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DREN: A GESTALT PLAY THERAPY APPROACH

by

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submitted in part fulfilment of the requirements for
the degree of

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(DIRECTION: PLAY THERAPY)

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Die doel van hierdie navorsing studie was om die **weerstandigheid van vlugteling kinders** te eksploreer met die gebruikmaking van die Gestalt benadering tot spel terapie. Die hipotese waarop hierdie navorsing gebaseer is, is dat die Gestalt benadering tot spel terapie vlugteling kinders se oorlewingsvermoe kan bevorder.

Daar was literatuur bestudeer as deel van die navorsings projek wat aangedui het dat alleenlopende vlugteling kinders uniek is as gevolg van die feit dat hulle trauma, verlies en verandering moet deurmaak terwyl hulle gekonfronteer word met die aanpassing van n nuwe land, omgewing en taal.

Verskeie gevalle studies is as navorsings metode gebruik en die intervensie navorsings model is gebruik as implementerings metode. Die Schoeman Model gebruik as Gestalt spel terapie benadering. Karaktereieskappe van **weerstandige kinders** was gebruik om die resultate te meet.

Die konklusie is dat spel terapie, met n Gestalt benadering, weerstandigheid in vlugteling kinders bevorder omdat dit die beskermings faktore kan bevorder.



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“ I declare that *Resilience in Refugee children: A Gestalt Play Therapy Approach*, is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.”

Signed **Date**



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sed in this thesis instead of “he/she”, “him/her”, or
“his/her”, no gender discrimination is intended, the reason simply being to preclude
a clumsy connotation.

The aim of the research study was to explore resilience in refugee children, using a Gestalt approach to play therapy. The hypothesis, was that a Gestalt approach to play therapy could promote resilience in Refugee children.

A literature review was conducted. This revealed that unaccompanied refugee children were unique because they need to deal with trauma, loss and change while having to adjust to living in a new country and many have to learn to speak a new language.

The research method was a multiple case study and an intervention research model was used to implement the research. Schoeman's Working Model was used as the Gestalt play therapy approach. Attributes of resilient children were used to measure the results.

The researcher concluded that play therapy with a Gestalt approach may promote resilience in refugee children because it increases the numbers of protective factors in a child's life.

Title of Dissertation

RESILIENCE IN REFUGEE CHILDREN: A GESTALT PLAY THERAPY APPROACH

Key terms:

Refugee; Unaccompanied Child; Integration; Resilience ; Protective and Adverse factors; Trauma and loss ; Gestalt Therapy; Play Therapy; Schoeman's Working model; Cultural identity



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resilience in refugee children and adolescents, using a Gestalt play therapy approach. The Gestalt play therapy approach was utilised to ascertain whether it could promote resilience in refugee children (adolescents). According to Rutter (2001:17), there are about 11,5 million refugees worldwide. The majority of these are children who have fled their home country due to persecution, armed conflict or war. Being children makes them so much more vulnerable than adults. According to Kidane (2001:4), the main reasons why, children flee or get separated from their families are: forced recruitment into military activities; the death of parents, or their inability to care for their children due to conflict in the region; forced re-education; being forced either to not take part in religious activities or precisely to do so; being forced to supply information about the activities of a group or members of their family; pressure to denounce family members; and involvement/non-involvement in political activities. Some children may therefore only be protected through separation from their parents and thus flee their countries unaccompanied. Children have no say in the decision to be separated and cannot choose where to go. Disruptions of this kind could last for any amount of time: days, months or in some cases years. This could seriously affect these children's education, development and opportunities to play (Kidane, 2001:4).

According to Rutter (2001:15), besides refugees who flee their country, there are some 10 million refugees who are displaced in their own countries, and more than half of these are children. Globalisation, mass movements, nationalism and poverty affect the way we respond to refugees and, in turn, the way refugee children are treated. Children often remain the silent and ignored victims who are not involved in any decision-making concerning their future and that of their families.

In the United Kingdom, play therapy has been used to promote resilience in refugee children; it can help them come to terms with their experiences and adjustment in their new country (Richman, 2001:21-36).

According to Richman (2001:35), refugee children are resilient and in spite of, or perhaps because of, the increased responsibilities and stressors in their lives, can show remarkable strength and maturity. It is therefore just as important to acknowledge and build on these strengths as it is to be aware of the distress they experience.

relationship is seen as the core of Gestalt practice, contact and for the healing connection between two people. Awareness is the cornerstone of Gestalt therapy. It can be described as knowing what is happening here and now. It is needed for all healthy living and the energy for assimilation, growth, self-knowledge, choice and creativity (Joyce & Sills, 2001:43, 27). It is the researcher's opinion that these concepts relate closely to the concept of resilience.

When providing therapy for refugee children one cannot exclude the child's environment. According to Woodcock (2002:276), it is important to understand the beliefs, values and worldview of refugees if we intend to work with them, because refugee children often have the dilemma of living in two cultures, one of their homeland and the other, that of the country they have fled to.

Gestalt therapy includes the concept of field theory. In field theory a person is never independent or isolated although the person may see themselves as such but always in contact and connected with everything else in the immediate environment. This will provide the space in therapy to speak about the child's country of origin, as well as being able to focus on the present. Field theory also allows one to explore the child's culture, race and religion within a global context, as these could be the very reasons why refugee children had to flee (Joyce & Sills, 2001: 24,25).

Many refugee children may have had little chance to play or have fun and their concentration span may be short. Games with older children, sport, dance, music, poetry, art, circus skills, oral history projects and gardening have been suggested to improve confidence and raise the self-esteem of refugee children (Richman, 2001:35).

The researcher will be discussing play therapy from a Gestalt therapy perspective, and describe how it may promote resilience in refugees through the concepts of empowerment and self-support. The research was conducted with children between the ages of twelve and eighteen, including their carers and case workers.

2. Problem Formulation and Rationale for the Research

Research on resilience in refugee children and research on a Gestalt play therapy approach with refugee children is limited. There does exist research on children's

but the experiences of refugee children are more deal with conflict or war in their home country, but

there may have also been subjected to traumatic events on their journey to safety or in the new country, for instance racism and discrimination. Also, despite the huge numbers of refugee children worldwide, research on therapeutic intervention with refugee children is very limited. This is also the case with research on refugee children's adaptation to their host countries.

Practitioners and development organisations would be able to use this kind of research in their programmes to address the emotional needs of refugee children. It is the researcher's opinion that most aid and development agencies focus on meeting the basic needs (food and shelter) of refugees and it is the researcher's opinion that Gestalt therapy moves beyond just meeting basic needs by simultaneously empowering the child. The research problem for this study was therefore formulated as follows: Meeting the therapeutic needs of refugee children and addressing the pathological view of refugee children by focusing on their resilience.

This research will also contribute to the knowledge about cross-cultural therapeutic intervention with children, as play therapists matching the ethnicity of the refugee child will usually be limited. The writer also hopes that the research will address some of the issues concerning refugee children's access to therapeutic services. Research undertaken by the Child and Adolescent Mental Health Service indicates a low uptake of services from minority ethnic children and families, and refugee children form part of this population (Lowe, 2006:5-25).

2.1 Motivation for the choice of topic

2.1.1. Need for an Intervention Plan

Along with the dearth of information on resilience, there also exists limited research on intervention programmes which can promote children's resilience. There was little research available on therapeutic intervention with refugees, including children. Intervention programmes aimed at promoting refugee children's resilience were even more limited. Given the large numbers of refugee children, in the United Kingdom as well as worldwide, including their complex needs, there is an urgent demand for an

me. While undertaking this research project, the researcher consulted with several professionals for consulting on work with refugee children. The researcher was also offered a job developing a programme for refugee children. This is an indication of the demand for an effective therapeutic approach in working with refugee children.

2.1.2 Personal Motivation

The researcher has developed an interest in the experiences of refugee children and their ability to overcome their traumatic experiences, as well as their ability to adjust in the host country. The researcher is also interested in the concept of resilience and the ways in which resilience could be enhanced in children. Children cannot always be protected from traumatic experiences, but methods can be developed to help them overcome such obstacles.

2.1.3 Professional Motivation

While the researcher's work involved working with refugee children, she was hampered by the limited research available on resilience in refugee children. Play therapy had been suggested, but there was also limited research on this, as well as on Gestalt play therapy within this context. The researcher had access to refugee children as well as to information networks. The researcher also had access to experts regarding refugees. In addition, there was very little information available on refugee children who had successfully adapted to life in the UK.

Given the current state of world politics and the ongoing violence in many countries, the researcher has developed an interest in how this affects children. It is the writer's view that many aid and development programmes are focusing on meeting the primary needs of refugee children while, in the researcher's opinion, the emotional needs of these children are overlooked.

2.1.4 Gestalt Therapy

The theoretical approach that forms the basis of the research project is Gestalt theory and therapy. There is no direct English translation of the word 'Gestalt'. Gestalt refers to the shape, the pattern, the whole form or configuration. The concept connotes a structural entity, which is both different from and more than just the sum of its parts.

Each is for each person to discover, explore and
form and wholeness (Clarkson, 1999:1).

According to Yontef (1993:200) Gestalt therapy can be defined according to three principles: Gestalt therapy is phenomenological, that is, its only goal is awareness; Gestalt therapy is based on dialogic existentialism; and finally Gestalt therapy's worldview is Gestalt, that is, it is based on holism and field theory.

2.2 Problem Formulation

The research problem should be clarified in terms of its feasibility, originality, importance and its contribution to a body of knowledge (Bowling, 2002:142).

As pointed out above, research on resilience in refugee children and research on a Gestalt play therapy approach with refugee children is limited. There does exist research on children's experiences of trauma and loss, but the experiences of refugee children are more complex, as they not only have had to deal with the reasons why they had to flee their home country but they also have to adjust to living in their host country. In the case of this research, the refugee children continually have to adjust to living in the UK. Furthermore, research on therapeutic intervention with refugee children is scarce, despite the huge numbers of refugee children worldwide. Part of the problem is also that refugee children and their families have limited understanding of therapeutic services, as many of the countries they originate from did not have any therapeutic services available. This, in turn, impacted on their accessing therapeutic services in the UK. It is the researcher's view that there is also a limited understanding of the emotional needs of refugee children within the social welfare system and the Child and Adolescent Mental Health Service in the United Kingdom.

2.3. Aim

The aim of the study is understanding and enhancing resilience in refugee children by using a Gestalt play therapy approach.

2.4. Research Objectives and Hypothesis

Objectives

Objectives are the steps that need to be taken in order to achieve the aim of the research. According to Fouché (2002: 107-108) objectives are more concrete,

ow of this, the objectives for this study are stated as

1. To do an extensive literature review on the topic including the following:
 - To document the experiences of refugee children. In doing this, the researcher would raise an awareness of the needs of refugee children.
 - Trauma, loss, separation and change will be discussed, specifically as experienced by the refugee. This would include loss of cultural identity, and a familiar way of life, and the impact thereof on the child.
 - Refugee children's adjustment to the new country and new way of life, will be scrutinised, including having to learn a new language and to deal with a different educational system.
 - Resilience can be described as how well a child can cope with damaging experiences, or the ability to overcome adverse circumstances. (Amerena & Kidane, 2004:45). The researcher will discuss resilience in respect of the refugee child.
 - The researcher will discuss Gestalt therapy in relation to the concept of resilience.
 - The researcher will discuss Gestalt play therapy and how play therapy from a Gestalt approach can promote resilience in Refugee children
2. To explore how play therapy from a Gestalt approach can promote resilience in refugee children.
3. To draw inferences and make recommendations to all those involved in delivering service to refugee children.

Research Hypothesis

The hypothesis or research assumption should be clearly specified. According to Bowling (2002:138), a hypothesis is an assumption, which expresses a tentative solution to a research question. For a hypothesis to be more specific, it is based on a concept or theory.

The researcher has made the assumption that a Gestalt play therapy approach will promote resilience in refugee children. The research question would be:

promote resilience in refugee children? The research addresses this question. In order to develop the hypothesis, the researcher addressed the following research questions :

- What were refugee children's needs and experiences?
 - Could play therapy enhance resilience in refugee children?
 - How does a Gestalt play therapy approach enhance resilience in refugee children?
- And:
- How do refugee children gain access to therapeutic and supportive services which can promote their resilience?

The researcher will also demonstrate the similarities in the concept of resilience and Gestalt therapy. The researcher's frame of reference is that of a Gestalt play therapist, with the Gestalt philosophy underlying and guiding the research.

3. Research Approach

A qualitative approach has been chosen in view of the broad experiences of refugee children. Through qualitative research the researcher will be able to identify gaps in previous research and through the proposed study will aim to fill the gap. A qualitative approach would allow the researcher to describe the experiences of refugee children. With this approach the researcher will be able to quote the exact words of the participant. Qualitative research enables the reader to enter the subjective world of the participant (Delpont, Fouché & de Vos, 2002: 357). 'Children's rhymes become part of their armour to cope with the world and perhaps to tell us, the adults, how they really think and feel' (Cattanach, 2001:69). The qualitative approach is also flexible so as to capture words, pictures and quotes which may form part of data collection.

3.1 Type of Research

The researcher used applied-descriptive research. According to de Vos, (2002:109), descriptive research presents a picture of specific details of a situation, social setting or relationship. Descriptive research should focus on 'how' and 'why' questions. In the research, the focus will be on resilience in refugee children, and how and why Gestalt play therapy enhances resilience in refugee children. The researcher begins with a well-defined subject and describes it. This can lead to a more in-depth

to look at deeper meanings thus a case study would
(Fouché, 1998:109)

Intervention research was used in the research project. According to Schilling (in de Vos, 2002:396), intervention research can be described as an action undertaken by a helping agent with the aim of enhancing or maintaining the functioning and well-being of an individual, family or community. It can also be defined as studies undertaken to prevent or resolve problems, creating and testing human service approaches or to maintain quality of life (de Vos, 2002:396). In this project the intervention will be Gestalt play therapy, undertaken with refugee children with the aim of enhancing their resilience.

The Intervention Research Model

The researcher applied the developmental and design model in this study. This involves a research process which consists of six phases. These are:

- Problem analysis
- Information gathering and synthesis
- Design
- Early development and pilot testing
- Evaluation and advanced development
- Dissemination

3.2 Research Strategy

A multiple case study was used, consisting of four case studies. The case studies presented are an example of the single -system design. A single -system design can be defined as the study of a single subject on a repetitive basis (Strydom, 2003:151). In the case of this research, it was refugee children. These case studies can be viewed as a single-design system because both observation and intervention was used. The writer used the single-design system because it is practice based and therapist-orientated. In addition, the evaluation of effectiveness of the intervention becomes possible. In this case the intervention used was a Gestalt play therapy approach.

When undertaking a qualitative study, one must ask how theory will guide the process. In the traditional qualitative strategies, it can be placed on a continuum,

is used before or after the data is collected. The case could be completely absent, or it could be used to guide the study in an explanatory way. It could also be used at the end to compare and contrast it with a theoretical model, to build theory or to propose generalisations (Fouché & Delpont, 2003:267-268).

In this study, the researcher used theory to guide the study in an explanatory way. The researcher used Gestalt play therapy theory to guide and explain the research.

A case study can be defined as an exploration or in-depth analysis of a bounded system (bounded by time and/or place), or a single or multiple case over a period of time. The case being studied can refer to a process, activity, event, programme or individual or multiple individuals. Where multiple cases are involved, it is called a collective case study.

The exploration and description of the case takes place through detailed in-depth data collection methods, involving multiple sources of information. This can include interviews, documents, observations or archival records (Creswell in Fouché & Delpont, 2003:275).

In this study the writer interviewed refugee children upon whom the case studies were based. She also gained access to case records of these children, and could observe the young people in their current accommodation. The researcher also interviewed their carers and social workers.

A qualitative approach was chosen in view of the broad experiences of refugee children. Through qualitative research the researcher was able to identify gaps in previous research, and through the study will aim to fill these gaps. A qualitative approach also allowed the researcher to describe the experiences of refugee children. With this approach the researcher was able to quote the exact words of the participants. Qualitative research also enables the reader to enter the subjective world of the participant (Delpont, Fouché & de Vos, 2002: 357).

ect and Method

As stated in 3.1 the developmental and design model was applied, and this consisted of six stages. The researcher was able to complete four stages. These will be discussed below.

4.1.1 Phase 1: Problem Analysis and Project Planning

The first phase involves five steps, which helped the researcher analyse the problem and plan the research project. These are: identifying and involving clients; gaining entry to and co-operation from settings; identifying concerns of the population; analysing identified problems; and setting goals and objectives. These will be discussed below.

- ***Identifying and involving clients***

According to de Vos (2002:398), a population is chosen on the basis that it is of current or emerging interest to the clients themselves, the researchers, professionals and society at large. It is the view of the researcher that this research study was of interest to the children involved, the professionals and society. Resilience in refugee children is of interest to refugee children themselves, in order to help them make sense of their experiences and empower them. Resilience in refugee children is also important to professionals and those caring for them so that their needs can be met through service provision. Simmonds (2004:72) states that he became aware of the significant practical, psychological, legal and educational problems faced by unaccompanied refugees. There were also many obstacles that agencies faced in trying to meet the needs of unaccompanied refugee children. In addition, there was the hostile media image of refugees.

It is the researcher's view that refugees are not only of interest to British society, but of global interest, given the fact that in 2001 there were 18 million asylum seekers and refugees worldwide. The plight of refugee children was highlighted when in December 1999 three Iraqi children were found frozen to death in a refrigerated lorry while being smuggled to Greece (Rutter, 2001:8).



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y was refugee children, living in Essex, who had
ylum Team for Essex Social Services.

- ***Gaining entry to and co-operation from settings***

A collaborative relationship needs to be formed with key informants, who can help the researcher to gain access to the setting. Successful intervention researchers also involve the informants in the project planning and in implementing intervention (Fawcet in de Vos, 2002:399).

In this research project, the key informants were the team manager of the asylum team, the social workers of the case study participants, and the foster carers of the children. In addition, there were the educational advisors of the Ethnic Minority Achievement Service, and the information development officer of the Corporate Parenting Service.

Data Bases

The researcher did not have difficulty in gaining access to the data bases as she was a social worker working for Essex County Council. The team manager, educational advisors and information development officer had a data base on refugee and asylum seeking children in Essex. The researcher also made contact with Tendring and Colchester Minority Ethnic Partnership, a community organisation working with refugees in Essex.

The researcher was able to access several data bases held on refugee children, including that of the Education and Social Service. The researcher also had access to the case files of the refugee children in the Asylum Team. This was made possible as the researcher worked in collaboration with the Asylum Team and their manager. The researcher also worked in partnership with the Ethnic Minority Achievement Service.

Access to social workers and foster carers

The researcher had access to the Social Service data system called 'Swift' which indicated social workers and foster carers allocated to refugee children. Once the

ed, the researcher contacted their social worker and the children. This was done by e-mail and telephone contact as well as a formal letter.

Access to refugee children

Despite the fact that the researcher had access to refugee children, engaging their social workers, parents and foster carers was challenging. Initially, the researcher had identified refugee children living with their families. For this, the researcher worked with Tendring Minority Ethnic Partnership. The researcher worked closely with the outreach worker who explained that some of the families were suspicious of strangers and officials and they would only be willing to meet the researcher if she was introduced by someone they knew, like the outreach worker. This was true; the families were only willing to allow the researcher access to their children if they themselves and the outreach worker were present.

The parents found it difficult to trust the researcher and were very protective of their children and despite meeting with them on several occasions, the parents refused to give permission for their children to be on their own with the researcher for the play therapy sessions. The researcher understood their concerns and therefore just interviewed the parents and children.

Due to this difficulty, the researcher approached the social workers and foster carers of refugee children in foster care. The social workers were much more willing to be part of the research project, while the foster carers had reservations about involving the young people they were caring for. The researcher contacted the foster carers by telephone and letter, in order to explain the research project. Gaining access to the children was particularly challenging as the foster carers were very protective of the children they were caring for, and needed to be reassured that the children would not be harmed in any way. The researcher will discuss the ethical aspects of the project separately.

Population

(2002:198) describes the universe as all potential subjects who possess the attributes that the researcher is interested in. The population refers to the individuals in the universe who possess specific characteristics. The population in this study were refugee children who arrived in the Essex between 2003 and 2005.

Fawcett (in de Vos, 2002:402) states that once access is gained to the setting, the researcher must try to understand the concerns and important issues of the population. Informal contacts can be used, as well as community forums and surveys. As the researcher was a social worker, she formed part of the setting and therefore had many informal contacts and access to information and to other professionals working with refugee children. The researcher was also part of the Asylum Seeker and Refugee Information Group which is a forum for professionals working with asylum and refugee children in Essex. The researcher also worked closely with the Children's Rights Advisor. In addition, the researcher conducted interviews with professionals working with refugee children and conducted a literature study to develop the research questions and problems.

There are approximately 6000 unaccompanied asylum seeking and refugee children in the UK. Some unaccompanied refugee children have seen family members arrested and killed, while others were sent away when life became dangerous or they were faced with military conscription. The families of unaccompanied children may be alive but they may have limited contact with them, and the pain of separation may be great. They may have experienced fear and anxiety on their journey to safety, maybe coping with bereavement and family separation (Kidane, 2001:4).

It is the opinion of the researcher that refugee children in the research study are children who have experienced severe trauma, several losses and changes both in their country of origin and in the UK. Due to their legal status in the UK as unaccompanied minors, they experience racism and may struggle to gain access to services, including therapeutic services.

Developmental psychology was medical models, which focused on symptoms and negative outcomes. This gave rise to 'Project Competence' a research project, which was part of the early research leading to the concept of resilience. The perspective of competence was closely related to developmental tasks which was the theme of 'Project Competence'. Project Competence was the first longitudinal study of competence. Competence was defined as effective performance in developmental tasks that are salient for people of a given age, society, context or historical period. The main part of this study was 'What makes a difference in the lives of children threatened by adversity or risk?' (Masten & Powell, 2003:4-5).

According to Newman (2002:8), a resilient child is better able to recover from trauma. It is the researcher's view that trauma also has long lasting impact on refugee children's internal resources to form relationships and may inhibit them from using external resources. Focus should therefore be on enhancing children's resilience and their ability to form relationships. Unaccompanied refugee children have so many needs that a holistic approach which integrates all their needs is important. According to Rutter (2001:176) play can help identify how a child is coping with the refugee experience, while at the same time being a means of healing.

Analysing concerns or problems identified

In order for refugee children to cope, Alayarian (2007a:xx) believes that inner resources are needed, such as a sense of mastery, self-esteem, and self-reliance, as well as external resources such as acceptance and support by others. The researcher's view is that refugee children therefore require an approach that includes both internal and external resources of the child, as well as the support of the family and community. Refugee children belong to a group who experience racial harassment in British society and may live in a community where they may be exposed to racial violence or physical attacks.

In addition, unaccompanied minors arrive in the UK without their families, reducing the external resources that they have available. According to Alayarian (2007a:xx), they require a therapeutic service that will help them rediscover their abilities;

problems; reduce social isolation; and restore their self-esteem. Low levels of social participation affect quality of life, increasing social isolation and mental health problems (Alayarian, 2007a:xx-xxi).

It is the researcher's view that a Gestalt play therapy approach is ideal to meet refugee children's needs in a way that empowers them through the Gestalt therapeutic relationship. Zinker (1978:123) states that therapeutic work is rooted in the client's own perspective. There is a respect for the individual's internal experience.

Gorman-Smith and Tolan (2003:405,408) state that as long as there is a balance between stressful life events and protective factors, successful adaptation is possible. Intervention should therefore be seen as an attempt to shift the balance from vulnerability to resilience, by either decreasing exposure to risk factors or stressful life events, or by increasing the number of protective factors. The researcher's view is that a Gestalt play therapy approach can enhance refugee children's resilience by increasing the number of protective factors in their lives and by enhancing self-regulation and self-support.

Lampert (2003:174) believes that the attributes of resilience can be encouraged in therapy and that Gestalt therapy with the principle of organismic self-regulation, and the I-Thou relationship promotes natural healing. Resilience is defined as the developmental process by which children acquire the ability to use both internal and external resources to achieve positive adaptation despite previous or current adversity (Yates, Engeland & Soufre, 2003:250). The researcher is in agreement with Lampert (2003:174), as the researcher's view is that the principle of organismic self-regulation in Gestalt therapy is closely related to resilience as defined by Yates, Engeland and Soufre, (2003:250).

- ***Setting goals and objectives***

Goals refer to the outcomes that the community of interest would like to achieve, while objectives refer to more specific programmes or practice that would contribute to the broader goal (de Vos, 2002:404). Problem analysis also enables the researcher to identify possible elements of intervention. According to Masten and Powell (2003:15), resilience arises from "ordinary magic" which refers to the idea that human

...ing resistance, coping, recovery and success in the ...ly with the usual adaptational capabilities, with resources functioning normally. It is therefore a priority to sustain and restore cognitive and social development for protecting children's development and promoting resilience in risky situations. Promoting healthy development usually forms part of health and social policy programmes. And if this is the case then protecting, restoring and facilitating human adaptational qualities is vital. When researching resilience, the focus needs to be on what works in interventions and programmes designed to promote good developmental outcomes. In order to find practical applications for resilience theory, our actions must be able to affect the way in which children cope with adversities (Masten & Powell, 2003:21).

It is the opinion of the researcher that the application of Schoeman's working model will enhance resilience in refugee children, because it empowers them to make sense of their traumatic experiences and loss and to maintain their cultural identity, rebuilding support networks and links with their community of origin, while integrating into British society.

4.1.2 Phase 2: Information Gathering and Synthesis

Qualitative research aims to study people in their natural surroundings and collect natural occurring data. The focus is on the meanings the participants attach to their social world. For the purpose of this study, methods of data collection were unstructured interviews, diary methods, group interviews and focus group techniques. The researcher had access to social work case files of refugee children.

Case studies may use triangulated methods consisting of observation, unstructured interviews, document research and structured or semi-structured questionnaires (Bowling, 2002:352,403). The researcher will be observing refugee children in various settings and use semi-structured questionnaires with the children upon whom the case studies are based, as well as documents relating to the legal status of the children and those dealing with rights of refugees namely those of the 1951 UN Convention Relating to the Status of Refugees. The primary methods of data collection for the proposed study will be document analysis, life histories and semi-

the refugee children, as well as semi-structured professionals working with refugee children.

4.1.2.1 Using existing information sources

- A **literature study** was conducted as part of the research project. The literature study covered more than one area. The main focus of the literature study was resilience as a concept and how it impacts on children, including refugee children, and their experiences and Gestalt play therapy. The literature review is also a critical analysis. The literature study indicated that resilience is children's natural ability to heal and adapt. It was also described as the way in which children cope with adversity. The research on refugee children indicated that the adversities that they experienced were diverse, in that they not only experienced several traumatic experiences at the same time but also had to deal with many losses and changes, while trying to adapt to a new country. Despite this, the majority of refugee children appeared to be resilient. Research also indicated that play and play therapy was successfully used to help refugee children make sense of their experiences. Research on intervention programmes aimed at promoting children's resilience was limited despite the significant research on resilience as such. The researcher found that there was even less information and research on intervention aimed at promoting resilience in refugee children. There was limited research available on resilience in refugee children, yet this research indicated that play and play therapy was thought to promote refugee children's resilience. Next, the focus of the literature review was on play therapy and how it could promote resilience. The literature on play and play therapy as such was considerable but there was little research on how play therapy and play promote resilience. One model of play therapy that directly linked play therapy to resilience was available. This happened to be a Gestalt play therapy approach used by Ruth Lampert (2003) to promote resilience. This enabled the researcher to integrate theories of resilience with Gestalt therapy and Gestalt play therapy. The researcher was therefore able to hypothesise that a Gestalt play therapy approach could promote resilience in refugee children. Ruth Lampert's approach, however, was not aimed specifically at refugee children.

...ple on how a Gestalt play therapy approach could
...e children. By critically analysing all the available
literature on the experiences and therapeutic needs of refugee children, the
researcher hypothesised that they needed a Gestalt play therapy approach which
was empowering. Considering the literature study and information available, the
researcher made the assumption that Schoeman's working model could promote
refugee children's resilience, as it is focusing specifically on empowering
children.

- Another source of information was **participant observation**. The researcher was a social worker and diversity project manager, with the task of improving outcomes for black and minority ethnic children. Refugee children were included in this group, and the researcher was then able to spend two months working and observing the Refugee and Asylum Team of Essex Social Services. The researcher could therefore observe the interaction between the professionals and refugee children, as well as the services available to refugee children. The researcher's official role of diversity manager was to be part of various professional forums concerned with the needs of refugee children. This enabled the researcher to use this information in the research project.
- **Semi-structured interviews** took place with social workers from the refugee team as well as their manager who was an expert on refugee children, due to her involvement with refugee children on a national level in the UK. Semi-structured interviews also took place with several experts such as Linda Marshall, the Children's Rights Advisor and Prue Reynolds, the Educational Advisor for the Ethnic Minority Achievement Service. An interview was also held with the Outreach worker for the Tendring and Colchester Minority Ethnic Partnership, Vibha Osbon, who works with refugee women and children in Colchester, Essex.
- The researcher's **professional and personal experiences** were also used as a source of information. The researcher has over 10 years experience of working with children in a social work setting. In addition the researcher had four years experience working with black and minority ethnic young people including

before the research project. The researcher also worked for refugee children. The researcher is also currently working in Looked after Children's Therapeutic Team as a social worker and play therapist where refugee children have been referred to for individual therapeutic work, or where their foster carers can self-refer in order to receive consultation in helping to care for them.

In addition the researcher also had personal experience of 6 years being a migrant worker and integrating into British society as a black person, and she forms part of the minority ethnic community in the UK of which refugee children are part of.

4.1.2.2 Studying Natural Examples

“Studying natural examples” refers to observation of how clients or people experiencing a particular problem have tried to address the problem. This could also involve service providers. In this research study, the researcher had access to all the settings involving refugee children, due to her professional role in the organisation she is working for, namely the Essex Schools, Children and Families, as well as social roles outside the professional arena.

The two months spent in the Refugee and Asylum Team enabled the researcher to be part of interviews and assessments of refugee children. It also enabled her to observe refugee children in the accommodation provided by the local authority. This was an important source of information, as the researcher could observe the interaction between the refugees among themselves, as well as the interaction between the children and their families. The researcher was therefore accepted by the refugee children and could gain their trust. This enabled the researcher to arrange interviews with refugee children as well as to plan a focus group to obtain information.

4.1.2.3 Identifying Functional Elements of Successful Models

When all the information has been gathered, the researcher will critically analyse the information. At this stage, successful models and ways of intervening with the problem will be identified. Fawcett (in de Vos, 2002:407) states that by studying successful and unsuccessful programmes or models of intervention the researcher is

elements of intervention. In this research project, the
t refugee children were able to overcome adversity.

Rutter (2001:123) believes that there are protective factors that would protect refugee children from long term damage and adverse factors that would make it likely that refugee children would suffer long-term psychological harm. Rutter (2003:131) and Hyder (2005:64) believe that by increasing the protective factors in refugee children's lives one could promote their resilience. Hyder (2005:4,56-59,63), believes that play, would promote refugee children's resilience, because it encourages natural healing and helps them make sense of their world.

According to Richman (2001:35), refugee children are resilient, and in spite of, or perhaps because of, the increased responsibilities and stresses in their lives, can show remarkable strength and maturity. It is therefore just as important to acknowledge and build on these strengths, as it is to be aware of the distress they feel. In the UK, play therapy has been used to promote resilience in refugee children and it can be used to help them come to terms with their past experiences and present adjustment in their new country (Richman, 2001:21-36).

The play therapy model that has been used with refugee children in the UK is mainly non-directive and a person-centred model. Another model which has been used to promote resilience in children was a Gestalt approach used by Ruth Lampert (2003). Her view was that concepts of the I-Thou relationship, organismic self-regulation and paradox of change was particularly suited to promoting resilience in children. The researcher felt that this model could be useful, even though Lampert's model was not aimed at the specific experiences of refugee children. After having analysed the attributes of resilient children and the needs of refugee children, there was an indication that refugee children needed an approach that would empower them such as Schoeman's working model.

4.1.3 Phase 3: Design

The design stage in intervention research is of the utmost importance in intervention research. There are two sub-stages in the design stage which need to be completed, namely:

- Designing an observational system

ments of the intervention.

4.1.3.1 Designing an observational system

The researcher needs to design a way of observing the phenomena so that the effects of the intervention can be detected afterwards. The observational system is also linked to designing the intervention (de Vos, 2002:408).

- **Part of designing an observational system means defining the types of behaviour associated with the problem.**

In this research study, the phenomena is resilience and the attributes of resilient children. For the control the researcher used the definition of Alayarian (2007b:1-2): *“Resilient people are those who have been able to move on in life after their traumatic experience, to integrate into a new society, to work effectively, to love and contribute to the life of the community they live in. Resilience is the ability to experience severe trauma or neglect without a collapse of psychological functioning or evidence of post-traumatic stress disorder”*, in combination with that of Masten and Powell (2003:4) where resilience is described as: *“doing ok”* and that there has been *“a significant risk or adversity to overcome.”*

For the case studies the researcher used the lists of attributes of Lampert (2003:174-176) and Woodcock (2002:75).

- According to Lampert (2003:174-176) the characteristics of resilient children are: a talent and a special interest that brings pleasure and a sense of competence; one consistently good relationship with at least one adult; the ability to distance; the ability to ask for help from appropriate adults; and being aware of themselves and their environment and plans rather than acting on impulse. Lampert (2003:174) stated that these attributes could be encouraged in therapy.
- In addition to these, Woodcock (2002:275) states that: for refugee children, being resilient will include experiencing some degree of choice over major decisions; being able to problem-solve actively in collaboration with others; being connected to networks which offer some degree of social and cultural familiarity; being able to talk about ongoing problems; being able to talk and reflect on past experiences, both good and bad; and being able to grieve actively. This list of attributes was especially helpful as it relates specifically to refugee children.

s of types of behaviour or products are provided of the type of behaviour

The framework of resilience that the researcher used to explain resilience in children was that provided by Rutter(2001:124) who states that in order to promote resilience in refugee children, the protective factors in their lives need to be increased and the adverse factors to be reduced. Protective factors are those that protect children's development, while risk or adverse factors are those that could make children suffer long-term psychological damage.

- **Scoring and measuring**

In this research, project tables and graphs were used to measure and observe resilience in the sample population as well as in participants in the case studies (see Chapter Four).

4.1.3.2 Specifying procedural elements of the intervention

According to de Vos (2002:409), procedural elements could be strategies, information, skills or procedures which may eventually become part of the intervention model. The procedural elements for this research project is guided by Gestalt theory, Schoeman's working model as a Gestalt play therapy approach and the concept of resilience. These are discussed in detail in Chapter Four.

4.1.4 Phase 4: Early Development and Pilot Testing

Thomas (in de Vos, 2002:410) describes development as the process by which an innovative intervention is implemented and used on a trial basis, developmentally tested for its adequacy and refined and redesigned if necessary. In this stage, preliminary methods of intervention are developed and a pilot test can be conducted.

4.1.4.1 Developing a Prototype or Preliminary Intervention

The process of intervention and detailed description and motivation for each step is described in this phase. The key elements that impact on the intervention are also discussed. Defining and describing the elements are important. The key elements for the research are discussed below.

ning. A refugee can be defined as someone who has fled from his or her home country or who is unable to return to it, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion. (Rutter, 2003:4) The Organisation of African Unity has broadened the definition of refugees to include people compelled to leave their home countries by external aggression or domination or by events seriously undermining public order. In African countries protection is thus given to large groups of people who are living in generally dangerous or unstable conditions, for example because of civil war in their home countries (Rutter, 2002:4).

Asylum Seeker

An asylum seeker is a person who has crossed an international border in search of safety and refugee status in another country. The definition of refugees is taken from the 1951 UN Convention on Refugees and the 1967 UN Protocol Relating to the Status of Refugees, International law, now signed by 137 states, including the UK. These two legal instruments enshrine the rights of asylum seekers and refugees, preventing them from being returned to countries where they fear persecution. In the UK an asylum seeker is recognised and granted refugee status and usually given indefinite leave to remain (ILR) upon meeting the criteria of the 1951 Convention on Refugees. A person who does not meet the criteria but for whom removal may be unreasonable or impracticable may be granted exceptional leave to remain (ELR) for a specific period of time, after which it will be reviewed when it expires (Kidane, 2001:4).

Unaccompanied Child

An unaccompanied child is a person who is under the legal age of majority (18 in the UK) and is not accompanied by a parent, guardian, or other adult who by law or custom is responsible for him (Kidane, 2001:4).

Resilience

Resilience can be referred to as a child's ability to overcome adverse circumstances (Kidane & Amarena, 2004:45). It can also be understood as 'active coping' (Woodcock, 2002:275). The Cambridge Dictionary defines resilience as the ability to

ion, being strong enough to get better quickly after
ra. (see p.21)

Integration

Harris (2006:82) describes social integration as being actively involved in a wide range of social activities or relationships. For the purpose of this research, integration to British society includes:

- Attending college or being able to secure full-time employment
- Being able to speak English
- Being involved in leisure and social activities.

Play Therapy

The British Association of Play Therapists defines play therapy as a mode of therapy that helps children to explore their feelings, to express themselves and to make sense of their life experiences. They state that conventional therapies may be inappropriate for children and young people who struggle to put their feelings into words. According to Woolf (2004) projective techniques are used which combine play with puppets, dolls, toys and play media such as sand, water, clay and paint (<http://www.outlands.demon.co.uk/playtherapy>).

For the purpose of this study, play therapy will refer to therapy using projections, which help children to explore their feelings, express themselves and make sense of their experiences.

