MINDFULNESS INFORMED DEVELOPMENTAL TRANSFORMATIONS: WORKING WITH CHILDREN WHO HAVE BEEN PHYSICALLY ABUSED

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A Research Paper
in
The Department
of
Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montreal, Quebec, Canada

SEPTEMBER 15, 2016

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CONCORDIA UNIVERSITY

School of Graduate Studies

This research paper prepared

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Entitled: Mindfulness Informed Developmental Transformations: Working With Children Who Have Been Physically Abused.

and submitted in partial fulfilment of the requirements for the degree of

Master of Arts (Creative Arts Therapies; Drama Therapy Option)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality as approved by the research advisor.

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September, 2016

ABSTRACT

MINDFULNESS INFORMED DEVELOPMENTAL TRANSFORMATIONS: WORKING WITH CHILDREN WHO HAVE BEEN PHYSICALLY ABUSED.

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This paper focuses on the use of Developmental Transformations (DvT) with children who have suffered from physical abuse. Certain mindfulness practices, such as being present and attending to the sensations experienced within that moment, seem to be embedded within various DvT interventions and techniques. Nevertheless, mindfulness-based treatments do not include the concept of 'play', which is a key feature of DvT and can be very useful when working with children who have been physically abused. Play can help children explore personal material which may otherwise be difficult to discuss. DvT possesses many of the necessary techniques required to work with children who have been physically abused. Utilizing a bibliographic research methodology, this paper focuses on the degree to which DvT is influenced by mindfulness and how it can inform the practice when working with children who have experienced physical abuse and trauma.

ACKNOWLEDGEMENTS

First and foremost I would like to acknowledge the presence of **play** and **positivity** in my life that has led me down the path of finding my passion: Drama Therapy.

I would like to thank several faculty members who have aided in my process of becoming the therapist I am today. **Jason Butler** for instilling my love for DvT, showing me how I can be both professional and playful in my work, and how to be supportive yet maintain the ability to have boundaries. Thank you Jason. **Shea Wood** for her time, effort, knowledge, and for helping me find my academic voice throughout this process. **Bonnie Harnden** for her abundant depth of knowledge and her guidance and support through difficult times. **Yehudit Silverman** for her guidance and inspiration to trust and believe in the creative process. **Stephen Snow** for giving an opportunity to experience different forms of theatre and the power they hold in healing. **Jessica Bleuer** for planting the initial seed of my love in Drama Therapy and her abundance of love, presence, and support. Last, but not least, **Susan Ward**, for her guidance with some of the difficult cases I have had in the past year and showing me that with time, patience, and trusting in the process, progress will happen.

Mariah St. Germaine, and **Michelle Kestle** thank you for your amazing English skills. Mariah, thank you for your constant support throughout the two years. Michelle thank you for your presence, humour, and love. **Alex Bolton** and **Alicia Winn** thank you for calming me down and turning this massive mountain I had to cross into just a little hill, thank you for your help in guiding me through this process, you made it possible. **Capucine Deslorieux**, my co-therapist, where do I start? Thank you for just being. We have started this journey together, and this is not the end, we will always continue to support each other. **Shannon Rzucidlo**, you are inspiration. Thank you for helping me find myself in moments when I was lost, this journey would have never been the same without you. **Savy Lassken** and **Patty O'Rourke** thank you for showing me how play and humour can never be lost. Thank you for your light heartedness and your support through times of difficulty. **Marjorie Poirier** and **Stephanie Russell** thank you for your constant support and unconditional love. **Christina O'Polko** thank you for being so inspiring and always sharing you knowledge and beautiful and soothing voice. **Asha La'Cree** and **Charlotte Steuter-Martin** thank you for your presence, inspiration, and beauty.

I would also like to thank my family, who without them I would have never been here. My father **Mohamed Hashem**, thank you for always pushing me to be the best me possible. My

mother **Abla Adel Khalil**, thank you for love, support, and presence. My brother **Nour Hashem**, thank you for always challenging me, and making me the tough person I am today. My sister **Yasmin Hashem**, thank you for you kindness, generosity, and love.

I would also like to dedicate a special thanks to **Moustafa Khalil** and **Hana Afifi**, who without you both I would have never gotten so deep into theatre. Thank you for paving my path towards Drama Therapy, without you I don't know where my life would have been today.

Finally, I would like to thank my **former** and **future clients** for moulding me into the therapist I hope to become.

May playing always be in our lives forever.

"We don't stop playing because we grow old; we grow old because we stop playing"

George Bernard Shaw

May we forever remain young.

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Chapter 1. Introduction

The goal of this research is to identify to what extent Developmental Transformations (DvT) is informed by mindfulness practices and what DvT can provide in the treatment of children who have been physically abused that is currently lacking from a mindfulness-based approach. DvT "is a practice involving the continuous transformation of embodied encounters in the playspace" (Johnson, 2005, p. 6). Mindfulness is a practice which focuses on accepting any thoughts that may come to mind with no judgement and trying to attune to the here and now (Burke, 2009). Based in a bibliographic research paradigm, this research aims to creating a synthesis of literature related to both mindfulness and DvT to further understand the ways in which elements of mindfulness overlap with the practice of DvT and can inform the treatment of children who have experienced physical abuse. There have been minimal documented interventions aimed solely at treating the mental health of children who have been physically abused (Greenwalt, Skylare, & Portes, 1998; Katz & Barnetz, 2014; Mullen, Martin, Anderson, Romans, & Herbison, 1996), rather the focus has been placed in prevention - stopping the abuse from happening and ensuring that the children are in a physically safe environment, removed from the possibility of future trauma.

Of the multiple trauma-informed interventions used with children who have experienced abuse, few interventions have been developed for specific use with children who have been physically abused exclusively. By trauma-informed approach, I am specifically referring to interventions which speak to specifically treat PTSD symptoms, or more generally speaking, symptoms which are a result of the traumatic event. A trauma-informed approach is one that recognizes that several symptoms, for instance misbehaviour by children, is an outcome of the traumatic event. Greenwalt et al. (1998) found that the majority of therapeutic treatments are catered towards the parents of the children, who in this study were the perpetrators. Focusing the treatment on the parent's behaviour decreases the prevalence of physical abuse and establishes a safer household environment; however it does not address the effects the child may experience as a result of the abuse. It is important to explore and build on research that focuses on finding possible interventions to fulfill the therapeutic needs of physically abused children even after they have been placed in a safe environment.

I was inspired to focus on physical abuse specifically due to my country of origin, Egypt. In Egypt, I have witnessed several incidents where parents have subjected their children to phys-

ical violence. Furthermore, unlike Canada, Egypt does not have child protective services nor does it have readily available interventions for those seeking help. Thus, it is my aim to find interventions that would be suitable cross-culturally, which I plan to take home and implement there.

Chapter 2. Methodology

Research Question

The primary research question is: How is developmental transformations (DvT) informed by mindfulness practices, and what can DvT provide for children who have been physically abused that mindfulness alone does not?

This research question will be pursued using a bibliographic research methodology.

Bibliographic Research

I will be using theoretical bibliographic research to investigate this question. According to the Art Therapy and Drama Therapy Research Handbook (2015) bibliographic research involves

> The collection, analysis, and synthesis of the significant empirical, qualitative, and/or other research done on a chosen subject. The purpose of this type of research is to organize and structure, as yet, non-synthesized areas of study, and to identify topics in need of future clarification. (p. 7)

This is the most appropriate method for my research question because it allows me to find the links between DvT and mindfulness and how they can be effective in working with children who have been physically abused. In order to find these links I must look at the literature available for both fields and through analysis create links between them. My question does not require conducting experiments, interviews or surveys. Intervention and other methodologies are not applicable because this research aims to identify points of intersection within the respective fields, to provide a basis and rationale for future research and practice in this area. This research will serve as a significant stepping stone towards identifying whether links between DvT and mindfulness actually exist, thus creating potential interventions. Conducting experiments, or surveys would be premature at this point until a valid rationale for such has been identified.

