier

between her and her child, she may not have been able to become a secure base for her

child. Group treatment with other sexually traumatized mothers experiencing insecure

attachment with their children may help the mother begin the process of working through

her unresolved trauma and restructuring her own damaged attachment frame. Second, the

child who experiences insecure attachment will more than likely reflect the impact of this

insecurity in his or her behavior, and this behavior will then need to be worked through. It

may also be beneficial for the child to have a safe space away from the reality of the

situation in which to make sense of what is happening in his or her world. Third,

treatment that includes intervention with both mother and child together can allow for the

quality of attachment and relational difficulties to be assessed and restructured, with a

primary goal of developing a greater sense of emotional security and trust with one

another.

What much of the literature has suggested regarding therapy work with women

survivors of CSA is that group therapy can be an especially beneficial approach and a

highly effective form of psychotherapy (Herman, 1997; Johnson, 1987; Meekums, 2000;

van der Kolk et al., 2007; Yalom, 2005). Yalom has described therapeutic change as "...an enormously complex process that occurs through an intricate interplay of human experiences" (p.1). This interplay of experiences which can be facilitated through group therapy is what Yalom refers to as *therapeutic factors*, which include instillation of hope, universality, imparting information, altruism, the corrective recapulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors.

According to Johnson (1987), group therapy provides what individual therapy with a therapist who has never experienced abuse cannot, which is a shared understanding that one is not alone in her pain. Herman (1997) suggests that group psychotherapy as an intervention could be particularly beneficial for trauma survivors since "Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity" (p.214). Both Johnson and Herman refer to Yalom's (2005) curative factor of universality, the sense that one is not unique in her anguish and suffering. Yalom has also indicated that members of a sexual abuse group can profit immensely from the experience of universality. Many women survivors have never revealed the details of their abuse or the long lasting internal despair and devastation they have endured. Group therapy can provide a safe container for this kind of intimate sharing, where members can converge with others who, as children, experienced and lived through similar violations and suffered profound feelings of rage, shame, guilt, and uncleanness. "A feeling of universality is often a fundamental step in the therapy of clients burdened with shame,

stigma, and self-blame" (Yalom, p.8).

Members of a group who have all experienced the violating and devastating trauma of sexual abuse have the opportunity and space to communicate with one another with a powerful authenticity that results from personal experience, something that a therapist may not have the ability to do. This is not to say that a therapist is not a necessary or essential presence but when clients become aware of their similarity to others and share their hidden emotions and concerns, there is catharsis connected with this process, along with an acceptance from other members which can be crucial to their healing process (Yalom, 2005). Meekums (2000) states that within her study, the need for safety was the single most referred to element in recovery by all fourteen participants. Meekums provides a list of ways in which a sense of safety was generated as identified by the participants, one being the revelation that the survivor was no longer alone; that others have suffered and survived their abusive experiences. Again, the need for what Yalom refers to as universality has proven to be imperative to the recovery process of women CSA survivors, and this factor can only be achieved within a group therapy environment.

In essence, group therapy can provide a structured and contained space where CSA survivors can safely address and work through issues surrounding intimacy, trust, openness, and interpersonal relational difficulties (Sanderson, 2006). Empathy is a central component within the framework for drama therapy, which is expressed through the structure of the drama therapy modality and the psychotherapeutic tools used within it. Emunah (1994) states, "...nowhere more powerfully than in acting do we learn about truly entering the world of another while simultaneously maintaining our own boundaries" (p.

30), which supports the notion that group drama therapy may provide an appropriate and beneficial therapeutic space for women CSA survivors. As group members share a common bond, drama therapy may facilitate a sense of emotional closeness, an essential quality for a mother trying to develop a more intimate connection with her child.

Working with women survivors of CSA may prove to be a delicate and intricate process, for the impact of the abuse may vary enormously between individuals and therapists must be careful not to make general assumptions about what each client is experiencing. Different researchers and clinicians who have worked with sexual abuse survivors within the creative arts therapies have indicated the benefits of a multi-modal approach (Bannister, 2002, 2003; Cattanach, 1992, 1994; Emunah, 1994; Gallo-Lopez, 2007; Haen, 2007; Johnson, 1987; Meekums, 1998, 2000; Silverman, 2007). The use of various treatment methods offers a level of flexibility that can perhaps provide a greater scope of healing potential, as specific therapeutic approaches may be more appropriate for specific issues. Bannister (2003) describes her work with sexually abused children using her Regenerative Model, a model which incorporates elements of psychodrama, play therapy, and drama therapy. Bannister postulates that the use of the creative arts therapies with sexual abuse survivors, which incorporate elements of these modalities, is beneficial for three main reasons:

(1) severe sexual trauma in early childhood causes damage to developmental processes (especially attachment processes), which must be addressed through therapy that repeats some of these processes is a positive way;

(2) because of the damage to the embodiment process which occurs during sexual abuse, treatment must address these physical problems by using complementary therapy which

uses the body;

(3) clients must not be re-traumatized by re-experiencing their memories of abuse. Metaphor and symbolism can be used to express and contain frightening or dangerous feelings (p.54).

The Significance of Metaphor Within the Creative Arts Therapies

A powerful force found within all creative arts therapies that has been proven to be significantly effective in the therapeutic process of CSA survivors is the use of metaphor (Gorelick, 1989; Jones, 1996). While the use of metaphor in therapy is not exclusive to creative arts therapies, it is utilized through the various modalities of drama, movement, and art in a way that cannot be attained through verbal language alone.

