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CHILD AND FAMILY DISASTER PSYCHIATRY (B PFEFFERBAUM, SECTION EDITOR)

The Function of Play for Coping and Therapy with Children Exposed to Disasters and Political Violence

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Abstract

Purpose of Review The objectives were to identify specific characteristics and patterns of children's play following events of political violence or disasters, examine their associations with risk and resilience, and explore their implications for preventive and therapeutic intervention.

Recent Findings Patterns of individual, dyadic, and social play are associated with measures of children's adaptation following collective traumatic events. Modifying the traditional child-centered play therapy, by integrating CBT principles or including parents, may increase efficacy.

Summary Preventive interventions in the aftermath of collective traumatic events must address children's need to play in safe spaces, with the support of significant adults. Recognizing that posttraumatic play is a multifaceted phenomenon implies the need for more individualized play therapy models, varying in level of therapist's activity and techniques employed. Research is needed to clarify the validity of play measures for assessing adaptation and to study the effectiveness of integrative play-based models.

Keywords Posttraumatic play · Play therapy · Play-based community interventions · Collective traumatic events · Risk and resilience · Family-based play interventions

Introduction

Millions of young children around the world are exposed to numerous traumatic events due to natural disasters, war, and terrorism [1]. Recent reviews provide consistent evidence showing that children exposed to political violence or disasters are at high risk for posttraumatic stress disorder (PTSD), psychosomatic symptoms, behavioral and emotional problems, sleep problems, and disturbed play [2, 3].

Recent longitudinal studies examined long-term risk and resilience trajectories of development in children exposed to political violence and disasters. They showed that effects of early exposure to prolonged or recurrent traumatic events do not heal "naturally" and may exacerbate over time [4•]. Similarly, research suggests that exposure of pregnant women to political violence and natural disasters may affect their child's future development [5, 6]. However, robust findings show that maternal posttraumatic coping is associated with trajectories of risk and resilience in their children [4•, 7].

It appears that special attention should be directed towards young children, since they may be at particularly high risk for developmental problems and psychopathology following traumatic events, in comparison with older children and adults [3]. Nevertheless, research on the coping mechanisms of preschool children and the effectiveness of preventive and therapeutic interventions is limited [2]. This is partly due to the reduced reliability of young children's self-reports [4•]. It is therefore sensible to focus on children's "natural language," namely, their play activity, in order to learn more about how they process traumatic events and how they can be helped.

Events involving natural disasters or political violence (war and terrorism) are collective and often affect the community infrastructure [1]. Given the paucity of comparative research on the play of children exposed to these types of events [8], this paper links together studies related to these collective traumatic events, often referred to as "mass trauma," which

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differ from traumatic events involving child maltreatment and family violence, which we did not include in this review.

In this paper, we set out to identify specific characteristics and patterns of children's spontaneous play following collective traumatic events (CTE). We examined their implications for assessing adaptation and for supporting children's coping via preventive and therapeutic intervention.

How Is Play Potentially Healing in the Aftermath of Traumatic Events?

Free play may be viewed as a creative natural mechanism, enabling children to gradually pace the revisiting of traumatic memories and to process them. A basic function of play is to afford engagement in a sphere removed from external reality, thereby supporting the emergence of positive affect, shown to benefit adaptive coping with acute and chronic stress [9, 10].

Terr [11] specified that healing traumatic experiences in children is aided by opportunities for emotional expression, cognitive understanding, and behavioral or fantasized change. Clinical reports and empirical research demonstrate that play may be a natural medium for promoting these processes. By playing, children organize their memories, integrate fragmented sensory experiences, and reconstruct them to increase comprehension. This allows the construction of a coherent and meaningful narrative that is satisfying and reassuring [12–14]. A major healing function of play involves the ability to experience self-efficacy by changing the passive victim role into an active one and by showing off in fantasy one's power and capabilities [14, 15]. Additionally, Prichard [16] argues that neuroscience shows that play and relationships are major means of regulating arousal and coping with fear. Thus, play allows trauma memories to be re-worked at both a metaphorical and a neurobiological level.