Rationale

I developed an interest in children who have been physically abuse from my day-to-day experience of living in Egypt. First of all, I came to notice that a great deal of physical abuse is imposed upon children on a daily basis, which may have detrimental, long-lasting effects on the children. Digging deeper, I saw a pattern emerging in research indicating that children who have been physically abused receive less attention in the literature than sexually abused children (Greenwalt et al., 1998). I began to think about and create, within my mind, combinations of

useful therapeutic practices, ultimately landing on DvT and mindfulness. However, after becoming more acquainted with DvT, I realized that it within itself is highly influenced by mindfulness and both practices share similar concepts and techniques.

The Post Traumatic Stress Centre in New Haven, Connecticut, incorporates DvT into addressing the needs of highly traumatized students through their ALIVE program in schools. It got me thinking that using DvT might be a good way to help children work on their trauma in an interactive and engaging way, as opposed to talking about their traumatic experiences and reliving it through their narrative, which may be inaccurate. Armsworth and Holaday (1993) explain that one of the symptoms of trauma is the inability to accurately remember the details of the event. Furthermore, individuals who have gone through trauma have high levels of anxiety and stress (Payne, Levine & Crane-Godreau, 2015). Using mindfulness as a technique in interventions has been useful in addressing stress and anxiety management and reduction (Follette, Palm, & Pearson, 2006).

Research Design

Upon identifying the focus of my research, I visited the online Concordia library database and searched for literature on mindfulness, DvT, and child physical abuse. Key terms which I used for my literature research are discussed later in the "Data Collection" section of this paper. Next, I started to comb through the articles that address DvT and mindfulness as separate entities, including the ways that they have been developed and their basic principles. I also included literature on physical abuse, the differentiation between physical abuse and corporal punishment, as well as articles on trauma. The motive for this breadth was because individuals who have gone through abuse could be traumatized and therefore might require a trauma-informed approach. Then I began to look at the available interventions for working with children who have been abused. Furthermore, I researched which interventions professionals in the therapeutic field find most effective for individuals who have experienced trauma and began to compare and contrast them with DvT and mindfulness. As I was making linkages I found a gap in my research; I needed to gather further information about mindfulness, including how and why it works. Thus, I took another trip to the Concordia library, with the intent on gathering materials that address the origins of mindfulness and its fundamental teachings.

Data Collection

The types of data gathered using this method include peer reviewed articles, theses, dissertations, research papers, and book chapters. I also used personal notes from lectures and classes I have attended, by professionals in the field as part of my Drama Therapy training. I utilized Boolean Search as an information retrieval technique, outlined in Gavin's (2008) Teaching Information Literacy: A Conceptual Approach. In Boolean search, the researcher uses the words AND/OR/NOT to narrow or broaden the search. "And" is used to include literature that have both keywords in the articles. "Or" is used to retrieve articles that include both key words separately; this technique is often used when both keywords are considered synonyms. "Not" is used to exclude articles that include keywords which are unwanted. Moreover, asterisks are used to include all articles which include any words that begin with the root word by which the asterisk was placed. For instance typing "psych*" may yield results including "psychology", "psychiatry", "psychological", or "psychosocial". Quotation marks are used to search for specific phrases such as "drama therapy", "child physical abuse", or "corporal punishment".

The main databases that I used are Academic Search Complete, JSTOR, Spectrum and Concordia library's book selection. Key words I used are "children", "physical abuse", "corporal punishment", "trauma", "mindfulness", and "DvT". Search terms which I used include "(physical abuse OR corporal punishment) AND children", "mindfulness AND children", "DvT AND children", "trauma AND (DvT OR mindfulness)", "physical abuse AND (DvT OR mindfulness)", "(physical abuse OR corporal punishment) AND mindfulness", and "mindfulness AND DvT". I used articles from several different scholarly journals including Developmental Psychology, The Arts in Psychotherapy, Journal of Applied Developmental Psychology, Cognitive and Behavioural Practice, Journal of Child and Family Studies, Journal of Clinical Psychology, Journal of Child Psychology and Psychiatry, Child Abuse and Neglect, and Journal of Clinical Child Psychology.

I did not use all of the articles yielded from the search results. I only included articles that were originally written in English, or translated into English. Furthermore, I excluded articles that were not accessible through Concordia's electronic library catalog or that were unavailable for free on the web. I also excluded book review chapters. The peer reviewed articles and book chapters I used included theory, quantitative, and qualitative research studies.

Data Analysis

To analyze my data I looked through all of the research and created a synthesis, identifying some similarities and differences between DvT and mindfulness practices. For instance in both DvT and mindfulness there is a focus on being in the body, but they do it in different ways (D. R. Johnson, personal communication, November 21, 2015). DvT focuses more on embodiment, which is engaging the body though action and physical movement (Johnson, 2005) whereas mindfulness focuses on raising one's awareness of their body and breath. I then looked at different therapeutic interventions used with children who have been physically abused and later broadened it to children who have experienced trauma. I also looked at the use of DvT and mindfulness individually with children who have gone through trauma. Then I identified which characteristics of the interventions were most suitable when working with children who have experienced physical abuse or trauma and whether DvT or mindfulness share these characteristics. I also looked to identify what elements DvT brings to treatment that mindfulness does not.

Establishing Quality

Tracy (2010) mentions eight different criteria for qualitative quality: worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. Tracy's (2010) first criterion is worthy topic, referring to research that is relevant, timely, significant and interesting. Currently there is no literature synthesizing the concepts of mindfulness, DvT, and the treatment of children who have experienced physical abuse. Some research (Greenwalt, Skylare, & Portes, 1998; Katz & Barnetz, 2014; Mullen, Martin, Anderson, Romans, & Herbison, 1996) has indicated that children who have been physically abused have been given less attention in research and literature than those who have been sexually abused. Additionally, Greenwalt et al. (1998) found that the priority of therapeutic treatments are catered towards the parents (perpetrators) to ensure that the abuse stops. Therefore, investigating interventions that are aimed at working specifically with children who have experienced and are coping trauma is a worthy topic, as trauma may affect several aspects of an individual's life.

The second criterion is rich rigour, which Tracy (2010) describes as research which has a rich amount of sources where the researcher dedicated "appropriate time, effort, care and thoroughness" (p. 841) in compiling their data. As mentioned above, I consulted a variety of databases. I collected the most relevant data to working with children who have experienced trauma through physical abuse. To yield an abundant amount of articles, I used different terms such as

corporal punishment, child physical abuse, childhood trauma, and violence. Furthermore, I looked at sources which discuss DvT, trauma, and children; and mindfulness, trauma, and children.

According to Tracy (2010), sincerity is the third criterion for quality, which is achieved when the researcher is transparent with the participants about the methods and challenges and is self-reflexive about their values, and biases. Since I do not have participants in my research there will be no need for transparency with them about my intentions. Nevertheless, I am being sincere by pointing out the personal resonance this topic has for me. I am forthcoming about my bias to this topic considering I have people who are very close to me and have been suffering from physical abuse by their parents. Witnessing their struggle and their pain is what motivated me to do this research and allowed me to see the need for it in the field. I realized how prominent the use of physical force and abuse for discipline and punishment is in Egypt, my home country, and realized that something must be done. Although this types of research may not have an immediate, direct impact on the population of Egypt or on individuals who suffer from physical abuse, it may influence them indirectly in the way in which this research will inform my future work with children in Egypt as well as future research.

The fourth criterion, credibility, refers to the trustworthiness of the research findings. Credibility in qualitative research is mainly characterized by "thick description, triangulation or crystallization, and multivocality and partiality" (Tracy, 2010, p. 843). Thick description refers to having in-depth descriptions and illustrations which explain and clarify cultural significance and potential meanings of certain information and/or trends. It is achieved by showing rather than telling the readers about what a culture is like, and providing ample detail that may paint an image in the reader's mind. In a sense, I will not have thick description as my research is not an ethnography and I will not be describing a culture. However, I will provide thick description in the sense that I will include the most relevant information about the population, DvT, and mindfulness. Triangulation is achieved when two or more sources converge on the same conclusion. It is similar to the concept of crystallization, which refers to accumulating several types of data using different methods to understand the depth and complexity of the phenomenon. Similarly multivocality refers to including research which represent various voices, such as hearing the participant's voice as well as the researcher or hearing about different populations. I achieved triangulation and crystallization by obtaining several different sources that discuss the same

point. For instance, when I found an article that described how Mindfulness Based Stress Reduction (MBSR) was used with a population who has been abused and yielded positive results where the clients/ participants reported feeling better, I looked for other sources that support or negate such findings. To achieve multivocality I tried to explored articles that use different research methodologies, some of which are quantitative and focus on the results, and others which are qualitative and speak through the voices of the participants, either through interviews or written stories.