The research on treatment for sexual abuse has indicated the importance of facing the reality of the abuse; speaking out about what has happened in order to gain new perspectives and move forward in the healing process (Anderson, 1995; Herman, 1997; Meekums, 2000; Simonds, 1994). However, facing and expressing that reality can be extremely painful and many CSA survivors may not have the words through which to express themselves, or the memories may just be too devastating to speak. The use of metaphor through the arts modalities can supply an essential alternative to the use of words and allow something that was once inexpressible to be expressed. When the use of metaphor through drama, dance, art, or movement provides an individual with emotional distance from painful or traumatic memories or feelings, a sense of containment and safety is established, preventing the individual from being overwhelmed and possibly re-traumatized by her emotions (Cox & Theilgaard, 1987). Cox and Theilgaard suggest that this containment achieved through metaphor can also help clients gain access to

experiences that may have previously been buried within their unconscious. As metaphor offers an alternative way of articulating and expressing complex, traumatic experiences, it then has the potential to deepen the individual's understanding of her experience and allow for the possible layers of meaning to be explored (Gorelick, 1989).

Meekums (2000), a trained dance movement therapist who has worked with colleagues trained in both drama and art therapy, began a series of successful therapy groups for women survivors of sexual abuse. As a result of her work with the creative arts therapies, Meekums has proposed the following rationale for why their emphasis on metaphor makes this approach to therapy potentially beneficial for individuals who have been sexually abused as children: (1) it is likely that survivors of CSA have suffered repeated and multiple forms of abuse which may result in complex issues that need to be addressed within therapy. Metaphor may supply ways in which to access some of this complexity; (2) memories of abuse are frequently connected to very early developmental stages which may result in the survivor's inability to have words for what she has experienced; (3) education may have been disrupted by the abuse making it generally difficult for verbal expression; (4) memories may be too painful to be verbally revealed; (5) the survivor may have significantly developed verbal skills which may be used as a defense against feeling; and (6) since the severe traumata are relatively rare, colloquial language does not contain the expressions which might adequately describe experience (p. 61-62).

Dramatic metaphors can be worked with through a variety of different media within drama therapy. With the use of story or fairytale a client may connect with a specific character, image, or object through which they can explore personal material

(Jones, 1996). The use of ones body to communicate is common within drama therapy work, and therefore the body itself, through movement, dance, or improvisation, can become a source of metaphoric material. Physical objects utilized within play and the use of fantasy roles can also assume metaphoric significance. In drama therapy, a client is able to develop a metaphoric connection between the material they have become "stuck" with and the dramatic form that becomes the metaphor through which the material can be explored.

Work involving the use of metaphor within drama therapy can allow the client to relate in new ways to their problematic material by providing the distance needed for gaining new perspectives. When clients are then able to connect this newfound awareness made through the dramatic form to their real life difficulties, the therapeutic potential of the metaphor may be experienced (Jones, 1996).

Drama Therapy Interventions for the Treatment of Mothers and Mother-Child Dyads

Drama therapy is a form of psychotherapy that "...uses the potential of drama to reflect and transform life experiences to enable clients to express and work through problems they are encountering or maintain a client's well-being and health" (Jones, 1996, p.6). Clients can utilize the content produced through different dramatic activities and processes, such as role-play, improvisation, and dramatic projection, and work through that content within a therapeutic framework. Drama therapy allows clients to develop a connection between the problems and difficulties they experience within their inner world and the dramatic activity being implemented within the drama therapy session. The goal is for the client to develop new relationships towards their problems, resulting in a new understanding and healthier functioning.

The use of drama therapy with sexual abuse survivors provides a unique opportunity for clients to develop a strong emotional engagement with the personal material they explore, and at the same time establish a secure emotional distance from it (Silverman, 2007). This balance can be achieved through various means: the client may choose an object such as a puppet or mask to work with; the client may use her body as the medium through which to express; the client may take on a role as an actor in order to work through a problem as someone other than herself; or perhaps remain outside the material and become the director or witness (Jones, 1996; Silverman).

Disclosing and reliving the experience of sexual trauma can potentially lead to further harm, causing the individual to become overwhelmed with anxiety and possible retraumatization rather than an integration of the experience; however, it has also been established that an individual suffering from long term effects of CSA cannot continue to avoid the expression and communication of her damaged internal world if she hopes to recover from it (Meekums, 2000; Silverman, 2007). Drama therapy can provide an intermediate space where the trauma can be worked with but without the accompanying intensified anxiety. Through the use of client-appropriate drama therapy techniques, the balance between emotional connection to material and distance can be maintained, giving the individual the ability to gain access to the dissociated parts of herself and eventually integrate them within. Kelly (1995) suggests that often the course of therapy with sexual abuse survivors involves a series of cycles in which the individual repeatedly returns to three core processes: testing the therapeutic relationship, addressing traumatic experiences, and undoing denial. These processes can effectively occur within drama therapy through the use of the following techniques and interventions.

Dramatic Projection

David Read Johnson (1998) describes a model used within the creative arts

therapies entitled *the psychodynamic model*. This model, which evolved from

developmental psychology, psychoanalytic theory, and object relations theory, proposes

that "...inner states are externalized or projected into the arts media, transformed into

health promoting ways and then reinternalized by the client" (Johnson, 1998, p.85).

According to Johnson, this model is widely used across all creative modalities and many

creative arts therapists from different disciplines have commended the therapeutic value

of their work through this model. This model suggests that psychotherapeutic change

occurs through three separate processes, with the first of those being projection.

Dramatic projection is usually an unconscious process that involves the act of

placing feelings, emotions, or other facets of ourselves into something other than

ourselves (Jones, 1996). When an individual unconsciously projects her inner feelings

into external forms, she is able to gain insight into the material. The essence of projection

within drama therapy is that clients are able to use this technique to reveal inner

emotional trauma through a dramatic outlet. This outlet provides the safety of distance

needed in order to explore the projected material and foster the development of a

profound relationship between the client's inner emotional world and her dramatic form

(Jones). It has been repeatedly suggested throughout the literature that the avoided or

unconscious affect of a mother's painful traumatic history is the problematic factor for

determining the repetition of her abusive past with her own child. If she is able to gain

access to those locked, fixed behaviors through the external dramatic form, she may be

able to create the safe distance needed to examine and gain the perspective required to

facilitate change and reintegration of the original projected material.