On an interpersonal level, play provides opportunities for sharing private subjective experience with others and strengthening attachment and social bonds. Parental involvement in play with their young children and mutual emotional availability significantly contribute to children's resilience in the face of continuous exposure to traumatic events [17, 18••]. Furthermore, research clearly supports the important function of social engagement through play with family and peers in protecting from developing psychopathology following exposure to political violence [4•].

Posttraumatic Play—Characteristics, Risk, and Resilience

Maladaptive Posttraumatic Play

Posttraumatic play (PTP) has been described in the literature relating to changes observed in the play of young children exposed to various traumatic events [15]. Few studies focus specifically on exposure to disasters [19, 20] or on war and terror [13, 21, 22]. The PTP literature tends to emphasize its abnormal aspects. Recognized descriptions of worrisome PTP characteristics include: the serious, somber, driven quality of the play activity; repetitive re-enactments of frightening events with unresolved themes; increased aggressiveness; fantasies linked with rescue or revenge; increased withdrawal; and reduced symbolization and concretization here [13].

Use of Play for Assessing PTSD in Young Children Exposed to CTE

Scheeringa [23] argues that given the limited reliability of child or parent reports, the criteria for diagnosing PTSD need to be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children. Play observation can therefore aid in evaluating specific behavioral features that are relevant to the diagnostic criteria for PTSD in the DSM-5 [24].

The re-experiencing domain for PTSD may be observed in young children through the expression of trauma reminders in words or gestures during play [22]. Re-experiencing is further evident through unique repetitive play in which themes from a traumatic event are re-enacted [25]. Additionally, the criterion addressing a diminished interest in significant activities and feelings of detachment may manifest behaviorally as social withdrawal from playing with peers, preference for solitary functional or constricted play, and increased interest in objects [23].

Clinical Distinctions of Types of PTP

We believe that PTP is a multifaceted phenomenon allowing differential considerations in planning therapy. In support of this view, some of the clinical literature alludes to two kinds of PTP: the positive and negative [26] or dynamic versus toxic [15]. In the positive type, children re-enact the trauma but are able to modify its negative components and gain mastery over the experience. In the negative type, the repetitive play, although driven, is unsuccessful in relieving anxiety, and fails to help the child attain resolution or acceptance. The risk of the negative type of PTP is that it may actually worsen the traumatic effects and cause developmental regression. Gil [17] provides a summary of comparative criteria between dynamic and toxic play, including differences in affect and in the structure, development, and creativity of the portrayed story.

The distinction between possible patterns of PTP is important as it may help to evaluate the levels of children's risk for posttraumatic distress and delineate the kind of support and treatment they may require. Few empirical studies provide data on the reliability of play assessments or their validity.

Research-Supported Patterns of Adaptive and Maladaptive PTP

Cohen and her colleagues [13, 14] employed reliable analyses of free play sessions with children directly exposed to incidents of terrorism. Using the Children's Play Therapy Instrument Adapted for Trauma Research (CPTI-ATR), they found that exposed children showing the best adaptation levels, according to their caregivers' reports, displayed more positive affect and engagement in their play. Furthermore, they showed a better ability to plan and play out a coherent, progressive, creative, and satisfying imaginary narrative. Their sense of self-efficacy was evident by displaying their "awareness of oneself as player" (being both the director and the actor in their play). They also revealed a better capacity for emotion regulation and self-soothing.

The distinct ratings of PTP characteristics allowed refinement into three theoretically derived patterns of coping and defensive strategies observed in play. These proved useful in predicting levels of adaptation and risk. The first pattern—"re-enactment with soothing"—included play activity characterized by re-enactment of aspects or themes of the traumatic event, accompanied by free expression of diverse feelings. The play narrative or activity achieved a satisfactory ending, resulting in a sense of mastery and relief. Children rated high on this pattern displayed the highest level of post-trauma adaptation. This pattern is similar to the clinical descriptions of adaptive or dynamic PTP.

The two other patterns of coping and defensive strategies "re-enactment without soothing" and "overwhelming re-experiencing" were significantly and negatively related to the first pattern and were associated with higher levels of posttraumatic symptoms. "Re-enactment without soothing" is similar to the descriptions of toxic play [15]. It included the repeated re-enactment of themes or aspects of the traumatic event, often expressed in an aggressive or rigid manner. Reworking of the traumatic event did not occur, and the child did not gain relief from terror and fear.