The fifth criterion refers to the "research's ability to meaningfully reverberate and affect an audience" (Tracy, 2010, p. 844). It is important to achieve resonance, as more readers will be able to relate to the research. Transferability refers to the reader's ability to transfer the research and relate it to something which is personally relevant to them. I hope that this research may achieve transferability where it may be generalized to individuals who have gone through trauma and different forms of abuse, not only physical abuse. Furthermore, as I hope to use this research to influence and inform my work in Egypt, I hope that it may achieve cultural transferability.

My research contributes significantly to the field, which fulfills the sixth criterion. It provides new insight in to the use of DvT and mindfulness practices in working with children who have been physically abused. It also has heuristic significance, which means that it drives people to further explore a concept (Tracy, 2010). It does so by providing suggestions for further research such as using DvT and mindfulness with different populations suffering from trauma. Finally, I have hope that it may have catalytic validity where it may, in the future, catalyze the community to create a change (Tracy, 2010). More specifically, I hope to raise awareness about the detrimental effects which physical abuse may have on children and to see a change in Egypt about its use.

Ethical Considerations

Ethical considerations for this method include being able to acknowledge both supporting and contradicting perspectives. I looked at different fields that discuss mindfulness, DvT, and/or children and trauma. For example, looking at articles that discuss trauma from different perspectives such as: behavioural psychology, cognitive psychology, psychiatry, and child and family studies. I searched through different databases and did not only focus on one, for instance I used different journals, such as the ones mentioned above. I was vigilant in citing relevant sources that contributed to the research. Furthermore, it is important for me to place myself within the

research and identify my position in relation to the research. I am a researcher/ aspiring therapist/ student with my own biases and privileges. I am an individual that has never personally gone through any physical abuse in my life, however I have witnessed it happening to people around me and sometimes to those with whom I have close relationships with. It is important that I present a balanced representation of the literature and findings in the field, despite my personal position and bias.

Chapter 3. Literature Review

Child Physical Abuse (CPA)

According to the National Clearinghouse on Child Abuse and Neglect Information (2000), child physical abuse (CPA) is

> …the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking or otherwise harming a child. The parent or caretaker may not have intended to hurt the child, rather the injury may have resulted from over-discipline or physical punishment. (as cited in Gershoff, 2002, p. 540)

Straus (1994) defines corporal punishment (CP) as "the use of physical force with the intention of causing a child to experience pain but not injury for the purposes of correction or control of the child's behaviour" (p. 4). Some studies have shown that the use of mild corporal punishment may be beneficial in disciplining the child. However other studies suggest that corporal punishment may have a negative impact on the child's well-being (Zolotor & Puzia, 2010). Since 1979, 24 countries have issued legislations banning the use of corporal punishment (Zolotor & Puzia, 2010), showing how detrimental the effects of this practice can be.

In Egypt there is a high prevalence of corporal punishment, which can often escalate to child physical abuse. El-Hak, Ali, and Abo El-Atta, (2009), studied the causes of child deaths in Dakahlia and Damiatta governorates in Egypt. They autopsied 315 children and found that 41 children, 13.02%, had died from the effects of family violence, defined by the authors to include "corporal punishment, violence against the child with the intention of harm and witnessing violence between parents" (El-Hak, Ali & Abo El-Atta, 2009, p. 388). Most victims were younger than 10 years old. This shows how serious CP can be and to what extent it may escalate to CPA which may lead to death. The main perpetrators in this study were the fathers of the children, however CP is also administered within other settings and with other perpetrators. Youssef, Attia, and Kamel (1998b) found that 79% of male students and 61% of female students had been physically punished within an Egyptian high school setting, despite the fact that corporal punishment was banned in 1971 by a ministerial decree. Recently, a child in fifth grade in Egypt died of a brain hemorrhage in a hospital three days after being beaten by his teacher for not doing his homework (Moftah, 2015).

Trauma and the effects of CPA and CP on children. The traumatic effects of a shocking event can manifest in a multitude of ways.

> Trauma and post-traumatic stress disorder (PTSD) is described as the person having experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone. The traumatic event or events are constantly re-experienced by intrusive recollections or dreams or the feeling that the events are recurring. This creates immense psychological distress. (Cattanach, 2008, p. 27)

Armsworth and Holaday (1993) describe four ways in which trauma may affect an individual, (outlined in the Table 1): cognitive, affective, behavioural, and somatic physiological. They found that children who have experienced trauma may have symptoms that meet the PTSD criteria and others which are not mentioned as one of the symptoms; in their words, “the diagnosis of PTSD seems to describe many symptoms frequently documented in the literature but does not include many symptoms that may be emotionally or socially disabling or distressing to the child or adolescent” (Armsworth & Holaday, 1993, p. 53).

Table 1

Child Trauma Symptoms Which Meet and are Beyond the DSM III-R Criteria for PTSD

	Child Symptoms Which Meet PTSD Criteria	Child Symptoms Beyond PTSD Criteria
Cognitive Effects	Time distortions about the event.	Confusion.
	Inability to recall event details in sequence.	Academic difficulties.
	Intrusive images and thoughts of the event with conscious suppression and avoidance.	Learning disabilities.
	Foreshortened sense of future; i.e cannot picture themselves as adults or having their own family.	Lowered IQ levels.
	No/ altered future goals.	Developmental delays.
	Hyper-vigilance.	Poor language and communication skills.
	Alertness to reminders of the event.	
	Guardedness against attack.	
Affective Effects	Labile affect: anxiety, panic, irritability.	Depression.

	Fears: excessive worrying, generalized phobias, fear of re-traumatization.	Excessive crying.
	Tension.	Sadness.
	Constricted emotions.	Withdrawal.
	Inability/ fear of expressing feelings.	Feelings of helplessness, hopelessness, powerlessness.
	Distress at trauma reminders: objects, people and situations.	Fatalistic outlook.
	Avoidance of pleasurable activities.	Feeling guilt, shame, and responsibility for surviving.
	Re-experiencing the event emotionally.	Impaired self concept.
		Discovery and belief in omens that predict the event.
Behavioural Effects	Post-traumatic play.	Self abusiveness.
	Regressive behaviour.	Self destructiveness: being involved in risk taking behaviours.
	Loss of previously learned skills, both academic and social.	Suicide attempts.
	Reenactments of event.	Chemical dependency.
	Retelling event without any affect.	Maladaptive attachment styles.
	Poor concentration, inattentiveness, hyperactivity, and impulsivity.	Poor/ decreased social behaviour.
	No regard for consequences of their actions.	Aggressive, belligerent, rebellious behaviour: non compliance, disrespect for others and engaging in animal cruelty.
	Avoidance of event reminders.	
	Change in behaviour because of feeling alone, estranged, left out, or different.	
Physiological-Somatic Effects	Autonomic response to trauma reminders.	Abuse dwarfism/ failure to thrive syndrome.

	Hyperarousal.	Skeletal, skin, internal or neurological injuries or scars.
	Low tolerance for stress.	Somatic complaints.
	Startle response and numbing of trauma reminder stimuli.	School absences.
	Sleep disorders.	Vaginal/ genital injury or infection.
	Fatigue.	Pain agnosia.
		Biochemical brain alterations.