The importance of dramatic projection is demonstrated in phase two of Emunah's (1994) five phase sequential method. In this phase, clients move to a level in which "stepping outside oneself" into developed roles and characters transpires and dramatic projection becomes a key component. Through the vehicle of scenework, clients are able to reveal themselves by way of theatrical process. Links begin to form between the roles they act out and real life, suppressed emotions emerge, and the client begins to feel a release from the constraints of everyday life (Emunah). Dramatic projection builds upon the idea of insight through expression as opposed to projection in traditional psychology, where it is seen as a defense mechanism needing to be confronted by the client; a way for the client to deny her feelings by placing them outside herself (Jones, 1996). The latter use of this process could be extremely counterproductive for an abused mother trying to escape the residual results of her defense mechanisms, which therefore establishes the possible benefit of projection used within a drama therapy framework when working with CSA survivors.

There are various mediums within drama therapy that can become a vehicle for dramatic projection such as puppets, masks, script and story, and character. Each is used in a very different manner; however, the one major commonality of all these approaches is their ability to create distance and provide an avenue for the client to express, explore, and work through problematic life areas.

In drama therapy, the projective technique of storytelling, including myth and fairytale, has been worked with in different ways by different therapists. Silverman (2007) discusses the use of drama therapy along with her approach to story work called

The Story Within - myth and fairytale in therapy with adolescents who have been sexually abused. From Silverman's perspective, every child who has experienced sexual abuse has a unique story, a specific pattern of horrific circumstances which led to tragic experience and shaped that individual's inner world. In Silverman's method, a myth or fairytale, character, and specific dramatic moment or situation within the story is selected by the client. Then while moving through various stages of creative process that involve the use of different artistic media such as scenework, writing, mask-making, movement, and artwork, the client works with her chosen story, connecting its symbols and metaphors to her own personal experience (Silverman, 2004). The process of discovering why the client chose her story is central to Silverman's method and can be psychologically revealing and ultimately healing (Silverman, 2007).

Silverman (2007) describes a case example of her work with a fifteen-year-old sexually abused girl who was living on the streets. Over a one year period, Silverman worked with this girl through her chosen story and other drama therapy techniques which guided the girl towards remembering the abuse she endured at the hands of her father. Staying and working within her metaphors led the girl to where she needed to go in order to begin her healing process. Through the use of metaphor and story the client was able to acknowledge her trauma and give it a voice in a way that allowed her to maintain a sense of distance and safety. Silverman states that once completing therapy, this client was no longer on the streets, had obtained a job, no longer engaged in strange sexual encounters, and was attending school part-time. Silverman (2004, 2007) demonstrates how her use of story and drama therapy in combination with other advantageous arts modalities, provides a safe container where clients who have suffered devastating trauma such as

sexual abuse, can work through their difficult material and reach a healthier level of

functioning. This approach to work with survivors of sexual abuse also presents the

possible need for and benefits to multi-modal recovery models with this population.

Embodiment and the Dramatic Body

A secure sense of self is something that can get lost within the darkness of a

mother's traumatic history, leading to distorted perceptions of herself and her infant.

Many dance therapists as well as drama therapists believe that emotion, body, and

identity are all connected. Siegal (1984) states that an individual experiences her entire

being, her "self", in and through her life's bodily experiences. The violence of sexual

abuse invades and impacts the body in the most disturbing and profane way (Valentine,

2007). Many survivors of CSA disconnect from their bodies and fear embodiment; they

associate connecting to their bodies with the evocation of intense and overwhelming

emotions that they are unable to regulate (Sanderson, 2006).

When working with the body in drama therapy, many approaches and techniques

can be used. Jones (1996) states that these approaches can be divided into three main

areas, which are not completely separate from one another but rather should be looked at

as different aspects of practice in relation to the Dramatic Body. The first area focuses on

clients developing their own body's potential with emphasis usually upon the client

inhabiting or using her own body more effectively. The second area concentrates on body

transformation through dramatic forms and the benefits of the client adopting a new

bodily identity within the drama therapy. Finally, the third area centers on exploration of

personal influences that affect the body and how drama therapy can evoke and work with

memories linked to the body. Various drama therapy techniques may be used when

working in each of these areas. Working within this framework of drama therapy may be extremely appropriate for survivors of sexual abuse who experience difficulties relating to and owning their bodies.

Jones (1996) describes how dramatic use of the body can facilitate distance by providing clients with the opportunity to try on a new dramatic identity, and this physical change can then provide a freedom from the patterns of her own mind and body. By involving the body in drama a person can then become more self-aware as she is able to see her own body, how she relates to it, and how the outside world has shaped and affected it (Jones).

An important task within treatment for individuals who have suffered sexual trauma is to regain a sense of safety in their bodies (Jones, 1996; Meekums, 2000; Sanderson, 2006; Simonds, 1994; Valentine, 2007). Since sexual abuse causes damage to the embodiment process in particular, treatment must address these physical issues in order for the individual to reclaim and re-inhabit her own body; however, treatment must be approached cautiously so that the client will not be retraumatized as she re-experiences the abusive memories (Bannister, 2003; Meekums). When a client is able to participate in a dramatic activity, the mind and body connect and are able to discover while engaged together (Jones). If a survivor has repressed her trauma for a prolonged period of time, the pain that is felt when bringing those feeling to the surface may be too painful, or simply impossible at the time to express through verbal communication. By creating a disguised self through dramatic technique, a person is able to move, feel, and respond in new ways that are freeing. From here, personal material can be explored and the client can find new opportunities to connect in her real life to the discoveries made in her

imagined world.

The use of the body can also become a catalyst for new forms of communication for both the mother and her child. As the mother begins to find insight into her own unhealthy ways of holding and experiencing herself, she will discover new ways to interrelate with her child so that she can develop the sense of security that her past traumatic experiences were preventing her from providing (Jennings, 1990; Jones, 1996). Healthier patterns can then be created within the dynamic of the mother-child connection as they are able to restore and recreate intimacy through this new sense of attunement (Harvey, 2000).

