INTRODUCTION

MENTAL HEALTH APPROACHES TO REDUCE THE IMPACT OF POSTTRAUMATIC STRESS OF NATURAL DISASTERS

SECOND RESPONSE AND PLAYSHOPS

When natural disasters strike, emergency organizations leap into action to address immediate need. First responders attend to the essential restoration of safety, shelter, food, and water. Media attention often focuses on the dead and injured while financial resources are allocated for the repair of the external landscape and infrastructure.

But little attention is paid to the inner landscape of victims of natural disasters. Besides seeing their communities chaotically destroyed, victims, especially children, are also traumatized by fear, grief, helplessness and other debilitating emotions.

During these times of disaster response, mental health is often marginalized; moreover, few psychologically oriented preventative measures have emerged with the potential to prepare communities for the overwhelming psychological impact of large-scale disasters.

Since its inception in the mid 1990's, the Fortunate Blessings Foundation has conducted seminars, workshops and conferences aimed at helping individuals adopt simple lifestyle practices to maintain health and reduce the incidence of preventable disease.

In 2004, following the massive tsunami in Indonesia, FBF launched Second Response, an initiative created specifically to address the post traumatic stress of victims of disasters. At the invitation of medical schools, government officials, health ministers and various educational organizations throughout disaster stricken areas, Second Response facilitators have deployed around the world, wherever disaster strikes, both working with children and building local capacity.

Our teams of trained mental health professionals enter the areas most severely impacted in order to help kids safely release the stress, anxiety, and fear pent up

after a traumatizing event, and gets them back into safe relationships with their friends and the environment. To date, Second Response has reached more than 100,000 children and conducted training in communities around the world from the Fukushima disaster in Japan to the coastal villages of Indonesia and the Philippines, and throughout the USA.

In the years that follow a disaster, most communities are burdened with the needs of victims of PTSD, one of the more serious repercussions of trauma. The number of these cases could have been reduced through effective interventions; however, more research is needed to demonstrate the efficacy of Second Response's approach and the enormous economic benefit preventative interventions like this can provide to affected communities.

What follows is a White Paper outlining various mental health approaches to disaster-related trauma and, in particular, the unique perspective of Second Response and PLAYshops.

What is Second Response?

Second Response is an initiative of the Fortunate Blessings Foundation, Inc., a US based 501(c)(3) organization providing disaster relief care focused on reducing the effects of post-trauma pathology, particularly post-traumatic stress disorder (PTSD) and other trauma-related disorders.

When the initial emergency phase of a disaster shifts to the recovery phase, and a sense of stability and safety returns to the impacted area, the trained mental health professionals in Second Response Trauma Teams conduct programs such as PLAYshops to support anyone dealing with emotional issues that could develop into more serious problems a few months later. Second Response operates on the conviction that unless the physical energies accompanying deeply repressed emotions are addressed sensitively, a burden of complex psychosomatic issues can result. Second Response's body-centered work is vitally different from the psychological counseling that is usually provided for traumatized children.

Second Response Mission

The mission of Second Response is that the methodologies our teams develop become an effective, global standard of disaster relief care for the reduction of the effects of post-trauma pathology, particularly post-traumatic stress disorder (PTSD) and other trauma-related disorders.

Second Response Goal

The goal of Second Response is to reduce trauma-related disorders and post-trauma symptomatology in children and adults, including but not limited to post-traumatic stress disorder, major depression, somatic complaints, generalized anxiety, separation anxiety, and impairments in daily social and occupational functioning.

Second Response Tenets

1. We believe that the use of body-centered therapies, specifically our own carefully crafted PLAYshops, can effectively reduce the probability of post-trauma pathology from developing in children and adults following a traumatic event.

2. We believe that body-centered therapies such as PLAYshops are transculturally appropriate, developmentally universal, and socially congruent methods to utilize with children and adults in the United States and foreign countries alike.

3. We believe that the existing repertoire of trauma-focused therapies – largely cognitive-based psychological and pharmacological treatments – address only part of

the pathology basis of trauma; therefore, the repertoire will benefit greatly by the inclusion of somatic based approaches. This is particularly important when considering the unique needs of children.

Second Response Strategies

* To conduct PLAYshops wherever needed in the world, and document their impact on populations.

* To build sustainable capacity on the ground through the training of local caregivers, social workers, teachers, parents, health ministries, and mental health providers so that future events can be met with similar and effective responses.

* To better understand service gaps within disaster relief services, particularly on a global scale, and to collaborate with effective organizations to deliver and provide emotional support to children and adults in areas where needed.