Armsworth and Holaday (1993) point out that “although we have moved further in delineating commonalities of responses to trauma, it is not possible to propose a single profile to describe a traumatized child or adolescent” (Armsworth & Holaday, 1993, p. 54). Therefore, in clinical practice it is important for practitioners to recognize the complexities of trauma and the uniqueness of every case. Clinicians need to consider each case closely and consider which trauma treatment would be the most helpful approach with each client. Children who have been physically abused show symptoms which may differ slightly from children who have gone through sexual abuse or a natural disaster.

Cattanach (2008) describes that “Children who are subjected to physical… abuse experience trauma which profoundly damages their lives to such an extent that they may need therapeutic help to recover” (p. 26). Physical abuse may result in several adverse effects. Such effects may manifest during their childhood years (Aucoin, Frick, & Bodin, 2006; Aber, & Allen, 1987; Pollak, Cicchetti, Hornung, & Reed, 2000) and/or in adulthood (Mullen et al., 1996; Styron & Janoff-Bulman, 1997; Unger & De Luca, 2014).

Childhood physical abuse may have an impact on the individual’s attachment style, both as children (Egeland & Sroufe, 1981), and as adults (Unger & De Luca, 2014). Attachment theories describe the way in which individuals form relationships with others, beginning in childhood with the primary caregivers. Many theorists have described attachment and how it influences behaviour. Bowlby (1990) describes attachment behaviours as “any form of behaviour that results in a person attaining or maintaining proximity to some other dearly identified individual who is conceived as better able to cope with the world” (p. 26), usually the primary caregiver. Bowlby also explains that “the quality of early attachment relationships is rooted in the degree to which young children can rely on [their] caretaker as a source of security or protection” (Styron

& Janoff-Bulman, 1997, p. 1015). Ainsworth identified three main attachment styles: secure, anxious-avoidant, and anxious-resistant (Minde, 1986). While the details of each attachment style is beyond the scope of this paper, it is important to note that the quality of attachment in early childhood has an impact on the child's psychosocial competence.

> A secure attachment has been found to be associated with good interpersonal skills, open and flexible use of language, and generally good adjustment at age six. By contrast, anxiously attached children show less emotional openness, more restricted language use, and a 'teasing' quality in their interactions with others. (Minde, 1986, p. 802)

Ainsworth and Bowlby's successors further developed the attachment theory to include adult attachment styles. Hazan and Shaver (1987) developed a three-category model which Bartholomew (1990) then developed to include a fourth category (Fraley & Shaver, 2000). She named the four categories: secure, pre-occupied, dismissing-avoidant, and fearful-avoidant, which can be described with the level of anxiety and avoidance which the individual displays (see Figure 1). Securely attached individuals display low avoidance and low anxiety, and they view themselves as worthy and lovable; preoccupied individuals display low avoidance and high anxiety, they hold a positive view of others as being available and reliable, yet they fear being abandoned; dismissing-avoidant individuals display low anxiety and high avoidance, they are avoidant because they want to maintain a sense of independence and self reliance; fearful-avoidant individual have both high levels of anxiety and avoidance, they fear getting hurt and do not want to show their vulnerability (Fraley & Shaver, 2000).

Figure 1

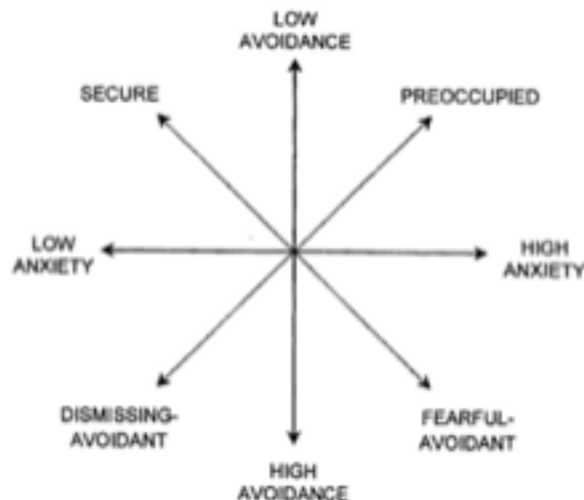

Figure 1: Adult Attachment Styles (Fraley & Shaver, 2000, p. 145)

Experiencing physical abuse in childhood can result in difficulties forming adult relationships (Unger & De Luca, 2014). Some studies have found that people who suffer from abuse tend to engage in more aggressive and negative romantic relationships (Styron & Janoff-Bulman, 1997). Moreover, those who have been physically abused tend to have insecure attachment styles (Egeland & Sroufe, 1981; Styron & Janoff-Bulman, 1997; Unger & De Luca, 2014). There are several responses to physical abuse: compliance, children lose their sense of self but are abused less often, or acting out, children maintain their sense of self but get punished more (Unger & De Luca, 2014). Unger and De Luca (2014), also found that physical abuse seems to significantly correlate with a negative view of self and others. Moreover, children who were physically abused are more likely to develop a fearful-avoidant attachment style (Unger & De Luca, 2014). However, adults who have suffered from childhood physical abuse, who have a strong social support system, seem to exhibit lower levels of psychopathology (Unger & De Luca, 2014).

Physically abused children often experience confusion about their relationships with those in and outside of their family. Katz and Barnetz (2014) found that some physically abused children began to believe that they deserved the physical punishment, rationalizing their parent's behaviours. Children seemed to internalize their parents' views of them, in turn viewing themselves negatively (Aucoin et al., 2006), as if they brought shame and disgrace to the family (Youssef et al., 1998a). Furthermore, Pollack, Cicchetti, Hornung, and Reed (2000) found that children who were physically abused were less likely to differentiate certain emotions and had an increased awareness of others. They found that physically abused children were more likely to identify faces that showed anger. These children also saw more similarities between angry, sad and neutral faces, supporting the notion that children who have been physically abused may interpret neutral faces as being masks that are hiding more malicious emotions (Pollak, Cicchetti, Hornung, & Reed, 2000). For example, when meeting a therapist for the first time, a child may be fearful of them, thinking that the therapist may have bad intentions. Another example of misinterpretation that may happen is when a child moves to a new school. They may have difficulty integrating with their peers because they may interpret children who are trying to approach them to become friends as having malevolent intentions. Children may have difficulty identifying other individual's true intentions when they misinterpret their affect, they may easily assume that the other individual has malicious intent. Unger and De Luca (2014), found that exposure to CPA

may result in difficulties forming relationships later in life as adults. The trauma of physical abuse can lead to uncertainty and doubt about the child's relationships with others.

Children who have been physically abused may experience global numbing (where they do not feel different emotions), emotional withdrawal, and/ or aggressive behaviours (Miller & Boe, 1990). Aucoin, Frick, and Bodin (2006) found that children who frequently experienced CP reported increased levels of emotional distress and conduct problems, and lower levels of self-esteem than children who experienced few or zero instances of CP.

Children who are constantly exposed to high levels of stress during their childhood, may develop maladaptive stress responses (Perry & Szalavitz, 2006). Having a constantly activated stress system during the early stages of life, hinders the stress response system's development and thus causes maladaptive behaviours. Children who have been exposed to high levels of stress in their early stages of life tend to look for threat everywhere they go and at all times, preventing them from being able to focus and enjoy the pleasures of everyday life (Perry & Szalavitz, 2006). They are always on guard and have restrictive affect (Miller & Boe, 1990), constantly looking for danger and showing minimal emotions. Children who were constantly physically punished struggled with the ability to name their emotions, as the abuse caused damage to their emotional language (Katz & Barnetz, 2014). As aforementioned, children may misread benevolent facial expressions on others as being threats and react accordingly, as a result of being constantly on the look out and having impaired socioemotional development (Pollack et al., 2000). Hindered social development may include a variety of behaviours and attitudes towards others, including opposition in the care of authority figures, which may also cause an increase in the use of physical abuse by the perpetrator who is trying to discipline them (Katz & Barnetz, 2014).

Treatments provided for trauma and cases of CPA. When providing treatments for children who have experienced trauma it is important for the therapist or counsellor to be aware of the multitude of symptoms and effects that may manifest differently for each case. The therapist must consider the specific needs of each individual and cater the treatment accordingly. Katz and Barnetz (2014), point out that is it important to be aware about what the children want when intervening in cases of physical abuse, to avoid making matters worse, by creating separation anxiety, for example, some children might prefer to forget about the abuse rather than be taken away from their family. Wohl and Kaufman (1985), suggest that mental health professionals use

treatments such as art therapy, play therapy, sand trays, or other techniques to help children bring up material which they may find frightening, shameful or repulsive.

