Creative Interventions for Indo-Canadian Children who Experience Trauma
as a Result of Being Exposed to Domestic Violence

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A thesis submitted in partial fulfillment of the requirements
for a degree of

Master of Counselling (MC)

City University of Seattle
Vancouver BC, Canada Site

June 13, 2017

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Abstract

Domestic violence is under reported amongst South Asian communities across the globe and within the Indo-Canadian community in Canada. This is due to cultural held values and beliefs. The Indo-Canadian culture, in general, is patriarchal and has a collectivist orientation. Silence is upheld because there is a belief that family matters are private. As a result, there is little to no research available on the experience of domestic violence in this community and its families. Children are the invisible victims of domestic violence and are significantly affected by being exposed to domestic violence. Childhood trauma can be experienced by these children leading to internal and external symptoms. Play and art based therapies are evidence based treatments for children who have experienced trauma as a result of being exposed to domestic violence. This paper will review creative, trauma informed interventions that can be used in a therapeutic setting with Indo-Canadian children who have been exposed to domestic violence.

Acknowledgements

First of all, I would like to thank my thesis advisor Christopher Kinman, M.Sc, M.DIV, of the Master of Counselling faculty at City University of Seattle. Chris has guided me and provided me with his wisdom throughout the duration of this process. I am ever grateful for his valuable comments and the time he spent working on this thesis with me.

Secondly, I would like to express my gratitude to Gary Thandi, MSW, RSW, founder of Moving Forward Family Services, and my Practicum Supervisor. It was my practicum experience at Moving Forward Family Services that inspired this paper. Gary's guidance and support has been invaluable and I appreciate all that he has done for me and for the community that Moving Forward Family Services serves.

I would also like to acknowledge Dr. Laleh Skrenes, Ph.D., R.C.C., C.C.C, of the Master of Counselling faculty at City University of Seattle. Learning from her experience in child counselling was instrumental to the development of this thesis. As the second reader of this thesis I was honoured to receive her thoughts and constructive feedback.

Dedication

I would like to dedicate this thesis to my family. You have supported me by creating the time and space to focus on a very important issue that faces our community. I would especially like to thank my loving parents, Max and Gurdip Srih, who have always encouraged me to follow my dreams and that I can accomplish whatever I set my mind to. My husband, Sean Johal, thank you for being on this journey with me. I would like to thank my daughter, Avery Johal, for teaching me the joy of childhood and what it means to be a mother. I also want to give thanks to my loyal companion, Molson, who spent many days sitting beside me as I worked on this thesis.

I also dedicate this thesis to my extended family and friends, who have provided me with words of encouragement during this process. A special thank you to Rory Armes, Sarah McNair, Julie Sihra, Navpreet Dhillon, Sokha Song and Paula Johal. I appreciate all the ways in which you have contributed to this thesis.

Table of Contents

Introduction

The World Health Organization deems domestic violence a public health concern (Garcia-Moreno, Henrica, Ellsberg, Heise & Watts, 2006). In comparison to men, women are disproportionately the victims of domestic violence (McCue, 2008). Unfortunately, women of Indian ethnicity are believed to be more likely to experience domestic violence than many other ethnic communities (Jordan & Bhandari, 2016). As a result, Indo-Canadian children may be at more risk of experiencing domestic violence. Some children are resilient, yet others experience trauma as a result of being exposed to domestic violence. For children who experience trauma, evidence based approaches such as trauma informed play and art therapies are appropriate.

This thesis was inspired by the clinical issues I encountered during my practicum at Moving Forward Family Services. I met with many Indo-Canadian families who either actively sought out counselling services or were referred to Moving Forward Family Services by a school counsellor or their social worker. Many of these families and individuals requested to meet with a counsellor who was Indo-Canadian and able to communicate with them in their primary language, which was Punjabi. Being an Indo-Canadian female and able to understand Punjabi I fell into a world I was familiar with, yet had not experienced before. I am familiar with many aspects of the Indo-Canadian culture including its values, beliefs, language and gender roles, however, it was my first time being with that understanding in a therapeutic context. I heard women describe the challenges they face due to patriarchy, the violence or abuse they experience because of their husbands and in-laws, as well as the violence and abuse children witness and experience in their homes. The children I met with presented with external and internal symptoms, including aggressive behaviour, lack of attention or focus, symptoms of depression,

anxiety and trauma. I began to research what interventions I could use with these children to alleviate their symptoms. Trauma informed play and art therapies seemed like a natural fit for the Indo-Canadian children I worked with.

An aim of this paper is to bring attention to the topic of domestic violence and its impact on children within the Indo-Canadian community. Given that domestic violence is under reported and the cultural obligation women have to their families, little to no research is available on Indo-Canadian women and children who experience domestic violence. Therefore, I conducted a review of the research and literature that is available on domestic violence and children who have experienced domestic violence in South Asian communities in the United Kingdom and United States. It is my hope that we can begin to understand the phenomenon of domestic violence in the Indo-Canadian community through the existing literature that is available on South Asian domestic violence in other parts of the world. The United Kingdom and United States are somewhat similar to Canada in the sense that they share elements of the mainstream culture of Canada and have also experienced people of Indian ethnicity immigrating to the country. However, given the differences that exist between Canada and the United Kingdom and the United States, it would be beneficial to conduct domestic violence research with South Asians or Indo-Canadians that reside in Canada.

Another aim of this paper is to review the extensive research and literature readily available on domestic violence, children who experience domestic violence and childhood trauma as a means to better understanding the plight of Indo-Canadian women and children who experience domestic violence. With this understanding in place, evidence based play and art therapies are reviewed from a trauma informed lens. These creative therapies allow children to

express and process their thoughts and feelings about traumatic events without relying on the use

of words (Waller, 2006). This is critical for children who have experienced trauma as they may

not be able to access traumatic memories through the use of language (King, 2016). I support the

use of trauma informed creative interventions, with Indo-Canadian children because trauma

informed practice is culturally sensitive and the traumatic events they have been exposed to can

be processed nonverbally (Steele & Mialchiodi, 2012). In the last two chapters of this paper, the

reader will find carefully selected creative interventions that can be used with Indo-Canadian

children who have experienced domestic violence.

Chapter 1: Domestic Violence

This chapter provides the reader with pertinent information about the Indo-Canadian community and its connection to domestic violence. Indo-Canadian culture, values and beliefs will be explored. The phenomenon of domestic violence and more specifically, domestic violence in South Asian communities, will be discussed from a feminist perspective. This chapter sets the foundation for later discussion about children who are exposed to domestic violence and how they can experience trauma as a result of domestic violence.

Indo-Canadians

Indo-Canadians are individuals who live in Canada whose heritage is partially or fully Indian. Indo-Canadians are sometimes referred to as Indian Canadians, East Indians or South Asians. Indians have migrated to places all over the world in search of a better standard of living. The National Household survey recorded 1.6 million Indo-Canadians living in Canada in 2011 (NHS, 2011). According to Statistics Canada (2007), Indo-Canadians are one of the fastest growing non-European ethnic groups in Canada and 70% of Indo-Canadians are born outside of Canada. Of this 70%, almost half arrived in Canada in the past ten to twenty years (Statistics Canada, 2007).

It is important to consider immigration and its relationship to culture. Over 250,000 people immigrate to Canada each year (CIC, 2014). Canada has been referred to as a *mosaic* where people from all walks of life come together, build a new life and new communities. When these individuals move to Canada they bring a culture, language, values, beliefs and customs from the country they call home. Inclan, (2003) explains how contradictions may exist "between the values of their culture of origin and those of the new culture, and between old and new

gender ideologies" and that contradictions may "present and mature at different points along the adaptation time line" (p.333).

Indo-Canadian Culture

Acculturation takes place when individuals migrate away from their home land. As Inclan (2003) states, "cultural adaptation is a process that evolves over time" (p.333). However, it is important to note that the Indo-Canadian culture has a collectivist orientation, where the individual is less important than the goals and harmony of the family and community (France, Rodriguez & Hett, 2013). Segal (1991) summarizes Indian values by stating that there is a higher value placed on males, children should be obedient, there is a higher level of dependency on the family and that relationships are governed by obligation and shame (as cited by Sharma, 2001).

There is a strong value of interdependence and the belief that the family is more important than the individual (McGoldrick, Garcia-Preto & Giordano, 2005). Segal (1991) describes how Indo-Canadians often live in hierarchical, joint family systems with multiple generations in one home (as cited by Sharma, 2001). For example, it is common for a married couple to live with their parents, their married siblings as well as their own children.

At its very foundation Indian culture is patriarchal; powerful males set the code of conduct for women (Dasgupta, 2007). Gender role ideals for women can be described as traditional and feminine. For example, women are valued for being giving, nurturing, caring and respectful to the needs of others in their family rather than their own (Agrawal, 2010). The supremacy of the male is the norm whereas the woman's role is of lesser importance. Alhabib, Nur & Jones (2009) share the idea that abuse could be a result of culture. Some cultures view

domestic violence to be a private matter and potentially justifiable if a woman is misbehaving according to cultural norms (Alhabib, Nur & Jones, 2009).

Indo-Canadian Domestic Violence

There is limited research available for domestic violence in the Indo-Canadian community. According to Shankar, Das and Atwal (2013), "no large scale studies on the prevalence of domestic violence in South Asian communities have been conducted in Canada" (p. 248). The research that has been conducted, is on South Asian populations found in the United States or the United Kingdom. "Anecdotal evidence from Canadian women's organizations and media coverage of abuse related deaths in Canada suggest domestic violence in the South Asian community is at least as prevalent as the general population (Shankar, Das & Atwal, 2013, p. 248)." Further research needs to be conducted in order to understand the cultural influences that interact with domestic violence in the Indo-Canadian community. There are complex differences between and within ethnic groups when considering domestic violence (Alhabib, Nur & Jones, 2009).