* To have a number of skilled Second Response Trainers in place at all times, available to deploy wherever an increased local capacity is needed.

* To continue developing awareness of cultural landscapes, signals, and meanings to ensure the highest level of respect and inclusion for all cultural groups and the smallest degree of hegemonic bias.

The Second Response Trauma Team

The Second Response Trauma Team consists of three to six mental health professionals extensively trained in disaster work, trauma-related disorders, and body-centered therapies dealing with grief and loss. The Second Response Trauma Team is able to respond swiftly following the initial emergency phase of a natural or human-caused disaster anywhere in the world. They travel to areas most severely impacted and provide body-centered interventions in the interest of preventing and reducing the effects of post-trauma pathology, particularly post-traumatic stress disorder (PTSD). To promote independent healing, Second Response also trains local community volunteers, before disaster strikes, to build on-the-ground capacity that is both cost-effective and easily replicated.

Background: When Disaster Strikes

We have all seen the faces of frightened children in the aftermath of a traumatic event – be it a natural disaster such as an earthquake, flood or fire, or a human-made disaster such as a terrorist act, train wreck, industrial explosion, plane crash, or war. Their tired faces and unsteady movements add years to their biological age and reflect the shock of having been displaced from home, family, community, and a sense of safety. When a

natural or human-made disaster occurs in communities with pre-existing unrest, the consequences are that much graver.

When a disaster strikes a community, what people remember most vividly are the images of uprooted buildings, howling sirens, and first responders rapidly gathering around the wrecked community in an effort to save and rebuild. What is not always so apparent is the internal, silent suffering of the survivors whose sense of safety, belonging, and self has been shaken to the core. Children have more difficulty than adults in verbalizing emotions. While both groups may have trouble expressing their needs following a traumatic event, children are often further constrained to non-verbal, somatic means of expression.

Traditionally the literature on trauma has focused largely on survivors' experience of helplessness and fear as the predominant response. More recently, researchers have increasingly begun discussing the role of anger and hostility as a major component of trauma symptomatology. Anger and irritability are often more prevalent in children, but precisely because social norms often cause their adult counterparts to mute their anger and children often model adult emotional responses, they too end up repressing their emotions. Anger is a natural, adaptive emotion in the face of danger, but more socially acceptable emotions such as sadness and anxiety may surface instead. Anger can be directed both externally and internally. Children exposed to terror are more likely to engage in risk behaviors and some studies suggest that following natural disasters, rates of suicides have risen.

Normal response to danger versus PTSD

What is the difference between a normal response to danger and post-traumatic stress disorder? In the words of the National Institutes of Mental Health,

> When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This "fight-or-flight" response is a healthy reaction meant to protect a person from harm. But in post-traumatic stress disorder (PTSD), this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they're no longer in danger.
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> PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed; the harm may have happened to a loved one; or the person may have witnessed a harmful event that happened to loved ones or strangers.
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> PTSD was first brought to public attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes.

In other words, distress is a natural response to danger; post-traumatic stress disorder may result when the stress is not dealt with properly.

It is common for symptoms of distress after trauma to diminish naturally over time. In fact, a significant percentage of survivors typically return to pre-trauma baseline levels of functioning and psychosocial wellbeing without mental health intervention. So why doesn't everyone? Factors contributing to the development of PTSD may include an individual's premorbid psychological state; chronic stressors; coping style; personality type; engagement with community; and of course the nature and intensity of the traumatic event as experienced by the individual. Other factors include extreme sympathetic response exemplified by increased cortisol and hyper-arousal; freezing responses; and attachment issues. Research shows that most of these factors can have also an impact on the recovery process.

As *psychologically* terrifying as trauma is, the *biological* shifts occurring in the brain and body to adapt to trauma are equally as real. Although trauma causes a degree of impairment in the lives of those inflicted by life-threatening pain, on a fundamental level it is more accurate to say that those with PTSD have "high-functioning brains trapped in survival mode," as described by Julian Ford and others.

Two Requirements for Healing

"Holding" and "*temenos*" are therapeutic concepts defined in 1955 by English psychoanalyst Donald Winnicott, a leader in the field of object relations theory in the early 20th century.

Holding: Winnicott defined the term "holding" as what is achieved during infancy through the mother's nurturance and physical contact while simultaneously allowing the infant to explore the world, by providing a safe and supportive home base to return to. In "holding," emotions can be fully expressed and the child learns she can openly process joyful as well as painful experiences. Developmental psychologists since Winnicott's time have supported this theory that children are best able to thrive, explore, and take risks when they develop a healthy relationship with a caregiver who serves as a secure base, much like a firmly rooted plant with the freedom and vivacity to flourish above ground.