Reconnection with the body is thus essential for a mother whose goal is to look at the maladaptive self beliefs that are coming between her and her child. Movement-focused techniques within drama therapy allow hidden or repressed memories that are linked to the body to resurface. These memories, and more importantly the associated affect experience, can then be worked with and a new and healthier relationship with her child can then hopefully begin.

Role Theory and Role Method of Drama Therapy

Role theory and role method are separate but closely connected in drama therapy. According to role theory, every human being demonstrates, feels, thinks, and acts in his or her own particular way and the term role is used to refer to these patterns of behavior (Landy, 2000). Role method is an eight-step extension of this theory into clinical practice. When a client begins working with role theory in drama therapy, it is assumed by the therapist that a role needed by the client to play in her life could be lacking in development, is inaccessible, or even misaligned with other roles (Landy).

The components of role theory consist of the role, the counterrole, and the guide. The counterrole is not a separate entity from the role, but instead is the other side of a role that may be denied, ignored, or avoided when one is stuck trying to play a single role (Landy, 2000). The counterrole should not be thought of necessarily as a dark or wicked figure, for Landy proposes that the ability to embrace and establish harmony with the potential amoral or immoral qualities that exist opposite the role is healthy and moral behavior. The transitional figure of the guide, which serves as a bridge between the role and counterrole, is extremely important for its primary function is integration. The guide also acts as a pilot by helping the client find her way through difficult territory in her life. According to Landy (1993), the role system is made up of interdependent roles where interplay exists between complementary roles, such as wife and mother, as well as between role and its counterpart(s), such as victim and survivor. A role system is also considered to contain "...the substance of one's identity" (p.44), a different way to think about personality structure. For a healthy person, there needs to be flexibility for change and a balance of all the roles and their counterparts within this structure, as well as the ability to call upon the guide for help with this when needed. A healthy person is then able to live within the contradiction of all the roles in her life; therefore "healthy" becomes a measure of both quantity and quality (Landy, 2000). An unhealthy person, such as a mother with a history of CSA who is unable to develop secure attachment with her child, may be limiting the quantity and quality of roles in both her outer and inner world. As a result of this limitation, she becomes stuck and is unable to internalize or attribute the qualities and functions to the roles she does identify with (i.e. the "mother"). Landy's eight-step role method allows the client to work through a role that she has

identified as problematic in her life. Different projective drama therapy techniques such as masks, puppets, and story work can be used as a way for the client to access and work with the role in hopes of gaining new insight into her dramatized material and consequently bring about personal change.

Emunah (1994) regards the experimentation and embodiment of roles to be fundamental to the process of drama therapy and expansion of role repertoire to be one of the primary treatment goals in drama therapy treatment. "Whether fictional or actual, the playing out of a multitude of roles serves to expand one's role repertoire, foster an examination of the many aspects of one's being, and increase one's sense of connectedness to others" (p.12). The betrayal of trust that has been observed in CSA survivors leads to a variety of considerable dynamics including later relational difficulties and impaired attachment (Sanderson, 2006). The shame associated with CSA can also cause the survivor to feel a sense of uncleanliness that may lead her to isolate herself and withdraw from others, creating further relational difficulties. Survivors of CSA may then benefit from an exploration of roles through the dramatic medium as a way of breaking old patterns of behavior and regaining a sense of interaction and connection with others, including their own children.

Landy's (1993, 2000) role method and role play within the framework of drama therapy can then provide the space for an individual to rework and reconstruct mental schemas in order to discover and live with all the appropriate roles and counterroles within her life. This could be an extremely beneficial treatment approach for a mother whose distorted thought processes have led her to internalize negative perceptions regarding the roles she plays in her life.

Psychodrama

Moreno's Theory of Child Development

Jacob Levy Moreno is responsible for inventing psychodrama, a method used for "... exploring psychological and social problems by having clients enact the relevant themes in their lives instead of simply talking about them" (Blatner, 2000, p.1). Moreno's method of psychodrama is strongly connected to his theory of child development which explains his suggestion that psychodrama may be a reparative approach for damaging childhood experiences (Bannister, 2003).

Moreno (1944) postulates that infant development occurs in three stages: the first stage of finding identity, the second stage of recognizing the self, and the third stage of recognizing the other. It is his suggestion that these stages are reflected in the actions of the infant's primary caregiver. When the infant is in the identity stage, the primary caregiver will frequently *double* the child as a way of helping them express feelings. For example, mothers will attempt to interpret their child's cries or actions by trying to place themselves in the child's position. *Doubling*, which is a fundamental technique within psychodrama, is used to help the protagonist gain greater clarity and express a deeper level of emotion (Blatner, 1996). The double stands beside the protagonist, becoming a part of her in order to give voice to certain feelings or thoughts that are unspoken by the protagonist (Leveton, 2001). The protagonist can then continually adjust or correct the interpretations given by the double until protagonist, double, and therapist all arrive at the same understanding of the protagonist's feelings. This process reflects that of the caregiver's continuous attempts to interpret until her child is soothed. Moreno suggests that when the child is able to express herself in a way where her primary caregiver

understands her, the successful formation of the child's identity continues throughout

early childhood (Bannister, 2003).

Once the child's identity has begun to develop, the primary caregiver

automatically looks to reflect this back to the child by *mirroring* her behavior, which is

the second stage of development. (Bannister, 2003) *Mirroring* is also a psychodramatic

technique that is used by an auxiliary who mimics the protagonist to demonstrate an

aspect of behavior that she is not aware of and how others perceive it (Blatner, 2000).

When a caregiver repeatedly reflects or mirrors a child's behavior, the child is able to

recognize it as her own; therefore, these reflections provide the child with the ability to

see how he or she is perceived by others (Bannister).

Role reversal, another cardinal psychodramatic technique, is used as a way for the

protagonist to put herself in the place of others in her life in order to develop emotional

and practical insights into others' situations (Blatner, 1996). Moreno suggests that in

phase three of his child development theory, children gain understanding that the feelings

and needs of others may be different from their own. As children take on different roles

through play with others, they are able to increase their role repertoire as well as learn to

share and interact more easily with others.