Gestalt Therapy

There is no direct English translation of the word 'Gestalt'. Gestalt refers to the shape, the pattern, the whole form and the configuration. It connotes a structural entity which is both different from and more than just the sum of its parts. The aim of the Gestalt approach is for each person to discover, explore and experience their shape, pattern and wholeness (Clarkson, 1999:1). According to Yontef (1993:200), Gestalt therapy can be defined according to three principles. Gestalt therapy is phenomenological, that is, its only goal is awareness; Gestalt therapy is based on dialogic existentialism; and Gestalt therapy's worldview is Gestalt, that is, it is based on holism and field theory.

Awareness can be defined as the non verbal sensing or knowing what is happening here and now (Joyce & Sills,2001:27). Awareness includes knowing the environment, responsibility for choices, self-knowledge, self-acceptance and the ability to contact (Yontef, 1993:145).

Phenomenology

According to Idhe (in Yontef, 1993:124), phenomenology is a discipline that helps people stand aside from their usual way of thinking, so that they are able to differentiate between what they feel and perceive in a current situation and what is residue from a past experience. The phenomenological approach is trying to stay as close to the client's experience as possible. This involves accepting the client with an open mind, where nothing matters except the discovery of his personal experience. By doing this, the awareness of the client of his own process and choices he makes is focused and sharpened. The goal of this approach is awareness or insight (Joyce & Sills, 2002:16).

Field Theory

Field theory refers to viewing the person in the context of his environment. Field theory is based on the idea that the individual/environment creates itself, with the individual part influencing the rest of the field and the rest of the field influencing the individual (Yontef, 1993:287). The issue for Gestalt therapists is how clients go about solving their own problems. Gestalt therapy facilitates problem solving through increasing self-regulation and self-support.

Self-regulation

In Gestalt a person is seen as having a natural or organismic tendency to regulate himself. In order to grow and develop, people strive to maintain a balance between need gratification and tension elimination. The healthy person differentiates this meaningful need and responds to it appropriately, thereby restoring the balance and releasing more energy and allowing the next important need to emerge (Clarkson, 1999:21).

From a Gestalt perspective, support is the necessary basis of all healthy functioning and the ground that enables healthy and satisfying contact. Healthy support is interdependence where the person is self-supported but also able to recognise when he needs environmental support. For the Gestalt therapist, the interest is not whether the person is self-supported or needing environmental support but how the person co-operates with his environment or community for mutual support, balancing his own needs with consideration for the needs of others (Joyce & Sills, 2001:83-84).

Gestalt Play Therapy Approach

For the purpose of this research, Gestalt play therapy refers to play therapy from a Gestalt perspective or play therapy which adopts a Gestalt approach.

Carers

In this research, carers refer to adults who have responsibility for caring for children and young people. This could be foster carers, biological parents or relatives.

4.1.4.2 Conducting a Pilot Test

The purpose of pilot testing is to ascertain whether the intervention will work. Pilot tests take place under similar conditions under which the intervention will take place. This is helpful when in difficult settings. Pilot testing provides the researcher with an opportunity to determine the effectiveness of the intervention and which elements of the prototype need to be revised (Fawcett in de Vos, 2002:411).

In this research project, the researcher conducted semi structured interviews with two social workers who were the case workers of refugee children, as well as with the parents of refugee children. The researcher also conducted three play therapy sessions with three refugee children. The researcher had to alter the scope and sample of the population due to language barriers and gaining parental permission to see children. This is discussed in further detail in Chapter Three.

4.1.5 Phase 5: Evaluation and Advanced Development

There are four steps in this phase of intervention research. They are:

- Selecting an experimental design

- Refining the intervention.

4.1.5.1 Selecting an Experimental Design

The experimental design is intended to help demonstrate the causal relationship between the intervention and the desired outcome or the types of behaviour intended for change (Fawcett in de Vos, 2002: 412). The researcher used the bar graphs to demonstrate the relationship between resilience and protective factors, as well as the relationship between resilience and adverse factors (see Chapter Four).

4.1.5.2 Collecting and Analysing Data

As data is collected from pilot tests and more formal evaluations, analysing takes place continuously. Ongoing graphing of the behaviour and related outcomes help to determine when initial interventions should be implemented or whether supplementary procedures are necessary.

In this research project, the researcher had to design a supplementary system of observation as the original graphs of protective and adverse factors were not sufficient to describe the attributes of resilient children and whether the resilient qualities were enhanced. A more qualitative approach was needed. This is discussed in Chapters Four and Five.

4.1.5.3 Replicating the Intervention under Field Conditions

According to de Vos (2002:413), the primary goal of intervention research is to develop interventions which are effective in a variety of real-life contexts with those who actually experience the problem. By replicating the intervention under field conditions, the researcher is able to assess the effects of the intervention. In this research project, the researcher undertook play therapy and applied Schoeman's working model as the Gestalt play therapy approach. This was undertaken with the same four refugee children who were the actual participants in the multiple case studies. This enabled the researcher to replicate the intervention necessary for this

also interviewed these children's foster carers and

4.1.5.4 Refining the Intervention

Janse van Rensburg (in de Vos, 2002:414) states that the above two stages can be combined into one operation. Fawcett (in de Vos, 2002:414) points out that the results of full field testing are used to resolve problems with measurement and intervention systems. Changes as to language, content and intervention methods may produce the desired behaviour changes and outcomes for the full range of beneficiaries. By repeatedly altering the intervention, the intended effects will be produced.

The researcher was able to achieve this, due to the fact that four case studies were conducted, enabling the researcher to refine the intervention. This was the final stage that the researcher achieved.

4.1.6 Phase 6: Dissemination

This phase was not implemented.

4.2 Universe, Population and Boundaries of the Research Sample

4.2.1 The Universe

According to Strydom and Venter (2002:198) the universe refers to all the potential subjects who possess the attributes in which the researcher is interested. The population refers to those who have specific characteristics, which the researcher is interested in. The respondents are chosen from this group. The universe for this was refugee children between the ages of 15 and 18 years.

4.2.2 The Population and Boundaries

The target population was refugee children, girls as well as boys between the ages of 15 and 18 years, who have been supported by the Refugee Team for Essex County Council. A list of these children was obtained from the Refugee team. The parents and social workers were included. For this study, refugee children who were supported by Essex County Council between October 2003 and October 2005 constituted the population. The total number of refugee children in the United Kingdom is unknown,

approximately 82,000 refugee children in schools in
carrier as only those who were able to speak and
understand some English could be considered. Their carers or parents also needed to
understand and speak English. This is discussed in more detail in Chapter Three.

4.2.3 The Sample

According to Bowling (2002:380), a common problem when undertaking qualitative research is the sample size, and because of the complexity of data, the sample size is usually small. The aim is to provide insight into social phenomena rather than statistical information.

Convenience sampling was used for selecting the case studies. This means, sampling for reasons of convenience, and this is usually used for complex issues (Bowling, 2002:187). For this study the researcher gained access to refugee children, who have been supported by Essex County Council Refugee Team. She has built relationships with some of them, due to undertaking her practical placement in the refugee team. The complexity of the issues facing refugee children, such as their legal status and asylum application, means that researchers need to build good relationships with them before undertaking the research. Convenience sampling is therefore more appropriate for the proposed study. The sample, therefore consisted of unaccompanied refugee children who were in foster care.

Key informants were consulted and social workers involved with the refugees were also regarded as key informants.

4.2.4 Sampling Techniques

According to Seaberg (in Strydom & Delpont, 2002:199), a sample can be defined as a small portion of the total set of objects, events or persons that together comprise the subject of study. The researcher used systematic random sampling and convenience sampling. Systematic random sampling can be defined as selection from a list, giving each one on the list an equal chance of getting selected. A sample fraction was used. The refugee team keeps a list in alphabetical order of refugee children whom they support (Bowling, 2002:184).

Convenience sampling was used due to the difficulty of accessing the children and their foster carers. Convenience sampling can be described as sampling for reasons of convenience, such as easy to recruit, easily accessible, or likely to respond (Bowling, 2002:187). The researcher was undertaking her internship in the refugee team of the Essex County Council, ensuring her access to refugee children.

5. Ethical Aspects

According to Strydom (2002:69), the entire research project must be conducted in an ethically correct manner, and ethical principles should become part of the researcher's decision-making process. In addition to meeting the ethical requirements of the university, the researcher was also expected to meet the ethical requirements of the organisation. Thus, in order to conduct the research project, the researcher had to submit a separate research proposal and meet the ethical requirements of the Research Governance Board of Essex County Council. The researcher also had to obtain a sponsor within the organisation who would support the researcher and ensure the research process to be ethical and the researcher competent to carry out the research. This proposal is contained in Appendix One.

5.1 Voluntary Participation

Participants should be made aware that they can withdraw at any time from the research process. By making sure that respondents are thoroughly informed about the process, and impact of the research, they are afforded the opportunity to withdraw, either beforehand or during the process (de Vos, 2002:64).

The researcher therefore sent out written information about the research project, and subsequently met with the respondents, social workers and foster carers to ensure that they fully understood the process and impact of the research. This information was also made available in the first language of the respondents if they did not understand English so well. The researcher ensured the full understanding of the respondents by discussing the process with them together with their social workers and foster carers.

Research is that respondents should not be harmed as a result of participating in the research and that they should give their informed consent. This consent should be in writing and be requested after the person has been given proper information about the aims of the research, confidentiality and anonymity, what it involves, and what is expected from the participants. This would include the warning that some questions might cause distress. Participants should also be informed that they are free to withdraw at any time. This voluntary consent safeguards the freedom of the participant to choose whether to take part, thereby reducing the legal liability of the researcher (Bowling, 2002:156-157).

Written consent was obtained from all the respondents after having received full information about the research and having met with the researcher. Participation was therefore voluntary.

5.3. Confidentiality

Confidentiality involves handling information in a confidential manner. This prevents outsiders from having access to the information (de Vos, 2002:66). This was important for the refugee children, given the sensitive situations of some regarding their legal status, age and information about their families. Keeping them anonymous and certain identifying information secret, was thus important. The researcher found it difficult to manage the balance of maintaining their anonymity and using the relevant information in the research, because it may have affected the results. The researcher was able, however, to achieve satisfactory levels of anonymity without directly identifying the respondents. The researcher's view is that this will always be the case on research with refugee children. The researcher also ensured that all information concerning the children was kept in a secure place and manner, and access was only available to the researcher herself.

5.4 No Harm to the Respondents

The researcher is responsible for protecting the respondents and ensuring that the respondents are fully aware of the impact of the research and that they can withdraw if they need to. This is especially important in situations where they might be emotionally harmed. Babbie (in de Vos, 2002:64) states that he should have only the firmest of scientific grounds if he extracts sensitive and personal information from

...ing that unless such information was crucial to the
... be left out of the measuring instrument. In this
research study, however, this was unavoidable due to the experiences of refugee
children and the aim of the research. On the other hand the intervention was based on
Gestalt therapy and theory where the aim is never to harm any individuals.

In spite of this the researcher was aware that the intervention could still be difficult
for the respondents. As an experienced social worker and training play therapist, the
researcher was acutely aware of the impact some questions might have on the
respondents, and the trauma it might cause. These children were particularly
vulnerable to being ōusedö in any kind of research. The researcher therefore ensured
that the research process itself as well as the outcome of the research proved to be
empowering for these refugee children.

The researcher was qualified with the necessary competency and skills to undertake
the research. She also ensured that these were maintained throughout the process by
obtaining guidance and support from the study leader. The researcher is a qualified
social worker who works with traumatised children on a daily basis. Also the
researcher previously had a job which entailed ensuring that black and minority ethnic
young people were not discriminated against in any way and that they were included
in the decisions that affecting their lives. The researcher therefore obtained specialist
training regarding the specific needs of black and minority ethnic children, which
including the needs of refugee children. In addition, the researcher has already
successfully completed her theoretical component of the Magister Diaconologiae
course in play therapy. The researcher has also worked with children who have been
traumatised by way of community violence and has had access to experts regarding
refugee children. The researcher debriefed the respondents appropriately. Termination
and withdrawal was done with the utmost sensitivity for the individual needs of the
children and the relationship the researcher has established with the respondents.

The purpose of the literature study, according to Marshall and Rossman (in Fouché & Delpont: 2002:266-267) is to:

- demonstrate the underlying assumptions behind the research;
- show that the researcher is knowledgeable about related research and theory that guides the research;
- indicate that the researcher has identified some gaps in previous research and that the proposed study will highlight a need; and
- refine the research questions and assumptions.

Bowling (2002:136) is of the opinion that a literature review should be a critical analysis rather than a mere description of the literature. This literature study describes what resilience is, how this relates to refugee children, and finally how play therapy from a Gestalt perspective, can be used with refugee children. The researcher also describes the circumstances of refugee children. A brief exploration of the main assumptions underlying resilience, play therapy and Gestalt therapy is given. Finally, the researcher provides a critical analysis of the research regarding resilience and play therapy with refugee children, identifying some gaps in existing research and pointing out the relevancy of this study.

2.1 Defining Resilience

Resilience can be described as patterns of positive adaptation in the context of significant risk or adversity (Luthar et al in Newman,2002:8). Resilience is an inference about a person's life that requires two fundamental judgements: That a person is doing well and, secondly, that there is at present ,or has been in the recent past, a significant risk or adversity to overcome (Masten & Coatsworth in Masten & Powell, 2003:4).

According to Alayarian (2007:1-2) *“resilient people are those who have been able to move on in life after their traumatic experience, to integrate into a new society, to work effectively, to love and contribute to the life of the community they live in. Resilience is the ability to experience severe trauma or neglect without a collapse of psychological functioning or evidence of post-traumatic stress disorder.”*

Woodcock (2002:275) resilience can also be seen as "active coping". It includes experiencing some degree of choice over major decisions, being able to problem-solve actively in collaboration with others, and being connected to networks which offer some degree of social and cultural familiarity. It will also involve being able to talk about ongoing problems being able to talk and reflect on past experiences, both good and bad and being able to grieve actively. Woodcock (2002:275) developed this definition specifically in relation to refugee children, therefore this is the definition that the researcher will use in the research.

2.1.1 History of Resilience Research

The concept of resilience became the focus of research only since the 1970s when researchers started to investigate the phenomenon of resilience in children at risk as to psychiatric, developmental and life issues, due to genetic abnormalities or adverse life events. According to Goldstein and Brooks (2002:3), resilience can be defined as the process by which children overcome great stress and adversity. Yates, England and Sroufe (2003:250) describe resilience as the developmental process by which children acquire the ability to use both internal and external resources to achieve positive adaptation despite previous or current adversity. It was believed that this research could provide insight into what could make a positive difference in the lives of children at risk.

2.1.2 A Universal Concept

Resilience as a concept appears to cross national and cultural boundaries. Cross-culturally the concept appears to be understood as the capacity to resist or "bounce back" from adversities. The International Resilience Project was conducted by the Civitan International Research Centre. The main purpose of this project was to identify what actions children and carers were taking that would seem to promote resilience. This project, which surveyed 600 children at the age of eleven, from 30 different countries, reported that children stated the following as the most commonly mentioned adversities: death of parents or grandparents; divorce; parental separation; illness of parents or siblings; poverty; moving home; accidents; abuse; abandonment; suicide; remarriage and homelessness (<http://resilnet.uiuc.ed/library/grotb98a.html>).

across cultures and countries, a resilient child can identify and recover more successfully from traumatic events. Despite the difference in culture and continent, parents universally want similar things for their children. According to Goldstein and Brooks (2002:3), parents across the globe would like their children to have happiness, success, satisfaction and good health. This would require children to possess inner strength and skills to cope successfully with the challenges and pressures they encounter.

2.1.3 Identifying Resilience in Children

According to Goldstein and Brooks (2002:10), children who are resilient have a particular mindset, although they may share the same qualities and ways of viewing themselves as children who have been unsuccessful in meeting challenges and pressures. According to Goldstein and Brooks (2002:10-11), resilient children:

- are able to translate situations into positive action;
- feel special and appreciated;
- are able to set realistic goals and expectations for themselves;
- can solve problems and make decisions;
- view mistakes, hardships and obstacles as challenges rather than stresses;
- have productive coping strategies., being aware of their weaknesses, strengths and talents;
- view themselves as competent;
- have developed effective interpersonal skills;
- can seek assistance and nurturance in an appropriate manner from adults who are available and can provide support when needed;
- are also aware of the aspects in their lives which they have control over and can focus their energy and attention on this rather than on issues which are out of their control.

Resilient children possess certain qualities which enable them to overcome adversity and stress. It is believed that resilience is the reason why some children overcome obstacles, while others become victims of their past experiences and environment. In

above Goldstein and Brooks (2002:3-4) identify

- able to cope effectively with stress, pressure and everyday challenges;
- capable of bouncing back from disappointments, adversity or trauma;
- able to set realistic goals for themselves and those in their lives;
- capable of solving problems and interacting comfortably with others;
- possessing self-discipline and a sense of self-respect and dignity.

2.1.4 Protective and Risk Factors

Accounting for resilience in the lives of children entails a search for the processes that protect development. Studies of resilience have taken different approaches to try to identify factors associated with better adaptation in children at risk. These processes and factors have been identified as "protective" factors. A risk is a factor that negatively affects children's development, which could lead to maladjustment (Masten & Powell, 2003:9).

Reviews of early research on resilience highlighted three major categories of protective factors. These are *individual attributes* such as good intellectual skills, positive temperament, positive view of the self; *family qualities* such as a high level of warmth, cohesion, expectations and involvement; and *supportive systems outside the family* such as strong social networks and good schools (Masten & Powell, 2003:13).

Research on resilience also focused on extreme trauma in the form of war, extreme deprivation and natural disasters. In a longitudinal study (Project Competence) involving Cambodian youth who were exposed to war and who immigrated to Minnesota (USA), many suffered long-term symptoms of trauma related to post-traumatic stress disorder, but were resilient compared to their peers who did not survive. Many had made friends while attending school and were well on their way to becoming productive citizens of America (Masten & Powell, 2003:9).

It is the opinion of the researcher that the significance of this research is that it indicates that despite the trauma of war and civil conflict with all the loss and change

natural instinct to survive and if given the proper protective and healthy lives. It does also raise questions about what the protective factors are for children; whether these factors are present in the lives of refugee children, and finally how resilience could be promoted using these protective factors.

2.1.5 Protective factors

There are several protective factors that make it less likely that a child will suffer long-term psychological stress. According to Rutter (2003:130) some of the protective factors for refugee children are: having parents who can give their children full attention and good quality child-care; having an extended family network; having access to other people, particularly from their own community, who offer friendship and support; having some understanding about the reasons for exile - obviously young children may have an incomplete understanding of such stressful experiences and be more vulnerable; being happy in a new school, and able to make friends and to perform well in school; being able to talk about stressful events and thus gain mastery over them; being able to ask for help when things go wrong; children who have good self-esteem are more likely to overcome traumatic events, feeling optimistic about the future and positive about making progress.

2.1.6 Adverse Factors

The duration and intensity of trauma, the child's age, personality and character, the quality of child-care in the host country and what is experienced there - all of these will affect the way the child comes to terms with being a refugee. Certain adverse or risk factors make it more likely that problems will arise, while other protective factors will help guard against long-term psychological distress (Rutter, 2003:129).

Adverse factors that make it more likely that a child will suffer long-term psychological stress can include: traumatic events, that are overwhelmingly intense and last over a long time; inconsistent child-care; and being unable to understand the changes in their lives. Younger children are even more vulnerable, as they find loss and death more difficult to understand. Other adverse factors include economic insecurity and poor housing; suffering bullying and /or isolation at school; being isolated from other people from their home country; and having low self-esteem and little to look forward to. Being unable to talk about traumatic events for fear of

Someone who withdraws or gets angry when things go
adverse factors. Having other problems unrelated to the
refugee experience can further add to these adverse factors (Rutter, 2003:129,130).

As long as there is a balance between stressful life events and protective factors, successful adaptation is possible. Intervention should therefore be seen as an attempt to shift the balance from vulnerability to resilience, by either decreasing the exposure to risk factors or stressful events, or by increasing and strengthening the number of protective factors (Gorman-Smith & Tolan, 2003:408).

A well-adjusted person is centred by a series of relationships. What exile does, is to strip refugees of their anchors. Research on risk and resilience has suggested three domains of resources which serve to protect children in the face of adversity: child characteristics, family characteristics and community characteristics (Masten and Powell, 2003:13).

It is the opinion of the researcher that those who provide education and social care to refugees should aim at helping them reconstruct the web of relationships. According to Rutter (2003:116-117) schools can help children establish new friendships and re-establish language, role and status. Those who wish to promote well-being in refugees should aim to maximise the protective factors in a child's life and minimise the adverse factors. The researcher is in agreement with Rutter and others that schools can help a child build relationships and that protective factors need to be maximised. However, there has been only limited research on how this can be done, as well as how children could gain access to services which would enhance these protective factors. It is the researcher's opinion that this would be particularly difficult, as research indicates that maximising the protective factors and promoting resilience involves not only the child, but the family and community as well.

2.2 Attachment and Resilience

According to Masten and Powell (2003:14), research should focus on attachment (systems underlying close relationships in development), mastery motivation (pleasure from mastering developmental tasks, that is, self-efficacy system), self-regulation (emotional and behavioural regulation or impulse control), cognitive development and

of human organisation. Cultural evolution has extended families, religious systems of ethnic groups and societies that offer adaptive advantages. The researcher's opinion is that this statement by Masten and Powell rests upon the assumption that all children have these opportunities and that they would willingly choose to become involved with these different groups that could offer support. It is the view of the researcher, however, that the results of this research study reveal that some refugee children on account of their past experiences are simply not able to take up these opportunities even if they were available, or the opportunities may not be available at all. Being a refugee means that people are not living in their country of origin, may not even be living with any family members, and may not feel part of the community they are currently living in. This research study, and previous research as well, has indicated that refugees often have to face racism, isolation and discrimination. They would have lost their friends, their family and community, and would need help in restoring supportive relationships (Wade, Mitchell & Baylis, 2005:155).

2.3 Promoting Resilience in Children

In a longitudinal study on the quality of life following early adversity, the conclusion was that traumatic events have much less impact on later life than is often predicted, and that it is possible to compensate almost completely for any single, short-lived early trauma by means of continuing care and attention (Vergodt in Newman, 2002:24). According to Newman (2002:23, 37, 51, 69), there are several factors which promote resilience in children throughout the developmental stages. He has developed a list of effective strategies to promote resilience in each developmental stage:

Factors promoting resilience in all phases

- Strong social support networks
- The presence of at least one unconditionally supportive parent or parent substitute
- A committed mentor or person outside the family
- Positive school experiences
- A sense of mastery and belief that one's own efforts can make a difference
- Participation in a range of extra curricular activities

same adversities so that beneficial as well as the
recognised

- The ability or the opportunity to make a difference by helping others
- Not to be excessively sheltered from challenging situations which provide opportunities to develop coping skills

(Newman, 2003: 51, 52).

2.4 Limitations of Resilience

Emerging research has indicated that as children make the transition into adulthood it is their strengths, abilities and assets that determine their success in life, not their problems and weaknesses. Resilience and the processes within offers an explanation as to why some children overcome adversity and others do not (Goldstein & Brooks, 2002:5). However, it is important to stress at the outset that no child is, or can be rendered, invulnerable to emotional or physiological stress. Where adversities are continuous and extreme, and not moderated by factors external to the child, resilience will be very rare (Cicchetti & Rogosch; Runyan et al. in Newman, 2002:8).

According to Masten and Powell (2003:15), resilience arises from 'ordinary magic'. This concept refers to the idea that human individuals are capable of astonishing resistance, coping, recovery and success in the face of adversity, equipped only with the usual adaptation capabilities, that is, their resources functioning normally. It is therefore a priority to sustain and restore cognitive and social development for protecting a child's development and promoting resilience in risky situations. Research conducted on resilience needs to focus on what works in interventions and programmes designed to promote good developmental outcomes. According to Masten and Powell, (2003:21) if resilience as a concept is to be applied to practical situations, actions must be able to affect the way in which children cope with adversities. The researcher has found, however, that research on programmes that promote resilience in children is very limited.

2.5 Refugee Children's Experiences

There are approximately 6000 unaccompanied asylum seeking and refugee children in the UK. Some unaccompanied refugee children have seen family members arrested, or killed, others were sent away when life became dangerous or when they were faced

families of unaccompanied children may be alive but contact with them and the pain of separation may be great. They may have experienced fear and anxiety on their journey to safety, maybe coping with bereavement and family separation. Refugee children are therefore vastly different from other children, both in the nature of their persecution and their circumstances prior to fleeing and will have different reactions to the refugee making process and to life in the new country (Kidane, 2001:4). Refugee children may undergo different events in their journey to the UK or any host country. According to Rutter (2001:121), they will experience loss trauma and change.

The most common reasons for children fleeing their countries of origin are:

- Forced recruitment into military activities
- The death of parents, or their inability to care for their children due to conflict in the region
- Forced re-education
- Being forced to either not take part in religious activities or precisely to do so
- Being forced to give information about the activities of a group or members of their family
- Pressure to denounce family members
- Involvement/non involvement in political activities.

2.5.1 The Psychological and Emotional Needs of Refugee Children

Refugee children go through a multiplicity of different stressful events and may cope with some or all of them. Like adults, most children can, to a certain degree, cope with the multiple forms of stress of being a refugee; some, however, remain psychologically vulnerable, while others may manifest disturbed behaviour (Rutter, 2003:127).

Their arrival in a new and strange land carries a risk of social isolation and means that they bring with them a range of psychosocial needs associated with separation and settling anew. Adults involved in their lives face the complex task of helping them minimise the disconnection between their past and present lives (Wade, Mitchell & Baylis, 2005:155).

ts, other key carers, siblings, extended family and friends, as well as a connection with their community. They may have lost their home, material belongings, and toys. They have lost their familiar surroundings and familiar lifestyle. They may have also lost their parents' attention and support in the new country. The process of leaving creates a social and cultural dislocation (Wade, Mitchell & Baylis, 2005:155).

2.5.1.2 Refugee Children in Local Authority Care in the UK

An audit in the UK revealed that although refugee children have multiple needs because of their experiences of loss, separation and dislocation, many were not receiving the same standard of care that local children receive, even though they had the same legal rights. Many are supported in temporary accommodation, living in bed-and-breakfast or hotel accommodation. Due to the difficulty in determining a child's age when there is no proof of identity, adults may claim that they are less than 18 years old in order to get more services. Due to this problem, some children may be placed where there is little support or no adult carer with parental responsibility (Kidane, 2001:5).

2.5.1.3 Traumatic Experiences

Refugee children will have had widely varied exposure to traumatic events. A small number will have no direct experience of persecution. Perhaps they were not in their home countries when things occurred or their parents were able to protect them from the direct experience of conflict and persecution. Other children were kidnapped and tortured, some witnessing the killing of parents, siblings or friends, and some are separated from their parents or spend periods of time in refugee camps. Some children come under direct fire, while others watch the conflict on television. Also, the impact of poverty as a stressor should not be underestimated (Rutter, 2003:6).

According to Rutter (2003:6), the greater the duration and intensity of traumatic and stressful experiences, the greater the likelihood that the child will suffer from a psychiatric disorder. A child's healing mechanisms may not be able to overcome such events.

Disorder

PTSD) is a cross-cultural phenomenon. The majority of refugee children, despite being exposed to highly distressing circumstances, are remarkably resilient, especially where support is available from extended family and kinship networks, a factor not encouraged by dispersion policies.

A range of studies from the Second World War to date indicates that vulnerability to PTSD is lessened or recovery from it is likely where children are supported by their families and they perceive that their immediate carers have influence over their circumstances. In addition to supportive families, children who appear best placed to maintain positive mental health are those who can identify with a community and its aims, and who have the opportunity to take part in meaningful social rituals which affirm their cultural values (Hodes in Newman, 2002:44-45).

Some of the traumatic experiences that refugee children may have been exposed to:

- High intensity war, bombing, or shelling
- The destruction of their homes
- The violent death of family and friends
- Injury to family or friends
- Getting separated from family and friends
- Being injured themselves
- The arrest or torture of family and friends
- Being arrested, detained or tortured themselves
- Being forced to join armies or the militia
- Rape
- Shortages of food, water and other necessities
- The fear of discovery or arrest
- Hostility in their new homeland
- Material deprivation in the new country
- Being with people who do not understand or know about the violent events they have experienced

(Rutter, 2003:128).

pent some time in a refugee camp. Circumstances of refugees may vary but refugee camps have several things in common from which refugees fled. According to Rutter (2003:9) life in a refugee camp is like living in limbo. Both adults and children can be exposed to distressing conditions from which they have fled ó rape, violence, organised crime, and shelling. Therefore, the mental health of refugees in camps will deteriorate. Conditions in reception centres or hotels where some refugees are placed may be similar to those found in refugee camps. Refugees may feel hopeless and experience a lack of control (Rutter, 2003:9).

2.5.5.6 Change

Refugee children may experience vast cultural changes, for instance, having to learn a new language and being faced with new cultural norms. They may have to adjust to a totally different school system, changes in standards of living and status in society. Relationships with their peers may change, as they may appear more vulnerable. When working with refugee children do not make assumptions about their experiences or just label them as different or traumatised. Every child's experiences of loss, trauma and change is different, and they may react differently to it (Rutter, 2003:128).

Children who are able to integrate their experience into their belief system, as well as having access to permanent housing, a permanent immigration status, and enjoying a reasonable standard of living in a new country are less likely to suffer long-term distress. Additionally, being able to maintain some links with their home country and remembering good things about life in their home will make it less likely that they will suffer long-term distress.

2.1.5.7 Racism

Many refugees report experiences of racism or even racist attacks. They also reported discrimination by their employers and other institutions. According to Hyder (2005:74) the media coverage of refugees is considerable but mainly negative. Hyder goes on to say that refugees have now become the scapegoats of everything that goes wrong in the UK. Rutter (2001:136-137) has a similar view, asserting that the following factors contribute towards the racial harassment which refugees experience: existing local

and bad housing, which lead to making refugees the refugees in the media; failure of the police to effectively deal with victims; inflammatory statements by politicians; and the failure of schools to assist these children in a proper way.

Rutter (2001:136) describes racism as treating people differently because they belong to a particular ethnic group. This can take on many forms from being treated differently than others by employers or other institutions, to violent attacks. Rutter (2001:136) is of the opinion that institutional racism can be described as an institutional culture in a school, business or public service where there is discrimination on the grounds of race, whether intentional or not. According to Fadal (2002:27), racism can be manifest in almost anything, such as a thought, feeling or action which uses the notion of race as activation or organising principle. He adds that it can be a form of organising people and the relationships between them by making reference to their race. It can also take the form of hatred of one group for another.

2.5.2 Access to Mental Health Services

According to Lowe (2006:5-25), the problem for the black and minority ethnic community is that therapeutic services for children are not accessible to them. There is also a low uptake of services from the black and minority ethnic community, of whom refugee children form part. The minority ethnic community may view mental health services as dealing with mental illness and its services are associated with a lot of power, control and authority. A study by Young Minds in 2005 found that young people from black and minority ethnic backgrounds did not make use of mental health services for reasons such as fear, lack of trust, and the stigma of accepting help from such services. That study highlighted the need to work with the parents of children referred.

2.5.3 The Asylum Seeking Process

In the UK, full refugee status entitles children and young people to a range of services, including permanent housing when they leave care, and grants for higher education. It also enables them to obtain travel documents. However, full refugee status does not give them the right to family reunions. Exceptional leave to remain (ELR) means that

settle in the UK and are entitled to the benefits discretionary and has only temporary status, ranging from one year to four. Indefinite leave to remain is not temporary. Thus, where an asylum application has been unsuccessful, the applicant is entitled to appeal against the decision to grant only temporary status. Such an appeal has to be lodged within ten days. In the UK, children are not automatically granted refugee status or indefinite leave to remain or exceptional leave to remain; they have to apply for this at the Home Office. They are therefore viewed as asylum seekers and the application process is called the 'asylum process'. The asylum process and outcome is a very important process in the life of an asylum seeker as it determines what they are entitled to and thus directly affects their future. While this remains unresolved many asylum seekers feel that their lives are 'in limbo' with their movements restricted (Kidane, 2001:23).

The asylum-seeking process can take up to six months for an initial response, and up to four months to appeal against a negative outcome. This is a very stressful and uncertain period for children and young people (Kidane, 2001:33).

2.6 Play

In order to develop, children need the following: love, security, food, shelter, a family, community, opportunities to play, self-expression, interaction, health care and welfare support, and education in its broadest sense. Across all human cultures, children in normal circumstances have an intrinsic desire to play (Hyder, 2005:5).

Play enables children to explore the customs and roles of their direct community, to reflect upon their inner selves and their emotions, to encounter abstract thinking and to develop communication skills. Play is often seen to provide a vehicle for children to create meaning from their experiences (Bruce in Hyder, 2005:15).

In early brain development, research has shown that play can shape and structure the brain. This does not happen in all play activities but in those which involve imaginative play, play which children initiate themselves and play which is repetitive. It activates neural pathways and promotes memory skills. Through individual and group play, children can learn to consolidate social and physical skills, share ideas, experiences and feelings, and learn to explore, experiment and create (Jambor in Hyder, 2005:12).

Play can make a positive difference to young refugees. She believes that play is a healing experience for children affected by war and conflict in such a way that they are able to reclaim something of their lost childhood.

The emotional impact of violence, conflict and oppression will vary from child to child, and community to community. In some cases, children may have witnessed or been directly subjected to violence. In many other cases, the impact may be secondary, where in a sense they will absorb the emotional states of the adults and carers around them (Hyder, 2005:45).

The direct or indirect impact of violence on children's lives erodes trust and reduces opportunities to explore their environment. Children's basic physical and emotional needs will not necessarily have been met. Children gain confidence through the exploration of their environment via play. But violence promotes fear and insecurity, and disrupts education and other community activities. When normal development is interrupted and a child is no longer in a position to play, all aspects of a child's development are affected, including the cognitive, physical and psychosocial aspects. The impact of not being able to play means that the child is not able to explore, assimilate and actively build a picture of their immediate world that encompasses all their senses and thinking. Trauma interrupts and skews a child's development by preventing play, and will even affect play itself (Hyder, 2005:48).

Trauma can alter the quality of a young child's play in several ways. Some traumatised children are quite restricted in their play. Many traumatised children are initially unable to use play symbolically. Trauma may have interrupted developmental processes to the extent that symbolic capacities were not generated. Early relationships may have been disrupted, preventing the child from using transitional objects and other toys as symbols for significant people and experiences. Some traumatised children's symbolic play is unlike that of most young children. Gone is the sense of joyful adventure, story, and spirited imaginative discovery that is characteristic of childhood. Traumatised children's play can become repetitive as the child is driven to play and replay his traumatic experiences in a compulsive attempt to master them. In addition, defences against re-experiencing feelings associated with trauma may be evident in play (Landers in Hyder, 2005:47).

Play to a child's development, it is the researcher's opinion that play therapy may therefore benefit children whose lives have been interrupted through war, conflict and trauma, resulting in limited or no opportunities to play.

2.7.1 History of Play Therapy

Sigmund Freud believed that play allows children to express negative emotions and to reconcile inner anxieties with the unconscious. Play offers the opportunity for children to come to terms with traumatic experiences and events by providing a safe way to express difficult emotions. In this way, children gain control over their feelings and are able to deal with situations which are stressful or traumatic. Freud believed that play is a means by which children express their innermost conflicts and desires (Hyder, 2005:56).

Historically, child psychotherapy was offered to the most damaged children on a long-term basis with two or three hour sessions per week for a year or more. The therapist would just observe the child's play, offering interpretations to help the child understand unconscious processes. Play was not seen as therapeutic in itself. Currently, psychoanalysis views play as symbolic expression of unconscious conflicts which need to be interpreted in terms of psychoanalytic theory. Humanistic and existential therapies view play as an expression of self and current experiencing, which need therapeutic understanding (Mook in Carrol, 1998:5).

2.7.1.1 Defining play Therapy

The British Association for Play Therapy describes play therapy as:

“ The dynamic process between child and play therapist, in which the child explores at his or her own pace and with his or her own agenda, those issues past and current, conscious and unconscious, that are affecting the child's life in the present. The child's inner resources are enabled by the therapeutic alliance to bring about growth or change. Play therapy is child-centred, in which play is the primary medium and speech the secondary medium ” (Association of Play Therapists Newsletter 1995 in Carrol, 1998:2). Play therapy according to Cattanach (1992:47) is a way of using play to heal hurting children.

foregoing describes non-directive play therapy, while in her opinion a Gestalt approach is more directive enabling therapists to use their initiative to explore with the child. According to Lampert (2003:8) this approach goes straight to the heart of what the child needs, in a way that is respectful and non-intrusive. It is the researcher's opinion that, due to the constant changes in a refugee child's life, long-term play therapy is not possible, and thus a more directive approach is needed, while still respecting the dignity of the child. It is therefore the researcher's view that a Gestalt play therapy approach is best suited to the needs of a refugee child.

2.7.1.2 Non-directive and Directive Play Therapy

According to Axline (1989:8), play therapy is an opportunity given to the child to play out his feelings and problems just as in certain types of adult therapy an individual talks out his difficulties. Many children who are referred for play therapy did not have relationships supplying love, security and belonging, but through the process of play therapy were able to acquire a feeling of personal worth, a feeling that they were capable of self-direction, a growing awareness that they had within themselves the ability to stand on their own two feet, accept themselves, assume responsibility for their conscious personalities, and by so doing, synchronise the two projections of their personalities, namely what the individual is within himself and how he outwardly manifests this inner self. Despite many approaches to play therapy, they have a common goal to alleviate distress and promote emotional well-being. Play therapy can be divided into non-directive play therapy and focused interventions. Axline(1989) advocates non directive play therapy and describes it as "an opportunity that is offered to the child to experience growth under the most favourable conditions; since play is his natural medium for self-expression, the child is given the opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment and confusion." Play in itself is the therapeutic intervention and not a stimulus for other forms of therapy. It is through the process of play that the child is healed (Cattanach in Carrol,1998:6). According to the researcher a Gestalt approach to play therapy can be described as a more directive approach to play therapy or as focused intervention.