Temenos: Winnicott paralleled parental holding with a similar therapeutic concept he coined "*temenos*," the sacred psychological space created by therapists for patients to safely unravel the layers of their deepest suffering. In the aftermath of a traumatic event, children rely heavily on their sense of holding, yet the rhythm of that pattern is disrupted. After trauma, it is common for children to protect their caregivers by remaining silent and unobtrusive; caregivers may also be preoccupied or overwhelmed with their own recovery, making it even more likely that the needs of children go unnoticed. In some situations, children may be separated from their caregivers without any sign of possible reunification.

Professionals and volunteers who are trained to act as temporary "holders" and creators of "*temenos*" are thus valuable assets in the recovery phase following a disaster, and the rebuilding of psychosocial well-being; of course, the more important task is to connect children with loved ones or surviving family members where possible.

From Treatment to Prevention

In its publication *Prevention of Mental Disorders,* the World Health Organization (WHO) emphasizes that in order to "reduce the health, social, and economic burdens of mental disorders it is essential that countries and regions pay greater attention to prevention and promotion in mental health." It goes on to say that priority should be given to preventive programs that can demonstrate empirical evidence of their effectiveness.

However, the majority of the current literature pertaining to mental health interventions is comprised of evidence for the efficacy of PTSD *treatment* rather than prevention. There is a fairly well-established pool of peer-reviewed articles citing empirically supported treatments such as Cognitive Behavioral Therapy (CBT) as having efficacious results in the treatment of PTSD within a mixed demographic and severity of sustained trauma; yet, in all our knowledge of trauma pathologies and methods of treating anxiety and stress, there is comparably less progress in the field of PTSD *prevention*. Even when discussed, the term "prevention" commonly refers to a predominantly educational component geared towards individuals who have not yet experienced trauma. This is labeled "primary pre-trauma" prevention of PTSD and distinguishes itself from "secondary prevention," which targets individuals who have sustained trauma and have a higher risk of developing clinically diagnosable issues compared with their non-trauma-exposed counterparts.

In this paper, "prevention" refers to secondary prevention methods, i.e. **interventions implemented to reduce the risk of post-trauma pathology as soon as possible after an individual has been exposed to a traumatic event.**

Due to the unpredictable nature of traumatic events, primary prevention randomized control studies are challenging to conduct and implement. When it has been attempted, primary prevention is categorized under "resilience-building programs," defined in a 2012 systematic review as "any kind of structured psychological skills training delivered to an individual or group of people with the aim of improving psychological functioning or well-being." Not only is this a broad inclusionary criterion, but the study filtered the initial yield of 15,014 studies down to a mere seven that were identified as relevant, all of which fell under the psych-education category. Seven studies are not sufficient to instill confidence – in responders or survivors – that the methods used will effectively aid in the healing process.

Although there are more *secondary* prevention studies, the bulk of the research focuses on psych-education methods intended to "normalize" stress responses. This includes teaching coping strategies or encouraging pharmaceutical interventions such as select serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors. The literature also lacks an expressed optimism that the most common preventive methods currently in the field are effective in reducing the pathological impact of trauma.

One of the more interesting programs developed by psychologist Rony Berger, PhD is the ERASE-STRESS resiliency program, tested in four randomized, controlled trials, following natural disasters in Sri Lanka, the United States (Hurricane Katrina), Turkey, Thailand, China, and Tanzania. Berger integrates art therapy, meditative, bio-energetic, and body-based approaches to aid in the processing of trauma.

Second Response is at the forefront of a movement to change the current state of post-trauma disaster work as pioneers in reducing and preventing trauma-related disorders and post-trauma symptomatology in children and adults, using state-of-the-art body-centered therapies which address the body's somatic responses to trauma. One of the goals of this paper is to provide an unbiased a perspective by letting the research and empirically validated data speak for itself. In the following section, some of the most commonly employed preventive interventions are explored.

Existing Approaches: Relief or Regression?

A number of approaches to post-disaster intervention currently exist. These include:

Psychological First Aid (PFA): Originally designed for simple application in the field following a disaster, Psychological First Aid (PFA) is one of the most widespread prevention relief methods developed by the World Health Organization and the Red Cross, then adopted by the International Society for Traumatic Stress Studies (ISTSS) as a systematic approach to assist survivors of trauma in the hours immediately after exposure. PFA has also been used in non-disaster settings such as hospital trauma centers, rape crisis centers and combat zones. PFA has eight core actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services. In addition to the first wave of services, Secondary Psychological Assistance was developed to serve as an adjunct follow-up for certain individuals requiring sustained support.