What is known, is that lifetime prevalence of domestic violence (physical, sexual, emotional and psychological abuse) in the United States is about 50% in the South Asian community compared to a 20% lifetime prevalence in other communities (Jordan & Bhandari, 2016). In addition to domestic violence, South Asian women in the United States are abused by their in-laws. Qualitative studies have found "in-laws tolerate or support domestic violence and also may directly perpetrate emotional and physical abuse against women" (Raj, Livramento, Santana, Gupta & Silverman, 2006, p. 937). 15% of women who experience domestic violence in the South Asian community also report emotional abuse by their in-laws (Raj *et al.*, 2006).

Women are vulnerable to experiencing domestic violence when they migrate to Canada, and are from a visible minority community (Shankar, Das & Atwal, 2013). Women can be financially dependent on their spouse for a period of three years after migrating to Canada (Shankar, Das & Atwal, 2013). This can result in women not having the means to escape violence. Like other immigrant populations, under reporting of domestic violence may be due to poor English language skills, lack of knowledge with regard to ones rights, loss of social support and lack of knowledge about community resources (Shankar, Das & Atwal, 2013). Acculturation or adapting to Canadian way of life can help women recognize their situation and be less likely to adhere to culturally held beliefs that perpetuate domestic violence (Jordan & Bhandari, 2016).

Culturally held beliefs increase an Indo-Canadian woman's risk of experiencing domestic violence and from seeking help (Shankar, Das & Atwal, 2013). The Indo-Canadian culture, in general, is shame based and is a culture of silence. This prevents women from sharing their experiences and from reporting domestic violence to authorities (Jordan & Bhandari, 2016). As victims of domestic violence, women feel it is their obligation to uphold the family image and reputation. Consequently, these women tend to stay in abusive relationships, experience high levels of domestic violence and have fewer resources (Jordan & Bhandari, 2016). Smaller studies and informal surveys of newspaper reports show the seriousness of the issue. Murder, murder/ suicide, attempted murders, attempted suicides and suspicious disappearances are more common than one would think in this community (Dasgupta, 2007).

Domestic Violence

The Intimate Partner Abuse and Relationship Violence Working Group, define relationship violence as including "physical, sexual, psychological abuse and stalking committed

by one partner against the other in a relationship" (Geffner, Ivey, Koss, Murphy Mio & O'Neil, 2002, p. 8). "Women are victimized more often than men and sustain more severe injuries" (Geffner *et al.*, 2002, p. 8). Violence against women has become an epidemic and no sexuality, ethnic or socioeconomic group is immune (Alhabib, Nur & Jones, 2010). Given the impact on women's physical, mental, sexual and reproductive health, the World Health Organization (WHO) recognizes violence against women to be serious human rights abuse and a public health concern(Garcia-Moreno, Henrica, Ellsberg, Heise & Watts, 2006).

Prevalence

In order to understand the significance of domestic violence today, it is important to know the facts. In 85% of reported cases of domestic violence, women are the victims (McCue, 2008). "Women disproportionately experience the most severe and chronic pattern of violence involving highly controlling and threatening behaviour" (Ansara & Hindin, 2010, p. 853). The WHO multi-country study found a high prevalence of violence against women in a range of cultural and geographical settings (Garcia-Moreno *et al.*, 2006). The multi-country study found lower rates of partner violence in industrialized settings and higher rates in more traditional or rural settings (Garcia-Moreno *et al.*, 2006). In addition, women who have a history of violence are three times more likely to identify themselves to have poor mental health, 96% of all murder-suicides are women killed by their intimate partner and almost 50% of women have experienced at least one form of physical aggression by an intimate partner (APA, 2016). "Physical violence is often accompanied by sexual violence" and "most women experience either a combination of physical and sexual partner violence or physical violence alone rather than sexual violence alone" (Garcia-Moreno *et al.*, 2006, p. 1267). In comparison to women who experienced less frequent physical violence, women who experience severe violence and control are nine times

more likely to fear for their life (Ansara & Hindin, 2011). Of the women who experienced the

most severe violence, "70% reported five or more episodes of violence in the past 5 years and

80% reported having been beaten or choked, fearing that their life was in danger, and having

been injured" (Ansara & Hindin, 2010). With that said, these statistics may not fully represent

violence against women. Many women are unlikely to disclose their experience of violence

because they are stigmatized and blamed for it (Garcia-Moreno *et al*., 2006). Over-reporting of

violence by women is unlikely (Alhabib, Nur & Jones, 2010).

Feminism

Feminism looks at the overarching patriarchal organization of society and its relationship

with gender and power (Pelc, 2011). Reforming legal and political systems that limit the freedom

of women is what initially sparked the idea of feminism. Even though women have made great

strides over the past fifty years, they still face gender challenges today. For example, the

feminization of poverty, which is "the social phenomenon of the growing numbers of women

living in poverty" (Hick, 2007, p. 130). Women earn less than men for doing the same job, bear

the primary responsibility of caregiving for dependents and one in four women will be sexually

assaulted at some point in their lives (Hick, 2007; Comack, 1996). From a feminist perspective,

these issues are structural and reinforce women's inequality in society. Over the years, feminist

philosophy has evolved to be inclusive of others and advocates that oppression is influenced by

gender but also shaped by sexuality, ethnicity, nationality and socioeconomic class (Enns, 1992).

Relationship violence is the use of power by one person in an intimate relationship

against another to maintain power, control and authority in the relationship. Feminist perspective

explains this over representation of women by viewing domestic violence as a form of

oppression and being rooted in patriarchy. There is a long history where men are the rulers of the home and women obey them (McCue, 2008). An example of this is when a woman marries a man, she leaves the family name she was given at birth, to take the name of her husband and his family. Women are an oppressed group and for that reason are more likely to be exploited. It is important to note that women are also at a greater risk of experiencing domestic violence if they are poor, live in a high poverty neighbourhood, are less educated or are dependent on drugs or alcohol (APA, 2016).

The Cycle of Violence

A key finding by Lenore Walker is the Cycle of Violence (Walker, 2009). It is a three phase cycle that most women who experience domestic violence have experienced at some point. The three phases are: Phase I - Tension Building, Phase II - Battering Incident and Phase III - Honeymoon (Walker, 2009). At the centre of the cycle is denial. Minimizing the violence or pretending as though violent acts did not happen keeps the cycle moving from phase to phase. Walker suggests using the Cycle of Violence during intervention with women who have experienced domestic violence. By mapping at least four battering cycles, women can better understand the application of the cycle to their own life and are empowered to break the cycle (Walker, 2009).

Battered Woman Syndrome

Domestic violence has been given many names over the years including, domestic abuse, intimate partner violence, family violence and Battered Woman Syndrome (BWS). Given the significance that BWS has had on the field, it is important to discuss this term in more detail. It was Lenore Walker who first introduced the term BWS in her 1977 funded research project,

which collected data from 400 self-referred women (Walker, 2009). Walker (2009) describes BWS as, "the pattern of signs and symptoms that have been found to occur after a woman has been physically, sexually and/or psychologically abused in an intimate partner relationship, when the partner exerted power and control over the woman to coerce her into doing whatever he wanted without regard for her rights or feelings" (p. 42).

There are many key findings from the original BWS research. For example, there are six groups of symptom criteria outlined for BWS: intrusive recollections of trauma, hyperarousal/ high anxiety, avoidance behaviour/emotional numbing, disrupted interpersonal relationships, body image distortion and sexual intimacy issues (Walker, 2009). The first three criteria are the same as Post Traumatic Stress Disorder (PTSD) whereas the final three are specific to victims of intimate partner violence; BWS has been used as a subcategory of PTSD in psychological literature (Walker, 2009). Women who have experienced domestic violence have reactions such as, depression, anxiety attacks, sleeping problems, shame, guilt, feeling victimized, being upset, hurt, disappointed, lower self esteem and difficulty relating to men (Ansara & Hindin, 2011).

Post Traumatic Stress Disorder

The clinical presentation of PTSD varies from individual to individual (APA, 2013). "While not all women abused by intimate partners experience PTSD, the reactions to the trauma of having been abused can be a major impediment for women thus affecting their ability to problem solve and make appropriate decisions with respect to their safety (Tutty, 2015, p. 102)." However, the Intimate Partner Abuse and Relationship Violence APA Working Group assert, "PTSD is highly prevalent among victims of partner violence" (Geffner *et al.*, 2002, p. 23). Wilson *et al.* (2012) also found, "prior trauma exposure is a risk factor for the development of PTSD following a subsequent trauma" (p. 541). For that reason, it is important to review the

PTSD diagnostic criteria for adults, youth and children over the age of six. Diagnostic criteria, as found in the DSM-5 (APA, 2013, p. 271-272), is provided in Appendix A.

Intergenerational Violence

When considering the risk factors for PTSD, the relationship between prior trauma and the development of PTSD has received particular attention (Wilson, Samuelson, Zenteno & Sorsoli, 2012). According to Wilson *et al.* (2012), prior trauma can create *vulnerability* and *inoculation*. *Vulnerability* suggests that repeated exposure to traumatic events will increase a woman's vulnerability to future trauma (Wilson *et al.*, 2012). *Inoculation*, on the other hand, suggests that repeated exposure to traumatic events will increase a woman's ability to successfully adapt and manage future trauma (Wilson *et al.*, 2012). Inoculation is similar to the concept, post-traumatic growth. Post-traumatic growth follows a traumatic event. When a woman experiences post-traumatic growth, the woman is more resilient, has an increased sense of self and a positive outlook on life.

Domestic violence can be traced back to violence in childhood. A Statistics Canada (2016) report identified an intergenerational pattern of family violence from those who self-reported being victims of spousal violence. Statistics Canada (2016) states "over one in five (21%) people who experienced spousal violence in the previous five years reported having witnessed abuse committed by a parent, step-parent or guardian as a child, compared with 11% of those in relationships free of violence". Tutty (2015) states that women who have had violence inflicted on them also suffered abuse in childhood (80.2%), 52.2% had been emotionally abused, 43.2% had been sexually abused, 42.7% witnessed violence between their parents, 41.8% were physically abused and finally, 32.1% had been neglected (Tutty, 2015). Overall, 41% of the

women residing in temporary crisis shelters experienced three to five forms of child

maltreatment (Tutty, 2015). Given childhood maltreatment and the experience of adult intimate

partner violence, it is not surprising that many women continue to exhibit trauma symptoms after

leaving the relationship (Tutty, 2015). As it relates to domestic violence, individuals with a

history of child abuse report higher levels of PTSD severity (Wilson *et al.*, 2012).