"Overwhelming re-experiencing" involved the expression of mental states lacking a coherent structure, resulting in overwhelming the child. This usually manifested by an inability to produce a coherent narrative and by disconnected, or tense and hyper-vigilant behavior. At times, when a play narrative was produced, it was chaotic and involved a loss of sense of boundaries. The play activity did not diminish the child's extreme emotional state; rather, it tended to prolong or intensify it. Descriptions resembling this pattern are uncommon in the clinical literature and may warrant special attention because of its strongest associations with a PTSD diagnosis.

An adapted coding scheme of coping-defensive strategies, the Children's Play Development Instrument [27] includes four play styles: adaptive, inhibited/conflicted, impulsive/aggressive, and disorganized. These allow reliable tracking of aspects of traumatic play over time in a single child.

Recent research further examines play from a more interactive-interpersonal perspective. This new emphasis reflects the growing recognition of the importance of human connections in coping with trauma and for healing in its aftermath [2, 28]. In their study of risk and resilience trajectories in young children exposed to political violence, Halevi and her colleagues [4•] used a "child social engagement" measure based on observations of young children during free play. The measure included several codes: child gaze/joint attention, positive affect, alertness, social initiation, creative or symbolic play, and competent use of environment. Lower social engagement increased the propensity for late-onset disorders in exposed children.

Cohen and Shulman [18••] used dyadic mother-toddler free-play observations to systematically analyze emotional availability in mothers and toddlers exposed to political violence. Emotional availability [29] refers to the degree to which each interacting partner expresses emotions and is responsive to the other's emotions. Cohen and Shulman found that higher exposure was associated with lower emotional availability, and that the dyadic emotional availability was associated with the mother's perceptions of her child's behavior problems. Additional studies are needed to document associations between play measures relating to the child's interactions with parents and peers and measures of risk and resilience.

Intervention and Therapy

There is a growing awareness of the need for community-based interventions especially in the first stages following CTE, mainly because it impacts multiple systems [30]. Community interventions are usually more feasible than addressing individual needs and may decrease stigmatizing and increase social support [31]. Later changing circumstances usually allow for additional interventions on small group, familial, and individual levels [3, 32, 33].

Community-Level Interventions

Creating Infrastructure and Promoting Psychoeducation In their review of children in war and disaster, Masten and her colleagues [1] conclude that the research supports the importance of normalizing everyday life for children and families by resuming school and providing opportunities to play and socialize. This is not a simple recommendation, because playgrounds and play spaces are often destroyed, or become unsafe in CTE. Therefore, recreating the infrastructure enabling children to play safely becomes an important community-level intervention. Facilitating opportunities for play may

improve play quality and quantity for resettled refugee children and strengthen positive resettlement outcomes [34].

Often, when the impact of the traumatic event is severe, and resources are depleted, psychological needs cannot be met without the intervention of organizations and volunteers from outside the community. This requires heightened cultural sensitivity and cooperation with local personnel [35••, 36]. Thus, Kinoshita and Woolley [37] described how following a series of 2011 mass disasters in Japan (an earthquake followed by a tsunami and a nuclear power station malfunction), many children had little opportunity for free play. Moreover, the perception of play as important for children following disasters was low and play was even considered disrespectful and inappropriate in the context of grieving. The intervention involved creating playgrounds, mobile play vehicles, and indoor playgrounds, and educating the community regarding the importance of children's play.

Another intervention that involved creating the infrastructure required for play is the "Child Friendly Places" intervention [32]. This intervention targeted children, considered high risk due to their exposure to traumatic experiences in war zones (including sexual exploitation, trafficking, and HIV). The goal of the intervention was to create a safe, supervised space to support the children's use of play, and to create opportunities for peer social support. Evaluations from children's teachers demonstrated their greater school readiness and social competencies.

Vanfleet and Mochi [20] describe a different type of play-based community program that is multi-level, which they initiated following earthquakes in Tahiti and Iran. They maintain that even at an early stage of mass trauma, it is possible to attend to psychological needs by engaging children and adults of the community in play-based activities; these help release tension and create positive relationships between the community and mental health professionals. At a later post-event stage, they select sub-groups of identified distressed children for group play therapy adding cognitive skills training.