Fortunately, there are many trauma-focused treatments available. There have been recent pressures on mental health professionals to use evidenced based treatments, which are treatments that have been empirically evaluated and shown their efficacy in reducing behavioural and/or emotional problems (Allen & Kronenberg, 2014). Nevertheless, there are several trauma treatments available which are not evidenced based, some of which are based on creative interventions. I will be touching on selections of both non/evidenced based treatments available.

Kolko (1996) compared the use of family therapy (FT) with cognitive-behavioural therapy (CBT) in treating cases of child physical abuse. He found that CBT was more effective in reducing the parents' level of anger and use of physical discipline. More children reported that there were less family problems after attending the CBT sessions than the children who attended FT sessions. In this study, the treatment involved both parents and children with the 17 clinical hours split between them. The fact that the child's perpetrator, the parent, was available during interviews and intakes may have altered the results. Children and parents may have been inclined to respond in a certain way and report a reduced amount of CPA to have more socially acceptable answers.

Child-parent psychotherapy (CPP) is another treatment which was originally developed for children who have been exposed to domestic violence and those whose primary caregivers have died (Kronenberg, 2014). It was also found effective in treating children with many traumatic stressors and mental health issues (Kronenberg, 2014). It is an evidenced based treatment which mainly focuses on children from birth through age 5 and their primary caregivers (Kronenberg, 2014). CPP utilizes several psychological paradigms, primarily attachment, psychoanalysis and trauma theory. It is relationship based, focusing on the child-caregiver relationship and aims to support children's development which has been influenced by trauma (Kronenberg, 2014).

CPP is one of the evidenced based treatments available. Another evidence based treatment is trauma-focused cognitive behavioural therapy (TF-CBT). Out of all the evidence-based treatments for children who have experienced abuse and trauma TF-CBT is considered to be the most commonly used treatment (Allen, Gharagozoloo, & Johnson, 2011). TF-CBT's main goal is to reduce and eventually eliminate the emotional responses to reminders of the trauma and the

use of avoidance as a coping mechanism, by placing importance on the implicit discussion and processing of the traumatic event (Allen & Hoskowitz, 2014). TF-CBT is a gradual process of desensitization which begins with the child discussing specific memories, thoughts, and feeling, then gradually confronting physical reminders of the trauma (Allen & Hoskowitz, 2014).

Parent-child interaction therapy (PCIT) is another evidence based therapy which is used in trauma treatment. It is a behavioural parent training intervention that was initially developed for families who have children exhibiting behaviours which are socially disruptive, such as being oppositional or aggressive (McNeil & Hembree-Kigin, 2010). However, it has also been used in improving parent-child relationships in cases involving physical abuse (Borrego, Klinkebiel, & Gibson, 2014). PCIT uses live coaching, where the therapist observes the parent and child relationship during the child's play and gives the parents pointers on how to better manage their child's behaviour, thus improving their relationship. Furthermore, the therapist aims to increase parent-child positive behaviours and decrease the negative ones (Borrego, Klinkebiel, & Gibson, 2014).

The previously mentioned therapeutic interventions usually focus on the parents of the child-parent relationship, rather than the child's inner world and trauma related symptoms. While there are minimal treatment approaches designed specifically for children who have experienced physical abuse, there are more general trauma treatments that attempt to address the individual's inner experience of the traumatic event and the resulting symptoms and dysfunctions. Non-directive play therapy is one intervention which is used with children who have suffered from traumatic experiences. Allen et al. (2011) conducted a study to research the use of evidence based and non evidence based interventions in working with maltreated children. They found that 70% of the clinicians in the study endorsed play therapy (and other non empirically supported interventions, i.e sand tray therapy and art therapy) and reported using it quite often; this was not surprising to the researchers due to "the decades of promotion of these techniques for use with maltreated children by clinicians" (Allen et al., 2011, p. 7). Play is a child's natural way of interacting and making sense of the world, it helps individuals to "engage with self, others and life in a spontaneous way" (Jones, 2007, p. 165). When a child has been abused it is important for them to be able to understand and make sense of the event in an age appropriate developmental level. Children need to have a way to release the feelings of hurt caused by the adult, thus their use of play can help reduce the lasting effect of the post traumatic stress (Cattanach, 2008). Play thera-

py uses a humanistic, client-centered approach where the therapist creates a safe environment where the child may release "their inner-directional, constructive, forward-moving, creative, self-healing power" (Landreth, 2012, p. 53). The play therapy room is equipped with dolls, puppets, blocks, a doll house, a baby bottle, stuffed animals, different textured toys (i.e. play dough, silly putty), and other toys. The child is given the opportunity to play with anything they want in whichever way they want. The therapist follows the child's lead and reflects back to the child emotions that may be coming up in the play.

Another fairly recent treatment developed by Peter Levine in the past 45 years is somatic experiencing (SE). SE focuses on alleviating the chronic stress and post-traumatic stress symptoms by using a bottom up approach (Payne, Levine, & Crane-Godreau, 2015). The client's attention is directed towards "internal sensations, both visceral (interoception) and musculoskeletal (proprioception and kinesthesis)" (Payne et al., 2015, p. 1). SE avoids focusing directly on and evoking traumatic memories; it approaches these memories indirectly and gradually, and also aids in creating new interceptive experiences that are physically opposing to helplessness, which is what many trauma survivors feel (Payne et al., 2015). In SE, a traumatic event is one that causes lasting dysregulation in the autonomic and core extrapyramidal nervous system (Levine, 1997). Thus, the basis of the treatment focuses on the individual and their body.

There is a myriad of treatments provided for trauma victims some of which include psychodrama (Kellermann & Hudgins, 2000); sociodrama (Kellermann, 2007); art therapy (Brooke, 2008); music therapy (Curtis, 2008; Clarkson, 2008; Hiliard, 2015); dance/movement therapy (Chang & Leventhal, 2008; Gray, 2015); drama therapy (Long & McKechnie, 2008; Brosbe, 2008; Pierce, 2008); prolonged exposure (Foa & Rothbaum, 1998); eye movement desensitization and reprocessing (Shapiro, 1995); life stories (Leydesdorff, Dawson, Burchardt, & Ashplant, 2004); the counting method (Ochberg, 1996); some have incorporated art and narrative therapy (Electris & Hnath, 2008); others have incorporated eye movement desensitization and reprocessing with art therapy (Urhausen, 2015); and some have used body maps (Santen, 2015). For further creative interventions for traumatized children or survivors of domestic violence, see Malchiodi (2015) and Brooke (2008).

Developmental Transformations (DvT)

DvT is another intervention used in trauma treatment. It "is a practice involving the continuous transformation of embodied encounters in the playspace" (Johnson, 2005, p. 6). It focuses on the use of embodiment, where the client and therapist use their bodies to take on different characters, roles, or movements; encounter, where it is based on a face to face encounter between with therapist and the client; and transformation, where every moment is changing and images being played are constantly transforming to something new. It is a form of improvisation where the client engages in play with the therapist. It recognizes the fact that the world is constantly changing and life is unstable. People have a fear of change and of this instability. DvT works on trying to help the client experience and find peace within this instability. It focuses on helping the client build "self confidence and capacity to remain balanced in unbalanced situations" (Johnson, 2014, p. 70).

Similar to TF-CBT, DvT focuses on reducing avoidance in the client through the playspace (Johnson, 2014). However, it does it differently; the whole therapeutic process, in DvT, occurs within the playspace which "is a mutual agreement among the participants that everything that goes on between them is a representation or portrayal of real or imagined being" (Johnson, 2009, p. 93). Within the playspace the biggest rule is to restrain from harm. One can pretend to inflict pain on another, however, nobody really gets hurt. Furthermore, "the playspace, like theatre, is a lie that seeks to reveal itself as a lie, and therefore, is honest" (Johnson, 2009, p. 93). There is a mutual agreement between the client and the therapist that everything that occurs within the playspace is not real, it is a constantly evolving improvisational space. Just like the thoughts in our mind are constantly changing, so is the playspace, thus, helping clients rehearse for the instability of life. The therapist follows the client's impulse.