Chapter 2: Children Exposed to Domestic Violence

Childhood is an important stage of life that requires emotional investment on the part of caregivers (Lourenço, Baptista, Senra, Almeida, Basílio & Bhona, 2013). Lourenço *et al.* (2013) state how a child's quality of life is significantly impacted by the level of care provided by family members. It is for that reason, domestic violence that takes place in the home between two adult caregivers is one of the most toxic forms of violence a child can be exposed to (Groves, 2001). Children who have been exposed to domestic violence are fearful and show more symptoms of depression and anxiety compared to children who have not been exposed to domestic violence (Meltzer, Doos, Vostanis, Ford & Goodman, 2009). Externalized behaviours like aggression and antisocial behaviours are also presented in children who have been exposed to domestic violence (Meltzer *et al.*, 2009). The greatest concern is that children who have been exposed to domestic violence may exhibit trauma symptoms, are at a higher risk of developing PTSD and PTSD symptoms may persist into adulthood (Meltzer *et al.*, 2009).

Terminology

There are many ways to define violence and its definition depends on who is defining it and for what purpose (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). The WHO (Krug *et al.*, 2002) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resuming in injury, death, psychological harm, maldevelopment or deprivation (p. 4)." Interpersonal or family violence is physical, sexual and psychological violence, deprivation or neglect that affects children, domestic partners and the elderly (Krug et al., 2002).

Holden (2003), highlights the definitional issues regarding the description of how domestic violence is experienced by children. For example, children who "witness" domestic violence can be understood as children who have "observed" domestic violence (Holden, 2003). Holden (2003) suggests using the word "exposed" rather than "witnessed" as it is more inclusive of the various types of exposure a child can have to domestic violence.

The types of exposure children can experience with regard to domestic violence include, prenatally, intervening, victimized, participating, eyewitness, overhearing, observing the initial effects, experiencing the aftermath, hearing about it and being ostensibly unaware (Holden, 2003). Prenatal exposure to domestic violence is when a pregnant woman experiences domestic violence and in turn "the fetus may be affected by the physiological state of a terrorized woman" (Holden, 2003, p.153). Intervening, being victimized and participating are three categories that reflect child involvement in a domestic violence incident (Holden, 2003). Children may call the police, jump in the middle of a fight, be verbally or physically assaulted or actively participate in the verbal or physical aggression directed towards their mother (Holden, 2003). Children may also see, hear or deal with the aftermath of abuse. For the purpose of this paper, Holden's all encompassing definition of child "exposure" to domestic violence will be used.

Until recently, children have been called the "silent" or "forgotten" victims of domestic violence (Edleson, 1999). Holden (2003) argues, "children exposed to domestic violence qualify as maltreated because they are living in an environment that is psychologically abusive" (p. 156). The mere exposure of violence itself can be a form of child abuse and make the child a victim of

psychological violence (Lourenço *et al.,* 2013). Children are not passive recipients to domestic

violence, rather, they are active agents and in many cases are forced to act (Overlien, 2010).

Ecological Model

Violence is a complex phenomenon that interacts with biological, social, cultural,

economic and political factors (Krug *et al*., 2002). The WHO uses an ecological model to

understand the nature of violence. The model consists of four factors or levels that increase the

risk of committing violence or becoming a victim of violence (Krug *et al*., 2002). First and

foremost, is the biological and personal factors that influence how an individual behaves. For

example, demographic characteristics, substance abuse, psychological or personality disorders.

The second level includes relationships such as family, friends and intimate partners.

Relationships can increase the risk of being victimized or perpetrating a violent act (Krug *et al*.,

2002). The third level consists of community contexts such as work, school and the

neighbourhood an individual lives in (Krug *et al*., 2002). Finally, is the broad societal factors that

create violence. Macro level factors such as cultural norms and policies related to education,

health and the economy (Krug *et al*., 2002). Each level of the of the ecological model overlaps

with other levels which illustrates that each factor is impacted by other factors.

Prevalence

There is limited data available on the prevalence of parental violence on children. So

much so that children are considered the "invisible" victims of domestic violence (Osofsky,

2003). There are methodological challenges with research that has been conducted on child

exposure to domestic violence. First of all, it is difficult to examine the effects of domestic

violence in isolation from other factors that may be present in a child's life (Holt, Buckley &

Whelan, 2008). As mentioned previously, Holden (2003) highlighted the definitional issues of "witnessing" domestic violence. He advocates for the term "exposure" as it is inclusive of all types of experiences children have in response to domestic violence. With that said, studies have not been consistent in identifying the type and level of violence children have been exposed to (Holt, Buckley & Whelan, 2008). Also, much of the research to date has been collected from shelters which is not representative of the broader population (Holt, Buckley & Whelan, 2008). At these shelters and elsewhere, mothers are the source of information which can result in an under or over reporting of violence (Holt, Buckley & Whelan, 2008).

What is known is that there is a significant amount of evidence that indicates that homicide, severe violence and moderate violence takes place amongst family members (Osofsky, 2003). Studies have found that children under the age of five are more than two times likely to be present in a home where domestic violence occurs and are more likely to be exposed to multiple incidents of domestic violence in comparison to older children (Osofsky, 2003). Children who live in violent homes are at greater risk of being physically abused (Benavides, Leon & Leon, 2015).

There is an association between domestic violence and child maltreatment. Familial risk factors for child maltreatment include, poverty, mental health problems, substance abuse, general family dysfunction or involvement with the criminal justice system (Osofsky, 2003). It has been reported that homes where domestic violence is present, children are fifteen times more likely to be physically abused or neglected (Osofsky, 2003). Devaney (2008) states "children who are living with domestic violence have a greater chance of experiencing physical or sexual abuse" (p. 444). 60% to 75% of women who are battered, have children who are also battered

(Osofsky, 2003). This co-occurance of child maltreatment and domestic violence is summarized by Osofsky (2003) as, "45-70% of children exposed to domestic violence are also victims of physical abuse and that as many as 40% of child victims of physical abuse are also exposed to domestic violence" (p. 167).

Indo-Canadian Child Exposure to Domestic Violence

The South Asian population has significantly increased in both Canada and the United States, yet limited data and research is available on violence in this immigrant community (Robertson, Chaudhary Nagaraj, & Vyas, 2015). Given the fact that there is limited research on South Asian domestic violence, it is not surprising that there is even less research is available on child exposure to domestic violence in the South Asian community. According to Maker & deRoon-Cassini (2007), "no study to date could be located on South Asian children who witness parental violence" (p. 633). Overall, there are very few studies that have examined the differences in children exposed to domestic violence based upon race (D'Andrea & Graham-Berman, 2017)**.** Robertson *et al.* (2015) highlight the issue of the "healthy and wealthy/model minority stereotype" (p. 922). This stereotype is described as persons from South Asian countries achieving success in terms of education and income and have lower rates of crime and family instability (Robertson *et al.*, 2015). For that reason, the South Asian community has not been a focus of health related studies.

Even if there was a focus on South Asian domestic violence, Robertson *et al. (*2015), posit that it is particularly difficult to determine the prevalence of violence in the South Asian community due to "pervasive cultural norms, including patriarchal ideology and traditional family and gender norms" (p. 922). The Indo-Canadian culture is a patriarchal social system that

hold males in higher regard than females. Gender roles in this community put females in much larger risk for violence and sex related diseases (Robertson *et al.*, 2015). Family violence is highly stigmatized. Sacrificing, suffering and accepting violence is promoted to preserve honour and family structure (Maker & deRoon-Cassini, 2007). It is a sign of maturity and strength to not wear your emotions on your sleeve in Asian culture (France *et al*., 2013). Maker & deRoon-Cassini (2007) define familism as "a family's cohesiveness, its integration with society, its honour and reputation as a source of self-worth and pride, and the harmonious merger between self, family and community" (p. 635). These culturally held beliefs put women and their children at a greater risk of family violence and researchers at a disadvantage when exploring the prevalence and affects of domestic violence in the Indo-Canadian community.

Adverse Impacts of Domestic Violence on Children

"The impact of family violence depends on several factors such as type of violence, the frequency and intensity of the violence, the extent of the child's exposure, and each family member's unique experiences and characteristics (Hines, 2014, p. 2015)." The most significant feature of domestic violence and its impact on children is that domestic violence robs children of both parents. One is an aggressor and the other is a victim; neither may be emotionally available to respond to the trauma that a child experiences as a result of domestic violence (Groves, 2001). Letourneau, Fedick, & Willms (2007) found mothers of children who are exposed to domestic violence have higher levels of depression and display lower levels of three types of parenting behvaiours (positive discipline, warm and nurturing behaviours and consistent parenting). Studies show that children who have loving relationships with their primary caregivers, usually their parents, are more likely to be socially competent, achieve academic success and are

physically and psychologically healthy (Hines, 2014). Conversely, the impact of domestic

violence on children can cause significant harm by affecting their "emotional development,

social functioning, ability to learn and focus in school, their moral development and ability to

negotiate intimate relationship as adolescents and adults" (Groves, 2001, p. 188).

Biology

Childhood exposure to domestic violence may alter several stress responsive biological

regulatory systems that are used to maintain physical and mental health (Yount, DiGirolamo &

Ramakrishnan, 2011). This dysregulation can cause delays and deficits in metabolic, immune

and mental activity. For example, children exposed to domestic violence generally have lower

sympathetic nervous system activity than children who have not been exposed to domestic

violence (Yount *et al.*, 2011). In addition, exposed children have higher heart rates, salivary

cortisol levels, dopamine levels, and more distress related symptoms (Yount *et al.*, 2011). This is

relevant because Yount *et al.* (2011) state that biological dysregulation can lead to deficits in

emotional processing, social competence, and behavioural self-regulation.

