To what extent can a series of play therapy sessions contribute to strengthening resilience in Syrian refugee children?

Abstract

The war in Syria has been widely reported, with many well-known aid agencies raising awareness of the impact that the war is having on children. This research was hosted by the Middle East Children's Institute (MECI) who are based in Amman, Jordan. The cohort comprised of twenty-one Syrian refugee children between the ages of six and twelve who participated in ten group play therapy sessions. The research study I undertook, used a mixed method design where comprehensive data was used to investigate what impact play therapy had on the children's resilience. The short-term play therapy intervention indicated a 15% decrease of emotional and behavioural difficulties using the Strength and Difficulties Questionnaire (SDQ), a 33% reduction of post-traumatic stress symptoms using the Children's Impact of Events Scale (CRIES), a resilience increase of 15% using the child scored Child and Youth Resilience Measure (CYRM) and a 17% increase in the parent scored CYRM. The results of this study support the use of play therapy with Syrian refugee children, provide a comprehensive understanding of how resilience was strengthened and how this was observed by the parents, the children, the translator and the play therapist.

Key words: Play therapy, refugee children, trauma, resilience.

Introduction:

War atrocities do not differentiate between children and adults and often whole communities are affected. Children are especially vulnerable because, unlike adults, they have not yet fully developed physical, emotional and intellectual capacities to protect themselves (Yahav, 2011). A considerable amount of research has illustrated that the mental health of refugee children is of concern (Yule, 2002, Mollica et al., 2004, Crowley, 2009, Henley and Robinson, 2011, Reed et al., 2012, Pacione et al., 2013). Increasingly play therapy is viewed as an effective intervention when supporting refugee children. Schottelkorb et al. (2012) demonstrated how

Child Centred Play Therapy (CCPT) was as effective as Trauma Focused CBT in reducing symptoms of Post-Traumatic Stress Disorder (PTSD) in refugee children.

Literature review

Refugee children

Refugee children often experience an accumulation of stressful or traumatic events which may include the exposure to war, the loss of their home, relocation to another country, physical illnesses such as malnutrition, lack of education and social exclusion or discrimination (Ehntholt, 2005, Schottelkorb et al., 2012, Measham et al., 2014). This does not mean that every refugee child should be given the label of being traumatised contrary to the viewpoint often portrayed by the media (Jones, 2008).

Resilience

Experts agree that in order for resilience to be present there must be two conditions: adversity and positive adaptation (Luthar et al., 2000, Masten, 2001, Cicchetti, 2010). Resilience is no longer viewed as absolute but relative, indicating that a child's response to adverse circumstances may vary instead of viewing the child as resilient for the rest of their life (Masten, 2014). This research will adopt the definition of resilience made by Luthar et al. (2000) as a "*dynamic process encompassing positive adaptation within the context of significant adversity*." Resilience is something which is constantly evolving and therefore cannot be described as something which is static (Vanderbilt-Adriance and Shaw, 2008, Cicchetti, 2010, Masten, 2014). Masten (2001) argues that resilience is the outcome when "ordinary human adaptive processes" (p. 234) are at work in a child's life such as: attachment relationship to parent or care giver, ability to regulate their emotions, self-confidence, motivation to learn, normal brain development and having a connection to their community.

Neuroscience

Understanding how adverse experiences impact brain development in children is of the utmost importance. The basic structure of a child's brain is the same whether they come from a Western background or from the Middle East. This explores current thinking on brain development and how it can inform play therapy interventions to help refugee children cope with their stressful experiences and be resilient.

Shonkoff et al. (2012) differentiate between three types of stress in a child's life: positive stress, tolerable stress and toxic stress. He argues that toxic stress in young children can change the brain architecture and have an impact on their future educational, emotional and physical development. This view is supported by the literature including Compas (2006), Carrion and Wong (2012), Shonkoff et al. (2012). Within the literature regarding refugee children, resilience, neuroscience and play therapy, the role of a supportive adult is emphasised as being of utmost importance (Gunnar and Quevedo, 2007, Betancourt and Khan, 2008, Shonkoff et al., 2012, Crenshaw and Kenney-Noziska, 2014). It is well documented how the experiences of refugee children are filled with multiple stressors (Yahav, 2011, Schottelkorb et al., 2012, Stern, 2015) and how parents are themselves often too overwhelmed by their own experience resulting in an inability to provide the emotional support children need to combat stress (Yule, 2002, MacMillan et al., 2015, Kaplan et al., 2016). Therefore, it may be argued that the definition of toxic stress used by Shonkoff et al. (2012) is applied when describing the refugee children's experience which includes prolonged stressful experiences with little adult support available. Yahav (2011) argues that the amount of social support a child receives is vital for understanding the resilience in a child. The experience of playing together within a therapeutic relationship, has the ability to reduce stress, regulate emotions, shape or re-shape brain circuits and influence future development for learning and mental health (Fearn and Howard, 2012, MacMillan et al., 2015, Stewart et al., 2016).