Psychological Debriefing (PD): Generally applied within the first few days after exposure to trauma and lasting 3-4 hours, Psychological Debriefing (PD) describes itself as a universally appropriate preventive intervention aimed at reducing initial distress as well as promoting long-term functioning through the use of psych-education and teaching of coping strategies. Psychological Debriefing is considered a variant of PFA

and is often referred to as the standard of care for disaster and a "prophylactic" crisis response. The structure of PD is often shaped by the following markers: educate the survivor on symptoms they might experience as a result of trauma exposure; normalize the survivor's emotional expressions; and encourage the sharing of emotional responses. Despite its proclamations of having zero iatrogenic risk, PD has consistently been criticized for its widely accepted use despite growing evidence suggesting it is not only ineffective but can be associated with poorer psychological outcomes. Further complicating matters is the manner in which prophylactic debriefing is typically utilized. Contrary to early interventions (such as Cognitive Behavioral Therapy), which are provided upon the request for psychological help for individuals who exhibit clinically significant presentations, PD is typically applied immediately following trauma as part of organizational mandates to safeguard against litigation. Many practitioners find it disturbing that PD, with its increasing evidence of contraindication, is mandated in so many organizations.

Critical Incident Stress Debriefing (CISD): A descendant of PD, Critical Incident Stress Debriefing (CISD) distinguishes itself through the use of group-based interventions and a structured didactic component. As defined by CISD prescripts, anyone with a master's level degree in a field "even remotely related" is qualified to implement CISD. The result is often a group of "peer providers" who practice CISD following a 3- to 4-day workshop with no standards for evaluation of competence. CISD has also come under scrutiny for similar reasons as its predecessor, with the Russian workshop of the North Atlantic Treaty Organization (NATO) reporting "there is still no consensus on the role, if any, of very acute interventions. Classic CISD debriefing can no longer be recommended."

The normalization of distress employed in PFA, PD, and CISD presumes a great deal about how survivors feel society expects them to act – in other words, how they believe they should be experiencing pain. The psych-education component generates the expectation of a pathological response in already hyper-impressionable individuals days after a trauma.

In a review of eight randomized trials studying the efficacy of PD in the prevention of PTSD, normalization was actually found to prolong the process of recovery. Although most Western practitioners would agree that eventually confronting (rather than avoiding) aversive emotions is favorable and associated with positive outcomes, the study suggests that the extremely brief nature of this early intervention may heighten, rather than alleviate, distress symptoms. Thus, while the intention is honorable, the ultimate impact is arguably more important. According to the research, the integrity of PD, and CISD are at best marginally effective and at worst harmful to the psychological wellbeing of individuals after trauma. Emerging research suggests PFA may also be problematic.

Traditional Talk Therapy: David Berceli, Ph.D., an internationally recognized expert in the areas of trauma intervention and conflict resolution, states that "trauma-induced behavior cannot be rectified with the use of traditional crisis intervention techniques that depend on logical processing because trauma behavior is an illogical, instinctual response not under the control of the rational brain." Many trauma researchers and clinicians agree that being able to tell the story is an important part of trauma processing, but often, using traditional Western "talk therapy" can also be high-risk for individuals in a state of hyper-arousal. The potential to overwhelm the nervous system and re-traumatize is a real possibility and counterproductive to facilitating a physiological restoration to a state of calm.

The field of PTSD prevention is still in its infancy and has extremely promising growth potential. Second Response PLAYshops have already repeatedly shown to be efficacious at safely releasing deeply held emotions.

The PLAYshops Difference

Second Response created PLAYshops in response to the lack of effective, transcultural, secondary prevention methods specifically addressing the needs of children in the short-term aftermath of a traumatic event. Very little research exists to guide and develop such methods, which is disturbing considering the estimated ten million children per year who are exposed to a severe traumatic event in the United States alone.

PLAYshops are 30- to 45-minute facilitated group experiences designed to create the "*temenos*" that has been ruptured or exacerbated by a disaster and reconnect children with their vibrant selves, what C.G. Jung calls "the Self." What is groundbreaking in the PLAYshop's approach is its **non-verbal, body-centered exercises** intended for children to effortlessly release fear, anger and grief from their bodies by accessing their innate ability to play. If these emotions are buried in their bodies, often the case following trauma, children's "Selves" become imprisoned and their developmental growth suffers as well as their capacity for happiness.