Psychology

The psychological outcomes of children who have been exposed to domestic violence is

not significantly different from children who have been physically abused as children (Meltzer *et

al.*, 2009). Exposed children are more likely to be fearful, have temperament problems and show

more anxiety, depression and trauma symptoms than those who have not experienced domestic

violence (Edelson, 1999). These characteristics are more prevalent in younger children than in

other age groups. Exposure also has a negative impact on academic performance (Carrell &

Hoekstra, 2010). Children show externalizing behaviours like aggression, antisocial behaviours,

involvement with bullying and more behavioural problems as a result of experiencing domestic

violence (Meltzer *et al.*, 2009). When considering the response of boys and girls to domestic

violence, boys usually experience more externalized behaviour problems, whereas girls

experience more internalized behaviours. There are also long term impacts of domestic violence

exposure. Edleson (1999) states that depression, trauma related symptoms, low self-esteem,

greater distress and lower social adjustment are experienced by adults who retrospectively report

exposure to domestic violence.

Resilience

Harmful impacts of domestic violence on children include "difficulties sleeping and

eating, family and peer relationships, attention, academic performance, depression, anxiety,

aggressions, low self-esteem, PTSD and impaired physical health" (Israel & Stover, 2009, p.

1756). However, not all children experience these deleterious effects and some are even

considered highly resilient given the type of exposure to domestic violence they have

experienced. Research has found resilience in 31% to 65% of children exposed to domestic

violence (Martinez-Torteya, Bogat, von Eye & Levendosky,, 2009). Each child is unique and

their reaction will vary according to a number of factors including, age, gender, personality,

socio-economic status, role within the family, nature and length of exposure to domestic violence

and whether the child has available supports (Holt, Buckley & Whelan, 2008).

"Resilience is the ability to bounce back after traumatic experiences, like witnessing

family violence (Hines, 2015, p. 109)." When the concept of resilience is applied to children

exposed to domestic violence it can be described as, an ability to adapt and function successfully

in high risk settings or following exposure to trauma (Howell, 2011). There are several factors

associated with resilience and they include, "self confidence, communication skills, problem

solving skills and the ability to mange feelings and impulses" (Hines, 2015, p. 109).

Resilience includes protective factors or buffers that help children find resources,

strategies and support systems that can help them effectively cope (Hines, 2015). Martinez-

Torteya *et al.* (2009) state three main protective factors for children exposed to domestic

violence: positive parenting, child temperament and cognitive ability. Positive parenting has been

associated with high maternal authority and mothers who are available. This type of mother-child

interaction leads to the development of emotional self-regulation (Martinez-Torteya *et al.*, 2009).

Some studies have found, "mothers of children exposed to domestic violence actually show a

greater increase in positive discipline and less of a decrease in warm and nurturing behaviours

compared to mothers of children not exposed" (Letourneau *et al.*, 2007, p. 656). This could be

because mothers of these children compensate for the violence by being extremely attentive and

sensitive to their children (Letourneau *et al.*, 2007). Children with easy going temperaments that

exhibit approachability, high adaptability, positive mood and low reactivity are less likely to

show behaviour problems. High intelligence is also a protective factor and has been associated

with higher levels of functioning in children exposed to domestic violence (Martinez-Torteya *et al.*, 2009).

Howell (2011) conceptualizes resilience in terms of emotion regulation and prosocial

skills. Emotion regulation is how individuals influence the emotions they experience, when they

have them and how they express them (Howell, 2011). How children manage emotions is based

on biological self-regulatory systems, however, secure attachments help children monitor and

adjust feelings across various settings (Howell, 2011). Difficulty regulating emotions is

correlated with externalizing problem behaviours and low prosocial actions. Prosocial skills, as defined by Howell (2011), is when an individual can successfully meet societal expectations, attend to social cues and solve interpersonal problems. Prosocial skills assist children to gather support and protection from individuals outside of the family. Children who can successfully navigate their social world are able to create more positive outcomes and avoid negative ones (Howell, 2011). Resilience is present when "children [who have been exposed to domestic violence] utilize informational or emotional support, or problem solving, distancing from the conflict, cognitive redefinition and emotional self-regulation strategies" (Hines, 2015, p. 110).

Chapter 3: Childhood Trauma

There is evidence that children who are exposed to domestic violence are at an increased risk to experience symptoms associated with trauma such as: PTSD, anxiety, suicidal ideation, substance abuse and aggressive behaviour (Stewart-Tufescu & Piotrowski, 2013; Leenarts, Diehle, Doreleijers, Jansma & Lindauer, 2013). Stewart-Tufescu & Piotrowski (2013) state, 10% to 50% of children exposed to domestic violence meet the criteria for PTSD. There is a wide variability in trauma symptoms and this may be due to the increased attention given to internalized and externalized beahvioural problems in children rather than trauma (Stewart-Tufescu & Piotrowski, 2013). Children who are abused in addition to being exposed to domestic violence are at a greater risk of developing PTSD in comparison to children who have exposed to domestic violence alone (Graham-Bermann, Castor, Miller & Howell, 2012). Children can begin to express trauma symptoms following exposure to domestic violence as early as infancy. (Bogat, DeJonghe, Levendosky, Davidson & von Eye, 2006). In this chapter, I will describe the effects, the symptomology and the diagnosis of childhood trauma, as well as provide a brief summary of the types of treatments available for childhood trauma.

Attachment, Domestic Violence and Trauma

When children witness their mother being threatened or abused they are left feeling helpless (D'Andrea & Graham-Berman, 2017). A primary caregiver is an attachment figure. Relationships with early attachment figures lay the foundation for future relationships between the self and others (Steele & Malchiodi, 2012). When one attachment figure, a father, acts violently towards another attachment figure, a mother, a child has lost safety and protection (Lieberman & Van Horn, 1998). "A young child exposed to domestic violence cannot form or

sustain internal representations of the parents as a secure base or a secure haven that provides

safety (Lieberman & Van Horn, 1998, p. 428)." A child's "increased perceived control over an

event and, in particular, perceived threat to personal safety were associated with greater odds of

clinically significant levels of several trauma symptoms" (Spilsbury, Belliston, Drotar, Drinkard,

Kretschmar, Creeden, Friedman, 2007, p. 495). Research highlights the important role of

attachment in children who experience trauma as a result of domestic violence (Kisiel,

Fehrenbach, Torgersen, Stolbach, McClelland, Griffin & Burkman, 2014). Children experience

feelings of love, hate, anger, and fear at the same time yet they do not have the developmental

capacity to process their experience. Inter-parental conflict can lead to high levels of emotional

reactivity, active avoidance and negative internal representations of inter-parental relationships

(Bogat *et al*., 2006). In addition, it has been found that mothers who have been abused are more

likely to experience depression relative to non-abused women and in turn maternal depression is

linked to the development of depressive symptoms in children (D'Andrea & Graham-Berman,

2017). A disrupted caregiving system, in the context of domestic violence has negative outcomes

for children.

Biology

Childhood is a critical period in brain development. "During brain development, very

complex precisely organized processes cause neurons to migrate into cortical and subcortical

layers and form appropriate connections between brain regions (King, 2016, p. 15)." Brain

development undergoes changes in structure and function from utero through to late life.

Bremner (2006) states that the bulk of brain development occurs in utero and in the first five

years of life; there is a significant overall expansion of brain volume in gray and white matter.

There is progressive increase in white matter and a decrease in gray matter between the ages of

seven and seventeen (Bremner, 2006). The corpus callosum, hippocampus and amygdala

increase in size during childhood (Bremner, 2006). The corpus callosum is responsible for

interconnecting the left and right hemispheres of the brain and is responsible for integrating

motor, sensory and cognitive functions (Rosenzweig, Breedlove & Watson, 2005). The

hippocampus is located in the temporal lobe and is primarily associated with memory,

particularly long-term memory (Rosenzweig *et al.*, 2005). The amygdala is part of the limbic

system and is responsible for emotions, survival instincts and memory (Rosenzweig *et al.*, 2005).

There is still much to learn about this development process, however, King (2016) states that

young neurons are extremely sensitive to environmental stimuli. Studies have found that children

exposed to trauma show structural and functional changes in the brain (Kisiel *et al.*, 2014).

Specifically, children exposed to trauma show "volumetric reductions in the corpus

callous left neocortex, hippocampus and amygdala" (D'Andrea, Ford, Stolbach, Spinazzola &

van der Kolk , 2012, p. 192). One study confirmed that children with PTSD in comparison to

those without PTSD, are more likely to have decreased volume in the corpus callosum, prefrontal

cortices and temporal lobe and increased volume in the superior temporal gyrus (D'Andrea *et al.*,

2012). Bremner (2006) states that these structural changes in childhood can lead to functional

changes in verbal declarative memory, deficits in autobiographical memory, dissociative

amnesia, attentional bias for trauma related material and fear responses. Children have also been

found to have lower levels of cortisol and norepinephrine, which are two neurochemical systems

that are critical in the stress response (D'Andrea *et al.*, 2012; Bremner, 2006). This is

problematic because lower levels of cortisol have been associated with decreased resilience and

increased affect regulation in children who have been maltreated (D'Andrea *et al.*, 2012).

D'Andrea *et al.* (2012) states, "parental verbal abuse or witnessing domestic violence, and particularly in combination, is strongly associated with emotional dysregulation consistent with malfunction of the limbic system and problems with depression, anxiety and hostility" (p. 192).

Symptomology

Studies evidence that exposure to domestic violence during childhood is associated with increased affect and impulse dysregulation, disruptions in attention, consciousness, attributions, schemas and difficulty relating to others (D'Andrea *et al.*, 2012). Affective symptoms commonly found in children exposed to domestic violence include anhedonia, flat or numbed affect, inappropriate affect, sudden anger, withdrawl, self-injury, oppositional behaviour or compulsive behaviour (D'Andrea *et al.*, 2012). In general, these children have increased negative affect, are emotionally reactive or have inappropriate emotional responses (D'Andrea *et al.*, 2012). Dissociation is prevalent in young children exposed to trauma (Hagan, Hulette & Lieberman, 2015). Disassociation, in children, may be observed as inattention or impulsivity and therefore may lead to a child meeting diagnostic criteria for Attention Deficit Hyperactivity Disorder (ADHD) (D'Andrea *et al.*, 2012). Domestic violence can create disrupted attachment styles. In turn, children exposed to domestic violence have difficulty trusting others, have poor social skills, boundaries and low perspective taking abilities (D'Andrea *et al.*, 2012). Overall, children experiencing PTSD as a result of domestic violence have distorted attributions of themselves and the world. Shame, guilt, poor self-efficacy, negative cognitions and a distorted locus of control are all too common (D'Andrea *et al.*, 2012).

