PLAY THERAPY INTERVERNTIONS TO BUILD RESILIENCE HELPING CHILDREN AFFECTED BY NATURAL DISASTER IN INDONESIA

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Abstract

Resilience research has informed the practice of play therapy, group play therapy, and group preventive play. Resilience research provides a comprehensive and coordinated approach to working with children and their families facing adversity. Resilience research can help a play therapist identify the child's strengths, family and community resources available, and the processes of joining them in reinforcing the child's immediate ability to cope and longer-term ability to be prepared for the next life challenge. Resilience as a set of interactional mechanisms combines a child's individual qualities with an understanding of how these qualities are enhanced or diminished within the social context of family, other support systems, and culture. This interactional approach has been an important factor in applying resilience research to clinical practice.
Keywords: play therapy, resilience, children, child centered, natural disaster

INTERVENSI TERAPI BERMAIN UNTUK MEMBANGUN RESILIEN ANAK-ANAK TERDAMPAK BENCANA ALAM DI INDONESIA

Abstrak

Penelitian resilien dilakukan dalam terapi bermain individu dan terapi bermain kelompok. Penelitian resilien dilaksanakan melalui pendekatan yang komprehensif dan terkoordinasi untuk menangani anak-anak dan keluarga mereka yang menghadapi kesulitan. Penelitian ini membantu terapis mengidentifikasi kekuatan anak, sumber daya keluarga dan komunitas yang tersedia dan proses menggabungkannya dalam memperkuat kemampuan langsung anak untuk mengatasi masalah dan kemampuan jangka panjang untuk siap menghadapi tantangan hidup berikutnya. Resilien sebagai seperangkat mekanisme interaksi menggabungkan kualitas individu anak dengan pemahaman tentang cara meningkatkan kualitas tersebut atau cara menguranginya dalam konteks sosial keluarga, sistem pendukung lainnya dan budaya. Pendekatan interaksional ini telah menjadi faktor penting dalam menerapkan penelitian resilien pada praktik klinis.
Kata kunci: *play therapy*, resilien, anak, berpusat pada anak centered, bencana alam

I. INTRODUCTION

Indonesia, the world's largest island country located between the Indian and the Pacific Ocean, regularly faces the hardship of many natural disasters, including earthquakes, tsunamis, and volcanic eruptions. There are around 400 volcanoes in Indonesia. A string of volcanoes runs from Sumatra to Flores, with more in Sulawesi and The Moluccas. Of these, 135 are active, about a third of all the world's active volcanoes. Indonesia is one of the most geologically active regions in the world. Sixty-one of these have erupted since 1900. Indonesia must remain in a constant state of natural disaster preparedness, as the country sometimes experiences multiple disasters in a year. On average, at least one major natural disaster has occurred every month since the 2004 tsunami, including earthquakes, tsunamis, volcanic eruptions, and events caused by climate change. Because of its geographic location

along the Pacific Ring of Fire, Indonesia has suffered hundreds of natural disasters, including earthquakes, tsunamis, volcanic eruptions, and floods. After a disaster, children may experience anxiety, fear, sadness, sleep disruption, distressing dreams, irritability, difficulty concentrating, and anger outbursts.

II. LITERATURE REVIEW

Over the last decade, there has been an increase in research and practice that puts children at the center of disaster risk reduction (DRR) efforts (e.g., Back, Cameron, and Tanner, 2009; Haynes & Tanner, 2015; Mitchell et al., 2008). This has come from the recognition that children are a distinctly vulnerable group and require a child-focused agenda that considers their needs and context (Bartlett, 2008; Peek, 2008; UNISDR, 2015).

While it is undoubtedly true that children are vulnerable (e.g., representing 30–50% of deaths in worldwide disasters, WHO 2011) and require protection, research and practice in the developing world are beginning to move beyond this sole assumption. Evidence is growing that involving children in the process itself not only benefits the child but can have a knock-on risk-reducing effect on the family and broader community (e.g., Haynes and Tanner, 2015; Mitchell et al., 2008; Ronan et al., 2015; Save the Children 2008; Tanner, 2010; UNICEF, 2012). The role of children and youth as agents (or 'drivers') of change has been formally acknowledged in the recent global commitment for DRR, the Sendai Framework for Disaster Risk Reduction 2015–2030 (UNISDR 2015).