Moreno (1944) believes that this process of interaction and development is

damaged when a child experiences a trauma such as sexual abuse. The techniques utilized

within the method of psychodrama echo the necessary developmental actions which

occur within his proposed stages of child development; Moreno suggests that creative

therapies such as psychodrama may be able to repair damaging childhood experiences

through the recreation of childhood events and the stimulation of imperative actions that

failed to be provided as a result of the trauma (Bannister, 2003).

Theoretical Framework

In psychodrama participants have the opportunity to re-enact significant life experiences; to use the here and now to modify and change feelings, behaviors, perceptions, or images of the past at the core level (Blatner, 1997, Holmes, 1992; Hudgins, 1998; Kellerman, 1992). One of the foundations for change is the repair of developmental damage. Crucial elements that were not experienced in the past, for example a protective father, can be created within psychodrama and the new experience can be integrated.

Life unfortunately provides many difficulties and constraints, some too painful to talk about, which makes it very difficult to deal with them comfortably in day to day life. The psychodramatic method provides people with the opportunity to express themselves in a way that regular life does not usually permit, which can make this approach so very powerful. By stepping away from the norm of "telling" and towards the idea of "showing", psychodrama allows individuals to become more engaged and connected to both their physical bodies and their imaginations (Blatner, 2000). Emotions, feelings, and ideas can be accessed through this action approach in a way that simply cannot be attained through the limitations of verbal communication.

Structure of a Psychodrama Session

A psychodrama session consists of three parts: warm-up, action, and sharing (Blatner, 1996; Chesner, 1994). The function of the warm-up is to get the group members in touch with areas of unresolved conflict and feelings, and help the group to focus their attention on a specific theme or common interest. Also, the central protagonist who will

enact and explore her psychodrama is chosen during the warm-up phase.

In the action phase, the director helps the protagonist to set up the first scene and choose other group members to become auxiliaries and play different parts within the psychodrama. The action phase then flows through a journey of scenes "...guided by clinical judgment of what aspect of the protagonist's reality needs to be experienced, explored, expressed, and processed" (Hudgins, 1998, p.330). The final scene within the psychodrama is where developmental repair occurs; this scene can portray an event or action that did not happen in the protagonist's life through which she can change future cognitive and emotional schemes and begin to experience the healing process (Hudgins).

Sharing, the final stage of the psychodrama session, shifts the focus from the protagonist to the rest of the group. During this phase, group members verbally share their own feelings and experiences in response to the protagonist's process and how they may have identified and resonated with the themes and issues that were explored. This sharing also provides the protagonist with support and "...the reassurance that she is not alone in her vulnerability and humanity" (Chesner, 1994, p.124).

Psychodrama with Sexual Trauma Survivors

Hudgins (1998) provides an in-depth description of her modified psychodramatic model used as an approach for her work with survivors of childhood sexual trauma. Within her model, Hudgins incorporates specific clinical therapeutic goals, an Action Trauma Team to help guide safe re-experiencing of traumatic material, types of re-experiencing dramas to prevent retraumatization, and advanced action interventions.

Hudgins (1998) presents three main clinical therapeutic goals within her psychodramatic model: (1) establish intrapsychic roles of safety and build interpersonal

connections among group members to support enactment; (2) structure enactment to promote regression in the service of the ego in order to access dissociated material while preventing retraumatization; and (3) enact original core trauma scenes so that the protagonist can consciously re-experience dissociated material for the purpose of developmental repair (p.330-331). Hudgins continual experiential work with sexual abuse survivors has reinforced the notion that structure is imperative to the prevention of retraumatization, and thus her therapeutic goals reflect this need.

Types of re-experiencing dramas were developed by Hudgins (1998) as a way to continue fostering further structure in her approach. Consequently each of the dramas is assigned a session goal and action treatment to help guide the experiential methods of treatment. An example of one of these dramas is entitled *Conscious Re-experiencing and Developmental Repair* and the intended session goal for this drama is "to support the protagonist to consciously re-experience all aspects of past trauma in order to retrieve, express, and process unconscious material to achieve developmental repair" (Hudgins, p.335). During the enactment of this drama type, the protagonist chooses to re-experience trauma scenes with the support of positive auxiliary roles to prevent retraumatization. One of the auxiliary roles, which has been adapted by Hudgins as a way to increase safety and treatment effectiveness when working with sexual abuse survivors, is an action intervention that she calls the *containing double*. This special application of doubling is a modification of the classical double used in psychodrama that still serves the purpose of an inner voice for the protagonist; however, the *containing double* is instructed to provide only reassuring and affirming statements in order to give full support to the protagonist when needed.

In a clinical vignette, Hudgins (1998) demonstrates the step by step process of her

psychodramatic model used with a client who has a history of childhood sexual abuse.

The client is guided through her *conscious re-experiencing with developmental repair*

drama towards a healing scene that emerges out of the action. The client, who is

supported throughout by both trained clinicians and group member auxiliaries, is able to

safely witness and reenact the horror of her past through different scenes, creating a new

meaning of what happened to her as a child and a sense of self-protection from the

residual traumatic images she carried with her through adulthood.

The major emphasis presented within Hudgin's (1998) model is safety through

structure, establishing the potential benefits of this approach with sexual abuse survivors.

It is made clear by Hudgins that to work at the level of depth that is utilized within this

model, clinicians need to be adequately trained in order to provide the level of

containment and safety necessary when working with sexual trauma; however, many

clinicians are able to take specific techniques used within psychodrama and ethically use

them as appropriate and beneficial additions to their own therapeutic framework in which

they are trained.

The Concept of Play in Treatment of Children and Mother-Child Dyads

Meaning and Function of Play

"Children's play is not mere sport. It is full of meaning and import"

~ F. Froebel (as cited in Landreth, 1991, p.7)

"Play is the central experience for the child in helping her make sense of the

world around her, her place in that world" (Cattanach, 1992, p.29). The importance and

gravity of play is often undervalued or misjudged, perhaps because many adults come to

see play as "childish" and a waste of time that could be put to better use. However, the value of play for both children and adults alike has been proven through extensive research extending back to the nineteenth century and through the evolution of numerous child development theories that have examined the centrality and importance of play within the development process. Play is a child's natural medium for self-expression and, as children grow and develop, self discovery is fostered through this medium.