Diagnosis

The DSM-IV had one diagnosis that specifically identified trauma and that was PTSD. D'Andrea *et al.* (2012) identified that PTSD, as defined in the DSM-IV, did not fully capture the spectrum of trauma symptoms experienced by children. The DSM-5 has two PTSD diagnoses. PTSD for children older than six years, youth and adults (see Appendix A) and PTSD for children six years or younger. Diagnostic criteria for PTSD for children six years or younger, as found in the DSM-5 (APA, 2013, p. 272-274), is provided for reference in Appendix B.

Complex Trauma

Comorbidity is common amongst children who have a trauma history. The DSM-5 (APA, 2013) states that individuals with PTSD are 80% more likely to meet diagnostic criteria for at least one other disorder, compared to those without PTSD. D'Andrea *et al.* (2012) state that 40% of children diagnosed with PTSD have at least one other mood, anxiety or disruptive behaviour disorder. Comorbidity between PTSD and oppositional defiant disorder and separation anxiety disorder are more prevalent amongst children (APA, 2013). The type and frequency of traumatic stressors children experience in childhood influences the complexity and number of their symptoms (D'Andrea *et al.*, 2012).

"Complex trauma typically represents severe and ongoing maltreatment by a caregiver that begins early in life and that can overwhelm the child's developing capacity to cope with stress (Dauber, Lotsos & Pulido, 2015, p. 529)." Maltreatment can include chronic physical and sexual abuse, neglect and exposure to domestic violence. Chronic stress related to domestic violence exposure can lead to maladaptive coping responses such as PTSD, internalizing and externalizing disorders, anxiety, depression, suicidal ideation and substance use disorders (Dauber *et al.*, 2015; Leenarts *et al.*, 2013). Another consequence of chronic childhood

maltreatment includes the potential for individuals to be re-victimized. Children with complex

trauma histories "may tolerate excuses for abuse, be more vulnerable to negative peer influences

or may have difficulties surrounding control, trust and boundaries" (Leenarts *et al.*, 2013, p.

270). This chronic experience of multiple, co-occuring trauma is what is meant by the term,

complex trauma.

Wamser-Nanney & Vandenberg (2013) posit that PTSD is diagnosed less frequently

following multiple or chronic traumatic events compared to single instances of trauma. This is

relevant because PTSD may be insufficient in capturing the consequences of complex trauma in

children (Wamser-Nanney & Vandenberg, 2013). It is for that reason, Developmental Trauma

Disorder (DTD) was proposed to be included in the DSM-5 by Bessel van der kolk. DTD was

intended to focus on the ways in which children are impaired following complex trauma (van der

Kolk, 2005). Several areas of dysregulation have been included as part of DTD: affective,

somatic, behavioural, cognitive, relational and self attribution (van der Kolk, 2005). With that

said, DTD was not included in the DSM-5. More research needs to be conducted. As Wamser-

Nanney & Vandenberg (2013) state, "research has not examined the impact of complex trauma

events specifically in children" (p. 673). What is known is that cumulative trauma is associated

with symptom complexity (Hodges, Godbout, Briere, Lanktree, Gilbert & Kletzka, 2013). For

now, the term, *complex trauma,* attempts to tackle symptoms that go beyond what is currently

defined by PTSD in the DSM-5 (Leenarts *et al.*, 2013).

Treatment

Assessment. "In order to formulate the problem and treatment, a thorough case history

must be obtained (O'Connor, Schaefer & Braverman, 2016, p. 78)." Child Trauma Assessment

Centre (CTAC) suggests assessment include five primary domains including, physical, medical, developmental, social/family, emotional/behavioural and trauma (Steele & Malchiodi, 2012). Caregivers are integral to assessment. Prior to commencing therapy, caregivers are asked to complete various rating scales including the Child Behaviour Check List, Child Sexual Behaviour Inventory or the Child Dissociative Checklist (Steele & Malchiodi, 2012). Caregivers also provide demographic information, a description of the presenting problem, a description of the child's personality and temperament, the child's developmental, school history and medical history aa well as the child's support network. The Trauma Symptom Checklist for Children (TSCC) is a standardized self-report measure for children 7 years or older that evaluates anxiety, depression, anger, post-traumatic stress and dissociation (Steele & Malchiodi, 2012).

Cultural considerations. Specific to the Indo-Canadian community, it is imperative for the therapist to be aware that family is of utmost importance and the opinion of society matters (France *et al.*, 2013). Children and family members could therefore be seeking counselling in secret. There is a stigma associated with counselling and feelings of shame associated with sharing family concerns with a stranger (France *et al.*, 2013). Domestic violence in particular has different meanings in various cultures (Steele & Malchiodi, 2012). Members of the Indo-Canadian culture may view domestic violence to be a private family matter. So, children who come from diverse backgrounds such as this often have to navigate two cultures, their family and peer cultures (Steele & Malchiodi, 2012). "Despite the fact that the brain's response to traumatic events is similar in most people, culture has an important role in how trauma is defined and managed in various survivors (Steele & Malchiodi, 2012, p. 132)."

Therapeutic Approaches. Being exposed to domestic violence has many harmful consequences for children and how a particular trauma is experienced by one child may be experienced very differently by another child. Even when the variables are as close as possible, the same trauma will create a completely different response (Sori & Schnur, 2014). The child's developmental stage may also influence how the child perceives and responds to trauma (Dripchak, 2007). Consequently, therapists who support traumatized children must not only be informed in the area of trauma but also have a strong understanding of various therapeutic approaches that can be used with traumatized children and the wealth of activities or techniques that can be implemented in session with a child. Depending on the child's developmental age, trauma symptoms, assessment information, possible diagnosis and the child's personality, interest and motivation, a therapist will decide upon which therapeutic approach to take. For example, Eye movement desensitization and reprocessing (EMDR), Cognitive Behavioural Therapy (CBT), Mindfulness and Trauma Informed Practice (TIP) are specific evidence based treatments available to children who have experienced trauma.

EMDR. EMDR is an evidence based therapy for trauma. During an EMDR session, the therapist will direct the clients' eye movement laterally using an external stimulus. EMDR was developed by Francine Shaprio to treat PTSD in adults, however, there are studies that prove EMDR can also be applied to children (Ahmad & Sundelin-wahlsten, 2008).

CBT. CBT has shown significant improvements in body safety skills, negative emotional reactions and intrusive thoughts (Leenarts *et al*., 2013). Courtois (2004) states that CBT interventions such as prolonged exposure and cognitive restructuring has been empirically supported for PTSD treatment. Specific group work approaches have been interventions which

have offered structured, psycho-educational that encourage problem solving skills, conflict

resolution and promote self-esteem (Bunston, Pavlidis & Cartwright, 2016).

Mindfulness. Mindfulness is an approach that supports self-regulation of the mind and

body. Traumatized children who are able to identify body sensations, moods and feelings

associated with other people, situations and environments begin to foster self-awareness (Steele

& Malchiodi, 2012). It is through this self-awareness children are able to learn how to regulate

their bodily responses. They do this by choosing environments, events, activities and people that

bring a sense safety, control and calm (Steele & Malchiodi, 2012).

Trauma-informed practice. TIP is a therapeutic approach for people with histories of

trauma that acknowledges trauma symptoms and the role trauma has played in their lives (Steele

& Malchiodi, 2012). TIP, "recognizes that survivors need to be respected, informed, connected

and empowered" (Steele & Malchiodi, 2012, p. 17). Steele & Malchiodi (2012) describe how

expressive arts, like art, music, dance, drama, play and sandplay are trauma informed because it

allows children to process trauma narratives through nonverbal expression.

The National Centre for Trauma-Informed Care (NCTIC), formed in 2005, has been

instrumental in understanding the impact of trauma on children. The NCTIC has ten principles to

TIP: (1) restoring a sense of safety, (2) applying trauma informed assessment, (3) capitalize on

interventions that address the right hemisphere of the brain (4) develop trauma informed

relationships between children and their caregivers, (5) create trauma informed environments, (6)

promote a new meaning for trauma events, (7) encourage resiliency, (8) recognize no one

intervention fits every situation or client, (9) develop interventions that respect cultural diversity

and empower children and (10) families to be active in therapy (Steele & Malchiodi, 2012).

In working with children who are experiencing trauma, TIP is sensitive to ethnic, gender, socioeconomic and religious backgrounds and world views (Steele & Malchiodi, 2012). "The expression of psycho-social problems and patterns of health care usage for children are likely to be affected by complex interactions between family, social structures and beliefs" (Vetere & Cooper, 2006, p. 31). A strong relationship with parents and caretakers is imperative to identifying any cultural values that are important to a child experiencing trauma (Steele & Malchiodi, 2012). A discussion of cultural and religious issues should take place during the initial stages of therapy with children and their family members. If language is a barrier, a translator of the family's choice or a professional from the same cultural and religious community should be included as part of therapeutic work (Vetere & Cooper, 2006). Steele & Malchiodi (2012) state "when ethnically matched professionals are available, retention and intervention benefits improve over those who receive services from non-ethnically matched professionals" (p. 131). It is my belief that TIP is most favourable when working with Indo-Canadian children who have experienced trauma as a result of being exposed to domestic violence.

Chapter 4: Trauma Informed Play Therapy with Children

Play therapies are used to treat children who have experienced trauma. "Traumatic sensory-motor memories are stored nonverbally and are accessible primarily through expression involving the body (Steele & Malchiodi, 2012, p. 76)." Creative interventions provide children the ability to express and process their trauma experiences without being restricted to verbal therapy. Children who have experienced trauma may have limited language or might not be able to verbalize their thoughts (Malchiodi, 2015). Furthermore, "traumas that are encoded in the subcortical memory will not necessarily ever be retrieved verbally and may be preferentially stored in the right hemisphere" (Green, Crenshaw & Kolos, 2010, p, 97). Children are more fully able to express themselves through self-initiated play rather than verbal expression.