Play therapy

Play is something every child should grow up with and is referred to as the right of any child under the United Nations Convention of the rights of the Child (Fearn and Howard, 2012, MacMillan et al., 2015). Play is a fundamental right because a child's emotional and physical well-being depend on it. Although play for each child can look different, it is something all children should have the opportunity to participate in thus, making it a multi-cultural experience.

Play therapy was first introduced in the 1940's and largely influenced by Axline (1969) who had a strong belief that when a child is given the opportunity to bring out their feelings, fears and anxieties through play, the child has the ability to heal themselves. This approach is further explained in studies by Landreth (2002), Bratton et al. (2005) and Bratton et al. (2009).

Play therapy can harness the natural ability of play and use it as a form of communication (Landreth, 2002) which is why Davis and Pereira (2014) strongly suggest play therapy can be an effective intervention when working with children from different cultural groups. The use of play as an outlet for traumatic experiences and as a form of communication is documented in Levine and Kline (2008) who advocate the restoration of resilience through the use of play.

Jordan et al. (2013) found that play therapy was effective when used with children who have experienced natural disaster and catastrophic events. They found that children experienced a complete lack of control over their environment and displayed symptoms of fear and anxiety. This is not unlike the experience faced by many refugee children. Play therapy offers children a safe space to express their feelings, reduce their anxieties by learning to self-regulate, develop their self-esteem, experience a therapeutic relationship, all off which have links to resilience (Malchiodi et al., 2008, Crenshaw et al., 2015, Seymour, 2015).

The healing property of play is documented in the use with refugee children who have experienced war (Hyder, 2005). Verbal communication and cultural differences may be seen

as obstacles when working with children from other culture groups. However, in play therapy the focus of communication relies strongly on play rather than purely on words alone.

Group work has been recommended for therapeutic, financial and humanitarian reasons bringing people together, empowering them and restoring human dignity (Barenbaum et al., 2004, Malekoff, 2008). Play is effective because it transcends cultures; it is a natural resource which is enjoyed by children and is developmentally appropriate (Fearn and Howard, 2012).

Study design

The study I undertook, used a fixed mixed method design which implemented the planned quantitative and qualitative data gathering processes (Creswell and Plano Clark, 2011) using a convergent design where both data sets were given equal priority and then analysed and compared separately, with an integrated conclusion. Pragmatism was used as the overarching philosophical assumption.

Measures

Quantitative measures:

1. Goodman's Strength and Difficulties Questionnaire (SDQ) (Goodman, 1997).
2. Child and Youth Resilience Measure (CYRM-28) (Ungar and Liebenberg, 2011).
3. The Children's Impact of Events Scale (CRIES 8) (Perrin et al., 2005).

Qualitative assessments:

1. Semi- structured pre-and post-interviews with the parent.
2. Process notes.
3. A drawing activity and assessment called, "My Week, My Day, My Life." This activity was carried out pre and post intervention (Oaklander, 2007, p. 44).

4. A Semi-structured interview with the translator upon completion of the play therapy program.

Participant recruitment and research sample

This research was kindly hosted in Jordan by The Middle East Children's Institute (MECI). The families and the cohort comprised of twenty-one Syrian refugee children who were between the ages of six and twelve years. The majority of the children (x15), attended all ten play therapy sessions whilst all of the cohort (x 21) attended at least eight sessions.

Ethical considerations

Given the vulnerable nature of refugee children (Measham et al., 2014), particular care was taken throughout the study to give attention to their emotional wellbeing. The study was guided and informed by the Leeds Beckett University Research Ethics Principles and the PTUK (The United Kingdom Society for Play and Creative Arts Therapists) Ethical Framework.

The use of interpreters

With increasing numbers of refugee children accessing mental health programmes the use of interpreters needs to be considered. Rousseau et al. (2011) provide practical advice on the use of interpreters and suggest that *"language and cultural barriers may lead to diagnostic problems, difficulties in therapeutic alliance and non-compliance"* (p.58). This is why this study made use of questionnaires and scales some of which had been translated into Arabic. A translator was utilised during the interviews and the play therapy sessions which provided me with a means of communication and a valuable source of cultural information (Veer, 1998, Webb, 2007).