PLAYshops consist of ten or more exercises that are presented and experienced as simple fun and games. These exercises restore fundamental bodily rhythms with clapping and stomping. They reestablish deep, steady breathing in mimicked play. The alternating of wiggling and loosening with intentional tightening and stiffening of the body releases unconscious muscular tension or holding. This group of alternating exercises, grounded in both theater training and scientific research, is designed to improve circulation and respiration, revitalize muscle tone, restore flexibility to joints, and unclog stagnated blood supply. Encouraging deep laughter, wailing, screaming and creative improvisation frees suppressed cries of anguish and clears the body of the trapped emotions of fear and pain. While children often separate from their emotions and body in response to fear, PLAYshop exercises bring them back into their bodies,

help them reconnect the fear-response emotions, and thus promote full expression and release of the traumatic energy.

Why PLAYshops Work: The Role of the Body

PLAYshops are rooted in the theories and methods of body-centered, somatically oriented, movement-based play therapies. These modalities help with the creation of what body-centered therapists call "potential space": the space where clients are allowed to regress and fully delve into pretend play, using objects and metaphors. In doing so, they are able to work through experiences that might otherwise be left unexpressed and unaddressed.

Many forms of therapy neglect to include the body as part of the treatment process, but an increasing number of research studies suggest that the psychological process is invariably tied to the body. Trauma is often thought of as being *embodied*, in other words, afflicted individuals hold implicit memories of the trauma in both their minds and bodies; even those who believe trauma manifests less somatically, including the most conservative psychologists, can still agree that there is tremendous value in understanding the physiological aspects of trauma.

Following are a few of the many resources exploring the body-mind connection in trauma.

- In her book *The Body Remembers*, Babette Rothschild, a psychotherapist and somatic trauma specialist, takes a psychophysiological approach to trauma. She suggests that existing treatments are adequate for treating the traumatized mind, but not the traumatized body, where a lot of pain and stress is stored. She credits her work to the research of Bessel van der Kolk, a psychiatrist most known for his work in attachment theory and neurobiological components of trauma. In van der Kolk's 1994 article in the Harvard Review of Psychiatry, *The Body Keeps the Score*, he states, "After years and years of working in this and grappling with this, the conclusion that many of us are coming to is that in order to help these animal, frozen, inappropriate, fight/flight/freeze responses to come to an end, you need to work with people's bodily responses. You need to help their body to feel like it's over." Antonio Damasio, a leading neuroscientist, was also part of the groundwork for Rothschild's observations due to his significant contribution to the field of psychiatry by offering a neurobiological theory about the relationship between mind, emotions, and body.

- The Polyvagal Theory, proposed by Stephen Porges of the Brain-Body Center at the University of Illinois, posits that there is a connection between physiology and behavior, specifically the influence of the phylogenetic system (the vagus nerve in particular) on neural structures regulating the heart and consequently behavior.

Porges states that when children feel unsafe, their behavioral response exists on a visceral level in the nervous system, which he calls "neuroception" or "gut response." Neuroception is the nervous system's way of evaluating risk and tracking danger. When it detects safety, the physiological response of the body resembles what we would label pro-social behavior; in the presence of danger, defense strategies of "fight, flight, or freeze" surface. Children, particularly those who have experienced chronic maltreatment or trauma, not only develop unreliable neuroceptions but also begin to shift the way they assess their environment, often relying on nonverbal cues and focusing their attention on the tone, pitch and rhythm of people's voices, mannerisms and facial expressions. This shift resembles the behavior of infants who lack the capacity to form coherent language. For this reason, Porges recommends therapeutic methods that use visceral components to cultivate "interpersonal rhythms" and recalibrate the gut response in children. PLAYshops incorporate these findings by including simple clapping games, rhythmic stomping, and marching as a way of restoring rhythm, stability, and control, which helps children balance what Constantin Stanislavski referred to as, "internal tempo-rhythm." Throughout the experience, Children are encouraged to soften their knees, relax their muscles and breathe deeply. Porges suggests that the parasympathetic nervous system is frozen as a defense response to shock; this component of the PLAYshop especially helps it to reactivate.