Play therapy helps children overcome the negative impacts of the trauma, empower children to release suppressed psychic trauma and encourage emotional growth (Dripchak, 2007).

Play therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained therapists use the therapeutic power of play to help clients prevent and resolve psychosocial difficulties and achieve optimal growth and development. (Malchiodi, 2015, p. 13)

It is for that reason that Landreth (2012) describes play as the medium of exchange in therapy with children. "Toys are used like words for children and play is their language" (Landreth, 2012. p. 12).

Therapeutic Approaches

Trauma focused integrated play therapy (TFIPT). This approach invites and engages children to make an investment in their own recovery process. Children guide the process while the therapist pays attention to their needs and decides the best type of play therapy to use in session (Sori & Schnur, 2014).The three R's of TFIPT are *re-experiencing*, *releasing* and *re-organizing* (Vicario, Tucker, Smith Adcock & Hudgins-Mitchell, 2013). *Re-experiencing* involves recalling the details of a traumatic event without feeling responsible for the traumatic event (Vicario *et al.*, 2013). It is important that the child understand that he or she was not in control or to blame for what happened. *Releasing* is when the child begins to understand that the trauma is over and in the past (Vicario *et al.*, 2013). *Re-organizing* is when the child sees the trauma as part of his or her life story but it does not define who he or she is (Vicario *et al.*, 2013). The three R's of TFIPT support children who have been exposed to relational trauma "develop a sense of self-empathy, personal agency and positive connection" (Vicario *et al.*, 2013, p. 108).

Non-directive play therapy. This style of play therapy may be implemented at any phase of the assessment and intervention process (Porter, Hernandez-Reif & Jessee, 2009). In order for children to disclose feelings at their own pace, therapists must be patient with the use of non-directive strategies (Dripchak, 2007). Non-directive play therapy is effective for children with communication difficulties and learning disabilities. It helps increase self-esteem and positive interactions, especially for children with attentional deficits or behaviour problems. Non-directive, highly empathetic, child-centred play therapy has been demonstrated to be effective for children recovering from trauma (Banbury, 2016).

Child-centred play therapy. A type of non-directive play therapy is child-centred play therapy. The founder of child-centred play therapy, Axline (1955), described how communication between therapist and child must be on a nonverbal level. "Therapists must be able to accept the

hypothesis that the child has reasons for what he does and that many things may be important to the child that he is not able to communicate to the therapist (Axline, 1955, p. 623)." Child-centred play therapy therefore "aims to have the therapist see the child's point of view, value and accept the child, not inflict beliefs or solutions on the child, and work within the child's cultural family values in order to promote a better chance of cooperation and positive outcomes" (Porter *et al.*, 2009, p. 1027).

Porter *et al.* (2009) describe eight guidelines of child-centred play therapy for therapists which include: (1) develop a friendly relationship with the child, (2) accept the child for who the unique person they are, (3) establish a rapport so the child can openly express his or her thoughts and feelings, (4) acknowledge feelings that the child is expresses, (5) maintain respect for the child's natural abilities (6) let the child lead, (7) let the session progress naturally, without an agenda, and (8) make limitations when it is necessary to make the child aware of his or her behaviour. Landreth (2012) believes child-centred play therapy helps children develop a more positive self-concept, assume greater self-responsibility, experience a feeling of control and engage in self-determined decision making.

Child-centred play therapy is appropriate when the therapist and the child are from culturally different backgrounds (Porter *et al.*, 2009). It supports children in expressing their feelings through play, regardless of how play looks for a child from a cultural subgroup. There is a "tendency to believe that play behaviour is alike across cultures" which is not necessarily true (Porter *et al.*, 2009, p. 1032). Some parents may find it difficult to understand that a therapist who is 'playing' with their child will be able to help their child resolve trauma. Some cultures may also find it inappropriate for a child to share private family matters as it is against their values and customs to share the details of family life (Porter *et al.*, 2009).

Posttraumatic Play

Dripchak (2007) explains how children, like adults, re-experience traumatic events through nightmares, flashbacks and intrusive thoughts. However, unlike adults children may not be able to verbalize their experience. Children may express the negative impacts of trauma through traumatic play. Posttraumatic play (PTP) is "compulsive repetition of the trauma or trauma related themes in play" (Dripchak, 2007, p. 126). Terr (1981) differentiates play from re-enactment by the sense of enjoyment that accompanies ordinary play. Ordinary play is usually free flowing and changes over time, however, PTP is ritualistic, repetitive and arrives at the same ending with specific play materials (Dripchak, 2007). It is as though the child is repeating the trauma that has been unconsciously incorporated into the child's play (Terr, 1981; Dripchak, 2007). Play behaviours of children differ depending on whether a child has a history of trauma or not (Findling, Bratton & Henson, 2006).

Positive and negative PTP exists. Positive PTP is a child who reenacts the trauma but is actively modifying the negative aspects of the trauma, whereas negative PTP is repetitive play that does not relieve anxiety, does not make the child feel strengthened and is not helping the child accept or resolve traumatic events (Terr, 1981; Dripchak, 2007). In the case of negative PTP, "therapists must keep the child's safety a priority at all times, be carefully attuned to the play in order to determine whether it is dynamic or stagnant in nature and be prepared to redirect and transform the play if necessary" (Green *et al.*, 2010, p. 98). If negative PTP is allowed to continue it can produce more terror than was present prior to the re-enactment (Green *et al.*, 2010). Negative PTP may constitute directive or structured play to ensure safety and encourage release of trauma (Landreth, 2012).

Sensory-Based Assessment

Dauber *et al.* (2015) describe a universally recommend phase-oriented treatment for

trauma treatment that Steele & Malchiodi (2012) term *extended developmental assessment*

(EDA). The goals of EDA are to evaluate the child's overall functioning such as communication,

affect and attachment patterns, the child's developmental level, evaluation of caregiver and

internal supports, impact of trauma and an observation of the child's level of enjoyment,

curiosity and creativity (Steele & Malchiodi, 2012). EDA is a trauma informed because it

primarily uses non-directive approaches and capitalizes on the relationship between therapist and

child (Steele & Malchiodi, 2012). The child controls decision making in activities and the

therapist provides unconditional acceptance (Steele & Malchiodi, 2012).

Through EDA the therapist observes developmental functioning, identifies symptoms,

determines the impact of traumatic events, identifies coping strategies, clarifies the child's

perception of social support and facilities support between child and caregiver (Steele &

Malchiodi, 2012). "Practitioners who use EDA make note of observations about physical

functioning, relational interactions, themes in play (Steele & Malchiodi, 2012, p. 52)." For

example, therapists may make note of what toys the child selected, what themes were part of the

play, what stories were told, how the child interacted with the therapist during play, culture

specific symbolism, suggested issues or whether the play was adaptive.

There are three cultural errors that therapists can make while working with children from

diverse populations. First of all, therapists may overestimate or underestimate the significance of

cultural factors in the child's life (Porter *et al*., 2009). It is important that therapists not

generalize all children of a culture and avoid cultural biases. Second, therapists may not be able

to discriminate between cultural groups. Third, therapists become familiar with a culture only

through the eyes of their client (Porter *et al*., 2009). To avoid these cultural errors, therapists

must become culturally competent and not assimilate the child into the dominant, mainstream

culture (Porter *et al*., 2009).

Family play genogram. A genogram is a visual depiction of one's family. Family

members are identified based on gender, their relationship to the client and to one another,

marital status, if there was abuse, addiction, separation/divorce and any other relevant details the

client shares (Gehart, 2014). A family play genogram is drawn on a large sheet of paper and uses

miniature figures to symbolize each person on the genogram (O'Connor *et al.*, 2016). As a

second step, the child can add items from the play room that symbolizes the relationship even

further. For example, a child may add a miniature sword, a coin, a miniature soccer ball or a

miniature tree (O'Connor *et al.*, 2016). Genograms provide therapists with intergenerational

patterns, family information and the child's perspective of the family (Gehart, 2014; O'Connor *et

al.*, 2016).

Treatment

Preliminary phase. The preliminary phase in play therapy is when the play therapist

creates physical and psychological conditions that foster a strong therapeutic relationship

between the play therapist and child. As Landreth (2012) states, "the play therapist is intentional"

and "works hard to create an atmosphere that is conducive to the building of a relationship with

the child" (p. 97). Play therapists achieve this by being fully present and available to the child.

They are also aware of the counselling environment and how it can impact the child's mindset

prior to beginning a session (Landreth, 2012). Play therapists are aware of agency location,

agency setting, office layout and are intentional in setting up the playroom layout and putting

appropriate play materials in the room prior to a session beginning (Landreth, 2012). In the

playroom, toys and materials should be developmentally appropriate and facilitate a wide range

of creative and emotional expression (Landreth, 2012). It is also critical that the amount of

sensory overload in a session is reduced (Malchiodi, 2015). The play therapist intentionally

creates a first impression that lets the child know he or she is supported and is in a safe

environment.

      Safety phase. The early phase of trauma processing is focused on creating safety (Dauber

et al., 2015). A feeling of safety, for example, can be promoted by consistency of the therapist

(Landreth, 2012). Dauber *et al.* (2012) state, "safety and stabilization develop emotional and

behavioural regulation" (p. 530). Free play is one technique that can be employed by play

therapists to foster a sense of safety in a child.

      Free play. To create a sense of safety and predictability the therapist may choose to greet

the child in the same way each session, sit in the same place and project a warm and friendly

image (Landreth, 2012). Upon meeting the therapist the child is introduced to the play room. For

the early phase of treatment, the child is invited to choose whichever activity he or she chooses.

Free play reinforces individual expression through play. The therapist provides understanding

and establishes a feeling of permissiveness through free play (Landreth, 2012).

      Release & re-experiencing phase. The second phase is trauma processing, which aims

to integrate and create meaning of traumatic memories into one's sense of self (Dauber *et al.*,

2015). This can be accomplished through family drawings, sandplay, creating self portraits,

playing with puppets, writing a story and other play activities (Steele & Malchiodi, 2012). It is

during this phase that the play therapists unconditionally accept the child as well as help the child

understand his or her affective experience (Anderson & Gedo, 2013).