The project

The timing of the play therapy sessions

The children took part in ten play therapy sessions. The first three sessions were once a week with the remaining seven sessions being held twice a week. The main reason for this was to provide a sense of routine for the children whose daily life was often unpredictable and to decrease the waiting time between the sessions which appeared too long for the children. It is worth noticing that Perry (2009) argues one weekly therapy session to be insufficient to help traumatised children which was another deciding factor in increasing the session frequency.

The play therapy room

A classroom was made available by the local school. Through this, potential stigma of attending play therapy was reduced (Kletter et al., 2013). It may be argued that the most important factor of providing culturally relevant play therapy is the understanding and appreciation a play therapist has of other cultures (Hinman, 2003). I went equipped with culturally relevant art and play materials such as, ethnic dolls and toys which represented the children's culture and a familiar environment (Davis and Pereira, 2014). I purchased local resources such as, sand tray figures (among them were people figures wearing the hijab, various prayer beads and local symbols) and musical instruments such as Arab drums called the 'tablah' (Chang et al., 2005).

Play therapy process at the beginning

During the intake interviews many parents mentioned that the children had no toys to play with or any opportunities to engage in playing with toys. All of the families lived in utter poverty. It quickly became apparent that the children were overwhelmed by all of the toys they were given access to during the first play therapy session. This resulted in children grabbing, hoarding and fighting with each other for the toys as they each tried to accumulate as much as possible for themselves. At the end of the first session, many of the children tried to take the toys home instead of leaving them in the room for the next session. The children hid the toys under their clothing, in their pockets and some even tried to push past in order to run away with the toys they so desperately wanted to keep. To some extent this theme was

repeated in all of the five groups. During the following three sessions, I offered a directive approach and introduced activities rather than free access to all of the toys and only provided what was necessary for each activity. Within the body of play therapy literature, there is an argument as to the use of directive versus non-directive play therapy with traumatised children (Ryan and Needham, 2001, Kenney-Noziska et al., 2012).

The children appeared dysregulated, hyper-vigilant and in a constant state of alert. Van Der Kolk (2006) and Perry and Hambrick (2008) link this type of behaviour to the experience of trauma. I knew from the parent interviews and from comments the children had made, that daily life was full of stressful situations for many of them. Stressful situations during displacement is highlighted by Wells et al. (2016) who further argue that increased mental health difficulties are likely to be prevalent in such circumstances. Having taken this into consideration, it was of no surprise that the children behaved like this. Research shows that such stressful experiences early in childhood places children at greater risk of developing mental illness with lasting effects on the brain (Gunnar and Quevedo, 2007, Gee and Casey, 2015).

In order to reduce their arousal levels to a level which was manageable children needed to feel safe. Van der Kolk and Najavits (2013) argue that it is imperative for arousal levels to be controlled, otherwise it would be impossible to reach higher functioning areas of the brain. I noticed that the children were finding it difficult to engage in activities based on their cognitive abilities which Carrion and Wong (2012) point out is because of Post-Traumatic Stress Symptoms. Therefore, I focused on developing a nurturing therapeutic relationship (Geller and Porges, 2014), offered sensory activities (hand massage, clay and scented play dough, messy play with paint, shaving foam etc.) and rhythmic activities (using musical instruments and drums) all of which were aimed at helping children become more regulated. Perry (2009) agrees with this approach pointing out it helps children become regulated. I also observed that children commented they were hungry, and often they had not eaten all day. Many parents had said that the children were often going to bed hungry. Evidence shows that a lack of food

can have implications on a children's learning and places them at greater risk (Taras, 2005, Fabio, 2014). A decision was made (with parental approval), that a healthy snack and drink would be provided during the play therapy sessions. This was available whenever the children wanted it. It was important that the children understood that it was not a "reward" but instead was seen as a time of nurturing.

Group dynamics

In the Middle East, there is a strong focus on community compared to the West which focuses more on the individual (Kalksma-Van Lith, 2007). This was one of the main reasons why the decision was taken to offer group play therapy sessions compared to individual one to one play therapy. The sense of belonging to a group is also proven to be a crucial part in positive mental health for children who have experienced war (Betancourt and Khan, 2008). Siblings were kept together wherever possible. This was to provide a sense of safety, especially to the younger children. It became apparent that although the children were in groups they were individually seeking the attention of me and the translator. If a child's individual need was not met, many quickly resorted back to their survival mode of fighting for what they needed. Due to this, the children were given their own selection of art materials such as an individual paint tray from which they could use as little or as much as they wanted which enabled the children to understand that there was enough for all of them without having to fight for it.