As the focus on children and disasters grows, there has been an associated increase in research in this sector, one of them being the impact of disasters on children and their psychological recovery by building the resilience of children and their communities and, therefore, are considered the most valuable in reducing disaster vulnerability and losses.
The following section outlines the definitions of CCDRR. This is followed by a brief discussion of children's particular vulnerabilities (physical and psychological) to disaster and how these can be reduced. The review then discusses the progress of CCDRR research, primarily on DRR education and children's participation in DRR. These two distinct areas are compared regarding the aims, methods, research locations, impact, and outcomes. Finally, the priority areas for further research are outlined.

While various terms have been used to reflect children's participation in DRR, such as child-focused and child-led DRR, CCDRR will be used here to reflect a commitment to values linked to protection and children's rights around participation.

The approach is a combination of child participation, including at times child-led, which reflects engaging children directly in the design and delivery of DRR activities in their homes, schools, and communities, and child-focused, which acknowledges the specific needs of children during the design and implementation, including protection needs and rights (Back, Cameron, and Tanner 2009).

Thus, there are two primary objectives in CCDRR: to recognize and address the specific vulnerabilities of children to disaster risks and to empower children by strengthening their skills and creating an enabling environment for them so that they can play an increasingly active role in household and community efforts to reduce the risks and impacts of disasters (Plan International 2010b; Towers et al., 2014).

UNICEF (2014b) recently reported that nearly one-third of the world's population are children. This is a significant change compared to 20 years ago when children made up less than a quarter of the world's population (UNICEF, 1996).

In general, children are regarded as a broadly vulnerable group and often combined with women, people with disabilities, older adults, and sometimes indigenous people in DRR policy and strategy documents at the global to local levels (Mitchell & Borchard, 2014; Peek, 2008). According to WHO (2011), 30– 50% of fatalities arising from natural events are

children. Many post-disaster studies have also documented that children are more likely to get injured, sick, or die following a disaster (Alexander & Magni, 2013; Cao & Kamel, 2011; Glass et al., 1977; Haynes et al., 2009; Ramirez et al., 2005). In addition, the mental health of children is more likely to be affected than adults, including post-traumatic stress disorder, behavioral problems, and depression (Jia et al., 2010; La Greca et al., 2008; Norris et al., 2002; Peek, 2008; Telford et al., 2006; Udwin, 1993).

The interdependent adjustment of children and their parents following disasters has been well documented. Children reported lower disaster exposure and fewer PTS symptoms but similar general distress levels as their parents. Children's and parents' disaster-specific PTS symptoms were the strongest predictor of their general distress. Parents or children's gender did not moderate findings. Although children and parents may respond differently to natural disasters, they may be best understood as dyads. Dyadic approaches to understanding mental health and treating symptoms of distress among disaster survivors and their families following trauma are encouraged. Many survivors of these terrible events have struggled with reactions of traumatic grief, posttraumatic stress disorders. The traumatic events can occur to anyone, at any place, at any time. In addition to the crises, they receive lots of public attention because of the numerous death and wide-scale destruction, that can affect the children at home life and at school.

When a natural disaster devastates an entire community, its survivors are often left with psychological remnants of the event, including general distress and posttraumatic stress (PTS) symptoms such as emotional numbing and avoidance (Norris et al., 2002). However, as proposed by social-ecological and family systems theory (Bronfenbrenner, 1979; Weems & Overstreet, 2008), individuals may be best understood considering their contextual and interpersonal surroundings. Many empirical studies show that disaster survivors do not experience their symptoms in isolation as these events also affect others (e.g., Kelley et al., 2010; Lambert et al., 2014; Salmon & Bryant, 2002; Spell et al., 2008). This is especially relevant for parents and young children who typically go through the post-disaster adjustment period together as an interdependent unit or dyad because physical proximity is required for the child to receive care and the parent to provide care. In addition, Attachment Theory (Bowlby, 1988) suggests that children and parents desire emotional proximity as it ensures survival, provides a sense of security for the child, and fulfills parents' inherent needs to care for their offspring. As such, parent-child dyads have a highly interwoven relationship marked with frequent and prolonged interactions (Cox & Paley, 2003); this presents an example of how a shared disaster experience may set the stage for interdependent mental health, such that one person's psychological disequilibrium is likely tied to the other's (Birmes et al., 2009; Charuvastra & Cloitre, 2008; Gil-Rivas et al., 2010; Hafstad et al., 2010; Li et al., 2010; Polusny et al., 2011; Scheeringa & Zeanah, 2008; Wickrama & Kaspar, 2007).