Approach

It would be to help children to become aware of themselves and their existence in the world. The aim of play therapy according to Violet Oaklander, a Gestalt play therapist, is to help a child go back and remember, regain, renew and strengthen something they once had as a baby and which now seems lost. According to Oaklander (1978:58), children do what they can to survive and there is no limit to what a child will do in order to survive and have their needs met. Her task as a therapist is to help the child separate himself from outside evaluations and wrong self-concepts and help the child rediscover his own being.

The goal of the therapist is to help children feel strong within themselves, to help them see the world around them as it really is, so as to let them know that they have choices about how they will live in their world, how they will react to it and how they will manipulate it. "We cannot make choices for them but give them the strength to make the choices they want to make, and to know when choices are impossible to make."

The writer is therefore in agreement with Oaklander (1988:291) who sees her task as helping children know that they cannot take responsibility for the choices that do not exist for them, and that they can then make decisions, perhaps to change the social structures that keep them from making the kind of choices they need to make.

It is the researcher's view that this is particularly relevant to refugee children in whose cases many decisions about where and how they live are out of their control and who therefore need to be creative to find alternative ways of meeting their needs.

2.7.1.4 Resilience and Gestalt Therapy

Gestalt therapy with its emphasis on the I-Thou relationship and organismic self-regulation is a logical method of promoting healing and enhancing children's resilience. Lampert (2003:174-176), mentions several aspects of resilient children.

1. They have a talent or special interest that brings pleasure and a sense of competency

A Gestalt approach will bring to the foreground special interests, skills and abilities that may have been overlooked by adults and others in the child's life. A Gestalt approach to therapy will also give the child opportunities to learn new skills and discover hidden talents. Lampert acknowledges that with resilience, the downside

en their pain through achievement, but the potential
e cases.

2. They have at least one consistently good relationship with at least one adult

Being in relationship with one person, even if it is for a very short time, when that person is consistent, trustworthy and commanding respect, will carry the message that if there is one person in the world like this there must be others.

3. They have the ability to distance

Children are able to distance themselves from difficult situations in various ways. This can be maladaptive, but play therapy's use of projections can help the child own this projection. A Gestalt approach accepts the child as he is and does not attempt to fix anything, but goes in confluence with the child. This can also be seen as organismic self-regulation and the Gestalt therapist will work to enhance the child's ability to heal himself.

4. Resilient children are able to ask for help from appropriate adults

Lampert looks at ways in which the child can seek assistance from appropriate adults. This is in accord with Gestalt therapy's aim to empower the child and help him look at alternatives.

5. Validating the child's feelings

The therapist at times will be the only adult to validate a child's feelings.

Lampert believes that therapists have the ability to develop strengths and thus enhance resilience (Lampert, 2003, 173-181).

According to Lampert (2003:8), a Gestalt approach to play therapy goes straight to the heart of meeting children's needs. They are accepted as they are. There are no expectations of performance or behaviour to meet the needs of another. It is a deeply respectful and non-intrusive method. "The goal is not to fix or change, but to facilitate self-healing" (Lampert, 2003:8-9).

Schoeman's working model is a Gestalt play therapy approach that the researcher has integrated in the research strategy. This model has various phases, which are based on the Gestalt therapy process. There are nine phases, which will briefly be outlined:

- *The relationship* – Building a relationship with the child is important before further work can be undertaken with the child. This is vital, as the child will not just open up to reveal his feelings.

Working with the children's senses enables them to come

- *The child's process* ó This refers to the way in which the child goes about to meet his needs. This includes the child's temperament or personality, which will be unique (Blom, 2006:79)
- *Projection* ó The therapist helps the child to make a projection using different mediums. The child 'projects' feelings and emotions on an object or person which he cannot express verbally. When the child owns the projection, healing can begin, as the child acknowledges what he feels, which he was previously not able to do.
- *Alternatives* ó Together the therapist and the child can find solutions to some of the difficulties the child may be experiencing. This helps the child to take responsibility for what is within his control.
- *Clarification* ó This phase involves summarising the difficulties and as clarifying these issues for the child. The therapist should use language that the child will understand. This provides the child with a sense of security.
- *Empowerment* ó This phase is unique to the Schoeman model. The aim is to give the child a sense of power and control. This can be some compliment or encouragement about the child's abilities, and can be seen as a way to improve the self-esteem of the child, building his assurance that he can make decisions and choices on his own.
- *Evaluation* ó This phase is aimed at helping the child evaluate what he has learnt or gained from the session and what he may want to learn in the future.
- *Self-nurturing* ó This is the last phase in the model. The therapist needs to enable the child to nurture himself. This takes place at the end of each session, so that the child feels emotionally safe to leave the session. This could be encouraging the child to do anything that he enjoys or finding a way in which he could 'treat' himself. This relates to the concepts of responsibility and self-support in Gestalt therapy (Schoeman, 2004:118,163,177,178,180)

It is the researcher's view is that Schoeman's working model has several aspects which could enhance resilience. These include the relationship, looking at alternatives, empowerment and self-nurturing.

art (2003:9) that the aim of play therapy is not to fix or change anything in the child's make up, but to empower the child to meet his needs in a way that is helpful to himself and to those around him. In order to understand how a Gestalt approach to play therapy facilitates this process, the writer will describe Gestalt theory that underpins a Gestalt play therapy approach.

2.8 Gestalt Theory

The word 'Gestalt' is a German word meaning a whole or complete pattern. A Gestalt approach means studying the whole of the Gestalt with the idea that the total is more than the sum of its parts (van Niekerk in Schoeman & van der Merwe, 1996:4).

According to Gestalt theory, the free functioning of the body in nature forms natural and healthy behaviour. A Gestalt approach could therefore be seen as self-regulating and as a natural way in which we mature as human beings (Schoeman & van der Merwe, 1996:4).

There are three main tenets, on which typifies Gestalt therapy:

- a) Gestalt therapy is phenomenological, that is, its only goal is awareness;
- b) Gestalt therapy is wholly based on dialogic existentialism; and
- c) Gestalt therapy's world view is Gestalt, indicating holism and field theory

(Yontef, 1993:200).

Phenomenological

Gestalt therapy being phenomenological means that it looks at multiple possibilities of a given situation as it is experienced subjectively by the people co-creating it at any moment in time. It shares the phenomenological premise that it is not possible to establish a single objective or absolute truth but only to be open to several subjective interpretations of reality. Each individual experiences reality and forms impressions differently with subjective meaning. The therapist aims to uncover each client's unique way of giving meaning to the events in his life and in the therapy session (Mckewan, 1996:58-59).

Phenomenological exploration aims for an increasingly clear and detailed of what 'is' and de-emphasises what would be, could be, was, and might be. Phenomenology works

tially and allowing sensory awareness to discover (Yontef, 1993:202-203).

Awareness

ōAwareness is a form of experiencing. It is the process of being in vigilant contact with the most important event in the individual or environment field, with full sensorimotor, emotional, cognitive and energetic support. A continuing and uninterrupted continuum of awareness leads to an 'Aha', an immediate grasp of the obvious unity of disparate elements in the field. New, meaningful wholes are created and therefore awareness is itself an integration of a problemö (Yontef, 1993:202).

There are three aspects to awareness:

- Awareness is only effective when it is grounded in the dominant current need of the person.
- Awareness cannot take place without knowing the reality of a situation. How one is, in a situation, and then owning that process. öOwningö the process is knowing oneö's control over, choice of, and responsibility for oneö's feelings and behaviour.
- Awareness can only take place in the öHere and Nowö; it is constantly changing, evolving and transcending itself. Awareness is also sensory (Yontef, 1993:202).

Growth and change can take place when there is awareness. According to Zinker (1998:90), awareness provides choice, because when we are unaware we act blindly without conscious choice. People are able to make the best possible choices for themselves as well as for others when they are aware of their needs and the needs of others. Deepening awareness and taking responsibility for choices are fundamental principles in Gestalt therapy (Zinker, 1998:80).

Awareness is the means by which individuals can regulate themselves by choice. Literally one can see this as the ability to respond, öresponse-abilityö, to be the primary agent in determining oneö's own behaviour (Yontef, 1993:180).

ect in the therapeutic relationship in play therapy. It is also debatable, as children cannot take responsibility for situations they have no control over. This is in line with Gestalt therapy. In Gestalt therapy awareness is equal to responsibility, individuals cannot be responsible without being aware (Yontef, 1993:141-145).

One of the objectives in play therapy is to provide the child with opportunities to assume responsibility and to develop a feeling of control. Children are responsible for what they do for themselves in the playroom. When therapists do for the child what they can do themselves, the child is deprived of assuming self-responsibility and a feeling of being in control which is a powerful variable, helping children's self-esteem. (Landreth, 1991:155).

2.8.1 Awareness: The Gestalt Approach to Change

In Gestalt therapy, awareness (including owning, choice and responsibility) and contact bring about natural and spontaneous change. Therapists cannot force people to change, and this goes against the principles of the Gestalt therapeutic relationship. The Gestalt therapy theory of change is that the more one tries to be who he is not, the more one stays the same. This is known as the paradoxical theory of change. In this approach, resistance is understood and is integrated in the awareness-work with the client. It is not seen as something negative. Working with resistance is one of the most important aspects of psychotherapy. The therapist needs to look at what is being resisted and that it is not necessarily the therapy or the therapist. The therapist that attempts to change the person is only doing this to a particular aspect of a client and this will inhibit organismic self-regulation (Yontef, 1993:12, 295).

2.8.2 The Gestalt Therapeutic Relationship

The therapeutic relationship in Gestalt therapy is based on Buber's theory of healing through meeting. Buber believed that it was only through a particular kind of person-to-person relationship that healing can take place. Healing is seen as restoring wholeness (Yontef, 1998:31). The dialogic view of relationships is that reality is about relating. We are constantly relating to our environment and to others. Awareness and our sense of self is also relational. We grow by what happens between people and not by looking inwards (Yontef, 1998:33).

actual relationship between the therapist and client. Contact the actual other person and also what is really true for you. This is what distinguishes Gestalt therapy from other approaches. There are two dimensions to this relationship. Buber calls it the I of the I-It and the I of the I-Thou. "Thou" occurs when there is a true meeting between people. In this situation, each person is treated as a separate other, and as an end in him-or herself. The person knows and confirms that the other person is separate and equal. In the I-It relationship, something is being worked towards rather than allowing interaction to just happen. In the I-It relationship, there is controlling and manipulating and planning. The therapist using their personality to help the client is operating in the I-It mode. However, the I-It is necessary and can be used to switch between the I-It and I-Thou. Yontef (1998:34) refers to this as the "I-Thou relation" where the I-It is in service of the I-Thou.

2.8.2.1 The Gestalt Therapeutic Relationship in play Therapy

The therapeutic relationship based on a Gestalt approach is an important tool helping to explore the child's deepest feelings, fears and frustrations. It is the medium used to heal the child in a therapeutic way. The child's needs should be met through the relationship. According to Lampert (2003:9), the "I-Thou" relationship is the single most important tool in promoting healing. The role of the therapist is to bring the child into contact with his sensory, emotional and cognitive needs. The therapist aims to help the child to meet his own needs through play therapy (Schoeman & van der Merwe, 1996:4).

Organismic Self-regulation

This concept refers to the way in which people meet their physical and emotional needs and has a natural tendency to regulate themselves. The aim of the therapist is to enhance the self-regulating process of the child so that he chooses to take responsibility for regulating himself. The aim of the therapist is to help children to meet their needs in a way that is right for themselves and their environment (Oaklander, 1988: 291).

The criticism about organismic self-regulation is that this does not necessarily bring about health, but it leads the person to make the most of what is available for him. This is a very crucial debate with children who are dependent on adults. In Gestalt a person

anismic tendency to self-regulate. In order to grow
tain a balance between need gratification and tension
elimination. The healthy person differentiates this meaningful need and responds to it
appropriately, thereby restoring the balance and releasing more energy and allowing
the next important need to emerge (Clarkson, 1999:21).

Self -support

Support is important in Gestalt therapy. People largely develop their styles of
psychological self-support through the quality of the environmental support which has
been offered to them (Mckewan, 1996:183-184).

The issue for Gestalt therapists is how clients support themselves in solving problems.
Gestalt therapy facilitates problem-solving through increases self-regulation and self-
support. An impasse arises when external support is not available and the person
believes that he cannot support himself. The person's energy is then torn between
impulse and resistance. The dialogic relationship in Gestalt therapy facilitates clients to
overcome the impasse (Yontef, 1993:145).

From a Gestalt perspective support is the necessary basis of all healthy functioning
and the ground that enables healthy and satisfying contact. Healthy support is
interdependence where the person is self-supported but also able to recognise when
they need environmental support. For the Gestalt therapist the interest is not whether
the person is self-supported or needing environmental support but how the person co-
operates with their environment or community for mutual support, balancing his own
needs with consideration of the needs of others (Joyce & Sills, 2001:83-84). Gestalt
therapy facilitates problem-solving through increasing self-regulation and self-support.

2.8.1.2 Field Theory

Field theory refers to viewing the person in the context of his environment. Field
theory is based on the idea that the individual and the environment create themselves,
with the individual part influencing the rest of the field and the rest of the field
influencing the individual (Yontef, 1993:287).

The issue for Gestalt therapists is how clients go about solving their own problems
within the field. Some of the main principles of field theory are:

stood in isolation but only as integral and interactive cultural backgrounds and ecological environment.

- Human behaviour cannot be attributed to any single cause but arises from the interlocking forces of the field.
- The field and the forces operating in the field are in continual flux. People actively organise and reorganise their perception of their circumstances (or field) by continually making some aspects of that field focus, while others become background and vice-versa. The need or interest organises the field.
- People attach meaning to their experiences. In this way they contribute to the creation of their own circumstances or lived experience (they co-create the field and they have existential responsibility for their own lives or the meaning they give to their lives).
- Human behaviour happens in the present and can only be explained in the present field.
- All aspects of the field are connected, and if change occurs in any part of the field, it is likely to affect the whole field (Mckewan, 1996:49).

2.8.1.3 Sensory work

A child's senses, body, feelings and intellect form the basis of the child's sense of self. According to Oaklander (1978:57), a strong sense of self makes for good contact with one's environment and people in that environment.

Oaklander (1978:57) states that the healthy, uninterrupted development of a child's senses, body, feelings and intellect is the underlying base of the child's sense of self. She has found that children who are seen as needing help, have one thing in common: some impairment in their contact functions. The tools of contact are looking, talking, touching, listening, moving, smelling and tasting. The way in which we use our contact functions shows how relatively weak or strong we may feel. A strong sense of self leads to good contact, and Oaklander (1978:57) has found that most children she has seen in therapy has a poor sense of self and tries to hide this. Children needing help are not able to make effective use of one or more of their contact functions. She describes therapy as going back to locate and restore the misplaced function. A child in therapy experiences his senses, his body, his feelings and the use he can make of his intellect,

ance towards life. Oaklander (1978:59) states that experiencing. She therefore gives the child as much experience as she can in the area where the child needs it.

2.9 play Therapy with Refugee Children

Play can be used with refugee children to help make sense of their experiences, explore issues such as fear, trust and helping newly arrived children. Refugee children would have experienced emotional trauma due to their circumstances. They need to work through their feelings which may be overwhelming, otherwise they may get buried and cause indirect problems. According to Rutter (2003:135), little work has been done to bring the philosophy and skills of play therapists into schools to help refugee children reflect on their lives and begin to settle in (Rutter, 2003:135).

Traumatic incidences may need to be brought out in the open, talked about, perhaps re-enacted symbolically. If children have survived the experience, then they can certainly survive the memory of the experience (Oaklander, 1988:248).

Play offers children the opportunity to come to terms with traumatic experiences and events by offering a safe way to express difficult feelings. In this way, children gain control over their feelings and are able to deal with situations which are stressful or traumatic. According to Hyder (2005:19), repetitive play is particularly important as it can lead to resolution of a problem or feeling. The play therapy approach which focus on the internal and emotional world of the child is therefore particularly relevant when working with children who have been affected by the disruption and disorder of war and civil conflict.ö (Hyder, 2005:19). Winnicott in Hyder (2005:19) views play as a healing experience which allows children the opportunity for solving their problems, resolve inner tensions and thereby coming to terms with difficult or overwhelming feelings(Cattanach in Hyder, 2005:20).

When undertaking play therapy with refugee children, the cultural context for play needs to be considered. Most theorists on play believe that play is universal for children and that play helps children to learn about their own culture. Play is seen as both a cause and effect of culture, play is an expression of a particular culture; play is an important context or vehicle for cultural learning/transmission (Roopnarine, et al. in

Children's play differs in its details in different cultural contexts. Researchers are interested to identify those aspects which are universal and those which are culturally specific. Haight (in Hyder, 2005:21), for instance, claim that the universal dimensions of play include specific play themes the extent to which children initiate in playing with caregivers, and the choice of play partners will lead to different developmental pathways for children (Roopnarine et al. in Hyder, 2005:21).

Another important factor when considering cross-cultural play is the importance that parents will attribute to the role of play in a child's development. Hyun (in Hyder 2005:21) describes how North American and European backgrounds tend to emphasise the cognitive importance of play with an individual perspective on play that is very object-and toy-focused. Families from other backgrounds tend to focus on the social dimensions of play. In these cases, the interactions within play and the emotional significance of play are of greater importance. Non-European families therefore view play and learning as 2 separate activities, while European families see play as a tool for learning. In some cultures children, are so integrated into the family and community that they understand the family and web of social relationships before they understand their selves.

Play looks different in different cultural contexts. Notable differences include:

- Whether or not adults play with children and especially whether they initiate play.
- The point at which children are expected not to play anymore ó ages will vary across cultures.
- The giving of toys ó in some cultures toys are seen as essential props for successful play and so are seen as a central feature of childhood.
- Play in mixed age groups away from adults

(Bruce in Hyder 2005:22).

2.9.1 Gestalt Play Therapy Approach with Refugee Children

Some theorists argue that children who have been seriously affected by trauma would need play to be supported and guided. According to Lampert (2003:8), a Gestalt approach is ideal as it fits in with their needs; they are accepted as they are. There are no expectations of performance or behaviour to meet the needs of another. It is not



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en. The goal is not to fix the child but to facilitate

The researcher is in agreement with Lampert (2003:173-181), who also states that a Gestalt approach to working with children promotes children's healing ability and resilience, especially the concepts of organismic self-regulation and the I-Thou relationship. The researcher feels that this is particularly relevant for children who have had traumatic experiences. It is therefore the researcher's opinion that Play therapy with a Gestalt approach appears to be particularly relevant with refugee children because of the following reasons:

- It takes into account the cultural context in terms of field theory in that it looks holistically at the child's circumstances (field theory), taking into account the child's community, family culture etc). Self-support and environmental support is closely related to resilience. Field theory also allows one to take into account the national and global context and experiences of refugees.
- It also makes sense, as it focuses on the "here and now", which is very helpful because a lot of the concerns for refugees are about how they survive currently, how they are adjusting to their current situation.
- Organismic self-regulation and the I-Thou relationship encourage resilience. The belief that human beings can regulate themselves and their potential for growth are particularly helpful in the case of refugees being seen as either pathological, victims and in need of great help on the one extreme, or on the other extreme, where refugees face racism and discrimination and undeserving of any help.
- Sensory awareness can address issues relating to trauma including post-traumatic stress disorder.
- Play is adaptable and universal in all cultures and goes across cultural and language barriers. Children do not need to express themselves verbally while playing, in order for them to benefit from the experience. Literature also indicates that play in itself promotes resilience in terms of developing and learning social skills and encouraging cognitive development.

ence many changes, and the Gestalt theory of change the client, not rushing the therapy, or trying to öchangeö the client is therefore ideal, as this is left to the client or, in this case, the child.

Conclusion

According to Hyder (2005:19), approaches which focus on the internal and emotional world of children are particularly relevant when working with children whose lives have been disrupted by war and civil conflict. The researcher feels that the literature available on Gestalt therapy and play therapy with a Gestalt approach is able to provide this. The researcher also feels that the literature available indicates that there is a strong likelihood that play therapy with a Gestalt approach will not only help refugee children overcome their past traumas but will also promote resilience in refugee children. At the same time however, literature on resilience indicated that there are some traumatic experiences and circumstances which children will not be able to recover from, or that there will be areas of development which will have been permanently damaged. They need to learn how to cope with this. Children's resilience is also dependent on the external and environmental support they receive, because of the fact that they are children and thus dependent on adults. It is the opinion of the researcher that the literature study also reveals that the resilience theory and, in fact, Gestalt therapy might be seen as an overly optimistic approach. The critics state that results on promoting resilience need to be viewed over a long period of time, that measuring resilience can be problematic, and that not enough research is available on the different outcomes in children, especially those who have been exposed to community violence. The researcher considers these points of criticism to be indicative of some gaps in literature on resilience. The researcher disagrees with the critics, and feels that the very large volume of research and definitions available on resilience indicates that resilience can be measured. The researcher admits that research on resilience needs to be very specific, and although this limits the use of such research, it does give rise to more questions.

In Chapter Three the researcher will discuss the research strategy and methodology that was used to conduct the research. In addition, the researcher explains the motivation behind choosing the specific research strategy. The researcher will explain



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specific research strategy. The researcher will also
and the selection procedure that was used.

This chapter describes the research strategy, and the motivation for using this particular strategy, namely the case study methodology. The methods of data collection used are also discussed. The sample population is described, and the barriers and limitations of the research strategy are discussed.

3.1 The Research Strategy

A qualitative approach has been chosen in view of the broad experiences of refugee children. Through qualitative research, the researcher was able to identify gaps in previous research. Having completed the research study, it is the opinion of the researcher that the research project was able to address some of the limitations and gaps in previous research. A qualitative approach allowed the researcher to describe the experiences of refugee children. With this approach, the researcher was able to quote the exact words of the participants. Qualitative research enables the reader to enter the subjective world of the participant (Delport, Fouché & de Vos, 2002:357).

Children's rhymes become part of their armour to cope with the world and perhaps to tell us, the adults, how they really think and feel (Cattanach, 2001:69). The qualitative approach is also flexible so as to capture words, pictures and quotes which may form part of data collection.

The researcher will be used applied-descriptive research. According to de Vos (2002:109), descriptive research presents a picture of specific details of a situation, social setting or relationship. Descriptive research should focus on 'how' and 'why' questions. In the proposed research, the focus will be on resilience in refugee children, and how Gestalt play therapy can promote resilience in refugee children. Multiple case studies may use triangulated methods consisting of observation, unstructured interviews, document research and structured or semi-structured questionnaires (Bowling, 2002:352, 403). Multiple case studies was used in this research study.

3.2 Theory Guiding the Study

When undertaking a qualitative study, the researcher needs to ask how theory will guide the process. In the traditional qualitative strategies, it can be placed on a

Whether the theory is used before or after the data is collected, it can be placed in the middle. Theory could be completely absent or it could be used to guide the study in an explanatory way. It could also be used at the end to compare and contrast it with a theoretical model, build theory or propose generalisations (Fouché & Delpont, 2003:267,268). In this research study, the researcher used theory to guide the study in an explanatory way.

The main theory guiding this research project was Gestalt play therapy and theory. In addition, the researcher used the Gestalt play therapy principles to explain the concept of resilience in relation to refugee children. The Gestalt play therapy approach that was used in this research study was Schoeman's working model.

3.2.1 Schoeman's Working Model

The Schoeman model is based on the process of Gestalt therapy. The purpose of the model was to provide the therapist with a guide to apply Gestalt philosophy. It is therefore based on the main principles of Gestalt therapy. Schoeman (2004:118) suggests that the sequence may not need to be followed but the principles need to be part of the process and outcome. The model is not meant to be strictly adhered to as it is an unfolding process (Schoeman, 2004:118).

3.2.1.1 Stages in Schoeman's Working Model

It is the researcher's view that the model is particularly helpful for new and training therapists, because it has a structure which helps the therapist to work with the most obvious issues first, while staying with the child's foreground. There are nine steps or stages to Schoeman's working model.

The relationship

Building a relationship with the child is integral to the model. If there is no trusting relationship between the child and the therapist, the child will not be willing to reveal his inner feelings and issues.

The sensory modalities

Working with the sensory modalities is an important aspect of Gestalt therapy and especially Gestalt play therapy. Schoeman (2004:118) states that the senses have the ability to unlock all the emotions through sensuality and the child's innate ability to

ness continuum within the process of therapy. The notions spontaneously.

Underlying the process of making contact are the senses which function together in a unique sensory system which enables the human to interact with his environment through his sense of hearing, seeing, touching, speaking, smell, taste and movement (Schoeman,2004:158).

The Child's Process

The child's process refers to the unique way the child makes sense of and behaves in his world. Blom (2006:52) defines this as what children do and how they do it. It also refers to the way they present themselves to the world and how they satisfy their needs (Blom,2006:79). Schoeman (2004:155) uses the term "process" interchangeably with "personality". The child's process can be assessed by considering his temperament. Schoeman(2004:157) refers to the DISC temperament analysis. Schoeman also suggests five components which can help identify the child's process. These are the child's contact functions; the child's process of self-maintenance; emotional expression; self-nurturing; and the child's handling of the inner process.

Projection

Schoeman (2004:163) describes projection as the child taking his own experience and placing it into another person or object. In this process, the child's boundary is blurred. According to Schoeman (2004:163), projections serve several purposes in the child's life. It gives the child the opportunity to deal with the world's expectations. The child also uses projection as a way in which to dispel issues he is not able to deal with yet. Projection also helps the child to maintain his self-respect and offers the child an escape when he is not ready to accept criticism and rejection. Projection is therefore a normal part of children's development.

Schoeman (2004:163) refers to Latner (1986:57) who asserts that projection is a fantasy process where reality is visualised as being different from how it is. Schoeman (2004:163) goes on to say that this enables the child to change reality in according to his own desires. When children are able to recreate their reality to meet their needs, they are better able to solve problems.

Oaklander's working model to help the children deal with his unfinished business takes place in the here and now, and helping children become aware of themselves and how they operate in the world is one of the main goals of Gestalt therapy with children. Projections are also used to promote self-growth in children. According to Schoeman(2004:166), states that the therapist uses her own charisma to facilitate rapid change in the child that is not reflected in play or dialogue blocks out the child's potential for own growth and self-support. Change occurs by helping children acknowledge what is, rather than what should be.

Projections also help children resolve unfinished business. This is done by helping children use projections to make sense of trauma in their lives. Children often have hidden resentments which they are not allowed to, or they are unable to express. Because of this unfinished business the child is unable to establish organismic self-regulation. As children attempt to gain closure and find their balance, they need to project their unfinished business. Due to lack of experience, children will project their unfinished business into their own bodies. This may manifest itself as physical aches or malfunctioning of some part of their body, or in internal emotional conflicts. Children may express this as angry and aggressive behaviour, or withdrawal, compliance or types of behaviour which cause children to be referred for therapy.

Schoeman uses a variety of techniques to help children make use of projections.

When children come to the realisation that the feelings they have projected onto the object in the projection is actually their own the projection has been owned. Once this occurs, the child is then able to work on solutions and find alternatives to these problems.

The researcher used Oaklander's working model as a technique. For this research project, the researcher used art and stories to enable the children to create a projection. According to Zinker (1966:236), the reason drawing or painting can be therapeutic is that when the person experiences it as a process, it allows him to know himself as a whole person within a relatively short space of time.

Alternatives

Schoeman describes this stage as 'alternatives', because the children are now able to make their own choices and decisions regarding their future. Schoeman emphasises

to give advice, but rather to facilitate problem-solving. This involves their responsibility and this involves them in the process of owning their feelings. By working in confluence with the child, the pace is set by the child. The child is able to think of alternatives by recognising obstacles or using polarities. Schoeman (2004:177) states that the therapist needs to make it possible for children to realise that polarities exist and that they are acceptable. When this happens, children are able to assimilate the polarities into the alternatives.

In this research project, this was an important aspect which helped to promote resilience in refugee children. This is discussed in detail in Chapters Four and Five.

Clarification

This is an important aspect in Gestalt therapy. By helping the children to clarify their feelings and issues, they are able to feel more secure. This should not happen too quickly as the child may then close up and not express all his emotions. He first needs to unload before the therapist decides to clarify. Clarification helps children understand and not feel guilty about their emotions. In addition, they are prevented from making assumptions. This helps children achieve a sense of security (Schoeman, 2004:178).

Empowerment

This is a stage unique to Schoeman's working model and was one of the main reasons why the researcher chose to make use of this model. Schoeman (2004:178) says that children need to be reassured about their role in the process. By being aware that they have taken responsibility for their own choices and decisions, children gain a sense of power and control. Empowering children can therefore be seen as helping them gain a sense of control and power in their lives. The therapist can do this by using an aspect which is true about the child. It needs to be true and the therapist needs to be authentic as children can sense insincerity, and this would seriously affect their trust in the therapist. This could also be an opportunity to build children's self-esteem and use their abilities, talents and identity. The play therapy sessions provide children many opportunities to exercise their choice, power and control. This enables children to take responsibility, which in turn helps them achieve self-support.

to help the child see what he has gained during each session. This can be done by asking the child what he has learnt in the course of the session or what he has gained from the session. There are different ways of evaluating and this can be left to the therapist and would partially depend on the needs of the child.

Self-nurturing

According to Schoeman (2004:180), the ability that people have to nurture either themselves or others is an indication of a caring and compassionate response. Schoeman (2004:180) recommends encouraging children to nurture themselves as a way to terminate the session in a positive way. She suggests that this can be done by encouraging the children to think of something they enjoy doing and are able to do. This helps restore the balance of the child, especially if the child has been vulnerable during the session. "Self-nurturing will give them a sense of control and safety, and most importantly, self-love" (Schoeman, 2004:180).

Polarities cause children to have fragmented views of themselves, and the therapist needs to help the child achieve integration. This enables the child to accept and nurture himself, and when this occurs they are able to maintain contact. Schoeman (2004:182) states that children need to have a level of inner strength before they are able to move on to the self-nurturing stage.

3.2.2 Rationale for Using the Schoeman's Working Model

The concept of resilience is based on the assumption that children have a natural tendency to survive. Gilligan (2001:6) states that "adverse experiences may block a child's natural drive for development and healing. Resilience, where it is present, serves to release the natural flow of recovery and development that might have otherwise been paralysed or frozen by negative experiences."

Gilligan (2001:6) is also of the opinion that services and professional interventions should avoid prolonging the problems unnecessarily by failing to see the potential for resilience in young people or their social context. Jewett (1994:99) also points out that separation and loss can cause children's natural healing mechanism to become

Some children may require short-term intervention to

As the research study progressed, the data gathered from the pilot study and experts indicated that refugee children are in constant transition and have limited resources. In addition they may not have access to therapeutic services, or it may not meet their needs. Also, refugee children are often not aware of therapeutic services as this may be a new concept for them. They might therefore be reluctant to engage in any therapeutic work for any length of time. The parents of children might also be reluctant to allow the researcher regular access to the children. Based on all the data available, therefore, the researcher is of the opinion that a short-term play therapy approach will be an essential requirement in working with refugee children.

The steps or stages in Schoeman's working model are structured in such a way that, the child and therapist are able to work through all the stages in one session. While providing the therapist with guidance on the main aspects that should be attended to in a session, it also allows some flexibility. The researcher therefore hypothesised that this may result in changes in the child over a short period of time and that Schoeman's working model may be well-suited to meet the needs of refugee children.

The literature review as well as the data gathered from the control group indicated that, due to refugee children's experiences, they required a therapeutic approach which was empowering. Alayarian (2007a:xx) states that refugees need an empowering approach so that they can deal with their problems and reduce their social exclusion. The data gathered before intervention, including the in-depth literature review, indicated that unaccompanied refugee children have very little control over the major decisions in their lives, due to the multiple losses and changes that they experience. The researcher therefore hypothesised that Schoeman's working model could be the appropriate tool to empower unaccompanied refugee children.

3.3 Short-term Play Therapy

The researcher had arranged to see the participants in the case studies for six to eight sessions. However, due to some of the reasons discussed above, the researcher was only able to have five play therapy sessions with each of the participants. Each session lasted for one hour. Landreth (2002:311) explains that due to the nature of

relationship, play therapy need not necessarily be a long-term process. The behavioural issues of children can be dealt with over a relatively short period of time. This is due to what he describes as the dynamic creative resources of a child, emerging in the safety of a therapeutic relationship. His view is that the child's natural state of development is continually moving towards the solution of problems. Landreth (2002:316) also states that remarkable change is possible when children experience a warm, supportive and empathic relationship with an adult, where the child is allowed to set the pace of the play therapy session. Research by Axline (1948) and Irwin (1971) (in Landreth, 2002:316-317) indicate that after less than six play therapy sessions, changes were observed in children.

Webb (in Landreth, 2002:318) also reports effective use of between one and three play therapy sessions. She had thirty minute sessions with the children as part of a crisis team. Barlow, Landreth and Strother (in Landreth, 2002:317) report that it is the atmosphere created by the therapist that was the single most important factor in enabling the children to feel the freedom to express themselves like they never had before. This research was conducted on child-centred play therapy. In view of the above results, the researcher is of the opinion that a Gestalt approach to play therapy could produce similar results in a short period of time, given the principles of the I-Thou therapeutic relationship, organismic self-regulation and empowerment in Schoeman's working model. The researcher therefore hypothesised that five sessions of one hour of play therapy were sufficiently intensive in order for changes to be observed in the participants.

Gilligan (2001:70) is of the opinion that resources will never be sufficient to meet the demand and that resilience may help to release some of the unrecognised resources in a child's daily life and natural social networks. The researcher agrees with this, believing that, in order for refugee children to be resilient, they need to be making use of their natural social networks of support. A short-term approach like Schoeman's working model therefore seemed appropriate; also because Gestalt play therapy focuses on the here and now, the reality for the participants was that their lives were busy and they had many practical issues which prevented them from engaging in more than five play therapy sessions. It appeared that there are times in their lives where dealing with their unfinished business may not be a priority. It is the

is an important issue which current mental health professionals ignore because they do not take into account the reality of refugee children's daily experiences.

3.4 Multiple/Collective Case Study

A multiple case study was used. The case study method can be defined as a systematic inquiry into an event or a set of related events, aiming to describe and explain the phenomenon of interest (Bromley, 1990:302). Data largely comes from documentation, archival records, interviews, direct observations, participant observation and physical artefacts.

The case study is an example of the single-system design. A single-system design can be defined as the study of a single subject on a repetitive basis (Strydom, 2003:151). In the case of this research, this subject will be refugee children.

The advantages of a single-system design are:

- A model of evaluation is provided to practitioners, clients and welfare organisations.
- It is cost effective.
- It is a direct form of research where results are immediately available.
- It may lack external validity but it gives valid and reliable information about an individual.
- It is easy to use and does not disrupt the treatment process.
- Therapists start to think scientifically about problem areas in client's lives and about interventions.
- Evaluation of the effectiveness of intervention becomes possible.
- The design is practice-based and therapist orientated.
- Modifications in intervention are possible.
- It attempts to work explanatory and thus is able to collect qualitative information.
- The design enhances goal-directedness in both therapists and clients.
- It makes possible a continuous report.
- Hypotheses about the relationship between a specific intervention procedure and changes occurring in the client can be tested.

antages to a single-system design. These are:

- It is difficult to present a good case for modification when the intervention is successful.
- To say that the change is due to a single variable, means that all other variables need to be controlled, and as the single-system design is practice-based there are many variables in reality, which may cause the design to seem artificial.
- It can be time-consuming.
- Single-system design studies experience problems with internal and external validity and are not as valid as a well-designed group study.
- Generalisations cannot be drawn from single-system designs. They suffer from a lack of comparison. Without something to compare the results with, valid conclusions cannot be drawn.
- Follow-up studies will need to be undertaken after the intervention has taken place, to see whether the intervention has retained its effectiveness.
- The single-system can only be used for behavioural changes. However, if a therapist can clearly define the problem and the intervention and ensure that both the problem and intervention are linked to the goals for intervention, then the single-system design can be used in each situation (Strydom, 2002:161-163).

3.4.1 Case Study Methodology

A case study can be defined as an exploration or in-depth analysis of a bounded system (bounded by time, and/ or place), or a single or multiple case over a period of time. The case being studied can refer to a process, activity, event, programme or individual or multiple individuals. Where multiple cases are involved, it is called a collective case study. A collective case study is the study of a number of cases in order to inquire into a particular phenomenon (Fouché & Delport,2002: 275).

In this research project, the phenomenon being studied was resilience in refugee children. The researcher first needed to identify whether the refugee children in the case studies were resilient. This was measured using the definitions of Woodcock

include experiencing some degree of choice over problem-solve actively in collaboration with others, and being connected to networks which offer some degree of social and cultural familiarity. It will also involve being able to talk about ongoing problems, to talk and reflect on past experiences, both good and bad, and being able to grieve actively. This definition was used, as it related specifically to refugee children. The list of attributes of resilient children by Lampert (2003:174-176) was also used to measure and identify resilience in the participants. The characteristics that resilient children have, are: a talent and a special interest that brings pleasure and a sense of competence; one consistently good relationship with at least one adult; the ability to distance; the ability to ask for help from appropriate adults; being aware of themselves and their environment; and being able to plan rather than act on impulse.

Schoeman's working model will be applied as the Gestalt play therapy approach. The researcher completed five play therapy sessions with each participant. The researcher used the Schoeman model as a framework to identify whether the participants were resilient or not and whether their resilience had been enhanced.

The researcher also used the "additive" model of resilience by Masten, Luthar et al., (in Masten, 2003:13), where protective factors have the potential to counterbalance adversity. This meant that the more protective factors children in comparison to the number of adverse factors, they could be resilient. The number and nature of protective and adverse factors were therefore also used to provide an explanation of resilience in the sample population as well as in the case studies. This is discussed in detail in Chapters Four and Five.