Our apprehension of play has shifted in the twentieth century, for it has been re-examined by a number of different fields. This shift has led to new approaches to how play is delineated and defined, provided greater insight into the way play relates to both emotional and psychological development, and consequently how play may be implemented within various treatment approaches for therapeutic purposes, including drama therapy (Jones, 1996). Many different theories have contributed to the increased understanding of play and its potentials, but the impact of psychoanalytic theory has proven to be extensive. S. Freud (1961), A.Freud (1975), Klein (1932, 1961), Winnicott, (1974), Axiline (1969), and Erickson (1963) developed psychoanalytic systems of child analysis, which use play to interpret the child's unconscious motivation. These systems of analysis place emphasis on play as a medium for revealing the source of problems, subsequently determining how traumatic experiences may impact the child's psychological development and in what way those experiences can be overcome and dealt with through play (Cattanach, 1992).

Another major contributor to the study of child development from a play perspective is Jean Piaget, who examines play as a factor in the intellectual development of the child and stresses its role in the process of accommodation and assimilation.

Piaget's (1962) concept of play's contribution to the development of children's thought

processes is demonstrated in his foundation of cognitive stages in which he connects

types of play to the age of the child: sensorimotor (practice play) - 0-2 years, pre-

operational (symbolic play) - 2-7 years, and concrete operational (play with rules) - 7-11

years.

The exploration of play's dramatic nature within the field of educational drama

demonstrates another way in which play has been re-examined (Jones, 1996). This

concept of play is distinctly expressed in various theories of Child Drama, where play and

dramatic play are regarded and valued as creative self expressions evolving through

process towards forms of art (Cattanach, 1992). Cook (1917), one of the originating

pioneers in the field of educational drama, proposes that learning is accomplished through

acting, that one learns through doing and play is considered the method of study. Slade

(1954), Way (1967), Bolton (1979), and Heathcote (1984) distinguish the interconnection

between play and drama, placing great emphasis on the educational value of dramatic

play and the individual's utilization and experience of the dramatic process for

exploration and development of the self.

An understanding of the roots of play and its significant value in the life of a child

helps to establish the necessary treatment approach that may be most appropriate for

helping an insecurely attached child make sense of his or her feelings and facilitating

exploration of their emotional world.

Play as Therapy

"The areas of communication, the manipulation, mastery and coming to terms

with reality and the notion of testing and assimilating which typifies the state of playing

are all relevant to the way play manifests itself in therapy" (Jones, 1996, p.173). When play and drama are used as therapy, they become the medium for healing. When working therapeutically with a child, play and drama are planted at the heart of the therapy and are used to move from reality into symbolic worlds.

Cattanach (1992, 1994) describes the four basic concepts used within her model of Play Therapy that help to examine the use of play as therapy and its potential for healing:

(1) centrality of play - play is a unique and central experience in the lives of children that allows them to gain an understanding of their experiences and explore their relationship to both themselves and the outside world (Cattanach).

(2) play as a developmental process - play is a developmental process, which, when used in therapy, will enable the child to engage in various levels of activities; allowing for the back and forth movement along the developmental continuum as a way of discovering individuation and separation (Cattanach, 1992, 1994). This developmental paradigm is explored through Jennings (1994, 1999) EPR (Embodiment-Projection-Role) model that provides "*markers* of life changes which are ritualized through playing and drama from one stage to the next" (Jennings, 1999, p.51).

(3) symbolic play - play is a symbolic process that allows children to escape the reality of their experiences into created fictional worlds, where they can explore and experiment with symbolic representations of their experiences. This process of using play in this way can enable the child to make meaning and resolution through exploration and possibly transform the experience (Cattanach, 1992, 1994).

(4) the therapeutic space - play happens in two areas of therapeutic space: the physical

space where therapist and child meet, which is a special space separate from the reality world, and the psychic space that will develop along with relationship. Cattanach (1992, 1994) promotes the essential establishment of a space that is safe, away from the chaos of the outside world, and allows for imaginative possibilities.

Play in Drama Therapy

Play therapy and drama therapy are closely connected; however, in drama therapy there is a specific focus on *dramatic* play.

> Dramatic play is the child's method of: symbolically expressing and resolving internal conflict; assimilating reality; achieving a sense of mastery and control; releasing pent up emotions; learning to control potentially destructive impulses through fantasy; expressing unaccepted parts of the self; exploring problems and discovering solutions; practicing real life events; expressing hopes and wishes; experimenting with new roles and situations; and developing a sense of identity. (Emunah, 1994; p.4)

When using dramatic play with a child, a drama therapist aims to help that child gain a new perspective of their troubles by playing through them and consequently enabling the child to make a shift in their experience (Cattanach, 1994). This movement from the reality of the outside world into dramatic reality is the essence of drama's healing potential.

The terms *projected play* and *personal play* in relation to dramatic play were developed by Peter Slade (1954), a pioneer in the fields of educational drama and child drama. *Personal play*, according to Slade is used to describe play that is physically

expressed through the body, for example, by assuming a role and enacting it, whereas *projected play* involves the projection of dramatic situations or issues into objects such as a toy or a puppet. The choice between these levels of dramatic play can be significant for projected play can provide a greater sense of distance, perhaps for a child whose experiences are more difficult to face.

Jones (1996) considers play to be an essential process within the drama therapy framework and has included it as one of his nine core processes, which are considered fundamental to the practice of drama therapy. Jones describes three particular ways that play is therapeutically connected to drama therapy:

(1) the first concerns the way in which *playfulness* and the general process of playing can be the vehicle of therapeutic change within drama therapy;

(2) the second relates specifically to the notion of *developmental play* and drama. Here both are seen as parts of a continuum of different developmental stages;

(3) the third focuses upon *content*. Play involves particular areas of content and has a particular way of articulating that content. Play also has a special relationship with reality. In drama therapy this content, form, and relationship with reality become particular ways for the client to express and explore experiences (p.168-169).