As aforementioned, TF-CBT begins with the client discussing the trauma and their specific memories then gradually moves to experiencing it physically. Similarly, in trauma- centred DvT prior to beginning the play, the therapist conducts a thorough trauma history inquiry with the client and immediately establishes a trauma-centered frame. After establishing the frame, the client and therapist enter into the playspace, which is an embodied encounter. The client's experience of the therapy session is entirely embodied and, in about 91% of the session, the client is engaged in dramatic embodiment (Armstrong et al., 2016). However, working through the trau-

matic event comes gradually (Johnson, 2014). More specific DvT concepts will be elaborated on more in the discussion section of this paper.

Mindfulness

When used in the context of therapy, mindfulness based interventions seek to teach mindfulness skills in order to promote mental health. It focuses on accepting anything that may come to mind with no judgement and trying to attune to the present moment (Burke, 2009), a concept which can be difficult for individuals dealing with trauma. Mindfulness stems from the Buddhist practice where it is "one of a number of virtues or qualities whose cultivation is presented as fundamental to the Buddhist path to 'enlightenment' or 'awakening'" (Gethin, 2016, p. 11). It aims to focus on behaviours, in both pleasant and unpleasant circumstances to help people feel and see themselves as part of a changing universe (Follette, Palm, & Pearson, 2006). This compliments the concept of DvT, which attempts to help clients build confidence and find peace within unstable environments, thus accepting change and becoming more fluid and spontaneous (Johnson, 2014).

With trauma, people usually tend to try to suppress the event and avoid it as much as possible (Armsworth & Holaday, 1993). The "rebound effect" refers to the phenomena of when one exert a lot of energy in trying to suppress any thoughts about the trauma, which results in the thoughts becoming persistent and coming back even stronger (Follette et al., 2006). Furthermore, "increased suppression and avoidance lead to emotional numbing and dissociation from cognitive or emotional stimuli" (Follette et al. 2006, p. 51). Through bringing the mind to the present moment, mindfulness is thought to increase clarity, attention, calmness and emotional well-being (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010). "The integration of mindfulness skills could improve the effectiveness of exposure treatments through increasing patiens' ability to contact painful memories, thoughts, and feelings without engaging in avoidance strategies" (Follette et al., 2006, p. 52).

Kimbrough et al. (2010) utilized mindfulness-based stress reduction (MBSR) (Kabat-Zinn, 2011) in working with child sexual abuse survivors, which I acknowledge is a different population from the one this paper is focused on, however, it is relevant in that both populations have experienced trauma from a form of abuse. The researchers found a significant reduction in anxiety, depression, and PTSD symptoms among the participants. The study was based upon three PTSD symptom criteria: reexperiencing, avoidance/ numbing, and hyperarousal. They

found that there was a reduction in all three aspects, most prominently in avoidance. A follow up study completed by Earley et al., (2014) with the same population tested the sustainability of the reduction of these symptoms. They found that MBSR has substantial benefits that can be maintained for two and a half years. Relevant aspects of mindfulness practices will be expanded on in the following discussion.

Chapter 4. Discussion

Developmental Transformations (DvT) and Mindfulness

One of the main tenants of DvT is the idea of prime discrepancy. This idea recognizes that Being is non repeating, every moment is unique in its own way (Johnson, 2014). People usually have difficulties accepting this change and therefore respond by "creating repeating forms" (Johnson, 2014, p. 70), in order to create stability. The sum of these repeating forms is people's representation of reality, which will never be exact, it will always be incomplete and inaccurate "because of the presence of a non repeating element in every moment" (Johnson, 2014, p. 70). People's dissatisfaction with the ambiguity is what creates "maladies" in the individuals. Thus, similar to desensitization which aims to lower people's fears, DvT aims to replace people's fear of instability with peace and comfort, which, in DvT, is called being centred (Johnson, 2014).

As aforementioned, mindfulness is originally rooted in Buddhist practice. Despite their being several schools of Buddhist thought and practice, they all hold the same basic tenants (Follette et al., 2006). All different practices of Buddhism follow the Four Noble Truths which state that "(a) suffering is ubiquitous; (b) suffering is a consequence of the automatic tendency to cling to phenomena; (c) the cessation of suffering is possible; and (d) this cessation can be achieved by practicing the Eightfold Noble Path" (Kumar, 2002, p. 41). Thus, similar to the way DvT describes maladies as being people's intolerance to instability and change leads to them trying to hold on to things and create repeating forms, Buddhism states suffering is a result of people wanting to hold on to phenomenas, in this respect phenomena refers to events, incidents, or situations.

By being in the DvT playspace, which is always changing, the individual is able to let go of the control and accept change (Johnson, 2014). Similarly, one of the uses of mindfulness, which is one of the eight teachings of the Eightfold Noble path, is to "direct attention to these [phenomena we try to stabilize], [to] begin to see them in a different way, that is for what they truly are: just physical and mental qualities or phenomena (dharma) that come and go according to certain conditions" (Gethin, 2016, p. 14). DvT and Mindfulness teachings believe that when individuals hold on to phenomena and try to stabilizes them, that is when maladies/sufferings occur, and both strive to eliminate/ reduce this tendency. One of the cognitive effects of witnessing a traumatic event is memory impairment. This is when the individual's intellectual function-

ing is negatively affected and individuals are unable to perform in the present or think about the future, which creates inflexibility where they remain stuck in the past, when the trauma occurred (Armsworth & Holaday, 1993). Additionally, individuals start to adapt avoiding strategies which then creates a rebound effect where the thoughts come back stronger (Follette, Palm, & Pearson, 2006), making it more difficult to avoid, thus requiring more energy, which depletes the child's energy from carrying out other daily activities. In adopting these avoiding strategies, the child is unable to deal with the trauma and therefore remains stuck in the past when it occurred. DvT and mindfulness aim to reduce this inflexibility by helping individuals try to be present in the moment. The end result of DvT and mindfulness, however are quite different, one aims to affect current life and the latter aims to affect the after life. "DvT attempts to help clients reach a state of readiness to encounter the world with all its surprises and demands" (Johnson, 2014, p. 71). In Buddhism, practicing mindfulness is believed to help individuals reach a state of freedom from rebirth into life or "will [help them] be reborn in one of the heavens known as the Pure Abodes and there attain such freedom" (Gethin, 2016, p. 14).

DvT theory explains that as a result of trauma, individuals develop a form of rigidity and an inability of being in intermediate spaces, which are "transitional spaces that have greater ambiguity, deeper nuances and textures, [and] more fluidity" (Johnson, 2014, p. 71). Clients may search for clarity about their trauma and develop rigidity, which leads to their avoidance of intimate relationships. Clients may experience a state of 'emotional flooding' or 'numbing' and an inability to experience being in an intermediate space of "emotional feeling". However, if the client is able to enter into this intermediate space they usually avoid, it can allow for "creativity, magic, dreams, intimacy, possibility, and indeed, the arts" (Johnson, 2014, p. 72), which the trauma prevents victims from experiencing.

From a Buddhist viewpoint, symptoms resulting from a traumatic experience is described "as a form of suffering" (Follette et al., 2006, p. 50). Trauma results in a narrowing of an individual's behavioural repertoire, which appears through a psychological inflexibility, explained by resulting from an inability to be mindful or present (Follette et al., 2006). This narrowing occurs with the increased use of avoidant strategies, including suppressing intrusive thoughts, or physically removing oneself from an environment which elicits painful memories (Follette et al., 2006). There are several trauma related symptoms which result in behaviours which are considered to be not mindful. The "avoidance of painful internal psychological experiences represents

the antithesis of mindful behaviour and it becomes a persistent strategy that is maintained by conditioning processes… such avoidance is a counterproductive strategy" (Follette et al., 2006, p. 51). Follette et al. (2006) also explain that the increased use of suppression and avoidance may "lead to emotional numbing and dissociation from cognitive or emotional stimuli" (p. 51) and this is considered to be behaviour that is not mindful. In mindfulness practices, the "inability to remain present without engaging in avoidance can be conceptualized as a skills deficit" (Follette et al., 2006, p. 52), which mindfulness aims to enhance. Both Buddhism and DvT recognize that traumatic events may result in a high level of avoidance and aim to reduce avoidance by increasing the client's ability to confront painful memories gradually by being present.