The main purpose of using a collective case study is to make comparisons between cases and concepts so that theories can be validated. The exploration and description of the case takes place through detailed in-depth data collection methods, involving multiple sources of information. This can include interviews, documents, observations and archival records. (Fouché & Delport, 2003:275-276). The Schoeman model is a Gestalt play therapy model and this was used to make comparisons between the cases.

Collection that was used was document analysis. The researcher analysed the assessments and case notes of refugee children and young people who arrived in the UK between 2003 and 2005. All the children were receiving a service from the Asylum Team of Essex Children and Young People. Other methods of data collection were semi-structured interviews, participant observation and play therapy sessions with the participants. The researcher used one-to-one interviews with foster carers as well as the young people who had given permission to be used as case studies. The researcher also analysed the process notes and observations of the play therapy sessions as well as the case files of the young participants.

Participant observation was one method of data collection. The researcher observed refugee children in their homes with their parents or foster carers, or where they were living in their own accommodation. The researcher also observed refugee children being assessed as they arrived at the Asylum and Refugee Team for the first time.

3.5 The Pilot Study

The purpose of conducting a pilot study is to ascertain whether the information one requires from respondents was obtainable. Such a study enables the researcher to test the questions asked, to interview experts and to build relationships with the respondents. On review, the researcher is then able to make the necessary modifications. This process also involves reviewing the literature. It can be seen as an assessment of the situation to be investigated. This is very important as the openness of respondents to the research can be tested (Strydom & Delpont, 2002: 337).

In the pilot study, the researcher interviewed social workers in the asylum team as well as the educational advisor for the Ethnic Minority Achievement Service who provide educational support to refugee children in schools. The researcher also had play therapy sessions with three refugee children.

The interview with the social workers revealed that the concern for refugee children was their ability to speak English, and their legal status. The social workers felt that refugee children needed support in learning to speak English, integrating into British

e. Some refugee children have to be assessed by a social worker to provide evidence for them to claim asylum. Many reports recommend that they were young persons receiving counselling or undergoing therapy. Many times this is not readily available. The social workers agreed that many refugee children may not necessarily be traumatised.

The data revealed that in order for the research to be conducted the participants would have to be able to understand and speak some English. It also revealed that refugee children would be open to play therapy sessions. However, the refugee children who formed part of the pilot study struggled to understand the concept of play therapy and therapeutic service. Stanley and Kohli and Mather (in Wade, Mitchell & Baylis, 2005:150) state that not all unaccompanied refugee children trust therapeutic encounters and may lack the understanding, of what it means, or they may be suspicious about disclosing information. This was in addition to the language barrier.

In the pilot study, the researcher also became aware that refugee children and their families are not aware of mental health services available to them. The pilot study also indicated that the parents of refugee children were suspicious of any official person and they were reluctant to leave their children with strangers. Where refugee children lived independently and were fluent in English, they were quite willing to be part of the study. Given all the information, the researcher modified the sample population to refugee children in foster care where both the foster carers and child was able to understand and speak English.

3.6 The Sample Population

For the document study, the sample population was made up of refugee children who arrived in Essex between 2003 and 2005. The target population was males and females between the ages of 15 and 18 years, who were able to speak some English. The researcher used systematic random sampling which can be defined as selection from a list, giving each one an equal chance of being selected. A sample fraction was used from a list of refugee children who have arrived in Essex.

For the case studies, convenient sampling was used. Convenience sampling can be defined as sampling for reasons of convenience, for instance that they were easy to recruit, easily accessible or more likely to respond (Bowling, 2002:187).

used in view of the fact that refugee children and young people do not have access to social welfare services and mental health services.

In addition, the carers and parents of refugee children were suspicious of professionals in both these services. This method was chosen because the countries where the refugee children come from have no mental health service or social welfare service, or where these have collapsed due to civil war or poverty. They were therefore suspicious about play therapy and the researcher had to spend several sessions getting to know the parents and children and overcoming these barriers.

This meant that the researcher needed to have some formal and informal access to refugee young people. The researcher was able to gain access to them as she is a social worker working for the Essex Children and Young People Service.

The participants who agreed to be case studies were four girls between the age of 15 and 17, of whom, two were from Eritrea and two from China. Convenience sampling was used due to the language barriers, as the parents and foster carers of refugee children also needed to speak and understand English.

3.7 Scope and Sample

The unit of analysis is refugee children, both girls and boys between the ages of fifteen and eighteen years old, who arrived in the UK between 2003 and 2005. This time scale was chosen so that the young people would have been residing in the UK for at least one year and the researcher would be able to ascertain how resilient they were by having had to adjust to life in the UK.

Four case studies were chosen. The case studies are refugees who came to the UK as unaccompanied minors and who were under the age of 18 years old, when they were seeking asylum. The sample for the case studies was also chosen from the five countries where most of the refugee children come from, namely Eritrea, Iraq, Afghanistan, China, Somalia and Zimbabwe. The participants who gave their consent to participate in the case studies were two females from Eritrea and two females from China, all four being between the ages of 15 and 17.

3.8 Barriers and Limitations

The research was conducted with four young refugees, between the ages of 15 and 17, living in Essex. This is only a small sample in comparison to the number of refugees and asylum seekers in the UK. The total number of refugee children in the UK is

there are approximately 82,000 refugee children in

Language was also a limiting factor, as only those who were able to speak and understand some English were chosen. Their carers or parents also needed to understand and speak English. This may have affected the authenticity of the data as all the participants were not equally fluent in English. Although refugees and asylum seekers in Essex come from over 16 different countries, the case studies were limited to two countries, which may have affected the data. However, previous research and this research study reveal that refugees on the whole have common experiences such as loss, change, trauma and adapting to their host country.

In order to increase the validity of the researcher the researcher used document analysis by analysing the assessments of all refugee children referred to the asylum team from 2003 to 2005. The motivation for this was that refugee children came from a wide range of countries, namely Eritrea, Iraq, Afghanistan, China, Ethiopia, Zimbabwe, Somalia, Liberia, Vietnam, Albania and Poland. These children include both females and males and their ages range from 12 to 18 years. The focus was on their resilience in being able to overcome trauma, loss and change while adjusting to the UK.

Professionals in the following areas were selected:

- Three social workers in the refugee team, in order to gain an overall view of the needs, rights, background and legal status of refugee children and specifically those who would be respondents for the case studies.
- The manager of the refugee and asylum team who is also serving on the National Consortium on Refugee Children, as well as a board member of the Essex Race Equality Council.
- The Children's Rights Advisor. The Children's Rights Advisor has specific cultural knowledge and experience working with refugee children in various African states.
- The Ethnic Minority Achievement Service.
- The Tendering and Colchester Minority Ethnic Partnership.

ards of refugee children who were being supported by the Refugee Team of Essex County Council. The case records of all the refugee children between October 2003 and October 2005 were used.

Information was gathered from the Refugee Support Team Assessment form and any reports on mental health and education. Information regarding the child's country of origin, reasons for fleeing, family history, current relationships and support networks were important.

Parents, foster carers and social workers of the selected refugees were also respondents. They form part of the support network of these children. According to Masten and Powell, (2003:10), when studying resilience in children researchers need to look at the nature of their relationships and interactions with the world. Caring adult relationships and academic competence can greatly affect resilience in children. According to de Vos (2002:340), the process for analysing data includes the following:

- Collecting and recording data
- Managing data
- Reading and memo-writing
- Describing, classifying, interpreting
- Representing and visualising.

The type of research that the researcher used was intervention research. That process was discussed in detail in Chapter One (3.1).The intervention research model was applied.

In Chapter Four which follows the researcher presents the data and the results of the research process. These results are also integrated with the literature review.

The data is presented and explained in this chapter. The focus will be on resilience in refugee children and Gestalt play therapy. The researcher first identified and provided an explanation for resilience in the sample population. The sample population was made up of thirty-two refugee children who were receiving a service from the refugee team between October 2003 and October 2005. The sample population forms thirty percent of the universe. Random sampling was done, as these were children whose files were available. Of this sample group, there were four participants who gave their permission to be used as case studies.

To account for resilience, the researcher made a judgement as stated by Gorman-Smith and Tolan (2003:405-408): "Resilience is making an inference about a person's life, making two fundamental judgements: that the person is doing fine and secondly, that there is or has been a significant risk or adversity to overcome." The researcher made this judgement on the basis of the information in the case files and categorised the two groups as those who were resilient and those who were not. For the purpose of this research study, the researcher describes the group who was not resilient as "non-resilient".

It was the researcher's opinion that the definition by Masten and Powell (2003:4) given above, does not describe how refugee children became resilient and whether resilience could be enhanced. Thus, to meet the objectives of the research, the researcher used additional criteria in order to explain resilience in the case studies. The researcher could only use these criteria with the case study participants, because the files of the sample population did not contain sufficient details, and she did not have permission to interview the children. The additional criteria are:

1. Resilience is the ability to experience severe trauma or neglect without a collapse of psychological functioning or evidence of post - traumatic stress disorder (see 2.5.1.4). This ability applies to persons who have been able to move on in life after their traumatic experience, to integrate into a new society, to work effectively, to love and contribute to the life of the community they live in (Alayarian, 2007b:1-2).

- g resilient will include experiencing some degree of
visions, being able to problem-solve actively in
collaboration with others, being connected to networks which offer some
degree of social and cultural familiarity. It will also involve being able to talk
about ongoing problems, being able to talk and reflect on past experiences,
both good and bad, and being able to grieve actively. This definition was used
as it relates specifically to refugee children. (Woodcock, 2002:275).
3. The researcher also used Lampert's (2003:174-175) description of resilient
children as a basis for her judgement: a child who "has a talent and a special
interest that brings pleasure and a sense of competence, has one consistently
good relationship with at least one adult, the ability to distance, the ability to
ask for help from appropriate adults, being aware of themselves and their
environment and plans rather than acts on impulse." This description was used
in the research because it has been used by Ruth Lampert in undertaking
Gestalt therapy with adolescents.

Alayarian (2007a:xx) is of the opinion that refugee children need a therapeutic
relationship that is empowering. By integrating the information on the experiences
and needs of refugee children, there was the clear indication that refugee children do
need an empowering therapeutic approach which is able to promote their resilience.
The researcher hypothesised that Schoeman's working model was an empowering
model which could promote resilience in refugee children. The researcher therefore
used the Schoeman working model in the play therapy sessions in the case studies.
The researcher also used a Gestalt play therapy approach to explain and enhance
resilience in refugee children. The research strategy was discussed in Chapter Three.
Qualitative research was used to describe the broad and varied experiences of refugee
children.

4.1 Identifying Resilience

Definitions and attributes of resilience were used as a criterion. Resilience in the
sample population was explained using Rutter's (2001:123) and Hyder's (2005:63)
concept of resilience, which involves looking at protective and risk factors in the lives
of refugee children. According to Rutter(2001:123) and Hyder(2005:63), protective
factors make it more likely that children will be resilient, while certain adverse factors

ver long periods of time, may cause long-term

The literature study revealed that resilience is a process (see 2.1.1). It was the researcher's opinion that protective and adverse factors may explain why some children were resilient and others not, but they do not explain the process of how some refugee children become resilient while others do not. After careful consideration of the emerging data, it was also the opinion of the researcher that the protective and adverse factors do not reveal whether resilience could be enhanced or promoted.

According to Lampert (2003:174), the attributes of resilience could be encouraged in therapy (see 2.7.1.4). The researcher therefore adapted her criteria for resilience using the list of attributes or characteristics of resilient refugee children described by Woodcock (2002:275) and those described by Lampert (2003:174-176). The researcher therefore hypothesised that these characteristics and attributes could reveal, whether resilience could be enhanced or promoted how this can be done. The researcher also hypothesised that a Gestalt approach to play therapy could reveal how some refugee children become resilient and others not. In order to test these hypotheses, the researcher therefore used the attributes mentioned by both Woodcock (2002:275) and Lampert (2003:174-176) to measure resilience in the case study participants.

4.1.1 Resilient Group

The resilient group could be described as being resilient because:

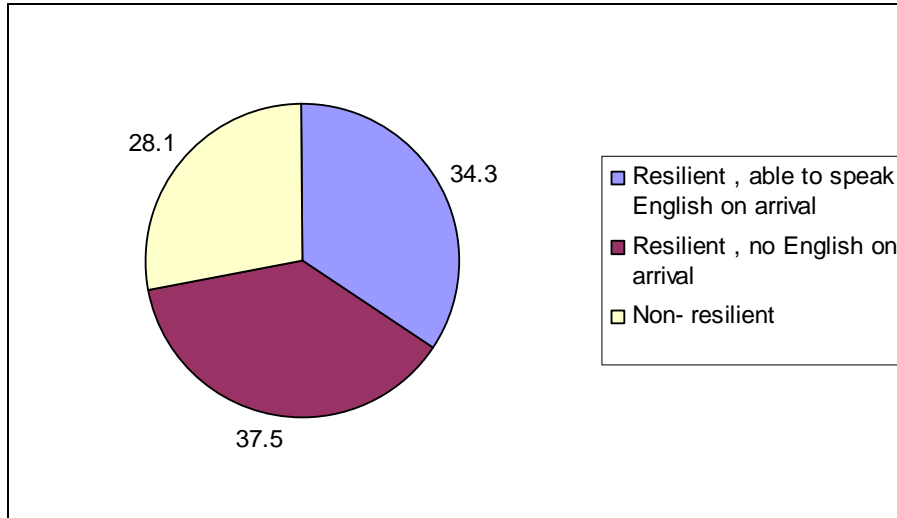
- They had successfully integrated into UK society and culture.
- They were in full-time education or work.
- There was no evidence that they were suffering from post-traumatic stress disorder.
- All had social support networks.

The resilient group was also divided into two categories, namely those who could speak English on arrival and those who spoke no English on arrival. The rationale for dividing the resilient group in this way was that being able to speak English was seen

previous research indicated, was a significant factor, By the same token, inability to speak English, was regarded as an adverse factor in the process of integrating into UK society.

The table below indicates the numbers of children in the sample population. Nearly two-thirds of the sample population were resilient.

Figure 1: Resilience in Sample Population



4.1.2 Non-Resilient Group

This group has been described as non-resilient, because in the researcher’s opinion they do not meet the criteria for resilience as discussed. Nearly a third (28,12 %) of the sample population could be described as “non-resilient”. This appears to be consistent with research by Wade, Mitchell and Baylis (2005:146) who reported that from case files there was evidence that thirty-one percent of refugee children appeared to have experienced or were continuing to experience some emotional turbulence that affected their overall well-being.

The reason why the researcher grouped the vulnerable young people in this category was that five of them had been traumatised to the extent that they were psychologically fragile and all the professionals involved with them were seriously concerned about their emotional well-being.

- ó One had to be admitted to a psychiatric unit due to an emotional breakdown.
- ó Three manifested symptoms of clinical depression and PTSD.

after collapsing at school and has no memory except the UK. The remaining four young people in the non-resilient group are in this group because they all have become involved in illegal activities. It appears that they were exploited by adults from their community of origin. It is the researcher's opinion that the vulnerability to exploitation is indicative of their lack of resilience. They may also not have been aware that the activities they were involved in were illegal.

4.2 Adverse and Protective Factors

To account for resilience in refugee children, the researcher has explored the adverse and protective factors in their lives. Adverse or risk factors are those which negatively affect children's development, protective factors are those that encourage normal development in the face of adversity (Masten & Powell, 2003:13). The researcher is in agreement with this, as the literature review as well as the research findings of this project indicate that refugee children who had more protective factors had better developmental outcomes.

4.2.1 The Adverse Factors

There was a total of 26 adverse factors to which the sample population collectively were exposed. There are several adverse factors that all refugee children in the research had in common. These are: displacement and resettlement; losing parents and family through death; loss of support network; and racism and discrimination for being a refugee.

Figures 1.(i),(ii) and (iii) below list all the adverse factors to which the sample population were exposed as well as the numbers of refugee children who were exposed to the various adverse factors. The graphs below also indicate which group the refugee children were part of, whether this was the resilient group who spoke English, or the non-resilient group.

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Figure 1 : Adverse Factors (i)

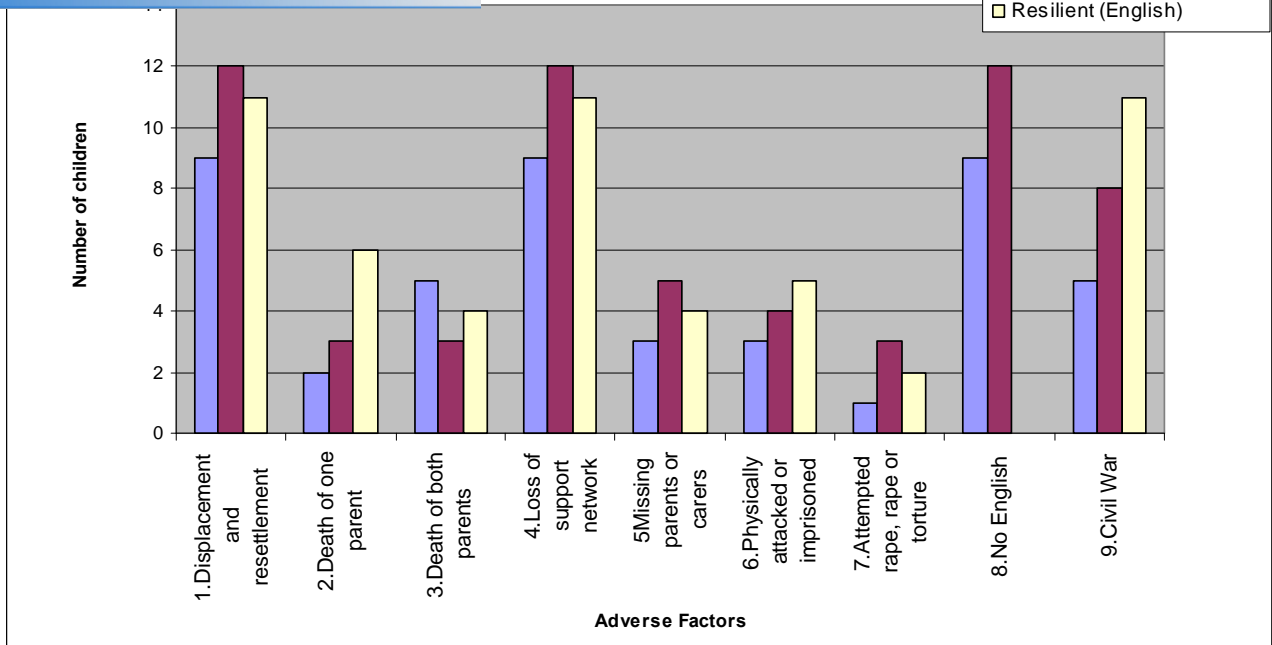


Figure 1: Adverse Factors (ii)

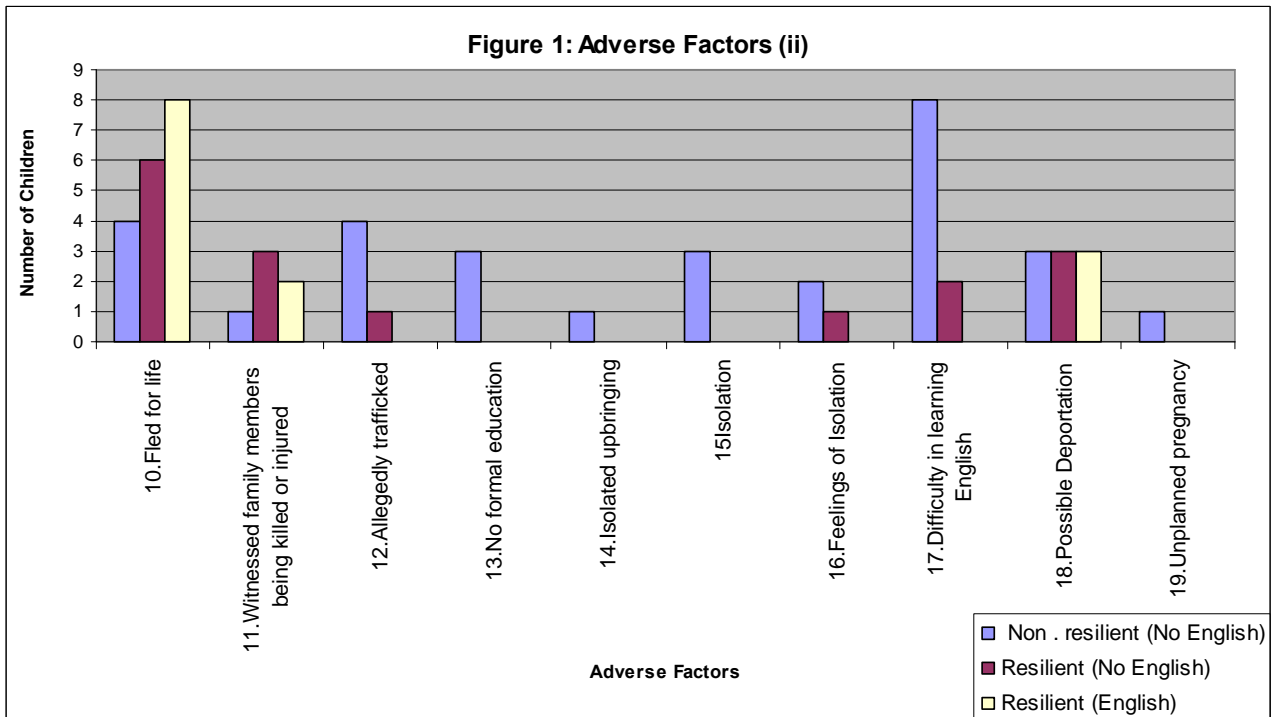
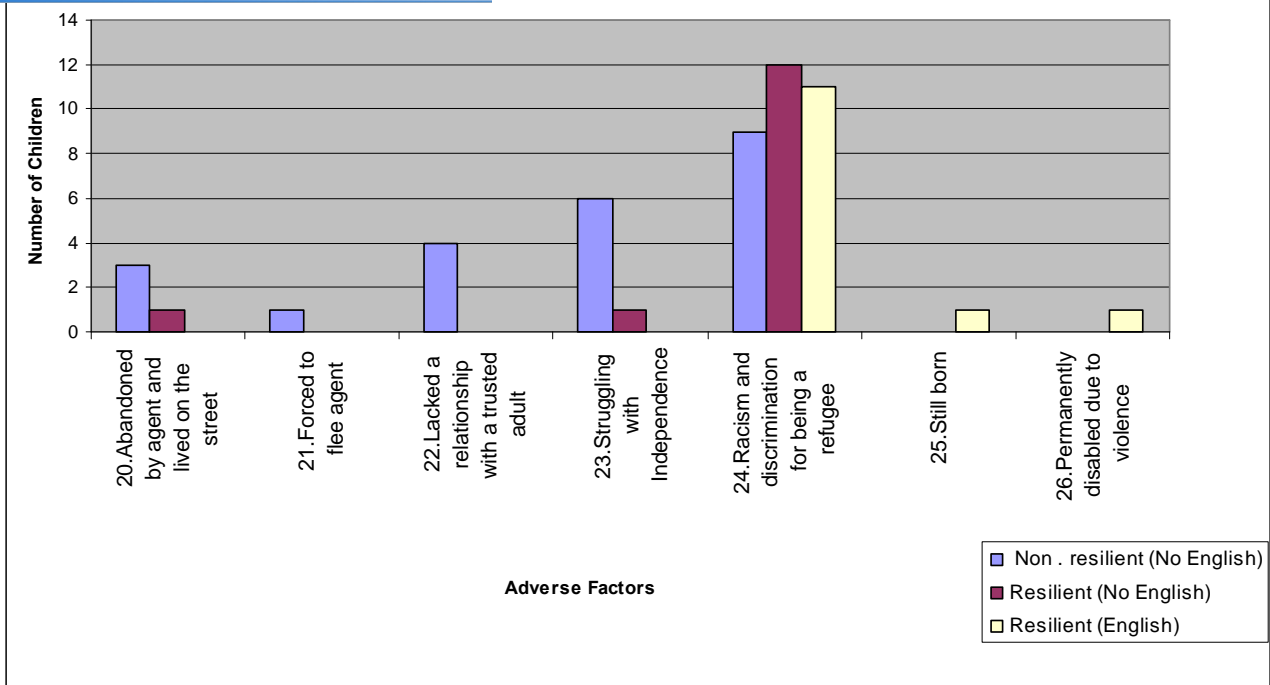


Figure 1: Adverse Factors (iii)



4.2.1.1 Similarities between the Resilient and Non-resilient group

The research indicates that despite coming from different countries and fleeing for different reasons, the sample population had the following adverse factors in common: displacement and resettlement, separation and loss, and racism. This is consistent with research conducted by Rutter (2001:122), Wade, Mitchell and Baylis (2005:144-145), Hyder (2005:26) and Alayarian (2007a:xvii).

Displacement and Resettlement

Displacement

Refugee children either had to flee their country of origin or they were sent away by family or friends for their own safety. For some unaccompanied refugee children the journey to safety ironically was dangerous in itself, where they have to rely on strangers or paid agents to help them to safety. Others have had to flee to safety from enforced military service, persecution or civil war.

05:3) uses the term 'resettlement' to describe the complex transitions necessary for refugee children to adjust to a new life in a new country. They also use the term to describe the forms of support children will require in order to successfully adjust to living in the UK. With unaccompanied refugee children, resettlement makes addressing the practical, psychosocial and cultural needs of the children a complex process. Unaccompanied children need to find a safe and supportive place to live; they need access to education and training; they need to maintain links with their past relationships, customs, culture and opportunities to create new ones; they also need opportunities to recover from traumatic experiences, re-centre their lives and find new purpose in their daily lives. This is a gradual and complex process which can be challenging to unaccompanied refugee children. Some are vulnerable and may not be able to meet the challenge of resettlement, while others are resilient and able to resettle and integrate into British life (Wade, Mitchell & Baylis, 2005:3-4).

Separation and loss

All unaccompanied refugee children experience the loss of their parents or primary care givers. This is usually through forced separation either through death, imprisonment or disappearance of the caregivers, or their caregivers may send them away for their own safety or to escape other forms of hardship. The process of displacement also creates social and cultural dislocation (Wade, Mitchell & Baylis, 2005:155). Refugee children, therefore, experience not only the loss of vital relationships, but also a loss of cultural identity and way of life. This can lead to separation anxiety where children may go through various stages of mourning and grief. The usual grief reactions to loss can include numbness, shock and disbelief. This occurs in the first stage. The next stage involves feelings of yearning, searching, pain, tension and misery. They then move on to the third stage which can include feelings of anger, resentment, and in some cases, guilt. The fourth stage is characterised by disorganisation, despair, depression and withdrawal. The fifth and final stage of separation anxiety involves adjustment and integration of the loss (Howe, 1995:58). According to Alayarian (2007a:xx), loss, dread and grief are inherent in refugees' lives. In order to cope with these experiences, refugees need to utilise their internal and external resources.

that refugees are exposed to racism (including institutional racism) and discrimination (see 2.1.5.7). Due to the extensive media coverage of refugees, the researcher is of the opinion that refugee children belong to an ethnic minority group who are used as scapegoats in the media, and her assumption was that the refugee children in the sample population would all have been exposed to some form of racism or discrimination. The researcher is also of the opinion that as they need to apply for refugee status to avoid being deported this further exposes them to a form of racism and discrimination.

4.2.1.2 The Non-resilient Group

Similarities within the non-resilient group

Trafficking

Figure 1 (ii) indicates that four of the non-resilient group of nine, were refugee children who were allegedly trafficked to the UK. Although trafficking regarding refugees is discussed in the literature, this was not viewed as a risk factor. Trafficking means that family members have paid trafficking agents to transport the children to the UK. It is felt that those who were trafficked to the UK are not genuine asylum seekers (Rutter, 2001:7). It is recognised that many children are being trafficked to the UK for sexual exploitation or domestic slavery. All the young people who were trafficked to the UK also had some involvement with the police. This group of young people appeared to have been exploited by adults from the same cultural community (Coker, Finch & Stanley, 2002:56).

Abandoned by agent and made homeless

Three of the four young people who were trafficked were abandoned by their agents on arrival in the United Kingdom and was therefore homeless. This was consistent with findings by Wade, Mitchell and Baylis (2005:43) that young people were sometimes abandoned by the adults who accompanied them to the UK.

Difficulty in learning English

None of the children in the non-resilient group could speak any English on arrival in the UK. What is significant, is that all except one had difficulty in learning English. In

English on arrival all except one was speaking fluent
1.

Difficulty in learning independent skills

This refers to skills that would prepare a young person for adulthood, such as budgeting, cooking and caring for himself. According to Wade, Mitchell and Baylis (2005:183), if primary needs such as building new attachments, social networks, engaging in education and stability have not been met, transition to adulthood will prove difficult. This could account for more than half of the non-resilient group who were struggling with independence.

4.2.1.3 Differences between the Resilient and Non-resilient group

Figure 1 indicates that there are several adverse factors experienced only by the non-resilient group. These are: no formal education, isolation, isolated upbringing in home country, no relationship with a trusted adult and an unplanned pregnancy. Collectively, there are a total number of 26 adverse factors experienced by refugee children in the study.

No formal education

Figure 1 (ii) indicates that three young people had no formal education. By 'no formal education' the researcher refers to refugee children who did not attend school but were taught to read and write by their parents. Although these number only three, this was a factor which was unique to the non-resilient group.

Isolation

Social workers working with these young people commented that they were isolated. It is the researcher's view that this could either be a cause or an effect. Not being able to speak English can result in isolation and, vice versa, being isolated would impair the ability to learn to speak English. This was a factor which only the non-resilient group experienced.

Isolated upbringing

There was only one young person where 'isolated upbringing' had an effect on his adjustment to the UK. Although this does not appear significant it may be a



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the total number of adverse factors experienced by this

Lacking a relationship with a trusted adult

There were four young people who did not appear to have a relationship with a trusted adult before they arrived in the UK.

Unplanned pregnancy

Unplanned pregnancy refers to refugee children who had become pregnant not out of choice, but by engaging in unprotected sex. Hyder(2005:36) refers to a report on refugee groups who stated that half of the women they had contact with had been sexually assaulted or raped before they arrived in the United Kingdom. According to Wade, Mitchell and Baylis (2005:142) young women, due to their vulnerability, are at risk of sexual exploitation. They also found evidence that it was not uncommon for refugee children and young people to struggle to gain access to adequate health services. There were several causes such as that letters were written in English and thus misunderstood, or sent to the wrong address, or the young person being in the process of moving; in addition a name could be incorrectly spelt with the young person not realising that the letter was intended for him, or the general difficulties where the health care staff and professionals were not culturally competent. The researcher would then assume that unplanned pregnancies could occur given the vulnerability of refugee children.

There was little research on the unplanned pregnancies among refugee young women. An unplanned pregnancy could also be either a cause or an effect of the person being vulnerable and therefore lacking resilience. In the interviews with the social workers in the refugee team, however, they asserted that the number of pregnant refugee children seem to be increasing and that this was a concern.

Forced to flee from an agent

In one case the young person was forced to flee the agent who brought her to the UK as she realised that she would be forced into prostitution. This is consistent with research by Wade, Mitchell and Baylis (2005:142) who found that some girls were trafficked for sexual exploitation and enforced prostitution. Coker, Finch and Stanley

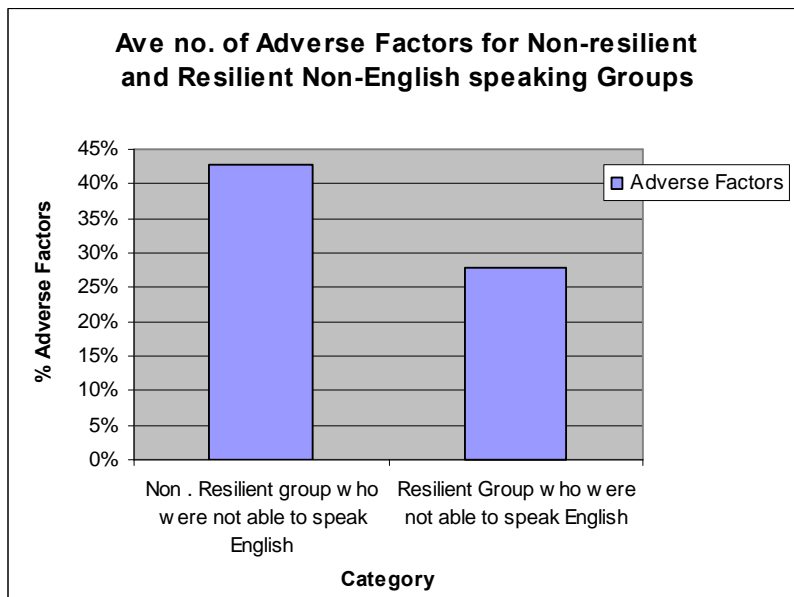
ls and some boys are particularly vulnerable to industry and may coerce a child into sexual activities.

4.2.2 Comparing the Numbers of Adverse Factors

The literature review indicates that the number of adverse factors that children experience impacts significantly on their resilience. The mere number and nature of some adverse factors make it likely that there will be children who will not be resilient (see 2.1.5 and 2.1.6). Early research on adverse factors mainly focused on one risk factor, but soon enough it became apparent that these factors would result in others, and this led to research on the cumulative risk by measuring risk through aggregating the risk factors. In Project Competence the adverse factors experienced by children over a period of one year were researched, and the results were found to be very reliable in predicting resilience and vulnerability (Masten & Powell, 2003:7-8).

Figure 1.2 indicates that the non-resilient group were exposed to nearly 45% of the adverse factors while the resilient group who had no English on their arrival were exposed to 27% of adverse factors.

Figure 1.2



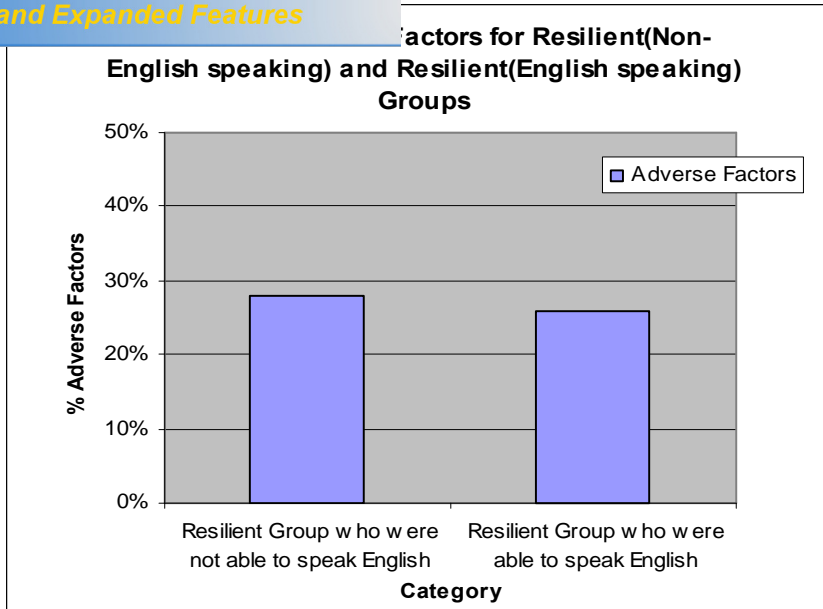


Figure 1.3 indicates that there is little difference between the numbers of adverse factors experienced by the resilient groups. It is the researcher's view that this may indicate that not having been able to speak English on arrival was not as significant as originally thought by the researcher. Their lack of English did not appear to significantly impact on their resilience. However, none of the non-resilient children were able to speak English. It is the researcher's opinion that this could indicate something about refugee children's ability to adapt, or resilient refugee children's ability to adapt. This appears to be consistent with previous research on resilience, namely that resilient children are better able to adapt to new situations. (See 2.1.3 and 2.1.4)

4.2.2.1 Implications for the Resilient Group

The researcher is of opinion that by comparing the number of adverse factors, the research indicates that it is possible that both the number and the nature of adverse factors may be significant. This would explain the difference in outcomes despite refugee children in the study having been exposed to similar adverse factors. Some were resilient and others were not. The researcher is of the opinion that Figures 1.(i),(ii),(iii) and 2.3 reveal that there was a difference in the total numbers of adverse factors that the resilient and non-resilient groups had been exposed to. The resilient groups had been exposed to less adverse factors than the non-resilient group. The

tentative hypothesis that the more adverse factors the less resilient they are. What the findings further highlight is that it could also be the nature of the adverse factors which made the group the non-resilient group. This is consistent with what is stated by Masten and Powell (2003:7-8).

4.2.2.2 Implications of the Results for the Non-resilient Group

It is the researcher's view that the number of adverse factors over a long period of time may cause poor mental health and further vulnerabilities in refugee children. This is consistent with previous research (see 2.1.6) The researcher believes that the results in Figure 1.4 could explain the poor mental health and vulnerability to exploitation and criminal activities of the non-resilient group. It appears that being trafficked to the UK made them vulnerable to exploitation and involvement in illegal activities initiated by adults.

This enabled the researcher to make a tentative hypothesis that the effect of both the number and the nature of adverse factors impact on children's resilience. There could be particular adverse factors and the number of these factors could make children vulnerable. Earlier in the chapter (see 4.2.1.3), the researcher discussed the adverse factors which were unique to the non-resilient group. These were: no formal education; lacking a relationship with a significant adult; isolation; an isolated upbringing; being forced to flee their agent; and an unplanned pregnancy. Further research is needed on these factors. However, the findings also indicate that it is not only the nature of adverse factors, but possibly both the nature and number of adverse factors that impacts on refugee children's resilience.