The concept of *playfulness* that Jones (1996) discusses is a central concept within drama therapy and can at times be considered a therapeutic goal, since it can be therapeutic in itself. Accessing one's ability to play can enable a client to playfully approach problematic material with a newfound spontaneity that frees them from uncreative and unhealthy response patterns to problems. Play as a developmental process within drama therapy is a crucial facet of play's relation to drama therapy, for one is

intimately connected to the other. The play-drama continuum used by the drama therapist

that begins with sensorimotor play, followed by imitative play, pretend play, dramatic

play and drama, provides a clear representation their intricate relationship (Jones). The

third key conceptual area in the relationship between play and drama therapy that Jones

promotes is the significance of content and its link to what he terms as a *'play shift'*,

which "...involves reality being taken into the play space and treated in a way that

encourages experimentation and digestion" (p.177). The shift acknowledges the notion

that play does encompass and retain elements of real life; however, the intention is altered,

and therefore a client is able to play with and possibly rework aspects in their lives as a

way to experiment with other possibilities or choices (Jones).Various activities or modes

of play within drama therapy are utilized to promote the continuity of this *'play shift'*.

Family Dynamic Play

Family dynamic play is an intervention style that incorporates the use of creative

modalities such as drama, dance/movement, and storytelling as an approach for helping

families address and work through their problems (Harvey, 1990, 1994, 1997, 2000). The

goal of the various play activities within this model is to help family members regain a

sense of creativity in their day to day lives and develop metaphors through which they

can transform conflict within the family dynamic. Through the process of play, family

interactive patterns, themes, and metaphors are discovered and extended in order for

members to engage in more mutual creativity and the development of a more positive and

hopeful emotional environment (Harvey, 2000).

Adults have as much of a capacity and need for both the inherent joy and the

healing that play can provide, but families are often unable to engage in such play due to

the seriousness of their issues (Harvey, 2000). The fundamental concepts and techniques used within family dynamic play are rooted in both play and attachment and therefore aimed at generating playful interaction between parent and child. Positive and healthy experiences of play have been shown to contribute to emotional growth within a family. It is then hopeful that the mutual play an insecure mother and child engage in will lead to a healing process in which they experience a new level of intimacy and a stronger sense of attachment security.

Harvey (1990, 1994, 1997, 2000) provides the following concepts that form the theoretical base of dynamic play:

(1) Play can help to rebuild a sense of security and intimacy following incidents of trauma, conflict, or isolation.

(2) Play is strongly influenced by a family's history with attachment, trauma, and loss.

(3) The observed level of flow within the family's play can provide insight into the emotional atmosphere and connectedness that is experienced between members.

(4) Interventions that make use of the intimacy that develops through mutual play can help to resolve and restore relationships that have become stuck in conflictual patterns (Harvey, 2000, p.388).

Families can experiences events in their lives of such intensity that their ability to effectively cope is impaired, which can unconsciously lead to damaging effects upon their relationships with one another. According to Bowlby (1973), a parent's history with attachment, intimacy, and trauma are manifested within the emotional life of her family, which can negatively impact their attachment security. Consequently, insecurity in a family's attachment may negatively affect their natural play together. The principal goal

of treatment through dynamic play is to help generate connection through guided mutual play and help family members evolve and acquire a greater sense of security within their relationships (Harvey, 2000).

The therapeutic process of family dynamic play occurs through four progressive phases: (1)Evaluation Period; (2) Development of Mutual Parent-Child Improvisation; (3) Identification of Core Theme, Conflict, and Interactive Process; and (4) Family Members Generate Their Own Positive Corrective Play. As families move through each phase of the process, they move towards a stronger mutual playful exchange and develop an expressive momentum with one another (Harvey, 1997). "Such moment-to-moment play functions as a natural curative process and regenerate positive emotional connections in a family setting" (Harvey, p.365).

Family dynamic play is an intervention style that has the potential to be extremely effective in restructuring the insecure relationship between a mother with a history of CSA and her child. The benefits of play have clearly been established in previous sections of this paper, and play used within the family dynamic framework may be an extremely effective therapeutic approach for this population.

Conclusion

There are obviously many challenges that the therapist must face when working with survivors of CSA. Although the literature reports a variety of techniques being used with CSA survivors, one of the major difficulties that arises when determining appropriate treatment plans is that only a small amount of research has been conducted that explores the relationship between specific interventions and treatment outcomes with this population. Therefore, little evidence exists to indicate the treatment approach that

may be most appropriate and effective with the specific individual issues that can evolve

from this complex trauma. However, research does indicate that the use of experiential

psychotherapy, such as drama therapy, with clients who have a history of severe trauma,

such as childhood sexual abuse, is effective and considered a treatment method of choice

as interventions are aimed at addressing various areas in need of healing with CSA

survivors such as affective, cognitive, somatic, adaptive, and behavioral processes

(Courtois, 1988; Hudgins, 1998; van der Kolk et al., 2007).

Communicating and expressing what has happened to them and the pain

associated with their experiences may be very difficult for women CSA survivors;

therefore, a form of expression is needed that offers a safe container through which they

can reveal their inner turmoil and discover ways in which to address and work through

their issues. Drama therapy provides a space that allows for the expression and

integration of self in ways that may not be accessible through other conventional

therapies that rely upon verbal communication. It is this expression and integration of a

mother's traumatic past that will allow her to begin developing a healthier quality of

attachment with her child. Therefore, it is the position of this paper that the use of

experiential drama therapy interventions would be an effective therapeutic approach

when working with women survivors of CSA and their children to help facilitate more

secure attachment relationships.

Research has shown that group therapy provides a critical element of the recovery

process for women survivors of CSA, that being the factor of universality (Meekums,

2000, Yalom, 2005). Having the opportunity to feel heard and understood, to realize that

one is not alone, can provide women with enough safety to explore their experiences and

increase the quality of interpersonal relationships with others (Sanderson, 2006).