- Neuropsychologist Allan Schore, a pioneer in the field of biopsychosocial approaches, argues in his milestone book *Affect Regulation and the Origin of the Self* that attachment style in infancy influences the development of brain structure. He uses attachment and psychoanalytic theories such as the previously mentioned "temenos" to explain not only the importance of the bond between infant and mother, but that early interpersonal style follows an individual into adulthood. Schore suggests that this psychological process also occurs on a cellular level and the interweaving of these psychological and neurobiological levels is critical to a child's capacity to self-regulate emotions, develop accurate neuroceptions, and cope with stress. In the same vein as Porges, Schore discovered that because emotion regulation is moderated by pathways in the right hemisphere of the brain, interventions that rely primarily on cognitive abilities such as supportive counseling, traditional psychotherapy, or cognitive restructuring are often ineffective in treating trauma.

The Vital Role of Movement

Movement, or motion, is fundamentally linked to emotion. Dating back to 1579, the word "emotion" is adapted from the Old French word *esmovoir,* meaning, "to set in motion." Physiologically, strong emotions literally move the body and may be followed by changes such as increased heartbeat and respiration, dilated pupils, laughing, active gesturing, or crying.

Mirroring: Perhaps one of the best known therapeutic interventions that illustrates the mind-body connection is Dance and Movement Therapy (DMT), defined as "the psychotherapeutic use of movement to further the emotional, cognitive, physical, and social integration of the individual." One technique used in movement-based therapies such as DMT is *mirroring*, which consists of imitating movements and expressions. Mirroring helps with the enhancement of empathy in addition to emotional understanding, and cognitive, physical, and social functioning. Charles Darwin, in his book *The Expression of Emotion in Man and Animals*, wrote that the very first type of communication is through the mirroring of bodily and facial expressions between mother and infant. Throughout PLAYshop exercises, participants are invited to mimic the emotions and behaviors of the facilitators. In this manner, mirroring is used as a way of regulating emotion through granting children permission to express not just their joy and laughter but their frustration, anger, and sadness as well. This approach facilitates unconditional acceptance of the range of reactions to trauma, rather than insisting they be dismissed or, worse, denied altogether; furthermore, it resists the dominant tendency to discuss or explain our experience.

Synchrony: Dance therapist Janet Adler developed a movement-based technique she named *synchrony* in her work with autistic children. Inspired by Mary Whitehouse's work on Authentic Movement, synchrony encourages the use of movement as a means of communication to connect with the self and others. It is defined as a "harmonious and simultaneous responsiveness without merger or loss of boundaries or self/object differentiation."

The Vital Role of Play

Unlike adults, for whom flashbacks are common, children more often process traumatic experience through enactment; thus, they are more inclined to act out rather than visualize or discuss their experiences. Play, on an elemental and innate level, facilitates "*temenos*" and allows children to express their inner psyche. In studies examining children who witness domestic violence, play therapy is shown to be an effective intervention because it enhances children's sense of control and provides organization to their experiences, both of which are undermined in the face of trauma.

- In 1995, Jasenka Roje, M.F.T. and colleagues used art therapy with children in an elementary school after an earthquake in Los Angeles, California and reported the intervention was highly effective in directing children toward normal functioning.

- In 1986, Rosemarie Galante, M.A. and Dario Foa, M.D. conducted art and play therapy with 300 elementary students in Italy once a month following an earthquake and reported the intervention significantly reduced the intensity of post-traumatic stress symptoms after seven months and the children's fears of earthquakes after 12 months.

- In 2002, the Happy Growth therapy program was created as part of the PTSD Children's Psychological Recovery project sponsored by the National Science Council in Taiwan in response to the September 1999 7.3 earthquake. The school-based program incorporates play, art, and storytelling to help children process trauma without being limited to their verbal ability.

Second Response facilitators are aware of children's need to loosen their joints, shake their legs, swirl their hips, laugh, scream, bounce and, quite simply, play. Jean Piaget, the iconic Swiss developmental psychologist, wrote in 1951:

> Children protect themselves from the tyranny of the world, from the prison of categorization, by using symbolic play as a dynamic, individual mode to preserve subjective feelings when collective language proves inadequate.

Friedrich Schiller, the 18th-century German poet described play as an overflow of energy over and above what is required for survival. Nanette Auerhahn and Dori Laub highlight the idea that play is more likely to occur when individuals are living, rather than simply surviving, in a 1987 article on the psychological and social impact of the Holocaust. The authors argue that if traumatized adults want to begin the healing process, they must first remember how to play. They explain that when a traumatized generation displays collective skepticism and disillusionment towards humanity, the capacity for mirroring and empathy – traits fundamental to creating and maintaining interpersonal relationships – are lowered, and social connectedness is weakened, leading to a collective internal loneliness that characterizes trauma-related disorders.