In the opinion of the researcher, the difficulty with the research available on resilience in refugee children is that there is a focus on certain aspects of the refugee child's life while others are ignored. What the research indicates is that it is not a single traumatic event or the intensity of the trauma, but rather the number and nature of adverse factors experienced that have a significant impact. One of the risk factors for refugee children, according to Rutter (2003:130), is trauma which is intense and sustained over a long period of time. The research findings are therefore consistent with previous findings. Five of the young people were exposed to civil war, and

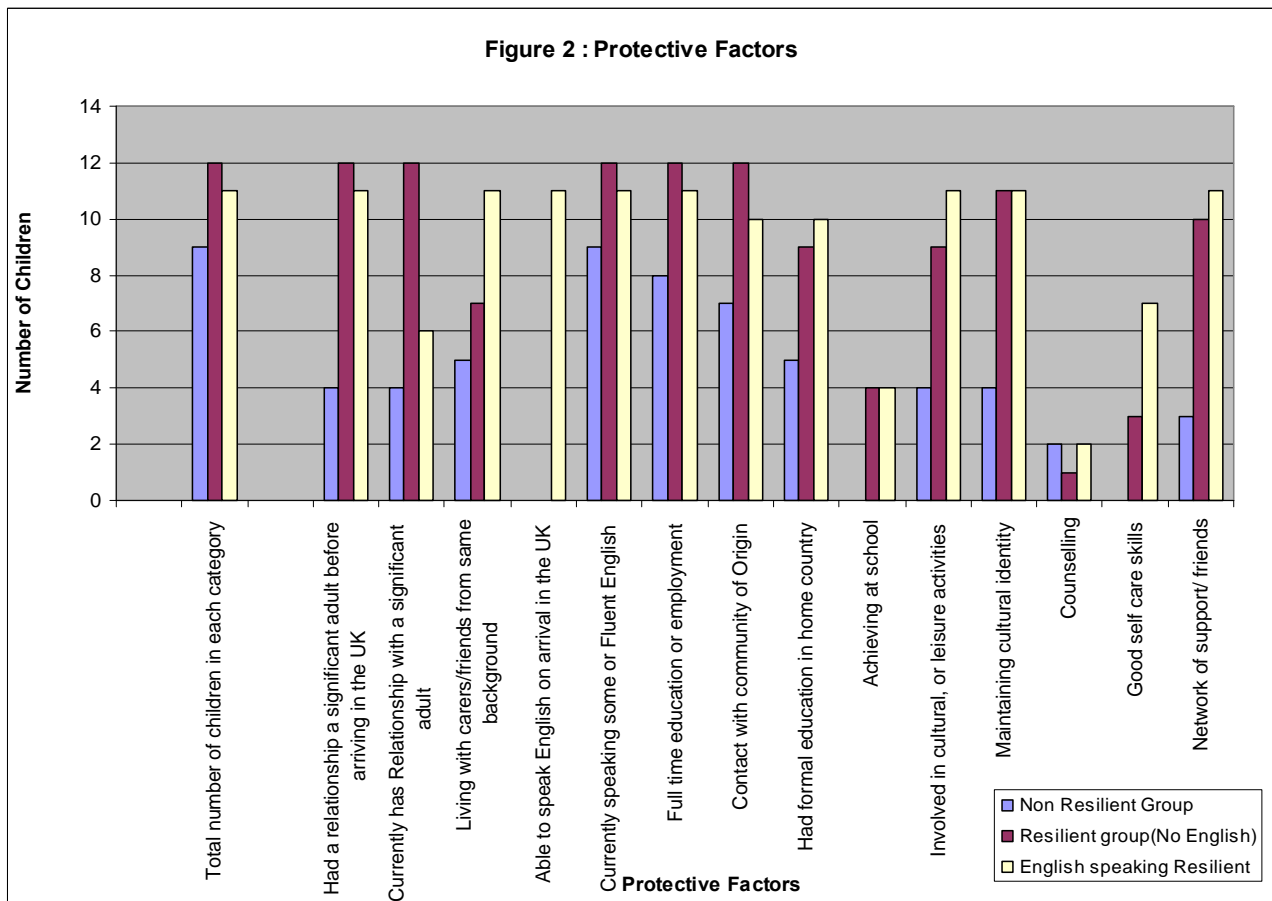
war has lasted for more than ten years. All the young
 oms of depression and poor mental health.

It is the opinion of the researcher that there is too much focus on the legal status of the child to the detriment of the emotional well-being of the child. What the research findings have shown, is that both resilient and non-resilient children were at risk of being deported, and that legal status alone does not affect children’s resilience. It is the researcher’s view that Gestalt therapy and theory as a holistic and phenomenological approach will focus on areas that are important to the child and have hitherto been neglected.

4.2.3 Protective Factors

There is only one protective factor that all refugee children in the research have in common, and that is their ability to speak English since their arrival in the UK. The differences and similarities within the groups will be discussed separately. These children may not all be fluent in English, but all have been able to learn some English.

Figure 2. Protective Factors



4.2.3.1 the Non-resilient group

Figure 2 indicates the protective factors experienced in the non-resilient group.

Most of the non-resilient group experienced the following protective factors: they are currently able to speak English; they are in full-time education or employment; and they are in contact with their community of origin. The other similarities within the non-resilient group are that none of them experiences the two protective factors experienced by both resilient groups, namely good self-care skills and performing well at school. The rest of the protective factors (eleven) were experienced by some but not all of the non-resilient group: relationship with a significant adult; taking part in full-time education or employment; contact with community of origin; being able to learn English; and had formal education in their country of origin. This led the researcher to ask why these young people had not adjusted to living in the UK as well as the resilient group, and why they were not resilient if they had been exposed to the same protective factors as those who were resilient.

4.2.3.2 Protective Factors within the Resilient Groups

Figure 2 also indicates the similarities and differences within resilient groups. The resilient group members who were not able to speak English had the following factors in common:

- They were all able to speak some, or were fluent in, English.
- All had a relationship with a significant adult before arrival in the UK as well as currently.
- All were in full time education or employment.
- All had contact with their community of origin.
- All except one were maintaining their cultural identity.

The resilient group members who were able to speak English had the following in common:

- They were able to speak English on arrival in the UK.
- They had a relationship with a significant adult before arrival in the UK.
- All were living with carers or others from the same or similar ethnic background.

education or employment.

social, cultural or leisure activities.

- All were maintaining their cultural identity.
- All had a network of support and friends.

The two groups therefore have the following in common, which the non-resilient group does not have: all had a relationship with a significant adult before arrival; and all were maintaining their cultural identity.

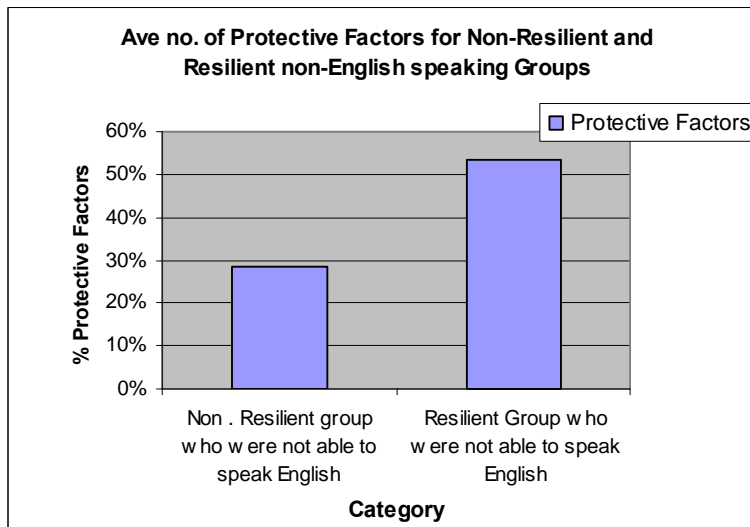
4.2.3.3 Numbers of Protective Factors

The literature review indicates that the more protective factors children were exposed to, the more resilient they would be (see 2.1.5 and 2.1.6). Masten and Powell (2003:19) state that asset-focused designs aim to increase protective factors in children's lives.

Comparisons with the non-resilient group and the resilient groups

As with the adverse factors, the figures below compare the average number of protective factors to which groups were exposed. In Figure 2.1 the comparison is made between the non-resilient group and the resilient group who were not able to speak English. The entire non-resilient group was unable to speak English on arrival. The research indicates that the resilient group were exposed to 20% more protective factors than the non-resilient group (see Figure 2.2 and 2.3).

Figure 2.1 Total numbers of protective factors



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results when comparing the non-resilient group with the resilient group who were able to speak English. The resilient group who were able to speak English were exposed to 20% more protective factors that the non-resilient group.

Figure 2.2

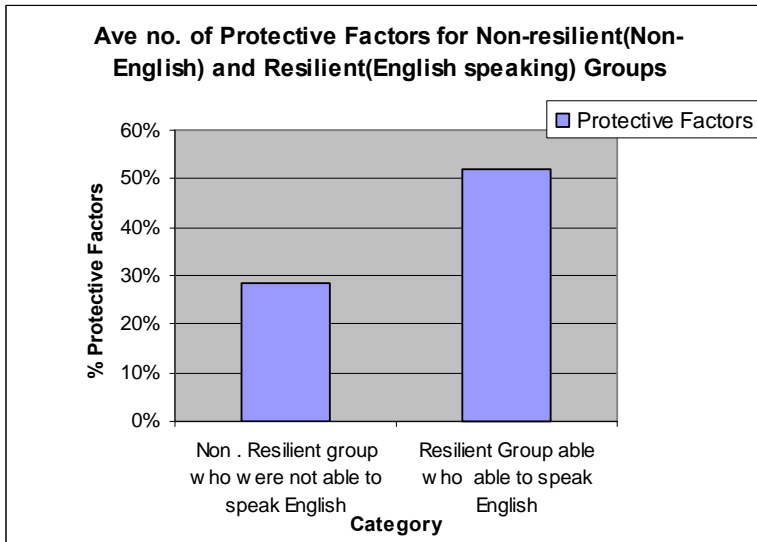
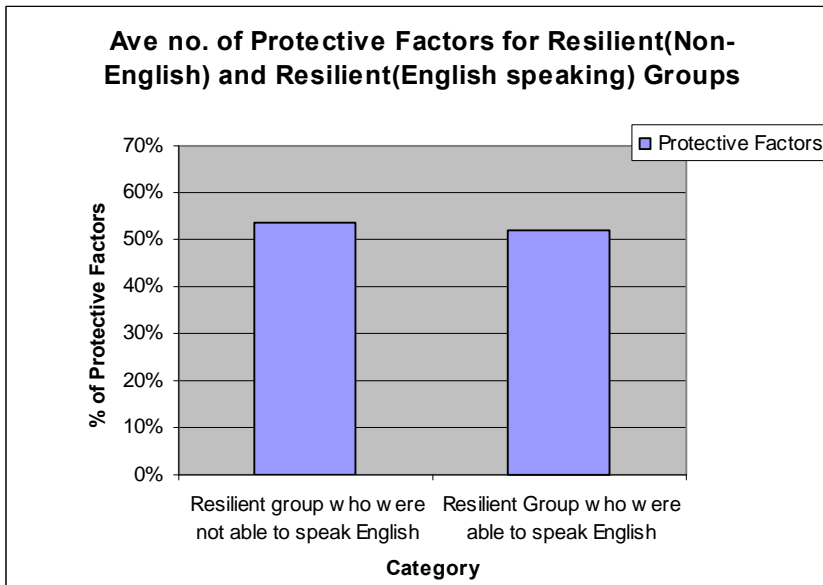


Figure 2.3



there was little difference between the numbers of English-speaking resilient group and the non-English-speaking resilient group.

4.2.4 Balance of Protective and Adverse Factors

Gorman-Smith and Tolan (2003:405-408) state that successful adaptation is possible as long as there is a balance between the risk factors and the protective factors. The hypothesis is by increasing the protective factors children's lives reduces the impact that the adverse factors they are exposed to (Masten & Powell, 2003:10). The researcher decided to compare the numbers of protective with the numbers of adverse factors in each group (see Figure 2.4).

Figure 2.4

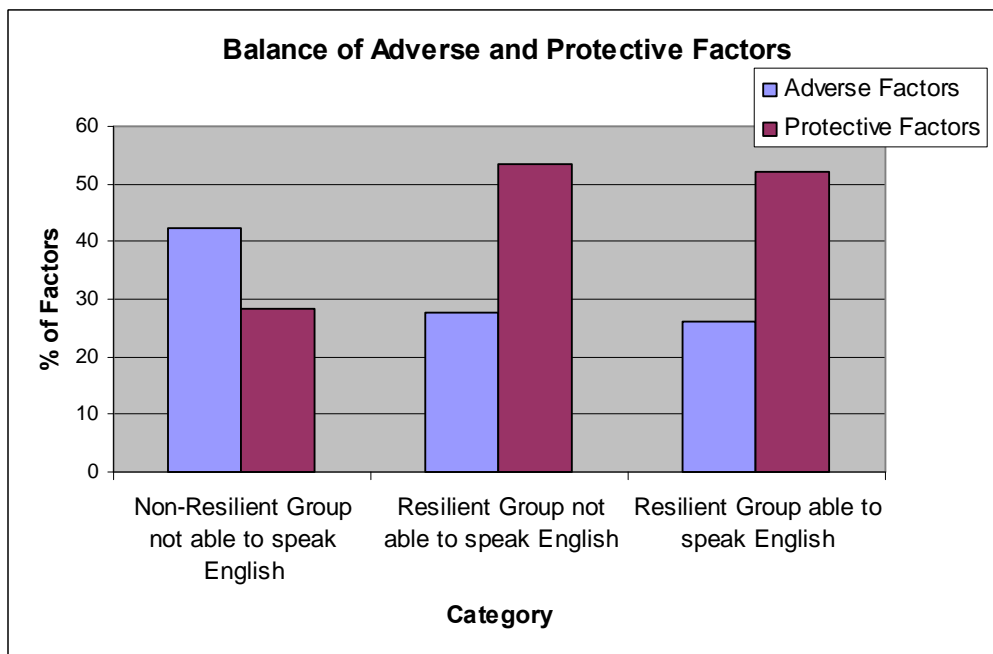


Figure 2.4 indicates that the resilient group have more protective factors than adverse factors. For the non-resilient group, however, there is a significant difference in the number of protective factors and the number of adverse factors. There is a significant difference when comparing the protective factors of the non-resilient group with those of the resilient group. The non-resilient group had more adverse factors than protective factors, while the resilient group had more protective factors than adverse factors.

the literature, namely that protective factors promote resilience (see 1.6, 2.3 and 2.4). This could explain why the non-resilient group had poor outcomes despite having the same types of adverse and protective factors. It is possible to deduce that it is not only the type of adverse factors that refugee children experience, but also the number of adverse factors experienced that affect children's resilience.

In addition it could be the lack of balance of protective factors in relation to the adverse factors that affects resilience. Gorman-Smith and Tolan (2003:405-408) assert that as long as there is a balance between the adverse and protective factors, resilience is possible. Intervention should therefore aim at either reducing the number of risk or adverse factors, or at increasing the number of protective factors. The non-resilient group, however, had more adverse factors than protective factors, which could also account for their poor outcomes. Garbarino (in Gorman-Smith & Tolan, 2003:403) suggests that a concentration of protective factors may be needed in order to overcome risk.

It is the researcher's view that reducing the number of adverse factors may not be possible in the case of refugee children, given that some of the adverse factors have already been experienced in their home country before the institutional and societal discrimination that refugees experience around the world. There are also adverse factors which occur on a global or international scale, such as natural disasters and war. Some adverse factors are simply a natural part of life and therefore unavoidable, for instance natural disasters and death. Refugee children or their families may also have little or no control over some adverse factors they experience, such as war, community violence or poverty.

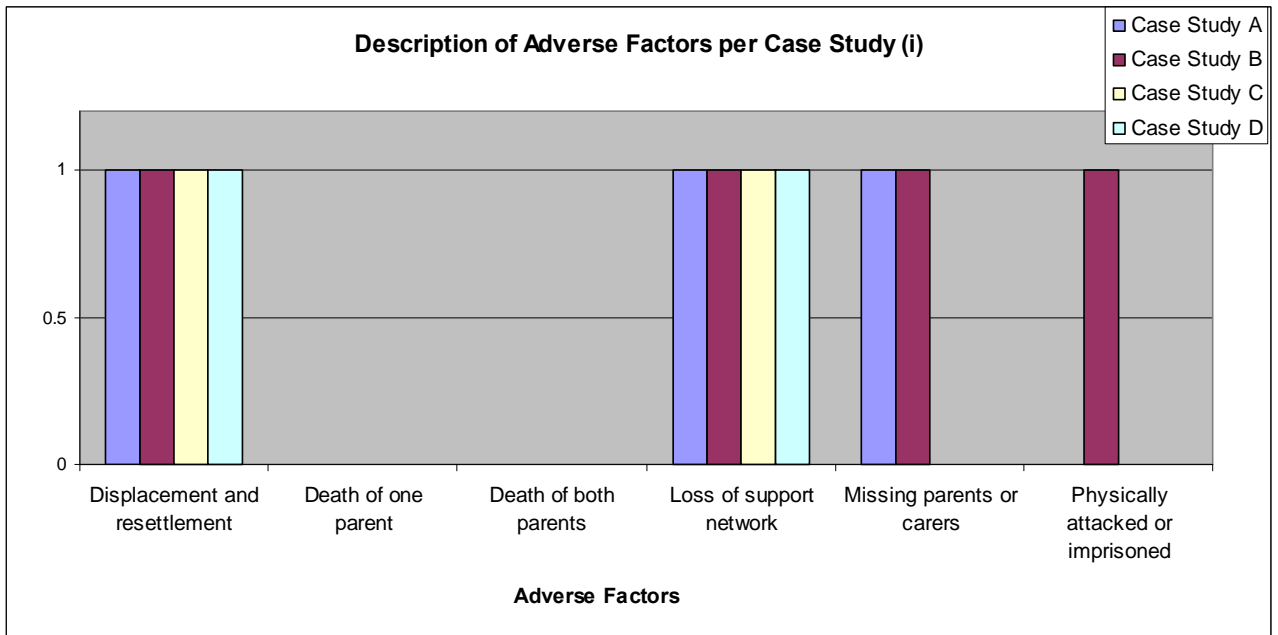
In addition children are even more vulnerable being dependent on adults, and thus have even less choice or control in their lives. It is therefore the researcher's view that the alternative to decreasing the numbers of adverse factors would be to increase the number of protective factors in refugee children's lives. It is with this in mind that the four case studies are presented.

It is the researcher's opinion that the more adverse factors children experience, the less resilient they are. And, by that token, the more protective factors that children experience the more resilient they were.

Factors

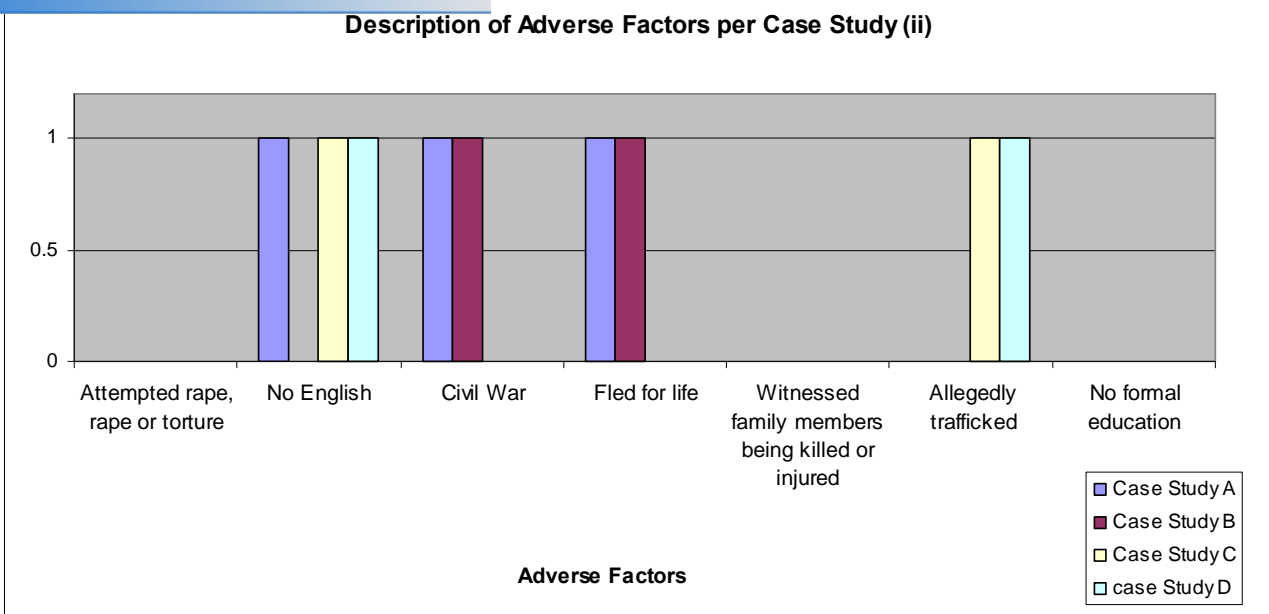
Given the research findings above and section 2.1.6 where Rutter (2003:131) suggests that there needs to be a balance of protective and adverse factors, it is clear that those working with refugee children need to increase the protective factors in a refugee child's life. The researcher therefore made the hypothesis that Gestalt play therapy could add several protective factors to refugee children's lives. The researcher has tested this hypothesis with the case study respondents. This can be seen in Figure 4.2 that shows how Gestalt play therapy has added several protective factors to refugee children's lives, thus enhancing their resilience. This was done in a way that was not intrusive, but instead encouraged children's natural healing process. Figures 3.1(i), (ii) and (iii) below indicate the adverse factors that each case study respondent was exposed to.

Figure 3.1(i)

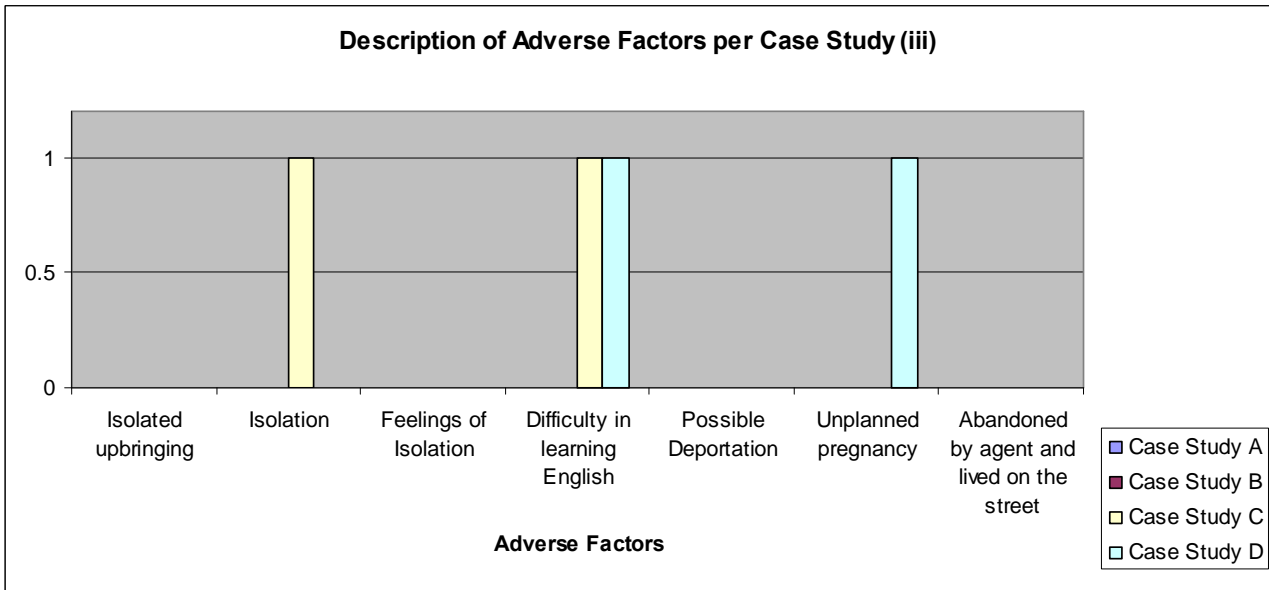


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Description of Adverse Factors per Case Study (ii)

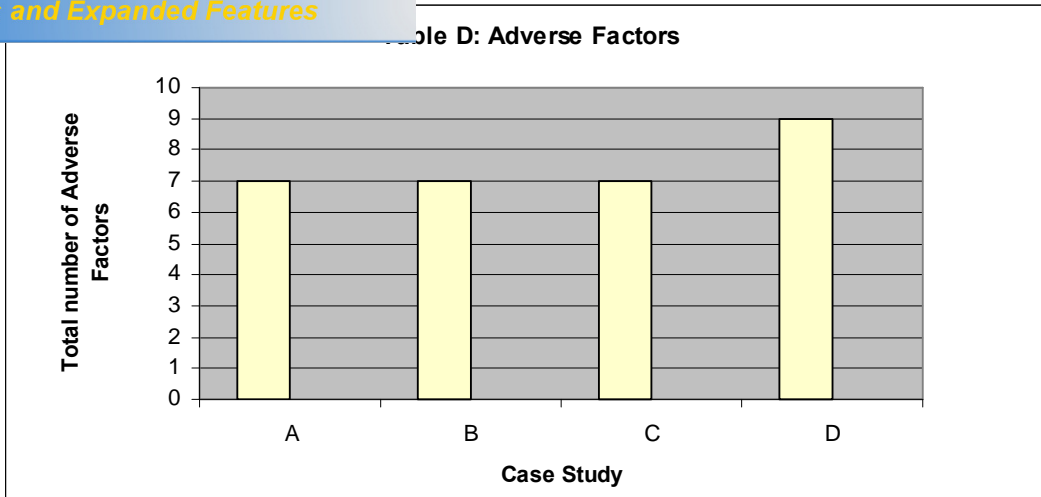


Description of Adverse Factors per Case Study (iii)



Adverse Factors per Case study

Table D: Adverse Factors



Protective Factors

Figures 3.3. (i), (ii) and (iii) describe the protective factors that the case study participants were exposed to, as well as the numbers of case studies who were exposed to protective factors

Figure 3.3(i)

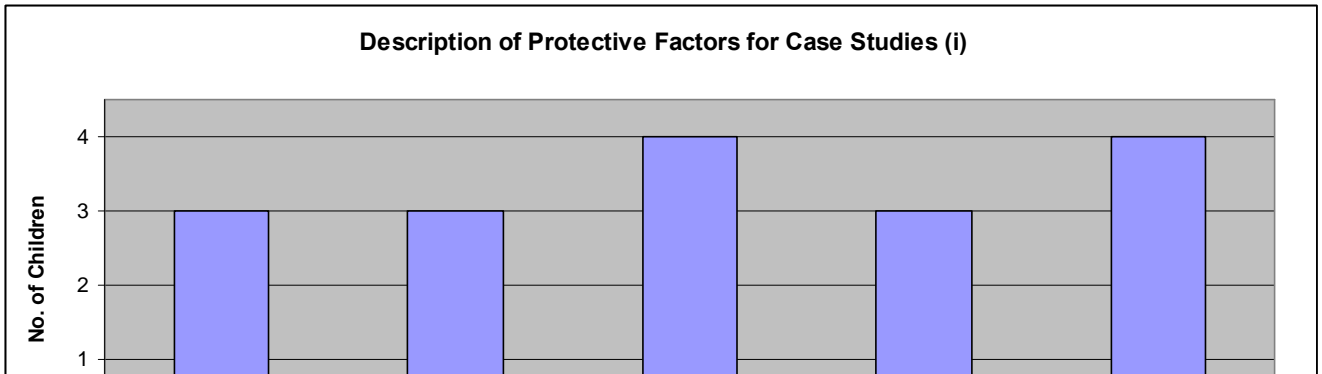


Figure 3.3 (ii)

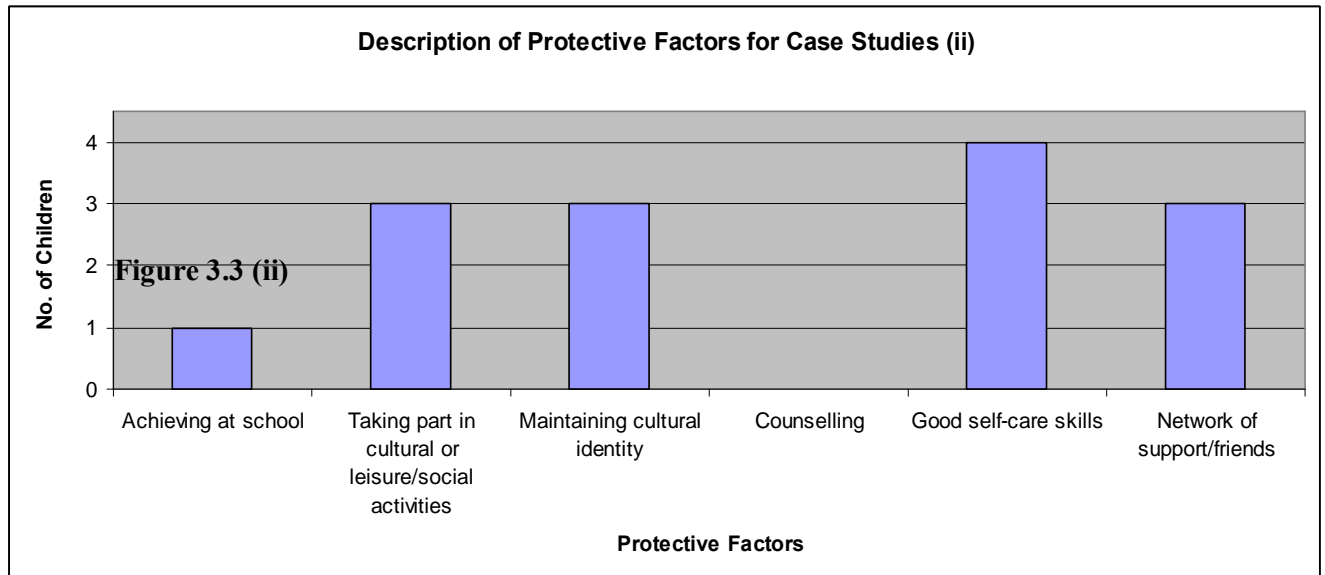


Figure 3.4 below indicates the numbers of protective factors that each case study participant was exposed to before they had play therapy.

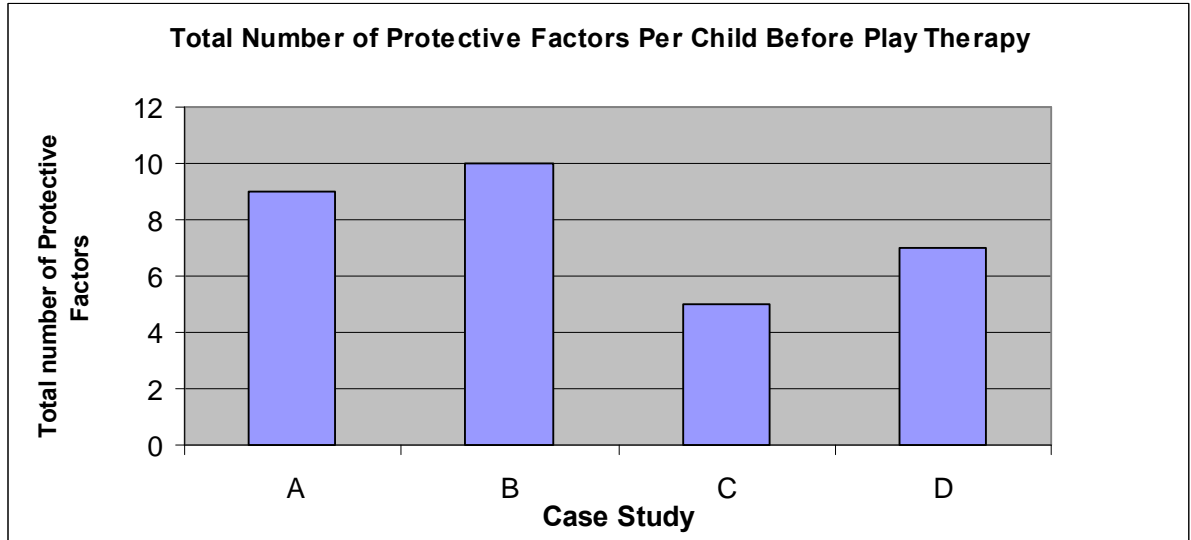


Figure 3.4 indicates that A and B had more protective factors than C and D. It is the researcher's opinion that this could make them more resilient than C and D. The findings are also consistent with the sample population where the resilient group had more protective factors than the non-resilient group (see Figure 2.1).

Figure 4.1

Protective and Adverse Factors per child Before Play Therapy

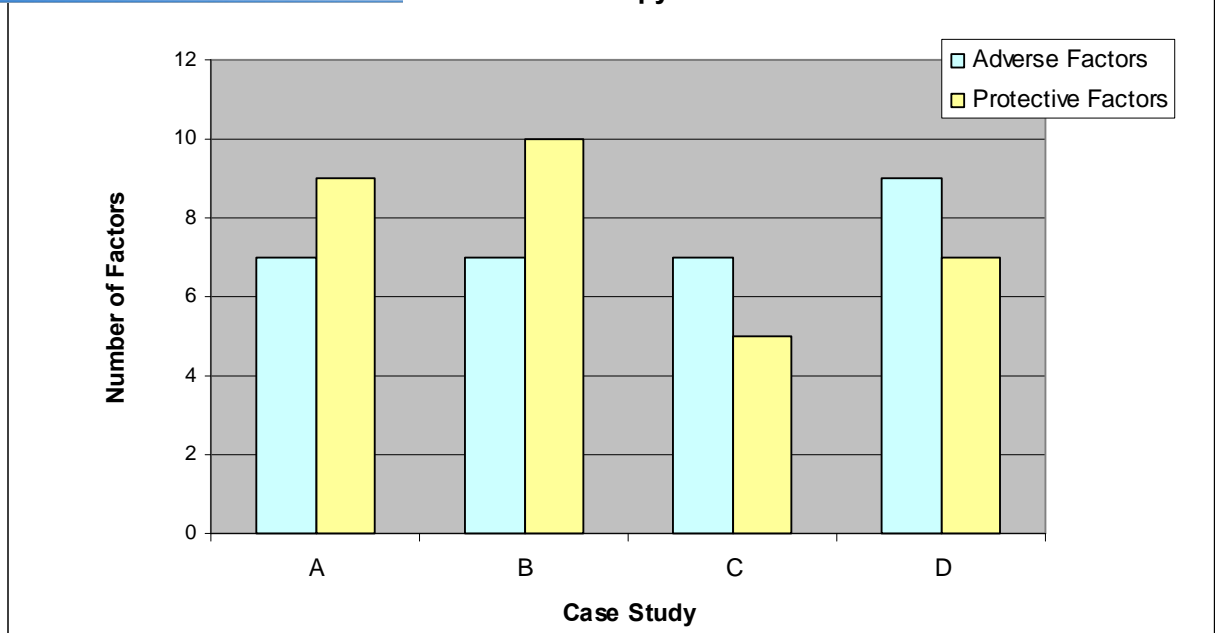
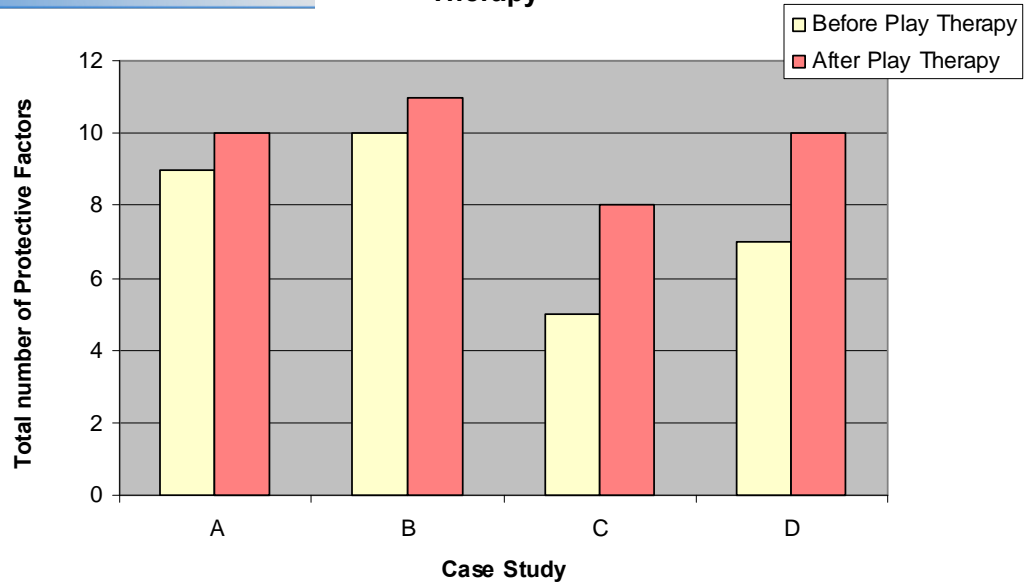


Figure 4.1 indicates the balance of protective factors and adverse factors before play therapy. A and B had more protective than adverse factors, and previous research indicates that the more protective factors children have in comparison to the adverse factors, the more resilient they would be. C and D had more adverse factors than protective factors and they appeared more vulnerable or non-resilient. This is also consistent with research findings in the sample population (see 4.2.5 and Figure 2.4).

Figure 4.2 Protective Factors before and after Gestalt Play Therapy

Protective Factors per child Before and After Play Therapy



It is the researcher's opinion that Figure 4.2 indicates how a Gestalt play therapy approach was used to increase the number of protective factors in the lives of each case study participant. Figure 4.2 indicates that there was a significant increase of protective factors for C and D, and the researcher would have described them as being non-resilient or vulnerable before they underwent the play therapy. A and B did not have significant changes in the protective factors. By being willing to share their experiences with me, all the participants' contacting functions had been improved. They have also built a trusting relationship with me. Interviews with the foster carers indicate that the young people were not willing to talk with them about their past. Some carers, in fact, appeared fearful that the young people were not at all ready to talk about their past experiences. During the research conducted, however, the young people were indeed ready to talk about their past, but they were just not aware of this need, as they were still repressing some unpleasant memories. After therapy, they were successfully making contact with their environment. Awareness includes knowing the environment (Yontef, 1988:144-145).