However, it is important within the therapeutic process to remember and acknowledge

that CSA and its impact will vary significantly from person to person, as each experience

occurs under a unique set of circumstances. Therapists must be careful to avoid making

assumptions about the impact or long-term effects of the client's abuse, and placing

clients into diagnostic categories (Sanderson). Various therapeutic dynamics and

challenges may arise as a result of how each individual's experiences manifests within

the therapeutic process; clinicians must therefore determine how to work with clients in

ways that address each unique experience. Drama provides an outlet where powerful and

diverse emotions and experiences can be safely expressed, and drama therapists utilize

many perspectives within the drama therapy framework in order to make contact with the

many facets of each client. Dynamics will vary along with the issues a client is struggling

with which requires the drama therapist to decide upon the most relevant theory to help

guide her towards insight into appropriate treatment plans (Emunah, 1994). By choosing

this approach, the drama therapist follows the client's lead and structures theory around

what has been observed and assessed, rather than placing the client into a pre-determined

therapeutic structure (Emunah). In drama therapy, it is the client who determines the pace

and course of the process, which can be an important factor for women CSA survivors

who struggle with the issues of control and trust (Silverman, 2007).

Determining which drama therapy techniques will be most appropriate for CSA

survivors will be dependent upon the distinctive nature of each particular client and

would therefore be chosen after a thorough assessment. However, it can be ascertained

from research that women whose CSA histories have lead to attachment difficulties with

their children need to first gain access to their own traumatic experiences in order to understand how their past continues to impact the present. Drama therapy can provide mothers with the opportunity to rework and eventually integrate the dissociated parts of self so that the quality of attachment between mother and child can be restructured, and a playful, healthy relationship can emerge (Silverman, 2007).

Rehabilitation within the insecure mother-child dyad may also involve some individual intervention treatment for the child. When a child is experiencing insecure attachment patterns, feelings of fear, mistrust, frustration, and anger may become prominent, since the misattuned relationship that has formed between child and mother leaves the child constantly unsatisfied. The use of play within drama therapy can give children an opportunity to communicate emotions as they "play out" their experiences and release feelings that need to be unleashed into the open but may be too threatening to be verbalized (Cattanach, 1992). Within the therapeutic process, the drama therapist can enter the child's world through their play and help facilitate the child's attempts to organize her experiences and explore her feelings (Landreth, 1991). The drama therapist can also become a caring and empathic adult, something that an insecurely attached child may not have in her life, who can help the child with expressing how she feels and how she has been affected by the limited relationship experienced with her mother. It can be important for a child to have a safe environment to be heard and nurtured; a place to face difficult life experiences at a fictional level in hopes of transforming them (Cattanach). Drama therapy can give a child this place.

Finally, treatment intervention that works with both parent and child together can be crucial for helping mother and child restructure essential attachment bonds. Drama

therapy utilizes a broad range of expressive forms and interventions as a means of addressing the therapeutic needs and creative capacities of the client(s). In this paper emphasis is placed upon the use of family dynamic play as a therapeutic approach for mother-child dyads, given its emphasis on relationships between family members, emotional intimacy, and creativity, as well as its basis in attachment theory (Harvey, 1997).

A mother's inability to remain sensitive to the needs of her child and to become a secure base is fueled by her unresolved abuse, leading the child to experience frustration and confusion when looking to the mother for security. Consequently, a family's attachment experience can be generated into patterns and become imprinted into their everyday lives, creating an atmosphere that is alienating and lacking in positive mutual emotional experience (Harvey, 2000). Play is a natural, spontaneous activity that can help families to become attuned and responsive to their mutual creativity, allowing them to develop a more positive emotional atmosphere. Through the intervention style of family dynamic play, the therapist can help mother and child to rebuild their intimacy by guiding them to discover their own organic play that can address their emotional problems and encourage the growth of a healthy attachment relationship (Harvey).

While this approach to mother-child dyad work has the potential to be a reparative therapeutic intervention by helping mother and child experience a greater sense of security with one another, it certainly is not the only one. Other drama therapy interventions may also be applied to dyad work that deal directly with attachment issues and help establish greater intimacy and connection, and again, the choice of those interventions will be guided by the specific needs and issues revealed by the clients.

As it was mentioned earlier, research revealing the benefits of specific interventions with women CSA survivors is scarce, and what is even sparser is research that examines the use of drama therapy with this population. The most exhaustive writing that describes the use of drama therapy with women sexual abuse survivors is Bonnie Meekums' (2000) book, *Creative Group Therapy for Women Survivors of Sexual Abuse*. Meekums' book is an extensive presentation of her thorough comprehension of sexual abuse and the use of different creative therapies, including drama therapy, as therapeutic approaches for women CSA survivors in treatment. Meekums also presents a detailed model of recovery from CSA describing how a therapy group using this model should be set up, how the group should flow, and how the closure of the group can be approached. This book provides crucial and welcomed information concerning the use of creative arts therapies with women CSA survivors; however, it is obvious that much more work in this area still needs to be done.

Further development of therapeutic models that incorporate and describe the application of drama therapy techniques in the treatment of CSA survivors would be of great benefit to not only practicing creative arts therapists but to other clinicians who can gain a greater understanding of the practice and value of drama therapy. Future research on the implications and outcomes of drama therapy with mother-child dyads where the mother has a history of CSA would also be a significant contribution to understanding the use and advantage of drama therapy techniques with attachment difficulties. Although it is important to acknowledge that secure attachment cannot be forced or guaranteed, it has been established that drama therapy can be an appropriate and creative avenue for working towards this transformation or development of quality emotional relationships.

"In sum, drama therapy is an active and creative form of psychotherapy that engages the person's strengths and potentialities, accesses and embraces the person's buried woundedness, and enables the practice of new life stances" (Emunah, 1994, p.31). For the reasons stated here, along with the documented information presented throughout this paper, it is put forward that drama therapy be considered by clinicians to play an important role in the treatment planning for survivors of CSA.

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