Dollhouse play. Family dynamics can be uncovered during dollhouse play and is

considered a strong intervention to elicit a child's view of family life (Schaefer & Cangelosi,

2016). "Children play out their personal experiences of child abuse and domestic violence when

they experience safety in the therapeutic relationship with a therapist (O'Connor *et al.*, 2016, p.

419)." Dollhouse play has been reported to reflect dysfunctional parent-child interactions,

express feelings about a child's home situation, expose child abuse, sexual abuse, neglect and

domestic violence (Schaefer & Cangelosi, 2016; O'Connor *et al.*, 2016). Stories that are shared

during dollhouse play can reflect the trauma children are exposed to at home.

Free puppet play. Puppet play helps children express feelings, reenact traumatic events

and ultimately try new, more adaptive behaviours (Schaefer & Cangelosi, 2016). Most

importantly, "puppets allow children the distance needed to communicate their distress" (Hall,

Kaduson & Schaefer, 2002, p. 520). Children may be able to more safely express feelings toward

a parent with a puppet (Schaefer & Cangelosi, 2016). Schaefer & Cangelosi (2016) share

empirical finds that having at least fifteen puppets to choose from is beneficial in play therapy. In

free puppet play, the child can select any puppet and can then animate and direct the puppet in

any way he or she chooses (Schaefer & Cangelosi, 2016). The therapist is the audience and could

ask the child to introduce the puppets and ask the child open ended questions about the puppet

story the child created (Schaefer & Cangelosi, 2016).

Non-directive music play. Music has been incorporated into therapeutic intervention with

children experiencing trauma (Davis, 2010). The playroom can be equipped with musical

instruments that give the child an opportunity to play out his or her feelings (Schaefer &

Cangelosi, 2016). Emotions can be expressed in tone and rhythm and in the actual instrument the

child chooses. For example, does the child choose a stringed instrument (i.e. guitar), one to blow

into (i.e. flute), one to press (i.e. piano), one to tap with a stick (i.e. drum) or shake (i.e. maraca).

"Music has long been a powerful way for people to connect, celebrate, entertain, remember and

mourn (Davis, 2010, p. 126)." Music play has lead to increased emotional development,

expression, communication, problem solving, self-esteem and awareness (Davis, 2010).

　　　　Sandplay. Margaret Lowenfeld developed the World Technique, which sandplay and

sandtray therapies have evolved (Swan & Schottelkorb, 2013). She wanted to develop an

intervention that allowed children to express themselves freely without adult interference.

"Sandplay therapy is a creative form of psychotherapy that uses a sandbox and a large collection

of miniatures to enable a client to explore the deeper layers of his or her psyche in a totally new

format; by constructing a series of "sand pictures" a client is helped to illustrate and integrate his

or her psychological condition" (Malchiodi, 2015, p. 13). Sand is an engaging medium for

children and no skills are necessary. Children are asked to create a world within the sand. They

can push sand together to create hills and mountains and clear sand to make space for water or

make holes (Malchiodi, 2015). The miniatures that children can choose to place in the sand could

be plants, trees, rocks, people, animals, vehicles, fences, bridges, gates, fantasy items, weapons,

buildings or religious symbols (O'Connor *et al.*, 2016). The miniatures give children a sense of

control over their circumstances because they can be manipulated and moved around in the sand

(Sori & Robey, 2013). An externalization of the child's inner thoughts and feelings is created in

the sand. "This may be represented by realistic of fantastic worlds, peaceful or aggressive worlds, orderly or chaotic worlds (Sori & Robey, 2013, p. 66)."

Resiliency & closure phase. The final phase of treatment aims to promote resiliency and client engagement with family members and their community (Dauber *et al.*, 2015). The traumatic experience is integrated into the child's life story (Dauber *et al.*, 2015). Resiliency can be supported in play therapy by including caregivers or other attachment figures. "An adult and child might co-create a scene with miniatures in sand or make a puppet together (Steele & Malchiodi, 2012, p. 183-185)." Davis (2010) also highlights the benefits of composing music with others. Trauma informed interventions that support resilience focus on the caregiver-child relationship, the child's feelings of safety and in re-creating positive memories using creative methods (Steele & Malchiodi, 2012). Reinforcement of attachment relationships is the key to enhancing resiliency.

Bubble breaths. Deep breathing helps children become aware of the mind-body connection and self regulate emotions and somatic responses to stress (Malchiodi, 2015). Bubble breaths "is a relaxation technique designed to teach children deep and controlled breathing (Hall *et al.*, 2002)." Hall *et al.* (2002) describe the bubble breath activity in detail. The therapist begins by filling the room with bubbles so the child can look at the bubbles and pop them as they fall. After a few minutes the child is asked to blow only one big bubble. The therapist will encourage the child to take a deep belly breath and slowly exhale through the mouth to make a bubble. Bubble breaths teach children a concrete relaxation tool to calm themselves when experiencing a stressful situation (Schaefer & Cangelosi, 2016). Relaxation tools, like bubble breaths, can be taken with the child once therapy has terminated.

Chapter 5: Trauma Informed Art Therapy with Children

There is a close relationship between play and art therapy. A session of art therapy may look like play therapy especially if there is sensory play or any kind of dramatization (Rubin, 2005). As Rubin (2005) states, "playfulness is often part of the creative process, and there is much artistry in good play therapy" (p. 350). The goals of both play and art therapy are the same, however, the modality is different. A therapist will provide a larger selection of art media and tools and has a more "refined understanding of symbolic meaning of a child's visual communication" (Rubin, 2005, p. 351). Also, children who may find it difficult to play may be more interested or open to exploring art materials in a therapeutic setting (Waller, 2006).

Art Therapy

Art therapy involves both parts of its name, art *and* therapy. Art therapy, simply put, is a form of therapy that involves the process of making art (Nicholson, Irwin & Dwivedi, 2010). For that reason the goal of each art activity must primarily be therapeutic (Rubin, 2005). In art therapy, art is created by the client while the therapist watches, listens, processes and reflects on the relationship and the art being created (Nicholson *et al.*, 2010). The difference between art therapy and traditional therapy is the art making process in and of itself. Art provides clients with an opportunity to explore different aspects of themselves (Nicholson *et al.*, 2010). It also helps those who are unable or uncomfortable expressing themselves verbally. Finally, once a client's art is created, a reflective process takes place in a therapeutic environment. The art "speaks back to the maker and has an effect on them" (Nicholson *et al.*, 2010, p. 162)

Waller (2006) outlines five basic principles of art therapy. First of all, art therapy views visual image making as an important aspect of the human experience and the human learning

process. Second, art that is made in the presence of a therapist allows the child to identify

feelings that may not be expressed using words. Third, art can be a safe container for

overwhelming emotions. Fourth, art is the language of therapy for children and therapists.

Finally, transference is highlighted through the use of art.

Trauma-Informed Art Therapy

"Art therapy seems to be well suited to meet the needs and address the problems of

children whose abilities to visualize and symbolize are impaired by trauma (Stronach-Buschel,

1990, p. 48)." Individuals who have experienced trauma have difficulty expressing themselves

verbally. This is even more prominent in children and those individuals who experienced trauma

at an early age because of the developmental changes in the area of the brain associated with

language (King, 2016). "Art therapy is a well-established therapy that facilitates nonverbal

emotional expression and facilitates therapeutic communication (King, 2016, p. 26)."

Trauma informed art therapy understands the mind-body response to trauma, recognizes

trauma symptoms to be adaptive and tries to move clients away from the "survivor" label into

"thrivers" (Malchiodi, 2015). Malchiodi (2015) describes five principles to trauma informed art

therapy. First of all, the use of sensory arts supports self-regulation. Second, knowledge of

neurodevelopment changes in those who have experienced trauma can lead to a better

understanding of the body's response to stress. Identifying bodily responses to stressful events

and memories and using art therapy interventions to create safety. Finally, the use of art therapy

to normalize a client's experience and increase resiliency. Trauma can have negative impacts on

children, however, trauma informed art therapy aims to improve self-awareness, resilience,

coping skills and give children a sense of control and a future orientation (Kuban, 2015).

For children who have experienced trauma, art therapy is encouraged for two main reasons. First of all, expression through art accesses traumatic images and emotions that are encoded in nonverbal sensation (King, 2016). Secondly, art aids in cognitive restructures and integration of traumatic experiences. Integration is when an individual is able to process nonverbal memories in the right hemisphere with verbal functions and memories in the left hemisphere (King, 2016). Early trauma impacts right hemispheric development, the ability to regulate emotion, process pain and maintain attention (King, 2016). Trauma is a sensory based experience, so the physical experience of creating art is an evidence based method to gain access to traumatic experiences (Racco & Vis, 2015).

Cultural Considerations

Trauma informed art therapy highlights the need for therapists, working with children who have experienced trauma, to be cognizant of the child's culture. "Any therapy situation involves some cultural differences" because "the client and the therapist bring with them values and beliefs conditioned by race, ethnicity, socioeconomic status and religion, among others" (Campanelli, 1991, p. 34). Campanelli (1991) urges therapists to gain an understanding of a client's values and beliefs but also how images created in art therapy may have different meanings depending on the client's cultural background. The use of symbols, colours and lines, for example, may have to do with one's culture. "Major differences concerning style and form are culturally conditioned, and the diagnostic value of any piece of art can only be determined in the context from which it originates (Campanelli, 1991, p. 34)." For this reason, therapists must be careful in how they interpret the art of a child who is from a culture that is different from their own or from a culture that is not the mainstream culture.

Sensory-Based Assessment

Human figure drawing. Steele & Malchiodi (2012) share how a human figure drawing (HFD) can be used as part of sensory based assessment with children who are traumatized. The HFD is created on a piece of white paper and with a pencil. The child is asked to draw a person. Steele & Malchiodi (2012) recommend the HFD be assessed using the UCLA-PTSD Reaction Index (UCLA-PTSD-RI). Scores on the UCLA-PTSD-RI indicate whether a child is experiencing PTSD and what his or her more troublesome symptoms are (Steele & Malchiodi, 2012). Therapists are aware and understand that depending on a child's developmental level, HFD's can look very different (Steele & Malchiodi, 2012). However, HFD's can be interpreted based on how the head, face, body, arms, hands, legs and feet are placed, whether they are missing and if there is asymmetry (Steele & Malchiodi, 2012). Heavy or light lines and the size of the HFD and corresponding body parts can also be noted.