Gluck (2013) claims that mindfulness is inherent to most drama therapy methods, but particularly DvT. Mindfulness focuses on bringing the individual to the present moment, the here and now, and to notice and "pay attention to… things that we do unconsciously or with little attention: breathing, walking, standing…" (Gethin, 2016, p. 13). Unlike mindfulness where the process remains internal and contemplative, in DvT clients are encourage to notice feelings which develop in the here and now and to externalize and express it; this process is called the recursive cycle (Johnson, 2005). It is a cycle of perception, processing and expressing which occurs between two people over a few seconds (Johnson, 2013). Being able to have both an internal awareness and ability to externalize it creates vehicles for insight, catharsis, and change (Gluck, 2013). In DvT the client and the therapist are constantly engaging through improvisation, which encourages both the client and the therapist to remain present and aware of every moment that arises with all its nuances (Gluck, 2013), in order to be able to go through the recursive cycle.

The first step of the recursive cycle is noticing a difference in the Other's behaviour, which requires being present. Most behaviour is highly repetitive and thus shifts to the unconscious. However, when a variation occurs in the behaviour it returns to consciousness, and that is when one notices and a feeling is elicited, which is the second step of the recursive cycle. The feeling is the individual's personal, internal response to what was noticed, it can be cognitive or emotional. The body's reaction to the feeling is the third step, called animating, where the feeling is translated into form in preparation for an action or a response. This can occur on both conscious and unconscious levels. Finally, expressing is the way the body communicates to the other, which is intended to be noticed by the other, even though it is not always noticed. Expressing

can take any form: verbal, nonverbal, authentic, inauthentic. "These expressions in turn will be noticed, felt, animated, and expressed by the other person, and so on, back and forth" (Johnson, 2013, p. 24).

Throughout the whole session the recursive cycle is repeated over and over again where the client and therapist go through the recursive cycle every time they notice a difference in the other's behaviour. This is how an individual creates a concept of the other and, similarly, we use the recursive cycle to form concepts of the world (Johnson, 2013). Thus, both mindfulness and DvT focus on attending to the here and now and the sensations which arise in our body; however, mindfulness remains as an internal process, whereas DvT externalizes what is noticed. DvT posits that "being able to fully notice, feel, animate, and express is what [is] mean[t] by being Present" (Johnson, 2013, p. 24). Some individuals might be stuck in any of these phases and through the modelling and feedback of this cycle by the therapist, the client is able to gain flexibility and an ability to go through every step to be present (Johnson, 2013), which is similar to the goal of mindfulness. Unlike mindfulness which posits that being present is attending to both the self and the other, being present in mindfulness focuses more on being present with oneself. With mindfulness the individual is encourage to be aware of their own sensations, both physically and mentally.

The process of DvT is very similar to Gluck's (2013) concept of Insight Improvisation, more specifically the concept of Entering Empty. Insight improvisation is a combination of drama therapy and mindfulness. Within it, there is an emphasis on the Being Mind, which "is a state of relaxation and awareness, in which one is present to the body, sensations, feelings, emotions, one's surroundings, other people… inspired and informed by this awareness, one is spontaneously expressive and creative" (Gluck, 2013, p. 109). Entering empty refers to the notion that the client enters the improvisational space without preconceived ideas of what they are going to do, instead they listen to their "body, senses, thoughts, feelings, inner imagery, roles, and other sources, allowing the spontaneous and unexpected to happen" (Gluck, 2013, p. 109). Both concepts of insight improvisation and entering empty parallel DvT's concept of being in the present moment and going through the recursive cycle.

Nevertheless, insight improvisation as an intervention is quite different from DvT. Within insight improvisation the therapist leads the client through several "active exercises"; while a detailed description of the different exercises is beyond the scope of this paper, I will briefly

name a few such as, “authentic movement”, “shared vipassana”, “role stream”, “psolodrama”, and “scene stream” (Gluck 2013, p. 111). Furthermore, unlike DvT, the client and therapist within an insight improvisation are not constantly encountering each other within an improvisational space. For instance, within “entering empty… the result is often a solo improvisation of great depth and symbolism” (Gluck 2013, p. 109). Within DvT, the therapist does not introduce previously prepared exercises for the session, the session is always led by the client and the impulses the client has within each moment in the session. Additionally, within an insight improvisation session, the therapist may lead the client through a sitting meditation, whereas in DvT, unless it is part of the scene being played, the therapist does not directly incorporate a sitting meditation segment within the session. Despite the differences in these two drama therapy approaches, it is clear that mindfulness practices are being integrated in to improvisation-based drama therapy approaches in order to address challenges related to the inability to be present and flexible in a changing environment.

“The main purpose of theory in DvT is to help the therapist/leader empty themselves of restrictive theoretical thoughts that will interfere with their open response to the client” (Johnson, 2005, p. 9). If within the play space a therapist is focused too much on the theory of DvT, it prevents them from being present with the client and will result in them missing important elements of the client’s behaviour, thus, undermining the impact of DvT (Johnson, 2013). Therefore, mindfulness and being in the here and now is an essential component of the therapist’s approach within the session. The therapist should know the theory, however, they should not be fixated on it during their encounter with the client. It is also essential that the client is present in the here and now and brings all their thoughts into the playspace in order to maximize their gain from the session. DvT aims to reduce the client’s fear of instability by gradually taking the client into the playspace. Within the playspace, they are invited to use embodiment (where they engage their mind and bodies together, taking on different roles, actions, and movements) and they are encouraged to focus on the here and now encounter (between the therapist and the client), which is continually transforming (Johnson, 2005). With continuous practice of the recursive cycle— noticing, feeling, animating and expressing— the client is led towards gaining a greater sense of presence. The more things are brought into the playspace and not withheld, “the capacity to give oneself to another, and allow another to give themselves to you, increases, as fewer and fewer barriers to the world remain” (Johnson, 2005, p. 19).

As aforementioned, individuals who have gone through trauma may have altered attachment styles and may be sensitive to signs of rejection (Unger & De Luca, 2014). Those that have developed a dismissing attachment style tend to take a defensive stand against any intense affect, may reduce or deny emotions, have difficulties trusting others and may keep an emotional distance from the therapist (Unger & Luca, 2014). Daly and Mallinckrodt (2009), suggest starting the therapy at the client's preferred distance then slowly working towards developing a closer proximity. If the therapist is not fully present with the client, then they may not be able to be fully aware of the client's needs and their proximity comfort levels. Moreover, the client may feel like they are not heard and may feel like they are not important to the therapist. Thus, it is important for the therapist to be able to be fully present with the client and be mindful of what they do.

DvT sessions can take both the form of group or individual therapy. Within the individual session the therapist utilizes a witnessing circle, which is placed in the corner of the room. During certain moments within the play the therapist may enter into the witnessing circle and is essentially in a mindful state where they attend to both the client and their own internal sensations waiting for the recursive cycle to occur and elicit an impulse or image, which brings them back to the play (Johnson, 2005). Finally, at the end of the session, the therapist asks the client to take a minute and leaves the room (Johnson, 2013). Within this minute, the client is advised to sit with the sensations that come up as a result of the session - this is essentially a state of mindfulness where they are present with themselves in the here and now. The therapist does not give the client specific mindfulness exercises, rather the therapist merely tells the client to take a minute and suggests to sit with any sensations that may arise.

