International Consortium of
PLAY THERAPY ASSOCIATIONS

Integrity • Quality

Disaster Response Guidelines (Position Paper)

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This position paper was developed by the International Consortium of Play Therapy Associations (IC-PTA) task force devoted to disaster response and crisis interventions chaired by Claudio Mochi, Psychologist and Psychotherapist, Registered Play Therapist Supervisor™ with over 20 years of international experience in disaster mental health and trauma work, in collaboration with (in alphabetical order) the Board Member representatives Isabella Cassina, MA, TPS, CAGS, PhD Candidate and Ryoko Honda, MPS, MA, CCP, CP. The proposed items received the approval of IC-PTA Board Members at the November 16, 2023 meeting.

This position paper is based on the authors' extended experience in the field. It is intended to suggest a general framework for working in crisis contexts and disaster response, but cannot under any circumstances be considered exhaustive or a substitute for proper training and supervised experience. All contents of the document are covered by Copyright; any references to the contents must be duly reported [International Consortium of Play Therapy Associations IC-PTA (2023). 'Disaster Response Guidelines (Position Paper)'. Available online at https://www.ic-pta.com/]. *For more information, please contact the IC-PTA by clicking here. The task force is working to develop additional resources in this area. We encourage you to visit the IC-PTA website regularly.*

Adhering to International Guidelines

Play therapy and therapeutic play practitioners who engage in disaster response activities and programs should be familiar with the basic principles of international standards and guidelines such as: the Sphere Standards, IASC Guidelines on Mental Health and Psychosocial Support in Disasters, Conflicts and Other Emergencies (IASC, 2007), Child Protection Minimum Standards, Psychological First Aid and guidelines for creating Child Friendly Spaces, etc. Common principles of these international standards and guidelines include: 1) human rights and equity; 2) participation of local people; 3) do no harm; 4) build on available resources and capacity; 5) integration of support systems; and 6) multi-layered support. We encourage play therapy and therapeutic play practitioners to consult with a critical and constructive approach the websites and documentation provided by the leading humanitarian agencies.

Overview on Crisis Contexts

- Crises are increasingly complex, severe, and protracted. They result from the intersection of three main components: nature of the crisis, individual factors (or people's vulnerability), and conditions of the support system (or level of community's coping capacity).
- The individuals and their context cannot be separated and this is why working on the support system is pivotal.
- Every country (or region) can be potentially in crisis, but the "starting conditions" make the difference in how we face and overcome it (resources available, timing, etc.). In any case, the crisis intervention must be co-created with local partners.
- The general aim of crisis work is to improve people's life conditions and improve future perspectives. Sometimes restoring the "previous" conditions is neither feasible nor optimal. That is why co-creation is even more important.
- Crisis professionals are required to have a combination of a high level of self-awareness, preparation, and flexibility. Critical contexts are unpredictable and potentially traumatic. Professionals must be ready to cope.

(Cassina and Mochi, 2023, p. 12-13)

Basic Considerations for Disaster Response

In the days immediately after a disaster, many survivors are preoccupied with their own losses, uncertainties, and worries. It is rarely the survivor who seeks assistance, they can be reserved and uncommunicative as they concentrate on their own needs. This is a natural response and survivors often do not have the energy to venture out to programs that have been established. "Post-disaster interventions are extremely time and space sensitive and should include a preparatory and an advanced phase. The first lays the ground for the success of the second" (Mochi and Cassina, forthcoming 2024). "The intervention should start from the less specialized activities addressed to the larger population, to the most refined forms of treatment addressed to smaller groups" (op. cit.).

At the initial stages, the main goal of play therapy and therapeutic play practitioners would be to make contact. This is accomplished by asking about and helping survivors acquire their basic needs (such as blankets, water, or clothing) and assisting with challenging tasks (such as accompanying them as they identify deceased loved ones). Empathy is critical. The relationships formed during this time lay the foundation for more effective intervention later. In subsequent weeks, some survivors shut down or become emotionally reactive. A sense of helplessness and hopelessness can arise. Others show their

resilience and seem ready for relationships with helping professionals. Although most remain in great need of practical support, they often are more approachable after the initial influx of external rescuers, helpers, and media has dissipated. We would like all play therapy and therapeutic play practitioners to consider 4 key points about crisis interventions:

1. *The hierarchy of needs must be respected*. Physiological and basic survival needs have priority as they are immediate of personal concern. It is tempting to assume that as mental health or humanitarian professionals, we know what is needed in critical circumstances (Mochi and VanFleet, 2009), but every situation and personal story is unique. Crises require understanding, not assuming. In complex situations, needs' assessment never ends and information is gathered across different circumstances.
2. *Safety comes first*. If a person perceives the context as threatening or unsafe, his/her major preoccupation will be to protect him/herself. This can happen when he/she is completely overwhelmed, suspicious, does not know what to expect from the situation, or is simply new to certain experiences. We cannot make assumptions about people's sense of safety since our process to detect danger or threat works below our level of consciousness (Porges, 2011: 20). We can learn, explore, connect with others, play, create, and access our resources only when we feel safe.
3. *Humans are social beings*. Individuals depend on each other to gain support, safety, and for adapting to new and difficult situations. Healthy interactions are our protective factor and as Ludy-Dobson and Perry (2010: 26–27) say, "the presence of familiar people projecting the social-emotional cues of acceptance, understanding, compassion, and empathy calm the stress response of the individual".
4. *Crisis professionals cannot intervene alone*. In crisis contexts, local actors already exist, and "real help is not that which makes people feel useful, but that which makes local people free and autonomous" (Naiaretti et al., 2009: 17). This approach finds support in the wider concept of "social change".