Child-Focused Collective Play Interventions An exceptional community-based intervention, aimed at strengthening children's sense of agency by enlisting their imagination and playful caregiving abilities, involves an adaptation of the "Huggy Puppy Intervention" (HPI) [38]. The adapted version was implemented in shelter homes for children who were orphaned following a natural disaster or domestic violence in Bangladesh [35••]. This play-based intervention originally included giving children a stuffed puppet of a puppy and asking them to care for the animal. In their adaptation in Bangladesh, Deeba and Rapee [35••] chose to replace the puppy with a teddy bear, since dogs are not pets in Bangladesh. One of the intervention groups received in addition to HPI cognitive training by practicing positive statements regarding themselves, the world, and the future. The data showed a reduction in symptoms of PTSD, anxiety and depression, and increased positive thoughts.

School-Based Intervention Over the past decade, an increasing number of studies show the beneficial effects of teacher-delivered interventions for children facing CTE. However, very few reports address programs for children in preschool or kindergarten [3]. Betancourt and her colleagues [40] describe a manualized group treatment delivered in schools to war-exposed children in Indonesia. The program encouraged cooperative play, creative expression, and trauma-processing activities. This intervention reduced PTSD symptoms and increased functioning, especially for girls. The authors reported that similar school-based interventions were beneficial for teenage war-exposed children in Gaza and Bosnia.

Adopting a more individualized focus, Bateman, Danby, and Howard [39] introduced a play-based intervention in a school setting following an earthquake in New Zealand. There, teachers helped pre-schoolers to process the event by creating a "Learning Story Book" for each child, reflecting the child's play, while describing their traumatic experience.

Individual Child Play Therapy Models

Child-Centered Play Therapy Child-centered play therapy (CCPT) is a classic form of non-directive play therapy with young children [41] considered among the treatments with confirmed effectiveness for traumatized children [3]. A review of CCPT studies with disaster-exposed children provides support for this treatment [19]. A randomized controlled trial comparing CCPT with trauma-focused CBT for refugee children [42] further demonstrates its benefits.

The clinical literature on traumatized children increasingly reports the necessity to incorporate play, art, or other expressive therapies in the assessment and treatment of young children. Several case studies demonstrate that play therapy is effective with CTE [43]. Play therapy and play techniques are especially suitable for young children with PTSD who are not able to deal with the trauma directly [44].

Integrative Play Therapy Some additional versions of play therapy, developed over the years, specifically target children exposed to CTE. Baggerly [45] developed an integrative approach called Disaster Response Play Therapy, which consists of a combination of CCPT with 15 min of CBT at the end of every play session. In her view, the CCPT portion of the session establishes in the child a sense of safety and encourages a re-enactment of the traumatic event. In the CBT part, the child is actively encouraged to develop coping strategies.

Ohnogi and Drewes [46], using their experiences in working with children affected by natural disasters, propose an integrative and personalized approach to individual play therapy with posttraumatic children. They demonstrate how they

attempt to match elements from directive play therapy and CBT to the specific symptom presentation by the child. They also propose to introduce relevant specific toys in the playroom (e.g., toy boats and sea creatures for tsunami survivors).

This personalized approach is very much in line with the argument presented by Gil [43] and by Cohen and her colleagues [12–14] that therapeutic interventions should be adapted to the different patterns of the child's observed play. Gil emphasized that therapists must respond to toxic posttraumatic play in a much more active and directive manner than they might respond to dynamic play. She describes a continuum of interventions, ranging from less to more disruptive to the child's play, designed to change the play's rigid pattern. Similarly, Cohen and her colleagues maintain that while children who display "re-enactment with soothing" may only need opportunities to play safely in the presence of a supportive adult, children who display "re-enactment without soothing" may need the active intervention of the therapist in proposing alternative hypothetical consequences or outcomes to their "stuck" and morbid narrative. Children with overwhelming re-experiencing may need gentle encouragement and support to stimulate their playfulness and to begin to engage in play. Additionally, they may need pacing by the therapist when they lose boundaries and help in introducing coherence in their attempts to create a narrative.