Through exploring the different DvT theories and concepts, it is evident that mindfulness concepts are intrinsically embedded within the practice of DvT. Mindfulness stems from Buddhist practices, which is also one of the influences of the development of DvT. Thus, it is not surprising that there are elements of mindfulness within DvT. Becker and Zayfert (2001), have found that "mindfulness skills [were] invaluable for reducing emotional avoidance" (p. 118). Mindfulness was a tool that helped PTSD clients remain present and understand their emotions, which were two things they had difficulties with; increasing their emotional understanding helped them gain more benefits from their treatment (Becker & Zayfert, 2001). Furthermore, surveys that have been conducted with previous clients at the Post Traumatic Stress Centre in

New Haven, which utilizes DvT, have shown over 95% rates of client satisfaction (Johnson, 2014). Additionally, they have also found that the drop out-rate within the first month of verbal only trauma treatment was around 15%, whereas DvT trauma treatment was only 4% (Johnson, 2014).

In a study conducted at the Post Traumatic Stress Centre focused on "severely abused children placed in foster homes through the state youth protection agency, using trauma-centered DvT" (Johnson, 2014, p. 89), they found that as a result of the DvT treatment, there was a significant reduction in the number of placement disruptions, such as the need for hospitalization or removal from foster homes (Johnson, 2014). In another study conducted with elementary school children who were provided trauma-centered DvT, they found quick and significant improvements in behaviours and symptoms, office referrals and incidents of aggression were drastically reduced by 83% (Johnson, 2014). Furthermore, based on student self reports of their stress level before and after the sessions, they found that there was an average of 90% reduction (Johnson, 2014). The results of these studies suggest that DvT, and the mindfulness practices imbedded in this therapeutic approach could be an effective treatment option for children who have experienced physical abuse.

Mindfulness Informed DvT in the Treatment of Children Who Have Experienced Physical Abuse

As previously mentioned, individuals who have experienced physical abuse may suffer from aversive effects of this trauma, which may include cognitive, behavioural, affective, and physiological-somatic effects. Mindfulness practices have been widely used with individuals who have experienced trauma and there have been many studies done showing the effectiveness of mindfulness-based treatments (Roemer, Williston, & Rollins, 2015; Follette, Palm, & Pearson, 2006; Early et al., 2014; Kimbrough et al., 2014). Most mindfulness-based evidence seems to point towards its efficiency in helping individuals increase their emotional regulation (Roemer, Williston, & Rollins, 2015); reduce avoidance (Follette et al., 2006; Kimbrough et al., 2010); increase self acceptance (Burke, 2009); increase clarity, attention, calmness, and emotional well-being, and reduce anxiety, depression, and PTSD symptoms (Kimbrough et al., 2010); increase the ability to be present (Follette et al., 2006); and reach a state of freedom (Gethin, 2006). DvT has also been used with individuals who have experienced trauma and has shown results in reducing externalized negative behaviours (Johnson, 2014). DvT has also been used in reducing

stress levels, avoidance and rigidity, increasing flexibility, and helping individuals find peace and stability within life's instability (Johnson, 2014); and increasing the individual's sense of presence (Johnson, 2005). Through the use of play, humour, and spontaneity, DvT which has mindfulness intrinsically embedded within it, seems to be very useful for children who have experienced physical abuse. Within the play space they may negotiate their level of readiness to working through the traumatic experience, at their own pace.

Chapter 5: Conclusion

The aim of this research paper is to answer the question: How is DvT informed by mindfulness practices and what can DvT provide for children who have been physically abused that mindfulness does not? The main way in which DvT is informed by mindfulness is in the emphasis of being present in the here and now and attending to the sensations and feelings one is having in every changing moment. Like mindfulness, DvT aims to help clients become centred and not be afraid of instability and change. Children who have been physically abused fear change and the unknown (Amsworth & Holaday, 1993).

Children who have been physically abused have a high tendency for avoidance. They may avoid any stimuli which may be a reminder of the event, including people, objects and places. Avoidance is a maladaptive coping strategy as it increases the occurrence of these thoughts and strengthens the negative emotional experience (Follette et al., 2006). Mindfulness and DvT alike, aim to reduce avoidance, however they do it in different ways. Mindfulness remains internalized by bringing personal awareness to one's internal sensations. With time, individuals learn to attend to and accept each internal sensation occurring, which may include sensations related to their trauma, which in turn begins reducing their avoidance strategies and increases the child's "ability to contact painful memories" (Follette et al., 2006, p. 52). Similarly, DvT encourages the clients to focus and notice feelings and sensations arising in the here and now, related to the self and other, and expressing them as they come. This way, the moment is always changing with the expression of every occurring feeling/ thought, helping the clients adapt and accept change, and become more present with themselves. DvT breaks the rigidity of being stuck in the past and creates more flexibility and ability to be in the present. As the client gets used to expressing every thought that comes to mind, they eventually stop using the avoidant strategies when a thought about the trauma occurs and gradually begin to express such thoughts.

There are a few features in DvT that are not present in mindfulness practice which may make DvT an appealing intervention for practitioners working with children who have been physically abused. Depending on the child's developmental level when the trauma occurred, they may not possess the language ability to express the details of the abuse (Armsworth & Holaday, 1993). It should be noted that child abuse survivors may develop very strong avoidant strategies and may choose to not talk about the event or forget about it, because some individuals

have impaired memory (Armsworth & Holaday, 1993). Even though both mindfulness and DvT work toward reducing avoidant strategies, DvT includes an embodied element, which mindfulness does not have, that makes it easier for children to address their trauma without having to directly speak about it.

DvT adds the element of play, which is the child's natural language and their own way of making sense of the world. Play becomes the child's way of expressing themselves and working with things that are normally very difficult to address and therefore avoided. The DvT session goes at the child's pace where it starts off with general play and gradually moves towards playing with specific elements related to the abuse. Sometimes, however, children may start to see improvements in their real life, outside of the session without directly working on the traumatic event. When children create fictional stories that are influenced by their personal lives, they are working on overcoming personal difficulties even though they are not being addressed directly (Miller & Boe, 1990).

Furthermore, DvT not only emphasizes the need for the client to be in the here and now, it also requires that the therapist be fully present with the client. Throughout the whole session the client and therapist are constantly engaging with one another in an improvisational space, the playspace, this requires that both of them be fully present and attuned to one another. Having the therapist be fully present may help make the client feel more attuned to and seen, which may increase their level of safety. Safety facilitates free expression where the child does not fear and worry excessively about being rejected. Safety creates an environment where the child is free of such worries and is able to start working on their own personal material that is not clouded by fears from their environment (Cochran et al., 2011). Individuals who have been physically abused may have difficulty forming an alliance with their therapist. Having a playful element and safety, with the therapist being fully present in every moment, may help strengthen and form the therapeutic alliance more.

With its influence from Buddhism and mindfulness, trauma-centered DvT may be an effective and specific treatment for trauma, as it targets "key areas of vulnerability in the traumatized client, and can be utilized to relatively quickly decrease symptoms, improve the capacity for intimate relationships, and differentiate past and present" (Johnson, 2014, p. 90).

While there was an attempt to offer a balanced representation of the literature in related fields of study, this research is not absolutely comprehensive. There are other relevant areas that

were either beyond the scope of this research or not included due to the limitations of this project (including time constraints and paper length). For instance, the effects of child physical abuse on genders and treatments may look differently for each gender. Furthermore, this study is lacking an exploration of the cultural differences on the views of the use of corporal punishment. Some cultures may deem corporal punishment as being unacceptable, while other may see it necessary in raising children. Additionally, there are several interventions in the mental health world which aim to work with children who are trauma survivors, some of which were addressed in the paper, however, addressing every study is beyond the scope of this paper.

For future studies, I would recommend focusing on gender and demographics in relation to the concepts of mindfulness and DvT in the treatment of children who have experienced physical abuse. Furthermore, exploring the cultural differences on the views of corporal punishment, this may require exploring articles in different languages conducted in different countries around the world. Moreover, perhaps conducting a quantitative research design where one can test the use of DvT and a different mindfulness based intervention such as mindfulness based stress reduction (MBSR) or dialectical behavioural therapy (DBT) in working with children who have been physically abused, may yield more conclusive results on the effectiveness of DvT with children who have experienced physical abuse.

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