After contacting the foster carers again, they reported that they saw a marked difference in the young people since the intervention. D's social worker said she appeared much happier and less anxious. C told her foster carer about her parents,

ng to do this. B spoke to her carer about her fears
very well at school.

It is the researcher's view that in order to overcome the limitations of viewing resilience as only increasing the number of protective factors, or having a balance of protective and adverse factors, we need to look at the qualities and characteristics of resilience and assess those. In order to do this, the researcher will discuss four case studies where the participants underwent six play therapy sessions, in order to determine whether a Gestalt play therapy approach enhances and promotes refugee children's resilience.

4.4 The Case Studies and Gestalt play therapy

4.4.1 Identifying Resilience using Gestalt Play Therapy

In order to ascertain if and how play therapy from a Gestalt approach can promote resilience in refugee children, the researcher needed to assess or establish whether the respondents in the case studies were already resilient or possessed attributes of resilience. This was done, using the definitions of Woodcock (2002:275) and Lampert (2003:173-176). Woodcock's definition of resilience describes the qualities and characteristics of refugee children who are resilient, while Lampert's definition describes qualities of resilient children in general. The tables below identifies resilience and the attributes of resilience in each case study before conducting play therapy, what was observed during therapy, and the outcomes after the play therapy sessions.

during Play Therapy

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Woodcock's Attributes of Resilience		B	C	D
Choice over major decisions	Able to make choices about her school subjects, social activities, finances, relationships	Able to make decisions about her career, finances	Not certain about what she wanted to do when completing school	Very vulnerable, struggled to make choices or communicate these choices
Being able to solve problems in collaboration with others	Able to say that she was unhappy where she was living and to tell her carer about being bullied at school	Able to do this effectively by asking for what she needed from the appropriate people	Struggles with communication with anyone; prefers to just withdraw	Not able to do this, due to a traumatic experience
Social and cultural networks	Has strong links with her cultural community, is involved in local church	Has links with her cultural community, was involved in sport	Has no links with her cultural community and has no friends	Has links with her cultural community and lives with others from the same community
Being able to talk about ongoing problems	Able to discuss the difficulties she has at school and learning English	Has been successful in securing a part-time job, is able to talk about problems with her carer	Has difficulty with this, has been bullied but did not inform anyone about this	Is limited by her lack of confidence in speaking English
Being able to talk and reflect on past experiences, both good and bad	Was able to talk about this to her carers as well as the researcher	Struggled to speak about some of her experiences	This was a struggle as she was only able to speak about the past year, they were told not to speak about their past	This has been limited as they were told not to speak about their past as it may endanger their family
Being able to grieve actively	Cried when she arrived at the carer but did not talk about it to her carers	Struggled with this and prefers not to think about her loss	Was not able to do this at all	Was able to do this to a limited extent

therapy

Case Studies	A	B	C	D
Woodcock's Attributes of Resilience				
Choice over major decisions	There was no significant change in this area after play therapy but in other areas there were	This young person decided that she would try to find her missing brother; before the sessions she did not want to, fearing he may not be alive	This young person was uncertain about her career choice but after the sessions she decided that she would go to college to study accounting	After the sessions D was able to make several decisions about her accommodation, college and managing her finances
Being able to solve problems in collaboration with others	Was able to ask other adults in her support network, including her social worker and adults at her church, being aware that this helped her adjust	There was no significant difference after play therapy, but she was made aware that it was helpful to ask others for help	After the sessions she was able to approach her carer more often about some of her difficulties at school as well as the bullying that occasionally took place	After the sessions she was able to speak to her carer and her social worker about her difficulties
Social and cultural networks	She became involved in friendships not only within her own cultural group but also other cultural groups	After the sessions she became involved with a group for young people in care, broadening her social network	Started to make friends at school as well as friends from her own community	Continues to build friendships and maintains her cultural identity
Being able to talk about ongoing problems	There was no significant difference after play therapy	After the sessions approached her carer & social worker regarding her fears about her legal status	The carer noted that she was more confident to approach her to talk about what was bothering her	Was able to speak to social worker, carer and researcher about her problems
Being able to talk and reflect on past experiences, both good and bad	Was more open to talk about her experiences to the carer	Was able to speak about her past and current experiences during the sessions	Was able to speak about living in her home country and to reflect on the positive experiences	Was able to speak about her home country and what she missed and what she enjoys about living in the UK
Being able to grieve actively	Was able to talk about missing her family and about what helped her adjust	Was able to talk more about her loss, her fears, missing her family & her hopes for the future	Was able to talk about missing her home country and her difficulty in adjusting	Was able to talk about her traumatic experience while living in the UK

before and during Sessions

Case studies	A	B	C	D
Lampert's Attributes of Resilience				
Has a talent and a special interest that brings pleasure and a sense of competence	She is very friendly and outgoing, also has a special interest in religious activities, including singing	Has a flair for languages and is able to speak several languages fluently, achievements at school gives her a sense of competence	Is talented in art and maths; however, has a very low self-esteem and does not believe that she's good at it.	Does not believe that she is good at anything
Has one consistently good relationship with at least one adult	Yes, with her carer as well as adult at church; also had a good relationship with her mother	Yes, with her carer and previously with her parents	With her carer	Only recently with her social worker
The ability to distance	Able to do this to a certain extent	Does this well but it has become harmful	Does this very well but appears cut off from her emotions	Is able to do this to a certain extent
The ability to ask for help from appropriate adults	Has done this in the past and appears to be socially confident	Is able to do this effectively but would prefer to try and manage things on her own	Struggles to do this and has not done this even when she is struggling or has been hurt	Can do this to a certain extent
Being aware of themselves and their environment	Is reasonably aware of herself and of the reality of her situation; able to accept her circumstances, able to mourn the past and focus on meeting her present needs	Is aware of her circumstances and accepts her situation; is partially able to move on to focus on meeting her current needs	Appears to be withdrawn and fearful of her environment; she copes by withdrawing; but will engage on a one-to-one basis	Appears to lack awareness of her environment and appears vulnerable
Plans rather than acts on impulse	Tends to be impulsive, but some of this is part of her temperament	Is generally a cautious person and will seldom act impulsively	Will seldom act impulsively and tends to plan things	Appears to be impulsive and struggles to plan

Therapy Sessions

		B	C	D
Lampert's Definition of resilience				
Talent and a special interest that brings pleasure and a sense of competence	Became aware of her competence in being bilingual & stopped comparing herself to those who speak English as a first language	Became more aware of her achievements	Became aware of how competent she was in being able to speak some English, and how special she was by being able to speak two languages	Became aware of her competence as she was able to practice her English while engaging in therapy
Has one consistently good relationship with an adult	The therapeutic relationship provided an additional consistent relationship	The therapeutic relationship provided an additional consistent relationship	The therapeutic relationship provided an additional consistent relationship	The therapeutic relationship provided a consistent relationship with an adult
The ability to distance	Through the projections she was able to distance herself and own the projection	Through the projections she was able to distance herself and own the projection	Through the projections she was able to distance herself and own the projection	Through the projections she was able to distance herself and own the projection
The ability to ask for help from appropriate adults	She grew more confident in asking for help	Was made aware of how important asking for help can be	Has approached her carer about the bullying she experienced in the place of residence	As her English improved, she grew in confidence to ask adults for help
Being aware of themselves and their environment	Became more aware as she was able to talk about the past, her current difficulties and what she currently needs	Became more aware and found it helpful to talk about her past; this helped her to speak to her carer about her current fears and insecurities	Became aware of the choices and opportunities she has in her current circumstances	Became much more aware of her environment and enjoyed the new experiences and creativity that the sessions provided
Plans rather than acts on impulse	There was no significant change after play therapy	There was no significant change after the sessions	There is no significant change	There was no significant changes

4.4.2 Identifying Resilience

The research findings (Tables B, C, D and E) indicate that participants A and B were able to make good contact with their environment. Their progress at school and

of this. They also have cultural links with their provides support. When the researcher observed A and B, they were fluent in English. This has aided their adjustment to living in the UK, and in the researcher's view it has also made them more resilient. A and B were also able to speak about past experiences during the sessions. Both A and B were attending school and college, were fluent in English and involved in social activities. A and B were able to make sense about their past, present and future. In the researcher's opinion, A and B were resilient.

C was in full-time education and was planning on attending college. D was not able to think about the future. C and D's English was not fluent. All except B felt embarrassed about the way they spoke English. They were also able to mourn the loss of their family. The researcher would describe C and D as non-resilient, as they appeared more vulnerable and were struggling to adjust to living in the UK. D's social worker was concerned about her emotional well-being, and C's foster carer was concerned that she was isolating herself.

4.4.3 Schoeman's Working Model and Resilience

As Schoeman's working model was used as the Gestalt play therapy approach, the researcher will discuss the tables when dealing with the various stages of the model. This was done in order to test the research hypothesis, namely to show how a Gestalt play therapy approach could enhance resilience in refugee children. The researcher attempts to show how the different stages in Schoeman's working model may be particularly relevant in bringing out or realising the attributes of resilience mentioned by both Woodcock (2002 :275) and Lampert (2003:174-176).

These stages are: the relationship; sensory modalities; the child's process; the projection; alternatives; and empowerment. The attributes of resilience listed by both Woodcock and Lampert are also discussed under each stage of Schoeman's working model. Each case study is discussed separately. The table below indicates the hypothesis that the researcher made, namely that particular stages of Schoeman's working model would enable certain attributes of resilience in refugee children. The researcher discusses each of the case studies separately, using the table below as a

ing model is a process and each child was unique. of resilience may have been realised in different parts of Schoeman’s working model.

Table E

STAGES OF SCHOEMAN’S WORKING MODEL	RESILIENCE AND ITS ATTRIBUTES
The Relationship	<ul style="list-style-type: none"> • Has one consistently good relationship with an adult
Sensory Modalities	<ul style="list-style-type: none"> • Being aware of themselves and their environment
The Child’s Process	<ul style="list-style-type: none"> • Plans rather than acts on impulse
Projection	<ul style="list-style-type: none"> • Being able to talk about ongoing problems • Being able to actively grieve • The ability to distance
Alternatives	<ul style="list-style-type: none"> • Being able to talk and reflect on past experiences, both good and bad • Being able to talk about ongoing problems • Choice over major decisions • Being able to problem-solve in collaboration with others • The ability to ask for help from appropriate adults
Empowerment	<ul style="list-style-type: none"> • Have talent and special interest that brings pleasure and a sense of competence • Social and cultural networks of support

4.5 Case Study A

The Relationship

Has one consistently good relationship with an adult

The therapeutic relationship provided A with an additional consistent relationship. Although she has had consistent relationships with adults in the past, the relationship

opportunity to have an affirming adult who was not memories. The phenomenological approach of Gestalt therapy is based on what is happening in the present, not what could be or what was. In this situation, A had a good relationship with her mother, but she was no longer living with her mother and the type of relationship she used to have with her mother has ended the day they were separated. She also had a good relationship with her carer, but her carer was fearful of probing or asking questions, in case it would upset A. According to Lampert (2003:9) the I óThou relationship is the single most important tool in promoting healing. It is used to help the child to explore his deepest feelings, fears and frustrations. Hearing the painful and horrific stories of refugee children can often lead those caring for refugee children to feel overwhelmed and powerless. Adults may therefore avoid listening to refugee children's stories (Hawkes, 2007:97-109).

A came to the UK because her home country was engaged in civil war. She would occasionally tell the carer that she had nightmares. The I-Thou relationship is therefore ideal, as A was accepted as she was. There were no expectations for her to tell her traumatic stories, neither were the stories avoided because the therapist did not want to hear them. Schoeman (2004:122) asserts that "the client builds a relationship of trust and feels safe to be vulnerable". It is the researcher's view that for refugee children the feeling of safety in the relationship is vital because it gives them confidence to unburden themselves to an adult who they feel will not be overwhelmed by their trauma or story. It is the researcher's opinion that refugee children will only trust you if you are your true self. What helped the researcher and child build a trusting relationship was that the researcher was also black and from a country in Africa and separated from her family. The uniqueness of the Gestalt therapeutic relationship where the therapist is expected to be her authentic self, has, in the researcher's opinion, has been particularly successful with A.

Sensory Modalities

Being aware of themselves and their environment

The sensory modalities are used to make the child aware of his feelings. The researcher used a wooden block game and this reminded A of the games she had played as a child. This enabled her to become more aware, as she was able to talk

abilities and her present needs. The researcher also used
Hyder (2005:45) points out that refugee children
will be able to gain confidence by exploring their environment through play (see
2.6.1).

The Child's Process

The child's process refers to the way the child experiences his world and meets his needs. This also relates to the child's temperament (Blom, 2006:79). As a Gestalt play therapist it is important to understand the child's process, in order to go in confluence with him, understand how he makes sense of his world, and in this way to facilitate healing and expression through self-regulation. It is also helpful in assessing the child's need and in planning play therapy activities that would support the child's process (Blom, 2006:52-53).

Plans rather than acts on impulse

Although Lampert sees this characteristic as resilient, the researcher believes that whether a child acts on impulse is greatly influenced by their process. A Gestalt therapist needs to work in confluence with the child's process. A is fast paced, always on the go and people-orientated. This would mean that she may be less likely to plan things and in the researcher's opinion this does not make her less resilient. There was no significant change after the play therapy sessions.

Projection

The aim of the projection is to help the child express feelings and emotions he cannot verbally express onto an object or person. The therapist used stories, magazines and games. The stories were particularly successful as A was also able to learn about British culture through the stories. The magazines were helpful in helping A become aware of British culture and to think about her aspirations. It appeared that A's need was really to continue making a successful adjustment to living in the UK and this was done by making her aware of herself and her environment through using sensory modalities.

Being able to talk about ongoing problems

able to discuss issues with her foster carer. She did not
problems made her feel. There did not appear to be a
significant difference after having play therapy. A was able to discuss some of her
ongoing problems during the play therapy sessions, as well as to express how she felt
about these problems. The researcher's view is that this was due to the process of
making the projection and owning the projection.

Being able to actively grieve

The only sign of any grief that A displayed, was crying on arrival at her new foster
carers. She told the carer that she was missing her mother. During the sessions A was
able to grieve. She was able to talk about having recurring memories which are
painful and of "wanting something to happen which isn't happening", as well as
feeling a lot of worry and fear. The carer reported that after the sessions A seemed
more willing to talk about her past. The projection helps the child to focus on what is
making him unhappy now. It is the researcher's view that projections enable refugee
children to grieve.

The ability to distance

Through projections children are able to "distance" themselves from emotions they
are unable to express. A Gestalt play therapy approach offers them this opportunity.
For refugee children particularly, given their traumatic circumstances, this can
become maladaptive, where they completely repress and deny their emotions. In
relation to refugee children, they may need to do this in order to be resilient.
However, a Gestalt play therapy approach accepts this, while helping them to own the
projection. This means that the child begins to realise that the emotions he gives to the
object in the projection are his own. After the play therapy sessions there did not
appear to be any significant difference in A's ability to distance herself. During the
sessions, however, she was able to own the projections she had made by stating how
she felt about living in the UK and being away from her family.

Alternatives

At this stage the therapist serves as a guide in helping the child find alternatives for
solutions regarding his past, present and future. At this stage, the child is able to make

about his future, as well as making sense of his past,

Being able to talk and reflect on past experiences, both good and bad

It is the researcher's opinion that this can only happen once you establish a relationship, and by means of projections. Wade, Mitchell and Baylis (2005:155) believe that refugee children need help in reducing the disconnection between their past and present lives. The dilemma for refugee children, however, is that they are not always listened to or allowed to express their emotions or tell their stories. Children who are not allowed to express their emotions may carry unconscious resentment, incomplete awareness and anger. Some children may not be able to express such emotions and may need help to do so. This can be seen as unfinished business which blocks organismic self-regulation (Schoeman, 2004:167). The researcher believes that this is where a Gestalt play therapy approach is particularly effective with refugee children, because it enhances self-regulation, by means of the various aspects discussed.

Before the play therapy sessions A was able to do this to a limited extent. In the interview with the carer, she mentioned that she did not want to ask too many questions of A for fear of upsetting her, but that A would occasionally speak about the past. The carer's view was that the timing needed to be right and that maybe 'A would need to speak to a therapist in the future or her past would catch up with her, later in life.' During the play therapy sessions A was able to reflect on her past experiences, both good and bad. She then became aware of her present and the positive experiences that she has had in the UK. It is the researcher's view that this was made possible by going through the various stages of the Schoeman model, thus of the Gestalt approach to play therapy.

It is the view of the researcher that refugee children have to cope with two polarities – they are experiencing two widely different cultures. Thus, in order to be resilient they need to integrate their own culture with the British culture and that a Gestalt play therapy approach can empower refugee children by facilitating the integration of these polarities.

in this young person's ability to make choices regarding major decisions. As stated in Chapter Two the aim of Gestalt play therapy is to make children aware of the choices they have. This was done by using the sensory modalities. Although no significant changes for A in this area were apparent, there were changes in other areas. Gestalt play therapy is a phenomenological therapy with emphasis on the present, while for A, the present was not an area that was on her foreground. At the time of the sessions she had no major decisions that she was concerned about or needed to make. It is the researcher's opinion that this is very relevant to refugee children who have to cope with many changes and grievous loss at the same time, and if we don't go in confluence with the child we will not be able to address the actual issue that is important for the child at that time. The researcher believes that this is an excellent way of addressing the gaps in refugee children's lives and the different needs of different children. It is also an excellent way of prioritising the child's needs. These changes and losses can be overwhelming for both the child and the professional, but by focusing on the here and now, we can make the present bearable for the child. We can therefore deal with unfinished business when the child is ready to deal with it. Projection helps the child to focus on what is making him unhappy now (Schoeman, 2004:167-177).

Being able to problem-solve in collaboration with others

Before the play therapy sessions, A was able to do this to a reasonable extent. The difference after Gestalt play therapy was that she became aware of how important it was to be able to talk to others about her problems. She said that she *"feels better after telling someone how she feels."* She also stated, *"I don't think it is a good idea to keep things in. You have to tell someone you have tears."* She was made aware of this in the session when we were discussing alternatives. *Alternatives* are part of the Schoeman model. This is the fifth stage in the Schoeman model and at this stage the child is able to come up with their own alternatives or solutions to their problems. The child is able to do this, due to the previous stages in Schoeman's working model (see section 2.7.4).

Being able to solve problems with others also involves making contact and being aware that she can approach others to resolve problems. This is an important concept in Gestalt therapy. Through awareness, the child is able to take responsibility.

appropriate adults

the past, but has grown more confident in asking for help. In the researcher's opinion Gestalt play therapy helps children to become aware of things that they have control over and therefore can take responsibility, as well as to become aware of those things they have no control over, and therefore cannot take responsibility for. This is very important for unaccompanied refugee children, as they have experienced so much loss and changes in their lives and they need to know what they have control over and what they do not. They need to know for what they are responsible and for what not. Many of them feel guilty and responsible for things that are out of their control. In all the case studies, it became clear that they felt responsible for what happened to them, because to keep them safe, their parents were forced to arrange for them to come to the UK. All of the respondents still have family in their home country, and all felt guilty about living in the UK while their families are still living under the conditions that they were able to flee from.

It is the researcher's opinion that being able to ask appropriate adults for help, problem-solving in collaboration with others, and making choices over major decisions are all forms of self-support. A Gestalt therapist's concern is how participants solve their problems, not to solve it for them or tell them what to do.

Empowerment

During this stage, the therapist helps the child recognise that he has taken responsibility for his own choices. This gives the child a sense of power and control. The therapist can also use something real about the child to empower him. This particular stage is unique to the Schoeman model and the researcher feels that it is particularly relevant to refugee children who have even less control and choice in their lives than other children.

Talent and special interest that brings pleasure and a sense of competence

Although A came across as a confident child, during the sessions it became clear that she had little confidence when speaking English. She commented on how poor her English was. By means of the therapeutic relationship and empowerment in the play therapy sessions A became aware of her competence in being bilingual, instead of comparing herself to others whose first language was English.

to form friendships with young people from other young people. It is the researcher's opinion that by making A aware of how well she had adjusted to living in the UK, as well as her ability to speak English, A was empowered to broaden her circle of friends. Schoeman (2004:179) sees this as making the child aware of his power and control. This also improves self-esteem. Previously, A's thinking that her command of English was poor, prevented her from making friends with English-speaking people.

Social and cultural networks

A already had strong cultural links and social networks within her own culture. Through the play therapy sessions she became aware of how important her culture and the links she had with her community of origin and her church were to her. The aim of a Gestalt play therapist is to help the child go back, regain and renew, and strengthen something they once had. It is the researcher's opinion that by giving A the opportunity to speak about her culture, she was able to regain and strengthen her sense of self. This also empowered her as she had some control and choice over maintaining her cultural identity.

4.6 Case Study B

The Relationship

Has one consistently good relationship with an adult

This young person had good relationships with her parents and carer. However, she was forcefully separated from them, and according to the carer, she seemed reluctant to want to talk about the past. She tended to see herself as fairly competent and independent. She stated *"Not everyone needs to know your business"*. This is a particularly difficult issue for many refugee children who may have been told to keep silent about the past, as their own safety and that of their friends and family may depend on it. The therapeutic relationship provided B with an additional consistent relationship, as well as an adult who was willing to listen to the painful stories of separation and loss without any expectations, while seeing her not as a victim but as someone who was an equal and competent. B had survived a particularly traumatic and violent past, and the therapist was aware that B had survived this by taking responsibility for her own safety and success thus far, so that to see her as a victim would not be respecting her and would certainly not engender her trust.

iculary relevant when working with children who have experienced trauma. The aim is to bring the child into sensory awareness so that they can make contact with themselves and their environment.

Being aware of themselves and their environment

B was able to become more aware as she began to talk about her past, her current difficulties and her present needs.

Traumatised children may have difficulties with one or more sensory modalities. For B, play dough and smelling different things were very useful during the sessions, as it enabled her to talk about her past experiences. The researcher's opinion is that this is an example of how Gestalt therapy enhances resilience in children. The sensory modalities stage is very important when working with children who have experienced trauma such as civil war and violence. A Gestalt play therapy approach like the Schoeman model regards the sensory modalities as important. Research indicates that when working with trauma, one has to work with the senses, as traumatic memories are stored in our sensory modalities. This is why the researcher considers a Gestalt play therapy approach to be enhancing resilience in refugee children, because it addresses trauma in a way that is not intrusive. As Lampert (2003:9) states, the goal of Gestalt therapy with children is not to fix them but to encourage self-healing.

The Child's Process

Plans rather than acts on impulse

B is fast-paced and task-orientated. This did not change after the play therapy sessions.

Projection

Being able to talk about ongoing problems

In order to earn additional funds, B was able to secure a part-time job, and generally was able to talk to her carer about any difficulties. She sees herself as independent and competent and will only speak when she feels it is appropriate for her. After the play therapy sessions, she did approach her carer about her fears regarding her legal status. She then also spoke to her social worker about this. In the interview with the carer before the play therapy sessions, B's carer mentioned that she has become

feels that it was due to her concerns about her legal natural progress for B to discuss this with her carer or it may have been a result of the play therapy sessions. In this case it is unclear.

Being able to actively grieve

B struggled to grieve. During the sessions, however, she was able to speak about missing family and friends. She was also able to speak about her future and seemed to understand that she needed to accept what has happened. She acknowledged having painful and recurring memories which she felt she was not able to speak about. She said, *“If I talk about it I will not be able to get on with living here, I will not be able to focus on my exams.”*

Maybe refugee children who have traumatic memories like B, will only be able to grieve when all their immediate needs have been met, or when it is on their foreground. Lampert (2003:11) is of the opinion that children who have experienced severe trauma may become reality bound as a defence against anxiety and depression, and that this should be respected and honoured. There is no idea of fixing the child but only of facilitating self-healing. This is the principle of self-regulation in Gestalt therapy, that human beings can regulate themselves and find ways of meeting their needs.

The ability to distance

B was able to do this very well before play therapy commenced. However, the researcher's view is that this may have become harmful. B was able to own the projection.

Alternatives

Choice over major decisions

Before the play therapy sessions, B was able to understand the choices she had. However, the researcher believes that becoming more aware of her choices empowered her to make a major decision regarding finding a missing relative. This happened after the play therapy sessions. She had been given the option of contacting the Red Cross to trace a relative, but was fearful in case the relative could not be traced and she would be told that he was assumed dead. After the sessions, nonetheless B made the decision to trace her missing relative.

fairly resilient and able to make major decisions, the play therapy approach made the difference. Children are self-regulating, but it is the researcher's view that a Gestalt play therapy approach enhances the self-regulation in refugee children. Play therapy with a Gestalt approach addresses the quality of resilience that children have. All children will find ways of surviving, but what Gestalt therapy does is to enhance this process by helping them find ways which are not destructive to themselves or those around them. Maybe later on B would have made this decision naturally, but what Gestalt play therapy does, is enhancing this self-regulating process through awareness and the therapeutic relationship. It is the researcher's view that self-regulation in Gestalt therapy can be seen as promoting the child's resilience.

Being able to talk and reflect on past experiences, both good and bad

B seldom spoke to her carer about her past experiences. From the carer as well as from information on her files, B had a traumatic past which included being physically attacked, imprisoned, and living in a country disrupted by civil war. The foster carer stated that she did not ask any questions when B spoke about her past, in case the child became upset. The researcher felt that the carer was fearful of the painful memories that B had, and therefore would not encourage B to talk about it. In the sessions with B, she was able to speak about some of her past experiences. The researcher felt that B was relieved to speak about her experiences. This is clear from her remarks, "I feel less upset when I speak to someone" and "Problems eat you up inside and you don't know about solutions available if you do not talk to someone." Research indicates that refugee children have a need to tell their traumatic stories.

Being able to problem-solve in collaboration with others

B was able to do this effectively before the play therapy sessions. There was no significant difference after the sessions, except that B was made aware that it is helpful to ask others for help. She stated that "Problems eat you up inside and you don't know about solutions available unless you talk to someone." This awareness could have also helped B make her decision to trace her relative. B's carer noted that after the play therapy sessions, she was more willing to approach her to discuss any difficulties, including the decision to trace her relative. Being able to solve problems with others is an external form of self-support (see 2.8.2.1).

appropriate adults

intated, preferred to manage things on her own. After the sessions she became aware of how important asking for help was. B was also able to speak to her carer and social worker about her fears for the future. This stage in the Schoeman working model helps a child look at what they have control over and what they can take responsibility for. In Gestalt therapy one can only take responsibility for what one has control over and what we are aware of (see 2.7.1.3). Children are generally more vulnerable and have less control over situations, due to their dependence on adults. For unaccompanied refugee children this is compounded, as they are dependent on the goodwill of the country they flee to as well as adults who are not related to them. This makes them particularly vulnerable, and they need to know adults they can trust.

Empowerment

Talent and special interest that brings pleasure and a sense of competence

Although B felt a sense of competence from all her achievements, it was only during the sessions that she really became aware of how talented and special she was. In the researcher's opinion, this was a young person who had a very traumatic past and yet she was achieving at school and fluent in several languages. She may have felt competent before, but almost seemed dismissive of it. The researcher made her aware of her school achievements and ability to speak several languages fluently. During the sessions she smiled and her body language indicated that she felt good about it.

Social and cultural networks

B was a sociable and friendly young person who was well-connected to her cultural community and had friends from different cultures, including white British. B was also involved in sport. In the sessions B was able to discuss her culture and how she maintains it while living in the UK. In Gestalt therapy, the individual is not viewed in isolation. This is the concept of field theory (see 2.8.1.2). By giving B the opportunity to speak about her cultural identity, the researcher believes that it enhanced B's self-regulation and empowered her. This could be a reason why B, after the play therapy sessions, became involved in helping and attending a group for young people who were all in foster care.

Has one consistently good relationship with an adult

The therapeutic relationship provided C with an additional consistent relationship. Due to C's timidity and lack of confidence, the sessions were mainly spent on building a relationship and empowering her. In therapeutic relationship in Gestalt, the client is accepted as an equal, which enabled the researcher to empower C by giving her the opportunity to teach her some Mandarin words. This proved to be highly effective in raising C's self-esteem, and it proved to be a joyful experience for both the therapist and the child. This is so vital for refugee children, because at school, on account of communication difficulties, they may appear incompetent or may fail as they are unable to express themselves appropriately. C was constantly embarrassed, saying, "My English is so bad." Through the therapeutic relationship and empowerment C became aware of her competence in being bilingual, instead of comparing herself to others whose first language was English.

Sensory Modalities

Initially, C found it difficult to engage with the sensory modalities. Blom (2006:89) states, "When children restrict their senses and body, their ability for self-support and emotional expression will be slight." This usually occurs when they experience some trauma, which blocks their contact functions. C was quite withdrawn and isolated. It is through our senses that we make contact with our environment, and this explains her isolation and difficulty in making contact. She was also resistant to engage with the sensory mediums.

Being aware of themselves and their environment

During the last two sessions C started to work with the sensory mediums, and gradually she became more aware during and after the sessions. She was able to use clay successfully and to speak about some of her sadness.

The Child's Process

Plans rather than acts on impulse

C is slow-paced and task-orientated. This describes C's temperament, and the researcher had to accept her as she was. The theory of change in Gestalt therapy is

no or what he is not, the more one stays the same

Projection

Being able to actively grieve

C was able to do this to a limited extent. During the sessions she was able to speak about missing her family, the difficulty in adjusting to living in the UK, and especially in having to learn English. After the sessions, she talked to the carer about her family, which she had not done before.

Being able to talk about ongoing problems

This was very difficult for C, to the extent that she was even unable to speak about being bullied. During the play therapy sessions with the therapist, C was able to talk about some of the experiences, such as the bullying that occurred, as well as her difficulties at school and children laughing at her accent and her incorrect grammar. The carer noted that after the play therapy sessions, C appeared to approach her more than before, telling her about the bullying that was occurring in her place of residence. During and after the sessions there was a significant change in C's ability to talk about her concerns, experiences and emotions. The carer also said that this is very difficult for some refugee children as they were told not to trust anyone, and they are frightened that people may find out about their backgrounds as some may have been trafficked to the UK. The carer also stated that some of the families pay agents a lot of money to bring their children over to the UK, and the children are not able to go back or say anything as it may place their families in danger.

The ability to distance

C was able to distance herself, although the therapist felt that it made her quite vulnerable, as she seemed cut off from all emotions. As previously stated, this can become harmful, but through owning the projections, children can express what they feel and take responsibility for what they feel. C had a traumatic past, including her journey to the UK. Her mother had died when she was young and her father was imprisoned in 2003. Lenore Terr (in de Zulueta, 2006:196) describes trauma as the mental result of one sudden external blow or series of blows, rendering the young

and breaking past ordinary coping and defensive attachments, as they would have lost their trust in people and relationships. Children subjected to such trauma will find it difficult to form

Alternatives

Choice over major decisions

C was uncertain about the choices she had. She appeared very timid, uncertain and withdrawn. The therapist therefore understood that she would struggle to make choices, as she appeared to lack self-awareness and awareness about her environment. After the sessions, she was able to make a decision about college and a career. It is the researcher's opinion that the empowerment stage and the therapeutic relationship played an important role with C.

Being able to talk and reflect on past experiences, both good and bad

This was a struggle for C and it was complicated by the fact that she was allegedly told by her agent not to speak about her family. During the play therapy sessions, however, C was able to speak about some of her experiences in her home country.

Being able to problem-solve in collaboration with others

Before play therapy, C struggled with communication with anyone. She appeared isolated and withdrawn. Part of this could be her process, being quiet and shy. However, her carer saw this as problematic at times, as she did not speak to the carer when she was having difficulties. After the sessions she was able to approach the carer about difficulties at school and in her place of residence. Given C's history and initial difficulties with the sensory modalities, it is understandable that she was not able to work with her carer in solving some of her difficulties. This included times when she was bullied.

The ability to ask for help from appropriate adults

C was not able to do this before the play therapy sessions. After the sessions, C was able to tell her carer that she was being bullied. The carer also stated that the girls are frightened to ask for help as they feel they need to be grateful and not complain or ask for anything.

...brings pleasure and a sense of competence

Through the therapeutic relationship and empowerment, C became aware of her competence in being bilingual, instead of comparing herself to others whose first language was English. The therapist was also able to make her aware that she had a talent for art.

Social and cultural networks

C was isolated and unable to make any friends or establish links with her cultural community. After the play therapy sessions, she started to make friends at school, and she made attempts to get in touch with girls from her cultural community.

4.8 Case Study D

The Relationship

Has one consistently good relationship with an adult

The therapeutic relationship was an important process with this particular participant. D had been through a particularly traumatic experience and was still traumatised when the sessions started. In addition, she was particularly vulnerable due to her limited skills in speaking English, as well as her being sexually exploited by adults in the past. The therapist had no expectations and could not predict what would happen in the interaction. The researcher was made aware of all the aspects of the Gestalt therapeutic relationship ó õpresenceö where the researcher could only be herself. The dialogue was õlivedö where the relationship was based on an energetic sharing interaction. The therapist also had to take a non-exploitative approach, due to the vulnerability of the child, while still respecting her dignity, uniqueness and wholeness. This was done through inclusion and confirmation. Despite all the vulnerabilities, trauma and apparent limitations, the therapist became aware that this young person had potential for awareness and growth. The researcher also had to be aware of the nonverbal communication of the client. The researcher was able to use games which required very little verbal input, but were providing fun.

Before the play therapy sessions, D was vulnerable, having very little awareness of herself and the environment. During and after the sessions, she became more aware. She was able to talk about her past, what she missed about the country she came from, as well as the difficulties adjusting to living in England. Together, the researcher and D were also able to speak about some of her present needs.

The Child's Process

D's temperament is fast-paced and people-orientated.

Projection

Being able to actively grieve

D was able to do this to a very limited extent by speaking about her home country and what she was missing. The researcher was able to use different sensory mediums, such as paint and clay. This proved to be very effective, as well as games that were fun, even though it required very little verbal input. Although the child never spoke about her trauma, the researcher believes that by going in confluence with the child, not trying to fix or change her, she was able to find a way of coping with the trauma, even if it was done by focusing on what was important to her at that time. For this participant, it meant learning English, having fun, and being able to speak to an affirming adult and not about her past trauma.

The ability to distance

As previously stated, this refers to children's ability to distance themselves from emotions or events they are unable to express. D was able to do this to a certain extent before the play therapy. During and after the play therapy sessions, she appeared to do this more successfully. According to Lennox (2007:58), refugee children experience terrible events and denying them is a mechanism to promote survival. They may later have to make sense of it. The researcher's view is that a Gestalt approach to play therapy allows the child to indeed make sense of it, through the I-Thou relationship and organismic self-regulation.

problems

ed by her lack of confidence in speaking English, as well as by her pre-occupation with her trauma. During the play therapy sessions she was able to speak about some of the problems she was experiencing at that time. The therapist also used the therapeutic relationship as a technique with D. The researcher used a game which required very little verbal input, but was fun, and enabled the child to experience success.

Alternatives

Choice over major decisions

D was very vulnerable before and during the play therapy sessions. She had just had a terrible experience which had left her traumatised, and with limited English had no way of effectively expressing how she felt. After the sessions, the social worker informed the researcher that D was doing very well, that she had made several major decisions regarding college, her accommodation and her finances.

Being able to talk and reflect on past experiences, both good and bad

Before the therapeutic sessions, D did not have the opportunity to talk about this with an adult. It was also limited on account of having been told by the agents who brought her to the UK not to speak about her past. During and after the sessions, this child did start to speak about her home country, what she enjoyed there, what she is missing, and what she enjoys about living in the UK. The researcher feels that this was due to using the Schoeman model with specific emphasis on the relationship, empowerment and the sensory modalities. This included listening to Chinese music, tasting Chinese tea, the child teaching the researcher some Mandarin words, and baking cakes. The researcher was also able to use art therapy with D who was very creative with paint and clay.

The researcher believes that a Gestalt approach allows a therapist to experiment and be creative with therapy, which is very relevant to refugee children. It is the opinion of the researcher that therapy has to be creative, especially if the child's communication ability is limited. This created an authentic situation, which was fun and a positive experience for the child. This was especially important, as positive and successful experiences are very rare for children who have suffered loss, severe trauma and many changes.

Collaboration with others

D was too traumatised to ask any appropriate adult for help. During the therapy sessions, D began speaking about her difficulties in adjusting in the UK. After the sessions, her social worker reported that D kept in regular contact with her if there was any difficulties, and she also started to speak to her carer.

The ability to ask for help from appropriate adults

D was not able to do this at all, in fact she was quite vulnerable, having been exploited by adults. A significant change was perceived after the sessions, and D's social worker reported that D stays in regular contact with her and has started building a relationship with her carer.

Empowerment

Talent and a special interest that brings pleasure and a sense of competence

Through empowerment, D became aware of her competence in being bilingual, instead of comparing herself to others whose first language was English. The researcher and D developed a game where D would say the Mandarin word and teach the therapist how to pronounce it. The researcher had to repeat the Mandarin words. D would then ask about the equivalent English words and their pronunciation, and would try them out. This usually ended up with both the therapist and D laughing at our attempts to speak each other's language. What this did for D, was not only making her aware of how difficult it was to learn another language, but also how competent and unique she was at being able to speak English at all. The important outcome for D was that this provided her with a sense of control, power and choice. The fun and joy that came from this exchange seemed to energise her. D was also very good with paint and clay. The researcher made her aware of this talent.