Cross-Cultural Considerations

Fear is considered by many researchers to be one of the only emotions expressed and perceived universally and across all cultures. Humans have the capacity to experience fear, helplessness, or horror when exposed to traumatic stress regardless of culture or racial/ethnic group; the difference between cultures is the way fear is conceptualized and how individuals respond. These differences often rest in where a group is located on the spectrum between individualism and collectivism, which can subsequently affect the assessment and treatment of trauma-related disorders.

In his 2011 book *Crazy Like Us: The Globalization of the American Psyche*, journalist Ethan Watters states that the influence of American culture does not stop at the golden arches or in Nike factories, but extends to the human psyche via the internationally recognized Diagnostic and Statistical Manual (DSM) of Mental Disorders, created by U.S. mental health professionals. Citing several devastating disasters around the world, Watters argues that interventions such as Psychological First Aid, often delivered by Western-trained providers, makes presumptions of the way people experience pain, and consequently the process by which they heal.

Two components of post-traumatic stress most commonly found in non-Western individuals compared to their Western counterparts are *somatization* and *dissociation*. In the DSM-IV TR, these were either missing from the diagnostic criteria or the focus was on only one symptom. The current DSM-V has incorporated and placed more weight on somatic and dissociation symptoms to reflect the increasingly consistent finding that post-traumatic stress and related disorders are not just chronic anxiety, but a rupture to the body's natural way of self- regulating. Somatization of trauma symptoms is commonly found in Asian and Central American refugees, while dissociation has been observed in Turkish women (particularly survivors of childhood sexual abuse), Japanese women, and Cambodian refugees.

Cross-culturally, post-traumatic responses do not necessarily include symptoms such as flashbacks and nightmares, as described by the DSM-IV TR. Survivors of war-torn Afghanistan have difficulty translating their dominant symptom to English; the closest phrase they can find to describe their internal state is "nervous anger." In El Salvador, a country that has seen its share of civil unrest, a common response to trauma can only be described as a type of "internal heat that is very intense." In Cambodia, rather than the DSM-defined re-experiencing of symptoms, survivors often say "angry spirits" visit them at night. Among East Africans, much of their pain manifests in the body, such as feeling exhausted or having sudden physical reactions when reminded of the traumatic event.

The vast majority of existing mental health treatments that are recognized and utilized are based on Western ideals of individualism, rather than the collectivism that is the orientation of many other cultures. One example cited in Ethan Watter's book is that of Gaithri Fernando, a cross-cultural psychologist specializing in post-traumatic stress who was in Sri Lanka in 2004 when the tsunami hit. Fernando noticed a striking difference between Western and Sri Lankan conceptualizations of mental illness. Western psychologists believe mental illness originates within an individual, causing poor social functioning, while the Sri Lankans viewed the symptoms of mental illness as the social disruption that then affects an individual. PLAYshops address both group and individual concerns.

How PLAYshops Transcend Cultural Bias

PLAYshops use time-honored methods similar to the non-verbal and body-based approaches (e.g. qi gong and yoga) to heal mental and physical disorders long before the advancement of treatments such as Cognitive Behavioral Therapy. While CBT approaches to healing are currently accepted and widely disseminated, the method is still relatively new and most CBT research has been conducted with middle-class Caucasian populations, rendering its administration to individuals outside those social groups less than practical.

In a 2005 study examining the therapeutic dynamic between Caucasian therapists working with non-Caucasian populations, the authors discussed the expression of "genuineness" as the moderating factor for creating a positive and effective rapport. Within the African American culture, the authors note genuineness typically refers to "a willingness to embrace a more egalitarian relationship." Participants in the study, mostly children, reported that clinicians who practiced what they taught and actively participated in role-plays and group games created a sense of openness within the group. By allowing children to call them by their first names, sitting on the floor with them, and playing and laughing together, the facilitators were able to reduce the power differential that is often inherent in a therapeutic relationship, and create a supportive and safe space. This is the approach used in PLAYshops.

Among Second Response staff, volunteers, and trainers, efforts are made that racial and/or ethnic minorities comprise approximately 15-20% at any given time, a number we will actively increase over the next two years. Second Response will remain sensitive to the prototypical Western to Eastern hegemonic bias, as well as the dynamics between our mental health professionals and PLAYshop participants.