Programme midpoint

Halfway through, the children had become calmer and more regulated, engaged and were able to interact with each other in a positive way. Fearn and Howard (2012) argue that play provides children with the needed experiences for self-regulation of emotions. I re-introduced all the play therapy toys to the room from Session Five onwards. During this session and every session thereafter, the children were able to engage without becoming completely overwhelmed. The routine of each session remained the same, starting with a 'hello' time, a structured activity which the children could choose whether they wanted to participate in or

not, a free play time and a ‘goodbye’ time. During each session, the intention was always for the children to feel safe, have their needs and feelings acknowledged and feel appreciated and valued. For the majority of the time, the groups sat down together at the end of the play therapy session and ate their snack together. Whilst eating, it was observed how the children talked about their current home life and how they felt. The children started to trust each other and friendships were built. Conversations about their past in Syria also became more frequent as they shared with each other what life was like, the things they remembered and the hopes they had for their future.

The ending process

Initially, the children’s focus was purely on having their own needs or desires met. Towards the end, both I and the translator noticed how the children were now proud to be part of their group, how they helped each other and at times even shared toys with each other. Careful consideration was given for the ending of the play therapy sessions (Oaklander, 2007). During the last session, a party was organised at the request of the children. I gave each child a certificate of attendance of which they were very proud. Afterwards, everyone joined in during the group games, dancing, and then ate some party food together. Although the play therapy project ended, it was the intention that I would remain available to offer support to the children in the future, if the need was identified.

Empirical Study Results

Whilst analysing the Strength and Difficulties Questionnaire (SDQ) pre scores, it was evident that the majority of the cohort had ‘total’ difficulties scores of either ‘very high’ or ‘high’. When this was compared to the post scores it was noticeable how the emphasis had shifted towards a more normal level with scores being either ‘slightly raised’ or ‘close to average’. The emotional, conduct and peer problem scores were classed as ‘high’ during the pre-phase but then had reduced to being ‘slightly raised’ in the post phase. Hyperactivity had been ‘slightly raised’ during the pre-phase and then reduced to ‘average’. The pro-social skills had been

‘slightly lowered’ but during the post scores indicated they were at an ‘average’ level. Therefore, it can be argued that there had been an improvement in all of the categories. When comparing the SDQ scores between boys and girls, it is interesting to notice how the boys average total score was two points higher than that of the girls indicating that the boys were suffering from a greater total difficulties score. When assessing the post scores, the boys also had a lower total score showing they had overall improved the most with an improvement of 7.91p points. The girls improved the most in their emotional problems.

In the Child and Youth Resilience Measure (CYRM) parent score, there was an increase of 13 points which equates to a progress of 17%. The children’s score showed an increase of 11 points which equates to a progress of 15%.

The Children’s Impact of Events Scale (CRIES) revealed a total score reduction of 13 points which indicated that post-traumatic stress symptoms had on average reduced by 33%.

During the parent pre interviews the parents were asked what the child’s behavior was like at home. The three themes most frequently mentioned were children being aggressive, hyperactive and an inability to express their feelings. Parents of fourteen children reported that their child’s behavior had deteriorated since moving to Jordan. Repeatedly, parents disclosed how they themselves felt overwhelmed and unable to help their child and explained that they were not “an expert”. When describing their child’s negative behavior only three blamed the experience of the war. In stark contrast, parents of nine children had indicated that it was the refugee experience which was to blame for their child’s negative behavior. Parents of seven children blamed a combination of war and refugee experience, whilst two suggested there may be other factors such as bullying and frustration. During the post interviews parents of nineteen children commented on how they had seen positive changes in their children at home due to coming to play therapy.

In the pre-interviews, many of the children were reluctant to draw (My life, my day or my week activity). Crucial factors may have been: a lack of confidence or trust in themselves and the

therapist, a wrongly held belief that this was an examination of their drawing abilities rather than an opportunity for self-expression, and or the fact that for many weeks and months they had not had the opportunity to draw for pleasure. Despite this, it was noticeable that during the post interviews the children were more engaged when completing their drawing, happier to talk about it afterwards and had included more details when compared to their pre drawing. During the post interviews all of the children gave it a title, were happy to draw, showed pride in their drawings by showing it to others and were enthusiastic to talk about the things they had drawn. During the post drawings, the drawing of 'self' had increased from three times to ten times and many of the drawings demonstrated positive real life memories or experiences. All of this indicates an increase in confidence, self-assurance and pride. Trust in themselves and the therapeutic relationship was clearly noticeable in the children's participation, willingness and happiness to draw. It could therefore be argued that, after the ten play therapy sessions the children had developed the confidence and ability to express themselves an essential factor in displaying resilience.