Social and cultural networks

D always has had links to her cultural community and a good social network. However, she had also been very vulnerable, ending up being exploited. Since the play therapy sessions, she was maintaining her cultural identity and continuing to build friendships. The researcher believes that by providing the child with the opportunity to speak about her culture, language and friends, D was made aware of

were to her. It also helped her with her sense of
by being separated from her home country, family
and friends.

4.9 Promoting and Enhancing Resilience

Before the play therapy sessions, the researcher would have described A and B as resilient and C and D as non-resilient. After the play therapy sessions, the researcher would conclude that A and B's resilience has been enhanced through a Gestalt play therapy approach, while C and D have become resilient through a Gestalt play therapy approach. This is demonstrated not only by the increase in the number of protective factors in each participant's life but also in their ability to regulate themselves and in developing self-support during the play therapy sessions and after the sessions were concluded.

In Chapter Five, the researcher integrates the research findings with the concepts of resilience and Gestalt play therapy. The researcher also attempts to show how resilience could be promoted and enhanced by using a Gestalt play therapy approach.

5. Enhancing Resilience by Applying Gestalt Play Therapy

Introduction

In this chapter all the data and research findings are analysed and integrated. The implications and conclusions are discussed. The researcher also integrates the research findings with the literature review as well as with Gestalt play therapy theory. In Chapter Four the research findings were presented and discussed. What emerged from the research, was that protective factors have a significant impact on the resilience of refugee children. It was these protective factors which appeared to enable refugee children's resilience. The non-resilient group had been exposed to more adverse factors than the resilient group and they also had less protective factors than the latter. It also appeared that there was a correlation between the number of protective factors and the number of adverse factors. In the researcher's opinion, the data revealed that the more protective factors refugee children had in comparison to the number of adverse factors, the more resilient they were. The protective and adverse factors may have explained resilience in refugee children, but it did not reveal how they became resilient. It was the researcher's opinion that in order to ascertain if resilience could be enhanced, further exploration was needed to understand the process of how refugee children became resilient.

The research findings on the case studies provided the explanation that a Gestalt play therapy approach could add protective factors to a refugee child's life, thereby contributing to their resilience. What was still needed to be explored, however, was whether and how a Gestalt play therapy approach could enhance refugee children's resilience. For this purpose, the researcher used Schoeman's working model for undertaking play therapy with the case study participants. It is the opinion of the researcher that the research findings indicate that by applying Schoeman's working model, a Gestalt play therapy approach may indeed be able to enhance refugee children's resilience. In order to make this evident, the researcher now proceeds to analyse and integrate all of the previous research and research findings in this project.

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are children who have experienced severe trauma, serious loss and profound change both in their country of origin and in the UK. Due to their legal status in the UK as unaccompanied minors, they are experiencing racism and discrimination and may have difficulty to gain access to services, including therapeutic services. This is reflected in the numbers of children who took up the opportunity for counselling or therapeutic services.

According to Alayarian (2007a:xx) in order to cope, inner resources are needed such as a sense of mastery, self-esteem, self reliance and outer resources such as acceptance and support by others. For this reason ,the researcher's view is that refugee children require an approach that includes both the internal and the external resources of the child, as well as the support of the family and community. Refugee children belong to a group who experience racial harassment in British society and may live in a community where they may be exposed to racial violence or physical attacks.

In addition, unaccompanied minors arrive in the UK without their families, reducing the external resources that they otherwise might have had available. According to Alayarian (2007a:xx) they require therapeutic service that rediscovers their abilities, empowers them to deal with their problems, reduce social isolation, and restores their sense of identity, belonging and self-esteem. Low levels of social participation affect their quality of life, increasing social isolation and mental health problems (Alayarian, 2007a:xx-xxi).

According to Newman (2002:8) a resilient child is better able to recover from trauma. It is the researcher's view that trauma also has long lasting impact on refugee children's internal resources to form relationships and may inhibit them from using external resources. The focus should therefore be on the child's ability to form relationships. As unaccompanied refugee children have so many needs, a holistic approach which integrates all their needs is called for. According to Rutter (2001:176) play can help identify how a child is coping with the refugee experience, while at the same time being a means of healing.

Gestalt play therapy approach is ideal to meet refugee children's needs that empowers them. Zinker (1978:123) states that therapeutic work is rooted in the client's own perspective. There needs to be respect for the individual's internal experience.

5.1.1 Resilience: A Cultural Perspective

According to de Zulueta (2006:203) cultural characteristics are significant in determining both how someone survives a traumatic experience and how his cultural environment responds to the person. According to Hyder (2005) it's the meaning that communities ascribe to events which gives them power. Meanings to traumatic events, however, will differ from community to community. This means that responses and interventions will also be different.

The scope of the research project does not include looking at the cultural response to refugee children's needs. This is therefore, an area for development and further research. It is the researcher's view that another explanation accounting for resilience in the young people could be that the countries they come from have their own informal way of dealing with trauma. War and violence are not new phenomena in Africa and communities have been coping in one way or another with the effects for centuries. Emphasis is placed on maintaining strong family bonds and this has meant that the effects of social conflict has been traditionally dealt with within the family (Bracken, Gille & Kabaganda in de Zulueta, 2006:203).

In research undertaken by Bracken, Gille and Kabaganda in 1992 on victims of trauma in Uganda they found that they had to provide initiatives which had the function of integrating and supporting local reactions and responses that already existed in the community. Direct intervention was aimed at only rape victims who did not receive any help, due to being ostracised. These researchers recommended that Western agencies do not impose their models of care on other cultures and that therapeutic strategies need to be as diverse as the cultures which they operate in. They also recommended that an attachment model of Post Traumatic Stress Disorder(PTSD) needs to recognise the need for traumatised individuals to be reattached or integrated within their community and/or family (de Zulueta, 2006:203).

with this, as the research indicates that the children from the same cultural community and who had a relationship with an adult were resilient. In the opinion of the researcher, play therapy with refugee children therefore needs to focus on improving the contact functions of refugee children to enable them to build relationships with others in their community and family. This is particularly difficult with unaccompanied children who may not have any family in the UK. This was the situation for the participants in the case studies. All four of them, were living with foster families who were British. There were however other refugee young people from the same cultural background living in the same household in each case study. There are also many established refugee communities from many cultures in the UK, with whom refugee children could make contact.

5.1.2 Resilience and Self-regulation in Gestalt Therapy

According to Lampert (2003:174) a first step to being a therapist is the belief that resilience can be enhanced. She believes that the attributes of resilience can be encouraged in therapy and that Gestalt therapy with the principle of organismic self-regulation and the I-Thou relationship promotes natural healing (Lampert, 2003:174). The researcher is in agreement with Lampert, as the researcher's view is that the principle of organismic self-regulation in Gestalt therapy is closely related to resilience. Resilience is defined as the developmental process by which children acquire the ability to use both internal and external resources to achieve positive adaptation despite previous or current adversity (Yates, Engeland & Soufre, 2003:250).

Self-regulation is the natural tendency for people to regulate themselves (see 2.8.2). A Gestalt approach to play therapy requires the therapist to believe that refugee children already possess these qualities but due to trauma, their contact functions may have been impaired. This will require them to talk about and possibly re-enact their experiences symbolically. According to Oaklander (1978:248): "If children survived the experience, then they can certainly survive the memory of the experience."

5.2. Identifying Resilience in the Sample Population

The aim of the research is to see whether play therapy from a Gestalt approach can enhance resilience in refugee children. According to previous research on resilience

Resilience itself not measured, but is the outcomes that project, the research findings indicate that it was resilient children who were able to integrate into British society. The outcome is integration into British society. In addition, Masten and Powell (2003:4) believe that resilience involves making two judgements about a person's life – that they have experienced adversity and that they are adapting well. The researcher adopted this approach as well, in order to determine whether the children in the sample population were resilient or not.

The researcher's judgement was based on the fact that the sample group had experienced adversity and that they were either integrating well into British society (resilient group) or not (non-resilient group). The researcher made a value judgement on resilience and the lack of resilience. The researcher used the literature study and the definitions of Alayarian (2007b:1-2) and Masten and Brooks (2003:4) as a guide to identify resilience in the sample group (see 2.1).

When analysing the data of the sample group, two groups were identified, those who were resilient and those who were not. The theme that emerged was that none of the non-resilient children were able to speak English on arrival. The researcher then made the hypothesis that the reason why this group were not resilient was their lack of English. Upon further analysis however, the researcher was able to divide the resilient group into two groups, those who could speak English on arrival and those who could not. The researcher based this on previous research by Rutter (2003:90) and Wade, Mitchell and Baylis (2005:83) which indicated that refugee children who were able to speak English were at a huge advantage compared to those who were not able to English. The researcher then attempted to test the hypothesis.

When analysing the data, the researcher was able to identify the similarities and differences between the non-resilient and the resilient group. These were based on the number of adverse and protective factors in their lives. This was consistent with previous research on resilience and, specifically on resilience in refugee children (see 2.1.4).

ose factors that have a negative impact on the development of a child (Masten & Powell, 2003:9). These can also be seen as factors which may cause psychological harm to a child (Rutter, 2003:129,130). In total 26 adverse factors could be identified which the refugee children in the sample population had been subjected to. Five of these all the refugee children had in common, regardless of whether they were resilient or non-resilient. These were: separation from and loss of culture and familiar way of life; separation from and loss from main carers, extended family and support network of friends; death of one or both parents or carers; and institutional racism for being a refugee (see Figure 1).

5.2.1.1 Separation and Loss

How a child responds to separation and loss will depend on their relationship with the person or persons. This includes the loss of parents and/or the child's main carers, extended family and friends through death or separation. Children respond to loss and separation by denial, disassociation, numbing, and shock. Children may suppress their feelings to support their denial. Children may lose interest in activities and appear listless, or they may lose body awareness and appear disconnected from themselves. Children may regress or temporarily lose a skill, reverting to old comforting ways of behaviour (Jewett, 1994:68).

Jewett (1994:12) believes that when a child suffers a significant loss or separation or impending change, they need to be told about it. Research by Rutter (2001:8) and Hyder (2005:35) indicates that many refugee children are not told about this, in order to ensure their own and their family's safety. It is the researcher's opinion that this complicates the grieving process for refugee children. Children who are supported through the grieving process may be more able to integrate their losses (Jewett, 1994:65).

Grieving

Jewett identifies three stages in grieving that children will go through, children also when experiencing minor losses. They may shift backwards and forwards through these stages. The stages will be briefly discussed.

and with shock and denial though dissociation, hyperactivity, irritability, protest, alarm and panic. Denial enables grieving children to suppress intense emotions which make them feel too vulnerable, and to conserve energy they will need to make future adjustments. At this stage, children may appear to lose interest in normal activities, withdrawing silently, avoiding people and conversation, and they may regress. Some children may become preoccupied and keep busy in order to avoid thinking about the loss. Children need help to give up their denial.

Acute grief

The second phase of grief is characterised by yearning and pining; searching; dealing with sadness, anger, anxiety, guilt or shame experiencing disorganisation and despair. Then children will eventually start reorganising. Each feeling helps the child to recover and accept what has happened, enabling them to move towards healing. Some children will be overwhelmed by anxiety and sadness, others by guilt and anger. Jewett (1994:80-81) states that each component of grief is important and must be worked through and not suppressed. This process can take between two or three years and sometimes longer. The greater the loss, the longer it takes to get over it.

Yearning and pining

Yearning and pining involves moving from anxiety, hope and despair. Having hoped that things could be different and then realising that they are not. This is indicative of how A, B and C felt in one of the activities in the sessions.

Bereaved children experience a compelling urge to recover the lost loved one, even when they are aware that the attempt is hopeless. This allows the child to confirm whether the loss is permanent or temporary. Searching behaviour can be seen as compulsive or irrational. It can involve an aimless restlessness, an inability to sit still, constantly searching for something to do. Jewett (1994:81) states that this drive is particularly strong in children who have been abandoned or whose parents are missing. Many of the refugee children in this study have parents who are missing, and some have been abandoned by their parents or carers. The searching behaviour will only end when children accept that they have tried everything effort at this stage and nothing has changed. A and B in the case studies had parents who were missing.

), some children may take great comfort in religion, as particularly involved with religious activities and said that it was a great support to her. Children may also avoid community gatherings where children are having fun and enjoying their families. It is the researcher's opinion that this is indicative of C's behaviour, and of the non-resilient group, where they were isolating themselves. It is the researcher's view that this could have been done as a way of avoiding the pain of their loss and avoiding possible rejection.

It is the researcher's view, therefore that the isolation that unaccompanied refugee children experience, may be a result of the stage of grief they find themselves in, where avoiding social and cultural activities is a normal response to grief. This must be particularly painful for unaccompanied refugee children who may not have any family living in the UK, being entirely dependent on unknown adults for their survival.

Sadness and disorganisation

Children may deal with their sadness by wanting to be on their own, in need of a quiet space or time, and this should be respected, as it is part of the healing process. This appears to explain C's behaviour where she was initially reluctant to make any friends, and her foster carer described her as a 'loner'.

During the disorganisation stage, children may become unfocused and vague. Jewett (1994:91) states that the preoccupation with loss, the effort needed to accommodate it, and the physiological changes connected to grieving, or not being allowed to grieve, reduce the ability to concentrate, to organise work habits, and to remember. Grieving is such hard work that it leaves the child with little energy to attend to other aspects of living. Loss can also cause physiological reactions, with their bodies responding as if they are in danger. Often insomnia is linked to experiencing loss. These physiological responses may leave the child feeling weak, vulnerable and exhausted (Jewett, 1994:91).

The foster carers of A and B indicated that they were suffering from sleep disturbances and would mention that they were having bad dreams. In addition, the foster carers also mentioned that they went to bed very late, despite having been told that they need to go to bed. In discussions with the experts and social workers, they all

en seem to go to bed very late. It is the researcher's symptom of grief or trauma.

In the opinion of the researcher, professionals working with refugee children need to work at the child's pace and not be in a hurry for the child to grieve or make disclosures. This could mean that refugee children, because they are grieving, may not have the energy to form new relationships and friendships, and this needs to be taken into account.

Disorganisation and learning

Jewett (1994:91), also states that due to the disorganisation, grieving can cause learning difficulties where children are not able to concentrate, so subjects like maths and English may cause problems. Learning difficulties can be so severe that children may end up not having the necessary information and skills to make progress at school. This will negatively impact on their self-esteem, as they may feel incompetent. It is the researcher's opinion that this could explain why the non-resilient group had difficulty learning English. All the case study participants except B, were embarrassed about their ability to speak English and this affected their confidence (Jewett, 1994:91-92).

According to Jewett (1994:95) in the case of children who are experiencing disorganisation, the opportunity to talk about their loss at school will be helpful. It will help them to distance themselves from their school work and deal with their grief, so that they can go back and focus on their school work. It is the opinion of the researcher that this could be very beneficial to refugee children who have so many adjustments to make, that they would need the opportunity at school to discuss their loss, so that they can go back and concentrate on their lessons. It can also serve as a physical release from the demands of lessons.

It is the opinion of the researcher that unaccompanied refugee children have many changes and practicalities to deal with at the same time. They may choose to delay grieving in order to get on with other parts of their lives they feel are important at the time. In the case study and sessions with B, she mentioned that if she had to think about her past she would not be able to do her school work. For all of participants,

a big concern. Those working with and caring for e that grieving will affect children's ability to learn, including their ability to learn English. In addition, refugee children may choose to focus on their school work instead of grieving.

Subsiding grief

Despair is very difficult to experience and to witness. The person sinks into a bleak and hopeless state of mind that resembles clinical depression. The symptoms are: lack of energy, not caring about grooming, lack of appetite or increase in appetite, and lack of interest in social activities. Life appears meaningless and overwhelming. For most children, this stage lasts from ten days to three weeks but it can last longer in adolescents, even up to three months. Jewett (1994:99) believes that if this persists still longer, or the child talks about killing or hurting himself, it indicates that the child's internal healing mechanism may be defective and professional help will be needed. It is the researcher's opinion that this is where a Gestalt approach to play therapy with its emphasis on enhancing organismic self-regulation would be beneficial to refugee children experiencing grief.

Integration of loss

Many children may need help to integrate their loss and grief. Jewett (1994:102) believes that some children may remain angry, depressed and seemingly suppressing their feelings, or they may be unable to move on, considering it disloyal to give up their pain and feel happy. They may lack the ability to become involved with others: and may even behave destructively towards themselves and others.

Jewett (1994:64) believes that every child's experience of grief will be unique. The researcher can add that every culture's way of dealing with grief and loss is unique.

It is the researcher's view that refugee children presenting signs of depression or who suppress their feelings may appear as non-resilient but actually according to Jewett (1994:97), this behaviour may be their response to dealing with all the loss and changes in their lives. It is the researcher's opinion that many forms behaviour and the responses that Jewett describes about children grieving and experiencing loss are completely normal responses to grief and loss.

the group described as non-resilient in the sample
be described as resilient and just responding to grief
and loss in appropriate ways? Measuring resilience however is about measuring the
outcomes. And where outcomes are concerned, there is a significant difference in the
outcomes of the resilient group and the outcomes of the non-resilient group, in that
the resilient group was able to integrate into British society while the non-resilient
group were not successfully integrating into British society. In addition the latter
group had fragile mental health and became involved in criminal activities.

Coping with loss and separation in adolescence can be particularly difficult because of
the changes that are occurring developmentally. Having become able to think
abstractly, adolescents also become aware of the ambivalence and internal conflicts
they experience in relationships, and this complicates the grieving when they lose
these relationships. The case study participants A and B, who were able to talk about
their past and present feelings and appeared well-adjusted in comparison to C and D.,
They were also not as isolated as C and did not suffer any trauma like C and D did
while they were in the UK. Both C and D appeared to have repressed their feelings
and emotions about their past experiences. Denial and withdrawal appear to be modes
of survival. Due to their youth, their protective mechanisms, and other complex
dynamic processes, their trauma may still be largely in a period of incubation, to
emerge in a variety of ways at a later stage. Adolescence is usually the time when
young people can find expression for their feelings and is therefore a good time for
engaging with trauma from an earlier period of development (Thomas, 2007:59).

5.2.1.2 Foster Carer's Response to Grief

How children respond to grief is dependent on whether the adults in their lives are
able to tolerate their expressions and feelings of loss. Complications arise when
children are not allowed, or feel they are not allowed, to express their feelings, or
when an awareness and expression of these feelings have not been encouraged or
supported (Jewett, 1994:64).

It is the opinion of the researcher that even though the foster carers said they would
like the children to express their feelings, they appeared ambivalent, saying it would

Other carers did not give any indication as to when they

Jewett (1994:99-100) stresses the importance for adults to realise that they can validate a child's hopelessness and helpless feelings, but that they will not be able to lessen the feelings of abandonment, isolation or despair. These painful feelings are part of the grieving process. It is the view of the researcher that caring for and working for refugee children can be overwhelming, as the person will have to tolerate the feelings of hopelessness and despair. Jewett (1994:97) mentions that this can be difficult to witness.

One foster carer admitted to having difficulty to care for refugee children, as she felt that they were entitled to many services that British children in foster carer did not have access to. In the view of the researcher her response may have been a result of feeling helpless in the face of the refugee child's despair. She may also not be aware that her response may be seen as stereotyping. It is the opinion of the researcher that this may also complicate the grieving process for refugee children, as they might feel they should be grateful for what they receive.

According to Jewett (1994:81), when the loss has deeply affected the main carers of the child, children are usually resistant and reluctant to express or process their feelings at home. This is where supportive adults outside the family home can help the child. Short-term play therapy has been recommended to address grief issues with children (Jewett, 1994: 70, 81).

5.2.1.3 Resettlement

With displacement comes a loss of culture, identity, and a familiar way of life. In addition, there is a lot of uncertainty. The loss of cultural identity and way of life adds to the numerous losses that refugee children experience. Loss of culture and a familiar way of life also implies a loss of relationships. Rutter (2001:124) states that a well-adjusted person is centred by a web of relationships, and what exile does, is to strip away these relationships. According to Davis (2006:47), our need to belong, to be loved and accepted is reflected in our relationships, and this is where we learn about ourselves. It is therefore the researcher's view that the grieving process will be complicated for refugee children, due to the extent of the loss they experience.

When your own country was not able to protect you and which does not offer respect or sanctuary? It is the view of the researcher that refugee children may experience this kind of internal conflict over their displacement, that is reflected in the above quote by Ashton (2005:57). They have fled their country of origin to be safe, but what they may experience is insecurity in the UK because of xenophobia and racism, and the difficulty of integrating into British society. These are the polarities in refugee children's lives, which will be discussed later in this chapter.

5.2.1.4 Racism

Research conducted by the London Borough of Hackney in 1995 revealed that refugee children are exposed to racist attacks and racial harassment. There have been incidents where refugees have even been murdered in racist attacks. Research conducted by 'Save the children' in *Let's spell it out* (1997) revealed that more than half of refugee children were experiencing racial bullying in school and their neighbourhood. Rutter (2001:136) states that refugees' experiences of racism in schools reflect the experiences of refugees in the wider community. According to Rutter (2003:130) certain adverse factors, including bullying, can cause long-term psychological harm. In addition, there is constant negative media coverage of refugees and asylum seekers which all impact on the emotional well-being of refugee children (Rutter, 2001:135-136).

There is little research conducted on the impact that racism has on refugee children. It is the opinion of the researcher that, due to the legal status of refugee children they do not have equal access to services. Hyder (2005:30) states that the provisions for refugee children under immigration laws in the UK mean that only the basic needs of refugees are considered, while their broader needs for development, learning and play are not considered. In addition, unaccompanied refugee children need to prove that they have a 'well-founded fear of persecution' in order to obtain the legal right to remain in the UK, or else they face deportation.

It is the opinion of the researcher, that there is a stigma and racism that goes with having refugee status. This has a negative impact on the emotional well-being of children, which in turn affects their resilience. De Zulueta (2006:287) believes that

traumatisation. She states, "How much more
st feel to be despised, rejected, mocked, hated and
even attacked on a daily basis for something you cannot do anything about such as the
colour of your skin, the religious or ethnic community you belong to." According to
Hooks (1995:134) living in a white society and faced with constant racist attacks and
abuse is psychologically traumatic. It is therefore the view of the researcher that for
refugee children, the experience of racial harassment could further traumatise them, or
may trigger their past traumatic experiences.

Racism and mental health

According to Alayarian (2007a: xix) there is a high incidence of mental health among
groups who are socially excluded. Research conducted by Chakraborty and McKenzie
in 2002 indicated strong links between perceived racial discrimination, psychosis and
depression in the UK (de Zulueta, 2006:287).

De Zulueta (2006:198) believes that, for traumatised people to make sense of their
trauma, is largely dependent on the way those around them respond to their needs.
Rutter (2001:20) believes that the "scapegoating" of refugees in the media has
contributed to the racism and xenophobia, including violent attacks on refugees.

The researcher is therefore of the opinion that refugee children's resilience is
dependent on the way the community responds to them. This means that recovering
from trauma in the UK is difficult in the face of xenophobia and racism and may re-
traumatise refugee children. In the opinion of the researcher in order to work with
refugee children's personal pain, professionals need to address the socio-political
understanding of refugee children's pain, not to acknowledge this would cause further
harm to refugee children especially if the therapist is from another culture, or British.

According to White (2006), where the patient and client are of different races, it is
always possible that in the therapeutic space, the therapist could re-traumatise the
patient. White (2006:85) quotes Cisz who states that by nature of institutional racism
and differential privilege given to some members of society just by participating in
the social world, the analyst may be complicit in some forms of oppression. She

Understanding the racial and cultural differences in

According to Simmonds (2004:71), individuals are terrified of being rejected and finding themselves on the outside of a group. In trying to belong, people become aware how easy it is to invoke the suspicion or rage of a group they do not belong to. He states that the need to belong is so primitive that individuals will do anything to achieve it, including to change who they are and what they believe in. It is therefore vital to discuss differences, including race, in therapy. White (2006:87), states that this will require that the therapist be willing to bear a measure of discomfort in order to learn from the patient.

5.2.1.5 Access to Counselling and Therapeutic Services

According to Lowe (2006:5-25), the problem between the black and minority ethnic community and therapeutic services for children is that services are not accessible to black and minority ethnic children. There is also a low uptake of services from the black and minority ethnic community, which refugee children form part of. Only 12% of the young people in the control group were involved in therapeutic services.

Simmonds (2004:72-73) states there are several assumptions made in intervention with refugee children. Among these is the assumption that refugee children are legitimate citizens of the UK. The reality for unaccompanied refugee children is that their membership is temporary or unresolved. They are made to prove their right to stay in the UK on a regular basis by having their age assessed, or proving by psychiatric assessment that they are psychologically fragile. They constantly have to tell their stories in order to prove that their lives would be in danger if they are returned to their country of origin. The services assume these children are fully fledged group members, but in reality they are on the edge of society as a group and this brings with it all the psychosocial risks.

In addition, the group that the child belongs to has a deeply conflicting structure. Although the young person may feel they belong in terms of culture, religion, language, community and family, the bonds are not available for the child in its true sense because the child is in another country. This in sense would mean that the child has lost everything, they are familiar with, which is in itself traumatic. In addition, the

What is different about refugee children are a number

- The message from the community and family the child belongs to is "We have to send you away to keep you safe". What the child may experience is, "I am being kept safe while being rejected and abandoned."
- Simmonds (2004:74) says that as adults and professionals would like to assume that the child is fleeing from danger to safety, in actual fact the child is fleeing from danger to danger.
- Making sense of that fact that the community and family you belonged to may have been the object of hatred, violence, murder and war.
- Trying to understand that the people they loved were also the people who sent them away.
- In order to be stay legally in the UK they may have needed to change their identity and life story. This leaves young people with the dilemma of keeping their real identity secret while trying to become a member of a new group. They have to do this in a language they may not understand and amidst laws they do not know, and if they get it wrong, they could be deported or arrested.

Simmonds (2004:74) asks the question, what developmental and mental health framework is available for refugee children to make sense of all their experiences. The researcher would respond by looking at resilience in refugee children. Despite all these dilemmas there are significant numbers of refugee children who are resilient and who do make sense of their experiences.

Moreover, there are, also significant practical, social, psychological, educational and legal problems experienced by refugee children. Some of these are discussed below.

5.2.2 Adverse Factors Unique to the Non-resilient

The following adverse factors were experienced by the non-resilient group only: no formal education; isolation; isolated upbringing in home country; no relationship with a trusted adult; and unplanned pregnancy. These will be discussed separately.

received any formal education in their country of origin. According to Wade, Mitchell and Baylis (2005:97), school provides a child with an important source of stability, security and reassurance. It also provides children with a sense of everyday normality, offering opportunities for building friendship networks. Research has shown that refugee children have identified schools as the main source of support outside the family. For unaccompanied children this is compounded, as they may have no family support. Research on refugee children indicates that some may not have experienced formal education in their country of origin, due to poverty or war or many have had their education interrupted because of war (Rutter, 2001:74;Hyder, 2005:52).

There is little research on the link between the lack of formal education and resilience in refugee children (Rutter 2001:102). It is also important to consider the impact that grieving has on those children who have had no formal education. There is an assumption that to have had no formal education would be an adverse factor, but this topic has not been extensively researched. The extent to which the lack of formal education impacts on refugee children's resilience is not known. This needs further exploration.

According to Rutter (2001:81) the education system in the UK does not adequately address the needs of refugee children, and work is ongoing to try and address these needs. The underachievement of minority ethnic children is an indication that the education system does not meet the needs of minority ethnic children, which refugee children form part of. It is the researcher's opinion that the educational support available to refugee children may not meet the needs of those who have not had previous formal education in their country of origin, and this will surely impact on their resilience. The link between resilience and the lack of formal education and educational support available urgently needs to be explored. The scope of this research project precluded covering such exploration.

5.2.2.2 Isolation

Due to refugee children's experiences of loss and trauma, they may isolate themselves as a means of survival and protection. According to Alayarian (2007a:xix) social and

factor resulting in mental health disorders in refugees. In the world it is necessary to risk reaching out to discover one's own boundaries. Isolation occurs when there is a disturbance at the contact boundaries. Isolation occurs when the boundary becomes so impermeable that connectedness is lost. The importance of others for the self is lost from awareness (Yontef & Simkin, 1993:137). It is the opinion of the researcher that intervention with refugee children needs to focus on improving contact functions of the children, to prevent isolation.

It is the researcher's view that traumatic experiences also impact on refugee children's ability to form new relationships. Self-support in Gestalt therapy refers to the internal and external means of support that is available to the child. External support refers to the support they find in their environment, such as supportive relationships. This is vital for refugee children who need to rebuild their networks of support. Internal support would refer to children's internal capacity to support themselves.

Professionals working with the group that was non-resilient were concerned about their isolation. In Gestalt therapy an *impasse* occurs when the external support is not available and the child believes that he cannot support himself (Yontef, 1993:145). This may manifest itself as resistance. Resistance is important in Gestalt play therapy as it is an indication to the therapist that there are issues that the child needs to address when he is ready to do so (Blom, 2006:44).

5.2.2.3 Isolated upbringing in country of origin

Twenty percent of the non-resilient group had an isolated upbringing. It is the researcher's opinion that this may appear insignificant when viewed in isolation, but when viewed holistically, in terms of the number of adverse factors refugee children experience it is significant. Research by Rutter (2001:124) and Gorman-Smith and Tolan (2003:408) indicate that adverse factors need to be reduced and protective factors increased if children are to be resilient.

There was little reference in research on refugee children who have had an isolated upbringing in their home country. It is the researcher's view that the research results indicate that this could be seen as an adverse factor. The closest reference has been related to refugee children needing consistent parenting and secure attachments. There

in general has a negative impact on children's resilience which their isolated upbringing impacted on their resilience is not known. Research does indicate however, that there is a correlation between isolation and poor mental health (Alayarian,2007a:xix; Wade, Mitchell & Baylis, 2005:155).

5.2.2.4 No relationship with an adult

From the information available for the sample population there was no evidence to suggest that they had a relationship with a significant adult. It is the researcher's view that unaccompanied minors are particularly vulnerable to not having a supportive adult available. Research was not available on the quality of the relationship the children had with their early care-givers or parents.

Most research available on resilience indicates that children need a relationship with a consistent adult if they are to be resilient. The relationship with a supportive adult appears to be one of the most significant and common features in all research on resilience. The findings of this research project is therefore consistent with previous research on resilience, and where the children did not have a supportive relationship with an adult they appeared to be non-resilient and their outcomes differed from those of the resilient group. All the members of the resilient group had a relationship with a significant adult. Attachment theory partially explains why not having a relationship with a significant adult impacts on children's resilience. Hyder (2005:8) considers the child's early experience of care-giving to be of enormous importance. Howe (1994:179) states that securely attached children are able to cope with traumatic experiences. It is possible that the non-resilient group may have had insecure attachments (see 2.1.3, 2.1.5 and 2.2).

5.2.2.5 Unplanned Pregnancy

Research by Wade, Mitchell and Baylis (2005:142) indicate that there were a small number of girls who were vulnerable to inappropriate sexual behaviour due to past experiences of sexual abuse, enforced prostitution or trafficking for sexual exploitation. There is research available that refugee children are often exposed to sexual abuse and rape. There is little research that specifically deals with the incidence of unplanned pregnancy in refugee children.

the sexual health needs of refugees, but there is little research that addresses how sexual violence affects resilience. This was not the focus of the research project and is being recommended as a topic for future research. The impact of sexual abuse and rape on children's resilience and whether there is a link to unplanned pregnancies needs to be explored.

Traumatised women, who have been abused, turn their rage into self-destructive behaviour due to the shame of being stripped of any worth. It is the researcher's view that this makes refugee girls who have been sexually abused particularly vulnerable towards having unprotected sex or being sexually abused again, leading to unplanned pregnancies (de Zulueta, 2006:281).

It is the researcher's view that another explanation for the unplanned pregnancies could be the searching behaviour in grieving children as described by Jewett (1994:85). Grieving children. Grieving could make them want to replace what they have lost, possibly their childhood, family and siblings, making them vulnerable to having unprotected sex, increasing the risk of an unplanned pregnancy. They may do this without being fully aware of the complexity of the consequences.

Research by Stockton on Tees in 2001, on the sexual health needs of refugees revealed that refugees needed access to services, sexual health education, support for people who had experienced sexual violence and rape, and an integrated approach that addressed the underlying need for community integration (Stockton Borough Council Proposal on Sexual Health Needs of Refugees).

5.2.2.6 Adverse Factors: Implications for the Non-resilient Group

It is the researcher's view that both the number and the nature of adverse factors over a long period of time may cause poor mental health and further vulnerabilities in refugee children. Of the total number of adverse factors that the sample population were exposed to, the non-resilient group were exposed to 40% of all the adverse factors, while the resilient group were only exposed to 27% of them. It is the researcher's view that the adverse factors cannot be viewed separately from the protective factors. This is because research has found that if children are to be resilient there needs to be a balance between the adverse and protective factors. The

There is a balance between the exposure to adverse and significantly more adverse factors than protective ones.

The researcher's view is the research is consistent with previous research by Cincchetti, Rogosch, Runyan et al (in Newman:2002:8). They stated all children are affected by stress and in circumstances where the adversities are continuous and extreme; it would be rare for children to be resilient especially where there are no external supports available to the child (see 2.4). The researcher's opinion is that some protective factors can be seen as the external support, which the non-resilient group appeared to lack.

The researcher believes that Figure 1 and Figure 1.2 in Chapter Four indicates that it is the cumulative effect of the adverse factors which also results in poor mental health and vulnerability to exploitation. Five of the young people in the non-resilient group were psychologically fragile, to the extent that one had to be admitted to a psychiatric unit for an assessment, another suffered from amnesia and the other three were suffering from symptoms of post-traumatic stress disorder. The remaining four were involved in criminal activities.

In the opinion of the researcher, the difficulty with the research available on resilience in refugee children is that there is a focus on certain aspects of the refugee child's life while others are ignored. What the research indicates is that it is not necessarily a single traumatic event that causes harm, but rather the combination of the number and nature of adverse factors experienced. This is consistent with previous research on resilience that states that children can recover from almost any short-lived single trauma. On the other hand research by Rutter (2001:123) also indicates that some risk factors make it likely that children will suffer from long-term psychological damage (see 2.1.6 and 2.3).

It is the researcher's opinion that the adverse factors need to be viewed holistically to understand the cumulative impact on the child's resilience. To view these factors and the child in isolation is detrimental to refugee children. Resilience involves understanding the impact that adverse factors have, not only on the child, but on their family and community as well. Nevertheless, each of the factors needs to be analysed individually to ascertain whether exposure to it has a significant impact on the child's

other adverse factors. One of the risk factors for
tter (2001:123) is trauma which is intense and over a

long period of time.

Gorman-Smith and Tolan (2003:397) describe a developmental-ecological approach to resilience where the way a family functions depends on the sociological characteristics of the communities they live in. The multiple outcomes of children exposed to violence and the level of the exposure makes intervention difficult and complex. Intervention to help parents protect their children from exposure is important but effective treatment for those exposed is also seen as an intervention strategy (Gorman-Smith & Tolan, 2003:405).

The research findings in this study are consistent with those of previous research. It is the researcher's view that focusing so much on the legal status while ignoring other needs is detrimental to the emotional well-being of the child and his resilience.

5.2.2.7 Adverse Factors: Implications for the Resilient Group

In a longitudinal study on the quality of life following early adversity, the conclusion was that traumatic events have much less impact on later life than is often predicted, and that it is possible to compensate almost completely for any single short lived early trauma by means of continuing care and attention (Vergodt in Newman, 2002:24).

It is the researcher's view that when researching resilience, there is an acceptance that significant risk or adversity had been overcome or needs to be overcome. The resilient group have shared some of the same adverse factors than the non-resilient group, namely losing parents and family through death; separation from birth family and country of origin; needing to learn a new language; living in another culture, and racism for being a refugee. The resilient group, however had less adverse factors than the non-resilient group to cope with. In addition, they also had more protective factors. Two-thirds of the sample group appeared to be resilient.

Children across cultures and nationality appear to have the potential to be resilient. Children who are resilient have also experienced adversity, so that the concept of resilience is based on the question, "What makes a difference in the lives of children threatened by risk and adversity?" (Masten & Powell, 2003: 4-5).

believes, that resilience results from the basic human systems that are in place. If these systems are protected and in good working order, then development can occur even under severe adversity. Research on resilience indicates that there needs to be a balance between the adverse and protective factors if children are to be resilient. In addition, it is the protective factors that contributes to children's resilience. The research findings on the resilient group in this study are therefore consistent with previous research (see 2.1.4, and 2.1.6).

5.2.2.8 Adverse Factors – Implications for Intervention

The adverse factors inhibit the organismic self-regulation of children. We need to decide which ones are out of the child's and therapist's control. Natural disasters cannot be prevented, but other adverse factors require a community and family response. However, for refugee children the opportunities for this are limited, as they live in a society where they experience xenophobia and they do not have their family, or they still are in the process of building their support networks.

The researcher is therefore in agreement with Hyder (2005:19) who remarks that refugee children need an approach which focuses on the internal world of the child, but will add that refugee children need an approach which focuses both on their internal and their external world.

5.2.3. Protective Factors

According to Hyder (2005:43) adverse factors interrupt children's developmental processes. Protective factors are those which protect children's development (see 2.1.4). Early research on resilience indicated three major areas of protective factors. These are: *individual attributes* such as good intellectual skills, and a positive temperament, and a positive view of self, *family qualities* such as high warmth, cohesion, expectations and involvement; and *supportive systems outside the family*, such as strong social networks or good schools (Masten & Powell, 2003:13).

Garmezy in Masten and Powell (2003:13) also mention three main areas of resources which protect children in adversity. These are characteristics of the child, family and the community.

In contrast, these protective factors the majority of the non-resilient group did not experience. In addition, a third of the resilient group were achieving at school, whereas none of the non-resilient group were. This is also consistent with research by

o stated that ÷intellectual skillsö can be viewed as a
al attributeö of resilient children.