Considering the inherent dynamics in parent-child relationships, there are several ways through which post-disaster PTS symptoms may spill over to general distress within parent-child dyads. For example, child-rearing presents normative demands on a parent (Deater-Deckard, 2004), but providing care for a child who exhibits PTS symptoms may be distressing (Costa et al., 2006). This may be especially true when parents simultaneously cope with the disaster and its aftermath. Furthermore, parents' natural tendency to provide for and protect their children may make it particularly difficult for them to see their son or daughter exhibit PTS symptoms, leading the parent to feel helpless (Appleyard & Osofsky, 2003) and even more distressed. In addition, whereas children's needs for attention are likely to increase after a disaster, their parent's ability to provide that attention could diminish (Schwerdtfeger & Geoff, 2007), especially as parents may be trying to re-establish lost resources (e.g., shelter, financial security) as well as manage their adjustment. Parents may experience their own PTS symptoms, subjecting children to inadequate parental support (e.g., emotional

unresponsiveness) and poor parenting behaviors (e.g., rejection, avoidance, distancing; Hafstad et al., 2010; Kelley et al., 2010). This, in turn, may make it difficult for children to process and adjust to the traumatic event (Salmon & Bryant, 2002), resulting in heightened distress emotionally and cognitively.

Indeed, parents and children's intertwined relationship (La Greca et al., 2010; Laor et al., 1997; Silverman & La Greca, 2002), as well as the links between their mental health following disasters (Bonanno et al., 2010; Masten & Narayan, 2012; Morris et al., 2012), have been researched extensively. However, two primary shortcomings remain within the literature. First, evidence consistently shows that parents' mental health spills over or contributes to their children's adjustment (Furr et al., 2010; Leen-Feldner et al., 2013; Levine et al., 2005), but findings demonstrating the relevance of children's mental health in their parents' adjustment are less frequent. Learn the signs of children's mental stress to help them cope after a disaster. Experiencing a disaster can cause stress for families. One form of intervention that can be applied to restore the psychological condition of children affected by disasters is play therapy.

Resilience

During the past 25 years, there has been a heightened interest in the study of resilience in children and adolescents and in how this concept might be applied to both clinical and nonclinical populations (Beardless & Podorefsky, 1988; Brooks, 2011; Brooks & Brooks, 2014; Brooks et al., 2012; Brooks & Goldstein, 2001, 2007, 2011; Crenshaw, 2010; Fagan, 1999; Goldstein & Brooks, 2013; Goldstein et al., 2013; Masten, 2001; Prince-Embury & Saklofske, 2013; Werner & Smith, 2001 Concomitantly, there has also been an increased interest in identifying factors involved in the neurobiology and physiology of resilience and adaptation in children (Karatoreos & McEwen, 2013). Studies in play and play therapy have been greatly enhanced over the past 20 years by interpersonal neurobiology research, which has not only expanded our understanding of interactional mechanisms of child development (Siegel, 2010, 2012) but reinforced the role of natural play as the medium of promoting healthy human development (Brown, 2009; Russ, 2004; Sutton-Smith, 2008). Internal human development is mirrored in children's interactions through their experiences and relationships, commonly mediated through natural play.

Through an extensive review of existing resilience studies, Ruther (1999) identified eight resilience mechanisms at work within two broad resilience processes: those reducing risk factors for a child and family, and those increasing the protective factors.

Rutter's (1999) eight therapeutic mechanisms have recently been updated and applied to play therapy (Seymour, 2014) to describe how resilience acts as a therapeutic power of play.

1) Reducing anxiety and increasing problem solving
2) Reducing self-blaming
3) Reducing blaming by others
4) Reducing isolation and enhancing attachment
5) Increasing self-esteem and self-efficacy
6) Increasing creative play to foster creative problem solving.
7) Enhancing nurturing relationships beyond the playroom
8) Learning to make meaning of life's experience.

The child therapist can implement therapeutic interventions that involve all four of the broad functions of natural play identified by Russ (2004) and mentioned earlier: providing a

means of expression for the child, communication, and relationship building; insight and working through; and practicing new forms of expressions, relating, and problem-solving. Subsequent research on resilience identified it as not an individual trait but an interactional process (Rutter, 1987, 1993, 1999, 2007).

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