A Vignette: Sri Lanka, 2005

On a Sunday morning in January 2005 only a few weeks after the devastating tsunami struck the entire region, the Second Response Trauma Team gathered in a muddy schoolyard in Weligama, a town in the Southern Province of Sri Lanka, and began an entirely spontaneous, unscripted PLAYshop with roughly 50 barefoot children. This report is by Second Response's founder William Spear:

"We start our echo game, clapping and dancing. Every child is a copycat to what we do. They love it. Our hands are up, then down. We are jumping, and then kneeling low. Jonah, Rony and I weave in and out of the circle effortlessly. We work well together with no script. Rony starts a different clapping game while Jonah and I join the circle. Next thing we know, Jonah is in the middle sounding, yelling, laughing. Jonah wiggles his butt. The time is right for me to begin the windup with my red clown nose in hand, a game Jonah and I have developed. Like a cricket pitcher, my arm moves like a windmill

gathering speed, the clown nose clearly between my fingers. Jonah stands like the catcher. I make to pitch the nose and Jonah, his own nose hidden in his hand, makes as if he catches it and slips it on his own nose. The kids laugh at what has appeared. Their laughter becomes mine, and mine, Jonah's, and Jonah's, Rony's, and back to the kids, who convulse with their own delightful laughter. I let out a hysterical laugh, Jonah follows and before long every single child is in stitches, and most of the onlookers, both children, and adults too, have joined in.

I notice the ITN cameraman struggling to steady his camera. The network anchorman, spotting valuable footage emerging for his new feature, grins wildly. This uncontrolled laughter, the contagious glee engulfs everyone in sight. Without warning, Jonah proceeds to the edge of hysteria, and his laughter shifts to wailing, tears, and torrents of crying. I follow, as does Rony, and soon all of us are crying like babies. Exaggerated tears, contorted bodies doubled up, we are a mass of sorrow 30 seconds after we were one happy family. The wailing intensifies until each exhale carries a louder and louder cry. The cry becomes a scream as every child continues his or her copycat routine. Our screams now become even more intense and soon everyone has hands raised and is screaming like there is no tomorrow. While we are screaming, we begin to move, jump, run – near chaos, in fun, breaks through the circle – and everyone begins their pretend hysterics, screaming for help. Laughter, tears and pretend terror blend into the only reason we really came: to release. The circle has unexpectedly grown to nearly 200 kids large; the entire schoolyard is filled with rings of adults who clearly approve of this explosion.

We are looking for the difficult ones, the ones who are disconnected, withdrawn, and still stuck. As I spot one, I move out of the circle and casually stand behind him. As planned, Jonah notices where I stop and sees the little one in front of me, arms crossed. Jonah turns around and faces other children and slowly changes his mannerisms to have his arms crossed in disgruntlement. Hrrrmph! The echo and hand gestures follow. Now every child's arms are crossed. Jonah steps around, hrrrmpphing. Kids follow. He feigns deep disappointment, frustration. Every child copies him. Then he turns partway around and slightly modifies his stance, suddenly flinging one arm wildly up while the other remains crossed in front of his chest. The wild arm returns, and both arms are again crossed in front. Kids copy, the camera rolls. This time, the other arm goes wild, soaring up to the sky, and right after that both arms release their grip and the body has opened. Copycats do the same thing. Jonah turns to see our subject, now smiling and loose. He interacts with Jonah, alternately flinging and re-crossing his arms and back again. Grumps, hrrmmphs, and 'bogga bogga boggas' explode from Jonah, Rony and me as each child returns the call. After two or three cycles, our little one is totally engaged and plays along. Jonah takes him on a ride of expression, release, and wild fun. He is unaware of the bioenergetic work he is doing to release his frustration, his fear – even a piece of his grief.

These songs, clapping, and breathing games continue for another five or ten minutes, until it is time to leave. A good 45 minutes after we walked into the camp as unknowns, kids encircle us to get their pictures taken, touch, shake hands, hug, and ask our names.

Mark, the ITN anchorman, makes his way over to me to tell me something, his face wide-eyed, smiling. 'I must tell you what that man over there said to our producer,' Mark began. 'He told us he's one of the teachers who lives in this village. As you were doing the wave game, he said to her, 'This is exactly what these kids need. They are children, and they have not had any chance to express themselves and have fun. Children have to release all this pent up energy after the tsunami and they needed these games and a chance to be children again so very badly. I am so happy now – the children got what they needed, a chance to be children again.' "

Conclusion

We are clear that somatically based interventions have great potential in the field of disaster relief; we also acknowledge the value of serious academic inquiry. Second Response actively seeks collaborators and opportunities for further study, leading to the development of research methodologies. All this can ultimately help more children recover their natural ability and return to health.

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