The translator also noticed a change in the children's behaviour from that of being out of control, hyperactive and aggressive towards being able to form positive relationships with others, express happiness and showing an increased ability to focus on a given task. In her opinion, play therapy was successful in enhancing resilience because children were able to play with each other, were happy, loved and cared for.

Comparing qualitative and quantitative data

It is interesting to note that both sets of data indicate positive improvements in the children.

Quantitative measurement tool	Mean total data result (n 21)	Qualitative findings from parent interviews, translator interview and play therapist's process notes

SDQ	15% reduction of the total difficulties score	• Parents of nineteen children reported positive improvements in their child's behaviour at home. • Play therapy provided a space for the children to play and socialize. • The behaviour and relationship between the children improved. • Less hitting and swearing by the children was noticed at the end of the 10 sessions.
CRIES	33% PTS symptom reduction	• Children were reported to be happier at home and they themselves drew more happy themes in their post drawings. • Post drawings were focused on the present instead of on the past. • Children were able to regulate their emotions and become calmer.
CYRM Parent	17% increase of resilience	• Parents said the children were now playing with their siblings at home without being aggressive all of the time.
CYRM child	15% increase of resilience	• At the end children were happy to draw, showed pride in what they had made, showed increased confidence and were able to express themselves freely. • Children were excited to attend the session.

Table 2. Mixed Method joint display. A comparison of the total cohort quantitative and qualitative data.

Discussion and findings

Through the quantitative analysis of the SDQ and the CRIES it became noticeable that in both measurements there had been a positive reduction of mean total scores. Masten and Narayan (2012) argue that emotional regulation skills are protective factors against the impact of adverse circumstances when assessing resilience. Therefore, it may be argued that the reduction of total difficulties scores (SDQ) indicated that the children were more in control of their emotions and behaviours which would then result in strengthened resilience. During the qualitative analysis, the deteriorating behaviour in the children since moving to Jordan highlighted a much wider problem. The researcher had expected the majority of behaviour problems to be linked to their experiences of war rather than that of their resettlement experience. Devakumar et al. (2015) also suggests that behaviour problems in Syrian refugee children may be linked to the experience of community breakdowns. I noticed that the living

conditions of the families who were located in poor areas were not child friendly and lacked available spaces for children to socialize and play. Parents had reported how they were afraid to let their children go outside which resulted in children staying inside in a confined space with nothing to do. The play therapy groups enabled the children to build friendships, play together and look forward to something happening again.

Conclusion

The realities of war have become far too common and this is having a major impact on innocent children's lives and development (Hyder, 2005). This research demonstrated that it was not just the experience of war which has had an impact on the children's lives, but also the consequent hardship of resettlement. During the pre-interviews, it became apparent that the children were not coping well. In the early sessions, I noticed how the children were emotionally dysregulated, hypervigilant, aggressive at times and unable to concentrate. In order to help these children adapt in a more positive way to their new life, their resilience needed to be strengthened (Diab et al., 2015). During the play therapy programme the children experienced a trusting therapeutic relationship, became emotionally regulated, built new friendships and engaged in play. All of these are crucial factors when strengthening resilience in children (Alvord and Grados, 2005, Fearn and Howard, 2012, Peltonen et al., 2014). The results of this study therefore support the use of play therapy with Syrian refugee children. It decreased their behavioural/emotional difficulties, reduced symptoms of post-traumatic stress, and enhanced resilience. Parents noticed a change in behaviour at home and the children themselves indicated they were happier, more confident and had built positive friendships as a result of participating. Play is multi-cultural and is seen as every child's right (Yule, 2002). Throughout my six months in Jordan I observed how Syrian children played as much as children from any other nation although it was self-evident that there were very few opportunities for the children in this study to engage in play, apart from the play therapy programme itself. Despite the cultural differences between the therapist and the Syrian children, play therapy was effective. This may be attributed to the variability of play therapy

itself, the cultural sensitivity of the therapist, the inclusion of culturally relevant toys and the freedom the children had to express themselves in ways which were appropriate to their culture.

A mixed method approach was suitable because it provided a comprehensive understanding in answering the research question. However, it is worth noting the limitations of this study. Among them are, the small sample size which means no generalization can be drawn, the lack of a control group that resulted in not being able to compare play therapy with another intervention type, and the use of a translator which may have compromised the validity of information with the researcher not speaking Arabic. The therapist would extol the use of a larger sample size and for further research to be conducted into the use of play therapy with refugee children, to assess how best to strengthen their resilience. However, it is hoped that this study provides answers for humanitarian organisations seeking to introduce programs for refugee children and also for other play therapists who may come into contact with refugee children in the course of their work.

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