Body scan or "show me the colour of your feelings". The National Institute for Trauma and Loss in Children has been using the body scan activity since 1994 (Steele & Malchiodi, 2012). Children use the outline of a body image and are asked to use colours to show where in their body they experience particular emotions. This activity creates a mind-body connection for children, whereas therapists are able to gain a further understanding of how the child experiences trauma on a sensory level (Steele & Malchiodi, 2012). It is helpful to identify feelings with colours in a legend on the same page as the body image or with a set of feeling cards as some children cannot name their feelings.

Treatment

Safety phase. Malchiodi (2015) states that providing safety and self-regulation with children who have experienced domestic violence is of utmost importance in trauma informed art

therapy. It has been found that children must experience a feeling of safety in their body, feelings, thoughts, words, ideas and the things that they make. In order to make traumatized children feel safe, therapists must consider if the therapeutic setting is a trauma-informed environment.

Trauma-informed environments establish a sense of control by giving children the opportunity to arrange seating, choosing their activity or by establishing hand signals for slowing down or taking a time out from an activity (Malchiodi, 2015). Children who have been exposed to domestic violence must also have a consistent and predictable experience in therapy. Home life for these children has typically been inconsistent and chaotic (Malchiodi, 2015). The use of art materials that are more easily controlled such as, markers, crayons or pre-cut collage materials rather paint or sand. Supporting a sense of mastery over activities, being culturally sensitive, providing reassurance and supporting self empowerment are also key elements to creating a trauma-informed environment (Malchiodi, 2015). "As the child gains a sense of trust in the art therapy environment, in the therapist, and in the child's own ability to deal with the affect that the artwork might produce, the child gradually begins to express more in art (Stronach-Buschel, 1990, p. 48)."

Creating a safe place for a small toy duck. This activity addresses care and safety for children who have experienced domestic violence. Children are asked to make a safe space for a duck by using art materials (Malchiodi, 2015). Materials can include a paper plate, coloured paper, tissue paper, feathers, fabric, yarn, twigs, leaves, acorns, a pair of scissors and glue. Malchiodi (2015) provides some prompts and questions from the therapist to the child in this activity. They include, "Where does your duck live?", "Where would your duck live to be happy

and feel safe?", "Does your duck live alone?", "Does your duck live with other ducks?", "What does your duck like to do?", "How does your duck have fun?" or simply, "Build a home for your duck". It is important to note that another toy animal could be used instead of a duck.

Release & re-experiencing phase. In the second phase of treatment, children are encouraged to talk about how domestic violence has affected them. It is a time of sharing personal experiences through various art interventions. "By reproducing aspects of the trauma in symbolic form, the child feels more in control of the emergence of memories and can begin to master feelings and integrate the trauma into the psyche without being overwhelmed (Stronach-Buschel, 1990, p. 48).."

Free art about "what happened". "The key to expressive work with traumatized families is to respect the power of the art to do the work (Carey, 2006, p. 129)." Drawing, painting and other art mediums are offered to children as outlets to express thoughts and feelings about the trauma they experienced as a result of domestic violence. The child is invited to create a drawing, painting or other visual image using any of the art materials available (crayons, felts, paint, clay, chalk, coloured paper etc.). Through visual art imagery "the client can then tell his or her story, which can be rearranged in a more understandable manner" (Desmond, Kindsvatter, Stahl & Smith, 2015, p. 448). The therapist pays close attention to the details and can ask open ended questions about the art work. Desmond *et al.* (2015) encourages therapists to be aware of creating and managing safety during sessions because children who tell their stories visually may re-live their trauma.

Clay Field. Touch is one of the most fundamental human senses and is a basis for secure attachment (Elbrecht & Antcliff, 2015). The Clay Field is a sensorimotor art therapy that differs

from play, sand or other visual art therapy because clay focuses on haptic perception. Haptic

perception, defined by Elbrecht & Antcliff (2015), is "perception through touch where the active

hands are neurophysiological sensory organs" (p. 210). The Clay Field is a form of therapy that

was developed in Germany by Heinz Deuser for children 2 years and older (Elbrecht & Antcliff,

2015). Haptic perception is important in therapy with children who have experienced trauma

because sensory motor functions develop simultaneously with emotional and social abilities

(Elbrecht & Antcliff, 2015).

Children are asked to create a world in the Clay Field. A bowl of water is provided to

help smooth and mould clay. In some instances, children may use miniature toys in the Clay

Field in the same way miniatures are used in sandplay. Therapists are non-directive in their

approach to children working in the Clay Field. Clay Field sessions are successful when children

are encouraged and supported in the emergence of their own body's impulses and movements

(Elbrecht & Antcliff, 2015). Relational trauma is repaired by touch in the Clay Field (Elbrecht &

Antcliff, 2015).

Body Map. The body map is created by using a large roll of paper that is at least as tall

and wide as the child. The child will stand beside a wall where the paper is being held or lay on

the paper while the therapist traces the child's body onto the paper (Malchiodi , 2015). The child

can be in any position while being traced and can fill the body outline any way they choose.

Malchiodi (2015) states how experiential body mapping "establishes more space between the

child's core self and his or her defensive system and can help to create a vantage point that

allows the core self to reconnect with the body and its wisdom" (p. 129).

Resiliency & closure phase. Family art therapy has been used as part of assessment and evaluation but can also be used with families who have experienced trauma (Carey, 2006). The goals of trauma focused family art therapy is to explore individual reactions to trauma, identify each persons role, help family members communicate needs and encourage family members to find support in one another or outside of the family (Carey, 2006). Successful trauma processing can lead to the outreach of other's in a child's support network (King, 2016). Finding social support is the key to building resiliency in children who have experienced trauma (Hines, 2015). Where domestic violence has been present, caregivers may not be able to provide emotional strength or support so extended family members or individuals outside of the family may need to be identified and included as part of family art therapy (Carey, 2006).

Family crisis crest. Individuals who have been identified to be part of the child's support system are invited to design a single crest that is shared amongst them. A blank template is provided on a piece of paper to begin the activity. Each section of the crest symbolizes traits that have helped the child during challenging times (Malchiodi, 2015).The use of animals, flowers, tress and plants could display strength, whereas a crisis scene could be represented by a mountain. One portion of the crest is a symbol or image that represents hope for the future (Malchiodi, 2015). Malchiodi (2015) suggests that the group include a motto under the crest.

The decision to terminate therapy is made between the child, caregivers and the therapist. Termination of therapy can be painful so it is meaningful to discuss what has been learnt and how the client has grown since starting therapy. Termination of art therapy, in particular, should include a review of the expressive work that has been created (Carey, 2006). Also, any art work that the child would like to keep or take with him or her should be returned to the child (Carey,

2006)."A reduction in symptoms along with the client's sense of being ready to move on in life

usually indicates it is time to end treatment.

Conclusion

Trauma informed play and art therapies are evidence based therapies that support children who have experienced trauma. They are compatible with what is known about childhood trauma and how it affects the brain. For example, creative interventions assist children to (1) externalize their experience, (2) provide sensory processing, (3) stimulate the right brain, (4) arousal and affect regulation and (5) relational aspects (Malchiodi, 2015).

The creative interventions suggested in this paper are activities that can be utilized with children who have experienced traumatic events like domestic violence. Please keep in mind each child is unique and that activities do not fit every child or every situation (Steele & Malchiodi, 2012). The activities included in this paper are suggestions only and it is my hope that researchers and practitioners will analyze and review the activities I suggest. I welcome the addition of more play and art based activities and for the activities I suggest to be challenged. The activities that were selected, however, were selected based on the following factors: accessibility to children, for children who have been exposed to domestic violence, children who are experiencing symptoms related to trauma and for children who are from a cultural subgroup, such as the Indo-Canadian community. These were the activities I used as therapist when working with Indo-Canadian children who were exposed to domestic violence.

Domestic violence is an all too common experience in the Indo-Canadian community. This paper emphasizes how women and children of Indian ethnicity are more likely to be affected by domestic violence than many other ethnic groups (Jordan & Bhandari, 2016). As pointed out in this paper, there are several reasons why this issue has yet to be researched and highlighted as a public health concern. I urge researchers to collect more data and collate more information on this important topic. I urge policy makers to begin considering how resources can

be allocated to provide better services and support to Indo-Canadian children. Childhood is a

critical period of human development, thus making childhood exposure to domestic violence an

issue that warrants immediate attention. The future of our communities are dictated by what

children experience today.

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Appendix A

**Post Traumatic Stress Disorder Diagnostic Criteria from the DSM-5
for Adults, Youth and Children Older Than Six Years**

Criteria A
Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse). Note: Criterion A. 4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Criteria B
Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Criteria C
Persistent avoidance of stimuli associated with the traumatic event(s),beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Criteria D

Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," 'The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Criteria E

Marked alterations in arousal and reactivity associated with the traumatic event(s),be ginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically ex pressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Criteria F

Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

Criteria G

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criteria H

The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Appendix B

**Post Traumatic Stress Disorder Diagnostic Criteria from the DSM-5
for Children Six Years or Younger**

Criteria A
In children 6 years and younger,exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary care givers. Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.
3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

Criteria B
Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: Spontaneous and intrusive memories may not necessarily appear distress ing and may be expressed as play reenactment.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.
3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to reminders of the traumatic event(s).

Criteria C
One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).

2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).
3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
4. Markedly diminished interest or participation in significant activities, including constriction of play.
5. Socially withdrawn behavior.
6. Persistent reduction in expression of positive emotions.

Criteria D
Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically ex pressed as verbal or physical aggression toward people or objects (including ex treme temper tantrums).
2. Hypervigilance.
3. Exaggerated startle response.
4. Problems with concentration.
5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Criteria E
The duration of the disturbance is more than1month.

Criteria F
The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.

Criteria G
The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.