Inclusion of Significant Adults in Child Therapy

Recent reviews and studies provide robust research evidence demonstrating how parental posttraumatic coping and psychopathology are risk factors for their child's mental health, and how parents can mediate the effects of traumatic exposure on their children. The reviews and studies consequently highlight the importance of engaging attachment figures in helping traumatized children [2, 3, 4•, 7] and in contributing to the therapeutic process. Pfefferbaum and her colleagues [31] reported in their review of early child disaster mental health interventions that almost 40% of the interventions studied involved parents, a strategy that was associated with success. The minimal level of parental involvement in play-based child therapy involves their inclusion as observers in some of the sessions, or requesting them to ensure that the child implements the intervention at home (e.g., [35••]). Other interventions include psychoeducation for parents related to recognizing the importance of play for children (e.g., [33, 37]).

Filial/Family Therapy The impact of CTE on the individual child is embedded in its impact on the family as a whole. Therefore, interventions focusing on the family and its resilience make theoretical and clinical sense [3, 47]. Sories, Maier, Beer, and Thomas [48•] present the theoretical rational and some evidence for using family play therapy for bereaved children of military families. The intervention involves both joint and separate sessions for the surviving parent and the child. The therapist helps the surviving parent to process the child's traumatic play, which can be challenging when both suffer loss. Similarly, Vanfleet and Mochi [20] demonstrated the use of filial therapy as an intervention aimed to strengthen the family as a whole following the 11 September terrorist event in NYC. Their intervention included both joint play sessions (child-parent) supporting the use of CCPT principles by the parents and separate sessions with the parents in order to prepare them for occasions in which the traumatic event will be reenacted in play.

Dyadic Play Therapy Dyadic therapy usually focuses on the interaction between a caregiver and a child, while engaged in play. Research shows its contribution to increasing parental sensitivity to the child and improving mutual communication and interaction. Harel and Kanner [49] describe the Haifa Dyadic Therapy (HDT) model and its adaptation for the treatment of children traumatized by war. The major focus in this model is enhancing the dyad's mentalization, facilitating the co-construction of the trauma narrative, and infusing their experiences with new meanings.

A promising pilot intervention is the NAMAL (acronym in Hebrew for "Let's make room for play") program targeting dyads of mothers and toddlers exposed to recurrent terror attacks in a group setup. The program focuses on improving parent-child relationships, supporting the child's coping with the traumatic events, and promoting play and playfulness. Various evaluations showed the beneficial potential of the program for helping mothers enhance their enjoyment and understanding of their child, improving mutual emotional availability and reducing child behavior problems [17, 18••, 50]. Further dissemination and study of these dyadic programs is recommended.

Conclusions

Accumulating and new research clearly demonstrate the long-term developmental risks for children exposed to collective traumatic events. The effects of traumatic exposure are evident in changes in children's play. Clinical experience and research suggest that play observation and analysis may serve as important tools for assessing posttraumatic adaptation and for the choice of appropriate interventions.

Both individual and social play activity are helpful spontaneous natural vehicles for children to process traumatic events and promote resilience. Therefore, basic interventions in the aftermath of CTE must address children's need for safe spaces to play. This activity needs to be encouraged and facilitated by significant adults, including parents, teachers, and community center personnel. However, certain types of spontaneous PTP

may be unhelpful or insufficient for child coping and recovery and may signify the need for personal play therapy.

We suggest that the growing recognition that the phenomenon of PTP is complex and multilayered implies the need for more individualized types of play therapy models, varying in level of the therapist's activity and in the techniques employed. Recent modifications of the CCPT model indeed involve differential use of techniques based on the child's play patterns and the integration of CBT principles into the play sessions. Additional promising modifications involve the inclusion of parents in the play-based therapy process.

Research is needed to support these recommendations, mainly to clarify the associations between play patterns of children exposed to CTE with measures of risk and resilience. It is also needed to examine the effectiveness of the integrative play-based models, to fine-tune the differential choice of individualized therapy techniques, and the use of varying levels of parent involvement.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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- •• Of major importance.

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