> Social change is only possible when people in a community have a sense of their own capacity to act, when they become aware of their resources and see themselves as able to re-make the world in which they live. The task of the [play and] expressive arts change agent is not to enter a community with a pre-existing plan, attempting to steer community action in an anticipated direction. (Levine, 2011: 28)

(Cassina and Mochi, 2023, p. 18-19)

Role of Play Therapy and Therapeutic Play Practitioners

As mentioned at the beginning of this paper, the most important and basic principle is “do no harm”. While play therapy and therapeutic play practitioners understand the value of play-based approaches for traumatized children, it can be potentially damaging to intervene without proper engagement of the survivor community. Because every disaster and every survivor is unique, the assumption that mental health providers know what is needed in post-disaster situations must be avoided. It is best to ask survivors about their needs and to start at that point to help survivors achieve them. Practitioners who assist at disasters must consider ways to assist families, schools, and the community-at-large in order to ensure that children receive the best care. Basic survival and daily living needs take precedence over psychosocial interventions.

The key factors in determining psychic trauma and malfunctioning are overwhelming, threatening and harmful events together with the perception of lack of control, therefore the supporting process should start with the establishment of an environment that has some predictability and safety. When considering mental health care for children, the priority must be to reduce stress and provide effective support to the adults around them, who are the ones who can provide the most reassurance to the children. Local community members must be included from the start. Many survivors have abilities that can be tapped for creating interventions, programs, and securing materials. Survivors know the local culture and can be valuable in identifying and addressing the needs of the community more readily. This is another reason to engage and empower them from the start. Continuity is essential.

Play therapy and therapeutic play practitioners need to link community resources, such as local therapists, teachers, athletic coaches, and others who work with children. Play-based interventions need to be coordinated from the beginning with those who will continue them. Practitioners must examine their actions, activities and programs based on a medium to long-term perspective, even when they will be in the field for a short period of time. It is necessary to always keep in mind that interventions must be flexible, creatively devised, and adapted to the current situation and culture in order to help individuals regain their original strengths.

Play therapy should often not be conducted immediately after disaster and it is not possible nor appropriate when practitioners leave within a few weeks. If play therapy and therapeutic play practitioners have limited time to work at disaster sites, they can focus on coordinating with parents and local professionals so that play-based interventions are done in the context of the children’s ongoing relationships. Capacity building should not be conducted in the absence of time, skill and preparation of the professional or appropriate connections in the area. If and when conditions are conducive to training programs, it will be important to use a culturally appropriate, participatory and hands-on format. Capacity building provides an opportunity for participants from the survivor community but should not be an imposition dictated by the mere will and time available to the play therapy or therapeutic play

practitioners. Abstaining is better than imposing. The impact of disasters remains long after many of the external helpers are gone. According to the principle of sustainability and out of respect, the best contributions leave something behind, such as locally-run psychosocial programs and well-trained and supervised local helpers and therapists.

At the risk of sounding repetitive, we would like to emphasize that play therapy and therapeutic play practitioners who intervene in crisis settings must have highly developed personal qualities and professional skills: among other things, they must be trained in multiple Play Therapy methodologies by approved providers and/or institutions with a relevant and recognized tradition in the field, they must likewise receive regular supervision by experienced play therapy/therapeutic play and crisis work specialists, they must have clinical experience in trauma treatment, project development and psychosocial interventions, they must have knowledge and marked cultural sensitivity especially when working abroad, they must fit into the context of a larger program than a single intervention and this implies having strong local connections.

Reasons for Applying Play-Based Interventions in Crisis

- Play is a universal language and, applied at the ideal time, has the advantage of creating a bridge between people while respecting individuals, communities, and cultures.
- "Children use play to work through and master quite complex psychological difficulties of the past and present" (Bettelheim, 1987). "From a child's play we can gain understanding of how he sees and construes the world – what he would like it to be, what his concerns and problems are" (op. cit.). "Play is [also] the child's most useful tool for preparing himself for the future and its tasks" (op. cit.).
- Play is fundamental for children and adults. Brown (Brown and Vaughan, 2009) argues that play unleashes human potential at every stage of life. Play "is a crucial dynamic for healthy physical, emotional, behavioural, social and intellectual development at all ages" (Elkind, 2007: 4). It is a source for learning new skills, and it can be useful in fostering personal growth and overcoming psychological problems.
- Play contains all the essential ingredients that foster Neuroplasticity (Cozolino, 2010; Wheeler and Dillman Taylor, 2016). In fact, play "promotes consistency and motivation to practice, the creation of a safe environment, the development of trusting relationships, and allows emotional involvement by exposing the player to an ideal level of stimulation" (Mochi and Cassina, 2021: 32).

(Cassina and Mochi, 2023, p. 20-21)

Common Symptoms in Children

Among the most common symptoms for infants following a disaster are that they might become very dependent, cling to parents, fear separation, have arousal symptoms such as being easily startled and irritable, and crying and a deep sense of shame. Preschoolers are likely to report nightmares of monsters, have a tendency to relive trauma in their play without realizing they are doing it, display regressive behaviors (encopresis, enuresis) and somatic complaints (headaches and stomachaches). Symptoms in school-age children include a reduced interest in customary activities, a foreshortened sense of the future which may be expressed, as well as omen formation (belief in the ability to predict future calamities), verbal or physical aggression, elaborate post traumatic play with possible involvement of friends in the reenactment, and guilt over actions taken. Adolescents, unlike younger children, might show adult like PTSD symptoms including flashbacks, preoccupation with concerns secondary to the traumatic event (parental punishment), increased drug and alcohol use, and fighting with parents and/or siblings.

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