Research also indicates that protective factors not only protect children's development as such, but also their development in the face of adversity, helping them adapt successfully under stressful conditions. According to Newman (2002:8), across cultures and countries a resilient child can resist adversity, cope with uncertainty and recover more successfully from traumatic events. It is the researcher's opinion that this is very relevant to refugee children who have experienced trauma, loss and many changes. In addition, they originate from different countries and cultures. This also indicates the universal concept of resilience. According to the researcher, this is very relevant to refugee children in that all children have the potential to be resilient, regardless of their culture and nationality. It is the researcher's view that what might be of significance is what different cultures may describe as a protective factor.

5.2.3.1 Implications for the Non-resilient Group

What the research in the sample population indicated was the marked difference in the numbers of protective factors. In the non-resilient group the average was 4 factors while in the resilient group the average was 7,3 for the group who could speak English on arrival, and 7,5 for the group who couldn't speak English. This meant that not only did the non-resilient group have more adverse factors than the resilient group, but they also had less protective factors.

From this the researcher deduced that the resilient group were resilient because they had a balance of protective and risk factors. This would make the research findings consistent with Gorman-Smith and Tolan(2003:408) who states that there needs to be a balance of risk and protective factors. Rutter(2003:131), also states that in order to enhance refugee children's resilience professionals need to increase the protective factors in their lives.

Rutter (2003), Hyder, (2005), Masten & Powell (2003) Gorman-Smith and Tolan (2003) all concur that protective factors should be increased in children's lives if they are to be resilient. Programmes and interventions should be based on increasing protective factors.

The burning question now is how refugee children can gain easier access to services which increase their protective factors when as members of a minority group in

discrimination and racial harassment. It is therefore that resilience in refugee children implies is more than being able to integrate into British society; but is also about finding ways of integrating into a society who does not welcome refugees.

5.2.3.2 Protective Factors: Implications for the Resilient Group

It is researcher's opinion that the positive impact of protective factors is the main reason that explains the resilience in the sample population. Due to their resilience, they were able to overcome severe trauma, grievous loss and drastic change. Only in this way were they were able to integrate into British society.

It is also the combination of individual, family and community attributes which served as protective factors. It is the researcher's opinion that refugee children need the combination of individual, family and community protective factors to enable them to overcome trauma, loss and change, and to facilitate their integration into British society. Rutter (2003:130) also mentions that there are specific protective factors which make it less likely for a refugee child to experience long-term psychological stress (see 2.15).

It is the researcher's opinion that the research findings in this study are consistent with previous research on resilience, as the protective factors present in the lives of the majority of the resilient group were : a relationship with an adult, and social networks of support, including links with the cultural community, as well as maintaining their cultural identity. These protective factors fit the description of Masten & Powell (2003:13) in that a relationship with an adult could be, described as a *family quality*, social networks of support and links with their cultural community could be described as *supportive systems outside the family*, and maintaining cultural identity could be seen as both *individual attributes* and a source of support outside the family.

5.2.3.3 Relationship with a Significant Adult

The research indicates that young people who have had a relationship with a significant adult before they left their home country and or currently have adapted well to life in the UK and in the researcher's opinion is resilient. This can be explained using Gestalt therapy theory and Attachment theory. It is the researcher's view that this finding can be explained using the Gestalt concepts of self-support and self-regulation (see 2.8.2.1).

the idea that from the beginning of life, the baby human being has a primary need to establish an emotional bond with a care-giving adult. This type of behaviour can be observed most often in childhood but can be observed throughout life, especially in crises. John Bowlby who developed the main theories on attachment describes attachment behaviour as any behaviour that results in a person attaining or maintaining proximity towards a preferred individual. These theories were further developed whereby different types of behaviour were observed when children were separated from their care-givers or attachment figures. One of the most important outcomes to come from attachment theory is the link between attachment, trauma, loss and deprivation (de Zulueta, 2006:61).

Insecure and Secure attachments

Insecurely attached children are less able to deal with trauma than securely attached children. What this means for refugee children is that the non-resilient group may have had an insecure attachment style which made them less able to deal with the adverse factors experienced in their lives. This resulted in their vulnerability to poor psychological health, exploitation and criminal activities. It was also discovered that those children who could overcome trauma, even though they have an insecure attachment were those who were able to reflect on their experiences. High levels of reflective functioning are associated with good outcomes. It is the opinion of the researcher that the young people who were found to be resilient may have had a secure attachment and/or the ability to reflect on their experiences. Piaget in Geddes (2006:36-49), believed that during adolescence children were able to think abstractly about their relationships enabling them to change their perceptions of their relationships.

The research findings in this study indicate that the participants who can be described as resilient are young people who may have had a secure attachment to a care-giver.

5.2.3.4. Social Networks of Support

The resilient group had social networks of support. This included friends, extended family and links to their cultural community. This could also include professionals, such as teachers, social workers and therapeutic support. Rutter (2001:124) observes

refugees from their support networks. Burnett and have similar views to those of Rutter saying that due to experiencing such huge losses and changes a refugee's social world needs to be rebuilt. A holistic intervention is needed rather than just a focus on trauma. According to Wade, Mitchell and Baylis (2005:155) refugee children bring with them issues associated with separation, dislocation and new settlement, and they therefore need to make new connections. Social support serves as a buffer against stress and depression.

It is the opinion of the researcher that research on social support networks of refugees appears to focus only on the loss of the support networks instead of also on ways in which these support networks can be rebuilt. The resilient group was able to do this, it is possible to do so (Harris, 2006:81-85; Wade, Mitchell & Baylis, 2005: 155).

According to Harris (2007:94) it takes time for refugees to rebuild their social world, mourn the loss and develop trust to build new relationships, and that the time available for psychotherapy and counselling may not be sufficient. The findings indicate that the resilient group was able to build this network of support without receiving therapy. The researcher believes that it is their resilience that enabled them to do this, overcoming trauma and loss and being able to rebuild their support networks. Goldstein and Brooks (2002:11) state that resilient children have developed effective interpersonal skills and are able to ask nurturance from appropriate adults.

Refugee children themselves say that cultural isolation negatively impacts on their well-being. According to Rutter (2001:64) refugee community organisations can offer refugee children long-term support and help them gain some control in their lives. In addition, maintaining links with their cultural community can provide refugee children with a safe space away from the racism of the broader society. This has been an important strategy for black and minority ethnic communities in dealing with racism and xenophobia (Watts-Jones, 2002:594).

5.2.3.5 Cultural Identity

Cultural identity refers to the culture that the refugee child has adopted. Simmonds (2004:68) states that in the world of childhood, the issue of identity is highly fluid and

social forces which impinge on who people are and

According to Wade, Mitchell and Baylis (2005:175), finding a cultural place and a sense of belonging were important in helping young people to adjust to living in the UK. Research also indicates that young people found religious fellowship in churches and mosques a great source of comfort. By practising their faith through participating in religious worship they felt that it provided them with a symbolic connection to their country of origin and with opportunities to make friends. Wade, Mitchell and Baylis (2005:182) also state that early investment in strengthening the young people's social networks will strengthen their resilience.

All the resilient participants in the sample population were maintaining their cultural identity. In some cultural contexts it is believed that children are so integrated into their family and community that they may understand these relationships before they discover themselves. In Gestalt theory there is no core self, instead the self is made up of a person's system of contacts. For the researcher, it is therefore understandable that maintaining their cultural identity will increase their resilience (Hyder, 2005:22).

In stages of emotional development, adolescence is a stage where the child needs to develop a sense of self in relation to others and to their own internal thoughts. There is also a substage where the child develops a social identity in relation to the group identified with (Erickson in Mortola, 2001:45-56).

Maintaining their cultural identity implies that they are participating in religious activities, speaking their first language, celebrating festivals and holidays they would celebrate in their country of origin, keeping in contact with people from their country of origin. This could also involve eating traditional foods, wearing traditional clothes and listening to music from their home countries, in this way maintaining the values and beliefs of their community.

According to Hyder (2005:83), maintaining their cultural links and identity is important for refugee children as it gives them the opportunity to be grounded in their first language and culture. She states that this promotes their resilience, adding that children are specifically competent in living in two cultures and learning new languages. Some children may have experienced persecution in their home countries because of their cultural identity, and therefore may find it even more important to

st country. Some refugee families intend to one day
which gives them an additional reason to maintain their
cultural identity.

It is the researcher's opinion that children's cultural identities are closely related to their sense of self. Oaklander (in Blom, 2006:106) states that helping children to define themselves in relation to others strengthens their sense of self. In turn, children who have a strong sense of self are able to make healthy contact with their environment. It is therefore the researcher's opinion that by helping refugee children become aware of their cultural identity, their sense of self is strengthened, thereby increasing their resilience.

In all of the case studies as well as the sample population, maintaining their cultural identity appeared to be very important in terms of support. In the resilient groups there was evidence in the document analysis that all members were actively maintaining their cultural identity. It is the researcher's view that this contributed to their resilience. According to Blom (2006:102), children with a strengthened sense of self accept their uniqueness, are willing to attempt new tasks, and also show love and acceptance towards other people. It provides the scope for healthy growth. It is therefore the researcher's opinion that maintaining their cultural identity serves as a protective factor in refugee children's lives. This explains the link between maintaining their cultural identity and resilience. It is well-documented in research that self-esteem/ self-image is linked to racial and cultural identity. A positive racial and ethnic identity is associated with improved self-esteem and a positive self-image. Literature suggests that black and minority ethnic children need a positive racial identity in order to counteract the negative stereotypes. It is the researcher's view that maintaining their cultural identity serves as a protective factor because it also ensured that they make contact with people from the same cultural community (Simmonds, 2004:68-74).

Hodes (in Newman 2002:45) indicates that children who were able to recover from trauma and achieve positive mental health, were those who were able to identify with a community and have the opportunity to take part in meaningful social rituals that affirm their cultural values.

maintaining her cultural identity and did not have links to any support network from her community. She appeared to be isolated, struggled to learn English and was bullied. She did not inform anyone of this. A, B and C, however, did maintain strong links with their cultural community and were able to attend cultural activities such as celebrations and festivals. Further research is required to establish the extent to which maintaining cultural identity serves as a protective factor.

5.2.4 Resilience: A Balance of Adverse and Protective Factors

According Gorman-Smith and Tolan (2003:408), if children are to be resilient, there needs to be a balance of protective and adverse factors, and that people working with refugee children need to increase the protective factors in a refugee child's life. Rutter(2001:131), states that the protective factors need to be maximised and the risk factors minimised. Table D in Chapter Four also shows the resilient group to have less adverse factors than the non-resilient group, and to have more protective factors than the non-resilient group. In addition, Figure 2.4 in Chapter Four indicates that the resilient group had more protective than adverse factors. It is the researcher's view that resilience involves children's developmental outcomes. The resilient group who had more protective than adverse factors, had better developmental outcomes as they were able to overcome trauma and loss and had adapted well to British society, while the non-resilient group who had less protective factors and more adverse factors, had poor outcomes, being psychologically fragile or involved in crime.

5.2.4.1 Implications for the Resilient Group

Referring to Figure 2.4 (Chapter Four), the research findings show that, on average, each child in the resilient group had more protective than adverse factors. This may indicate that the number of protective factors can make a difference. It is the researcher's opinion that this creates a favourable ratio between the protective and adverse factors. According to Masten and Powell (2003:9), resilience involves identifying processes that protect children's development. It is therefore the opinion of the researcher that the research findings on the protective factors are consistent with previous research on resilience (see 2.1.4 and 2.1.5).

group with the non-resilient group, the indication that the resilient group has more protective factors than the non-resilient group, while also having less adverse factors. It is therefore possible that the resilient group is resilient because they have more protective than adverse factors rather than a strict balance. It could also indicate that this ratio between adverse and protective factors is more significant than an exact balance. This could mean that the more protective factors you have in comparison to the adverse factors, the more resilient you will be.

It could also indicate that it is the nature of the protective factors, rather than just their number, that makes a difference in the lives of children. Gilligan (2001:13) states that the concept of a secure base relates to the physical and emotional ties that support and sustain us in times of distress. This is where we move on from when we feel safe, and return in times of crisis, confident that we will get the help and support we need. It is the researcher's opinion that this statement by Gilligan (2001) explains the nature of protective factors in the resilient group. These are: relationships with an adult; social networks of support, including links with the cultural community; and maintaining their cultural identity. These enabled them to overcome the trauma and loss, and thus to integrate into British society. The researcher is also of the opinion that this is consistent with research on attachment which states that children who are securely attached and have a secure base are resilient, enabling them to overcome traumatic experiences.

The researcher is therefore of the opinion that the findings of this research indicate that the protective factors contribute significantly to the children's resilience (see Table B in Chapter Four). It is due to their resilience that they were able to integrate into British society. This served to protect their development, even while they were experiencing adversity.

5.2.4.2 Balance of Protective and Adverse Factors: Implications for the Non-resilient Group

The research findings indicate that the non-resilient group had more adverse factors than the resilient groups, as well as less protective factors (see Chapter Four, Figures 2.1 and 2.2). It is the researcher's opinion that having experienced more adverse than protective factors, almost one third (28%) of the sample population is rendered non-resilient. The researcher categorised them as non-resilient because they were

and poor mental health. Considering the definitions of Resilient and Brooks (2003:4), they were not resilient. The more adverse factors children are exposed to, the more they will be vulnerable to long-term psychological stress (see 2.1.6). Upon further analysis, it is the opinion of the researcher that these findings indicate that it may be both the imbalance of protective and adverse factors, and the nature of adverse factors that render this group of refugee children non-resilient.

With the focus of the research being resilience in refugee children, the researcher is of the opinion that the balance of protective and adverse factors could be more significant than the number and nature of adverse factors, because all the refugee children in the research were exposed to loss of culture and a familiar way of life, separation from and loss of main carers, extended family and support network of friends, death of one or both parents or carers, and institutional racism for being a refugee.

5.3 Limitations of Resilience

According to Lampert (2003:175), the ability to distance, which is one of the attributes of resilience, can be a "double-edged sword", where distancing oneself can become maladaptive. Alayarian (2007:7) agrees with this by observing that there is a fine line between being resilient on the one hand, and oppressing one's feelings on the other.

It is the researcher's view that this is dependent on the particular context, subjective and value-laden. In Project Competence (see 2.1.4), children exposed to war suffered long-term symptoms of trauma but were considered resilient compared to those who had died. It is the researcher's opinion that this indicates that what may seem to be resilience in one society may be seen as suppressing emotions in another.

In addition, once resilience has been identified, the question arises how resilience is to be measured. In terms of the qualities, the ability to distance can become maladaptive, as mentioned above by Lampert (2003:175). But how is it decided that it is indeed maladaptive? When conducting research on resilience, it is the outcomes that are measured. It is the opinion of the researcher that the theoretical approach of a

influence the evaluation as to whether outcomes are consistent with this research project, Gestalt theory and therapy has guided the researcher. The goal of Gestalt therapy is awareness, and not to fix the person, and therefore it would be up to the client to decide whether his behaviour is maladaptive or not.

The researcher believes that resilience has limitations and that there are children who will not be resilient because of the number and nature of adverse factors experienced, as against the number and nature of protective factors in their lives. The researcher therefore feels that this research study is consistent with previous research, namely that the adverse factors should be reduced and the protective factors increased in refugee children's lives.

It is the researcher's opinion that another limitation of resilience is how much genetics and personality would influence a child's development. This brings up the 'nature versus nurture' debate.

The researcher is in agreement with Alayarian (2007b:2) that working with resilience is about working with the healthy aspects of an individual, as well as exploring the unhealthy ones, in order to achieve integration. Enhancing self-regulation promotes natural healing. It is the opinion of the researcher that questioning the validity of resilience goes against the principles of Gestalt therapy. In Gestalt, there is the acceptance that a child will do all he can to survive, and the goal of a Gestalt approach to play therapy is to make the child aware, so that he can find ways of surviving without being destructive to himself or his environment. The researcher is also in agreement with Lampert (2003:174) who stresses that the first step of a therapist is to believe that resilience can be enhanced.

5.4 Overcoming Loss and Trauma

Where refugees recovered from trauma over a period of time, it was linked to rebuilding their networks of support (Burnett & Peel in Wade, Mitchell & Baylis, 2005:149). According to Woodcock (2002:275) refugee children need to be able to reflect on their past experiences and be able to grieve. It is the view of the researcher

Play approach is based on the here and now, grieving
not be the refugee child's main concern or need. It is
the view of the researcher, therefore, that he will only be able to reflect and grieve
when it becomes his main concern, or when the need to make sense of his past
becomes his main concern. In addition, he would need to feel safe in a relationship in
order for him to deal with his unfinished business.

It's the researcher's view that refugee children should be accepted as they are as
competent unique individuals. The I-Thou relationship empowers them to reflect on
their past and in this way they may start to make sense of their experiences, including
their trauma. The researcher is in agreement with Lampert (2003:9) who emphasises
that the goal is not to fix or change the child but to facilitate self-healing. This
permits children to honour their own basic way of being (Lampert, 2003:9).

5.5 Play Therapy with Refugee Children

Play offers an opportunity for children to come to terms with traumatic experiences
and events by providing a safe way to express difficult emotions. In this way, children
start gaining control over their feelings and are then able to deal with situations which
are stressful or traumatic. Freud believed that play is the means by which children
express their innermost conflicts and desires (Hyder, 2005:56).

The aim of the research was to establish whether a Gestalt approach to play therapy
can enhance resilience in refugee children. This means that the researcher had to
assess whether the participants were already resilient or not. The researcher thus
needed to identify whether, or to what extent, the participants possess the
characteristics and qualities of resilient children. Assessment in Gestalt play therapy
takes place in the 'here and now'. In assessing, a Gestalt therapist is therefore more
interested in the 'what' and the 'how' than the 'why' of the child's behaviour.
Assessment in a Gestalt play therapy approach thus has the same goals as Gestalt play
therapy as such, namely to help children become aware of themselves and their
existence in the world (Blom, 2006:51-66).

It is the researcher's view that this explains why a Gestalt play therapy approach can
produce significant changes within a few sessions. The researcher believes that this
could also be an explanation for the significant changes that occurred in some areas of

behaviour in the course of the case studies. This is in circumstances that refugee children find themselves in.

Working with refugee children means that the therapist will have to be creative in her therapy. It is the opinion of the researcher that a Gestalt approach to play therapy allows therapists to be creative, as they are able to see therapy as an experiment.

It is the researcher's view that given the constant changes and lack of control refugee children experience, a Gestalt play therapy approach is more suited to their needs. Oaklander (1988:199) is of the opinion that children do not have as many layers of unfinished business as adults and therefore they do not necessarily need long term play therapy. In addition, she believes that children need an opportunity to integrate and assimilate the growth that they may be experiencing in therapy. According to Landreth (2003:319), research indicates that as few as two or three play therapy sessions can help children cope and develop skills that will enable them to work through their emotions and move on to more adjusted behaviour. This could also explain the changes that occurred with the refugee children in the case studies. Because Gestalt therapy is based on phenomenological principles, this enables growth to take place in the here and now.

The Gestalt therapist claims neither to cure nor to condition but perceives himself as an observer of ongoing behaviour as a guide for the phenomenological learning of the patient (Yontef, 1988:50). The researcher agrees with Yontef, as the aim of the play therapy sessions was not to cure the participants but to encourage resilience through self-regulation. The researcher was also able to develop a positive relationship with the young people, and this was indicative of their ability to trust the researcher as well as their willingness to engage in the therapeutic process. In all except one of the case studies, the participants wanted the researcher to stay in touch with them.

5.6 Identifying Resilience in Refugee Children in the Case Studies

Research by Luthar and Zelazo (2003:510-511) indicates that resilience as a concept cannot be measured, instead, it is the outcomes of resilient children which can be measured, while it can be established, at the same time, whether the children have the attributes or characteristics of resilience.

undertaken to enable the researcher to identify and children, using the definitions of Lampert (2003:174-176) and Woodcock (2002:275) as a guide. In addition, the case studies enabled the researcher to explore whether a Gestalt approach to play therapy could enhance resilience in refugee children (see Tables A,B,C&D)

According to Gorman-Smith and Tolan (2003:408), to shift children from vulnerability to resilience, either the number of adverse factors needs to be reduced or the number of protective factors needs to be increased. Naturally, if both could be accomplished, so much the better. It is the researcher's view that Gestalt play therapy adds several protective factors to refugee children and this enhances their resilience. It is the researcher's opinion that the play therapy sessions enhanced resilience by increasing the number of protective factors in their lives (see Table F, Chapter Four). This was done in a way that was not intrusive, but aimed at encouraging the children's natural healing process. The research findings also indicate that the refugee children who were judged to be resilient have had more protective factors than the non-resilient group (see Table C, Chapter Four).

It is the researcher's view that Woodcock's and Lampert's definitions can be used in conjunction to identify resilience in refugee children, and through play therapy with a Gestalt approach resilience can be enhanced. In order for refugee children to become resilient in the sense described by Lampert and Woodcock and to successfully integrate into British society, they need protective factors that enable and promote their resilience.

5.7 Schoeman's Working Model

The researcher used Schoeman's working model as a Gestalt play therapy approach with the participants in the case studies. The researcher was of the opinion that Schoeman's working model would best encourage the attributes of resilience described by Lampert and Woodcock.

Schoeman (2004:118) states that the main aim of the model is to provide the therapist with a framework within which to apply Gestalt philosophy. Schoeman's working model has nine stages, but these do not have to be strictly followed (see 2.3).

Schoeman's working model enhanced the resilience of the researcher discusses various stages of Schoeman's working model and how it relates to refugee children.

5.7.1 The Gestalt Therapeutic Relationship

According to Schoeman (2004:121), the healing process does not occur as a result of the therapist's interpretation of the client's symptoms but through the relationship built between the therapist and client. Schoeman (2004:122) emphasises the relationship as well as the safety of the relationship. The researcher is of the opinion that this is vital for refugee children in order for them to become less vulnerable. The researcher is therefore of the opinion that unaccompanied refugee children who are particularly vulnerable or who have experienced significant trauma will need the safety of a therapeutic relationship to speak about their painful experiences. The researcher considers the Gestalt therapeutic relationship to be ideal, given the characteristic of the I-Thou relationship and the fact that the relationship develops and functions in the phenomenological experience of the child.

It is the researcher's opinion that the process of building a Gestalt therapeutic relationship with refugee children is an important means of empowering them.

Research on refugee children indicates that they need a therapeutic approach that is empowering, given their experiences and changes. In order for refugee children to deal with the trauma, loss and changes, they need to be resilient. It is the opinion of the researcher that the qualities that Woodcock and Lampert define as being resilient, are qualities that can only be developed in children after they have experienced an affirming, authentic, securely attached relationship with an adult. It is the researcher's view that the Gestalt therapeutic relationship is the ideal type of relationship for the refugee child. In the researcher's opinion, the difference with Gestalt therapy and working with empathic attunement in comparison with verbal and interpretive therapies is that, although the client may despair and feel hopeless and overwhelmed, a Gestalt therapist could tell the client that the therapist does not despair or feel hopeless about the client (Yontef, 1993:262).

The researcher is of the opinion that the Gestalt therapeutic relationship enhances refugee children's resilience in the following way: Because refugee children need a

es them aware of their choices and gives them back
considers the I-Thou principle in the Gestalt therapeutic
relationship to succeed in accomplishing this, and thereby in empowering refugee
children.

This finding is also consistent with the view expressed by Lampert (2003:175) who is
also a Gestalt therapist, namely that having one positive relationship will help
children believe that they can have positive relationships with others as well; and that
the I-Thou relationship can promote resilience in children.

5.7.1.1 The I-Thou Relationship with Refugee Children

An I-Thou relationship is a highly developed form of contact, where there is a mutual
form of inter-human meeting. This facilitates awareness and growth (Yontef,
1993:208). The I-Thou dialogic relationship has five characteristics which the
researcher will discuss in relation to refugee children.

Inclusion

This refers to the process whereby the therapist enters the phenomenological
experience of the child and accepts the child as he is. This is done by appreciating and
respecting the way the child experiences and operates in his world. The therapist does
not judge the child in any way, but accepts the child as being equal and competent
(Yontef, 1993:218).

It is the researcher's view that this is very important for refugee children as they have
survived trauma and many losses. There is no expectation for him to disclose and
speak about his past trauma, neither is his avoidance of it being addressed. Refugee
children have also taken responsibility to keep themselves safe and adjust to living in
the UK. Rutter (2001:128) believes that it is not helpful to label all refugee children as
traumatised and see them as victims. In fact, Goldstein and Brooks (2002:10) believe
that resilient children view themselves as competent. This was consistent with the
research findings in that the respondents A and B had some sense that they were
competent, but through the play therapy sessions became more aware of how
competent they were. It is also the researcher's view that by accepting them as

felt safe enough to speak about their past experiences
viewed as competent.

Because the principle of inclusion allows the therapist to view people as competent, the researcher was able to use the children's bilingualism as a means of empowering them and making them feel competent. During the sessions they became aware of how competent they were by being bilingual, whereas previously they were embarrassed about their inability to speak English fluently. Experiencing the researcher's struggle to pronounce some words in their first language made the children aware of how special they were, in being able to speak their second language as well as they did at the time.

Presence

The characteristic of "presence" in a Gestalt therapeutic relationship refers to the therapist being his true self in the play therapy session. The therapist not only allows the children to be themselves, but also the therapist is true to self in return. This goes beyond acceptance, because the therapist shows his self-doubts, expresses limits, anger and boredom. In addition he also shares his observations about the child even if this is denied by the child (Yontef, 1993:219).

Cultural differences

In the researcher's view, this was a crucial aspect to building a relationship with the participants. The fact that the researcher was also black and living in a foreign country, separated from her family, helped in building trust in the relationship. It is the opinion of the researcher that the participants felt that the researcher understood some of their experiences, due to the similarities. The differences were also discussed, and this was also empowering as it gave the refugee children the opportunity to appreciate their own cultural identity. The researcher was able to be herself and express her doubts and limitations of her knowledge of their culture. It is the researcher's view that actually expressing her limitations and self-doubts empowered the refugee children. It was empowering for the children because it gave them the opportunity to inform and teach the researcher about their own culture. It validated and affirmed their experiences and identity, it also made them feel competent, and therefore equal in the relationship. It is the researcher's view that this process



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e it met their need to have some feeling of control

This is in contrast to research by Daniell (2007:72) and Blom (2006:54-55) on working with families from different cultures. It is the researcher's view that by being honest, accepting his own limitations, knowing his own cultural prejudices and an awareness of his own cultures history in relation to the child, is less harmful and less patronising to the children than by trying to be culturally competent. In addition, a therapist who denies the role his race or class has played in relation to that of the child's race or class is not true to himself in therapy and will hamper the therapeutic relationship. It is the researcher's opinion that trying to be culturally competent would be equivalent to what Yontef (1993:219) describes as "seeming" where the therapist appears as something he is not (White, 2005:87).

Yontef (1993:230) states that the therapist needs to put his whole self to the task of therapy. According to Cisz (in Leary, 2005:85) by virtue of differential privilege operating in the social world, we as therapists may actually "disempower" our clients. In order to create meaningful relationships, therapist will need to be willing to deal with some discomfort to make it possible to learn with and from a client. It is the researcher's opinion that this is especially difficult when the therapist belongs to a social group who has more power, or has perpetrated acts of violence and torture against the group the child belongs to.

If the Gestalt therapeutic relationship is to be non-exploitative with refugee children, therapists cannot ignore the impact that their race and cultural identity may have on the therapeutic relationship, and they may even need to refer the child to another therapist. This is particularly relevant to refugee children, as the torture and violence affects their ability to trust. As stated previously, presence is more than just warm acceptance; it is also confirming and believing in the potential of the child.

Commitment to dialogue

Inclusion and presence are necessary for a dialogic relationship. Presence allows the child to be affected by the therapist and inclusion allows the therapist to be affected by the child. Commitment means that each person expresses his inner self to the other but allows what happens between the two to affect the relationship. In this situation

and controls the relationship. A relationship develops separate needs, contact each other, recognising and allowing for the differences between them. According to Yontef (1993:220), "Yielding solitary control means each person is affected by the 'differentness' of the other, and there is an allowing of and dedication to the dialogue process." When this happens, there is an energetic exchange and growth can take place. In order to give up control, a therapist needs to believe in organismic self regulation.

It is the researcher's opinion that trusting in what happens between the therapist and the child, and organismic self-regulation are both particularly needed with refugee children who are resilient, in that on the one hand, they overcame significant adversity, but on the other hand, may be surviving in ways that are not self-supporting. In addition, language barriers require that the therapist give up even more control, and have to rely more on what happens between the child and therapist, than when both the child and therapist speak the same language. This occurred in the research study with three of the participants in the case studies.

The researcher believes that a commitment to dialogue was particularly useful in building a relationship with the participants as the researcher had no expectations of the children, no specific goals and trusted in the process of building a relationship as well as self-regulation. According to Blom (2006:54) the I-Thou relationship enables the therapist to become the playmate of the child. It is the researcher's opinion that as she became the playmate of the participants they were able to feel safe with her and trust her. This is critical for refugee children who find it difficult to trust someone, due to the trauma and violence they may have experienced or witnessed (Hyder, 2005:45).

In addition, it is the researcher's view that the therapist's commitment to dialogue gave the non verbal message that she would not be overwhelmed by their trauma or experiences. The researcher also felt that this is what the "between" interaction was about in the relationship. It gave them the message that the researcher was willing to listen to them as competent and equal, but also able to see them as children who had experienced huge losses, change and trauma.

Stories of refugee children can often lead those caring for them to feel overwhelmed and powerless. Adults may therefore avoid listening to refugee children's stories (Hawkes, 2007:97-109). Research by Rutter (2001:126), Hyder (2005:95), Alayarian (2007d:161-162), and Wade, Mitchell and Baylis (2005:28) all indicate that professionals can become overwhelmed by the trauma and multiple needs of refugee children. This was also apparent from discussions with the social workers, experts and foster carers that they do become overwhelmed by the children's needs and some become fearful of the anxiety and pain of the children. Regarding the foster carers, the researcher felt that they were avoiding listening to the stories of the children. According to Alayarian (2007b:9-10) those caring for refugee children need to be resilient themselves so that they do not become overwhelmed by the needs and pain of refugee children.

It is the researcher's view that by practising inclusion, presence and commitment to dialogue, this will not occur. The therapist will be affected by what the child has told, but will not feel overwhelmed because the relationship takes place in the phenomenological experience of the child. The phenomenological approach will de-emphasise what could be, would be, what was and might be (Yontef, 1993:203).

Non-exploitation

Gestalt therapy is non-exploitative and non-manipulative. Instead, the child is regarded as an end in himself. In Gestalt play therapy the relationship between the child and therapist is horizontal. According to Blom (2006:56) the I-Thou relationship with a child is where the therapist meets the child at the child's level and where both are equal. According to Yontef (1993:224), Gestalt therapy is based on the belief that individual growth, awareness and responsibility flow from an I-Thou contact, and that therapy is best done in an I-Thou dialogue and not by trying to change the client.

It is the opinion of the researcher that an approach which is non-exploitative and non-manipulative is vital with refugee children, as they are vulnerable and some have been exploited by adults due to their vulnerability. In addition, the safety of some of their family could depend on the child's ability to keep silence. Some refugee children may also have been told to lie about their age and may have false documents to ensure that they were able to stay in the United Kingdom. According to Hyder (2005:34), refugee

it is virtually impossible to obtain travel documents war. Some young people may have been sworn to secrecy about how they have arrived in the UK. Others are trafficked, or the child's family pays an adult to bring the child to the UK (Rutter, 2001:8).

This was the case with some of the young people in this research (see 4.2.1.2). One of the foster carers interviewed, explained that refugee children in her care including one of the case study participants, may have been trafficked, and this young person has been particularly withdrawn and has isolated herself. The foster carer also explained that the issues regarding trafficking and the secrecy surrounding her arrival in the UK, also prevent the young person from meeting up with people from her own culture, in case they found out about her background. Young people often cannot even trust people from their own background because of particular circumstances like civil war where there was ethnic group conflict, persecution based on religion, or, in some cases, torture was used as a means of betrayal. This makes unaccompanied refugee children extremely vulnerable, because at the same time that they need to rebuild their social support network, they need to be aware of the real danger this could pose for themselves and their families. In addition, some refugee children may have been trafficked to be used for sexual exploitation or to be involved in other criminal activities. Some have little knowledge about drugs and alcohol and are therefore quite vulnerable and at risk of exploitation by adults. It is the researcher's opinion that refugee children take huge risks in building relationships, and therefore a therapeutic relationship needs to be non exploitative and non manipulative. Despite these vulnerabilities, the case study participants were able to build a trusting relationship with the researcher and engage in the therapeutic process. It is the researcher's view that the I-Thou relationship facilitated this and is therefore ideal for therapy with refugee children. The researcher is therefore in agreement with Yontef (1993:214) that the I-Thou relationship is the medium through which awareness and growth can take place. The researcher also agrees with Lampert (2003:9) that the I-Thou relationship promotes healing in children.

Awareness is the goal of Gestalt therapy. Resilient children, according to Lampert (2003:10,177), are those who are aware of themselves and their environment. It is the researcher's opinion that through sensory awareness in the play therapy sessions the

themselves and their environment, thus enhancing their
applying Schoeman's working model, which has a stage
for sensory modalities.

5.7.1.2 The Sensory Modalities

One of the characteristics of resilient children, according to Lampert (2003:177) is that they are aware of themselves and their environment. According to Oaklander (1978:57-58), a strong sense of self makes for good contact with one's environment and people in that environment. The tools needed for making good contact are looking, talking, touching, listening, moving, smelling and tasting. Trauma impacts on children's ability to trust and explore their environment (see 2.6.1). The impact of not being able to play means that the child is not able to explore, assimilate and actively build a picture of their immediate world by making use of all their senses as well as their thought process (Hyder, 2005:48).

In the case studies, A and B were able to talk about their past and present feelings and appeared to have integrated well in British society, in contrast to C and D. In addition, they were not as isolated as C and did not suffer any trauma like C and D had while they were in the UK. Both C and D appeared to have repressed their feelings and emotions about their past experiences. Denial and withdrawal appear to be methods of survival. Alayarian (2007:7) states that as a means of self-protection one has to employ the defence mechanisms of denial and cut oneself off from the situation, but there is a fine line between being resilient and oppressing one's feelings. Oaklander (1978:57) describes therapy as going back to locate and restore the misplaced function. Children protect themselves in various ways; for instance, some children may withdraw to keep from getting hurt, while others may fantasise to entertain themselves and make their lives easier and liveable (Oaklander, 1978:57-58).

According to de Zulueta (2006:196), traumatised children may experience sleep disturbances, nightmares, difficulties in concentration, memory problems, being overly alert to danger, and have a foreshortened view of the future. Young people often feel very guilty, due to the egocentric stage of development they are in. In addition, they often show a need to talk about their trauma but refrain from doing so, because they fear upsetting their parents. It is the opinion of the researcher that all

es showed some or all of the symptoms described by

Traumatic memories are stored in the senses. ðIt is as though the sight, smell or sounds associated with trauma were imprinted on the brain and body.ö Just because clients can describe their past traumatic experiences does not mean that they have worked through their trauma, because narrative memory and traumatic memory do not completely overlap. Narrative memories can be recalled at will, but traumatic memories are triggered by images and sensations. Through sensory awareness in play therapy, the child gains access to these memories. Shifting from traumatic memory to narrative memory assists survivors in moving from sensation to awareness (Bauer & Toman, 2003:56-63).

It is the researcher's view that play therapy and working with different sensory mediums, helped the participants to move from sensation to awareness, as they were able to talk about their traumatic experiences. The researcher was able to work with the sensory modalities of the participants by applying Schoeman's working model.

Phenomenology and self-regulation

According to Yontef (1993:202), a phenomenological exploration involves being clear about what is presently being experienced, and it de-emphasises what would be, what could be, was and might be. Organismic self-regulation requires the capacity to sense the external reality and its needs, feelings and beliefs, and then knowing holistically what fits for the person in the environment (Yontef, 1993:210).

It is the opinion of the researcher that the sensory modalities therefore help children focus on the ðhere and nowö. The researcher feels that this is specifically relevant for refugee children who may have many practical and emotional needs that overwhelm them as well as the professionals working with them. By bringing refugee children into awareness, they become able to focus on what is currently important to them. It is the opinion of the researcher that this prevents both the child and the therapist from feeling overwhelmed. It also helps children to prioritise their needs and express what their needs are. This would enable professionals and those who care for refugee children to effectively support them. Support is then not based on what the

needs, but on the needs that the child himself has

The researcher believes that by applying a Gestalt play therapy approach, the refugee children in the study were able to distance themselves from the past, while still being able to grieve. This was achieved by applying the projection phase in Schoeman's working model.

5.7.1.3 Projections

According to Schoeman (2004:167), projections help the child work through traumas and feelings they are usually not allowed to openly express. This enabled the participants in this study to distance themselves from the situation while owning their feelings and emotions. According to Oaklander (1988:55), children do not always have to own their projections, sometimes they may not be ready and sometimes it is enough that they have got something out in the open. She states, "They've expressed what they needed to or wanted to at the time in their own way" (Oaklander, 1988:55). The researcher is in agreement with this, for refugee children it may just be enough to talk about what is currently going on in their lives, rather than to talk and reflect on their traumatic experiences, or to grieve.

Lampert (2003:175) sees children's *ability to distance* themselves from traumatic or painful situations as a characteristic of resilience. Alayarian (2007b:7) also states that denial and withdrawal are a means of self-protection for refugees. The researcher is of the opinion that refugee children can only reflect on and grieve about their past when they feel safe and when they feel they no longer need to survive by denial, withdrawal or distancing themselves. They need to become aware that suppressing their emotions no longer meets their needs. The researcher believes that the participants in the case studies survived their past by being able to distance themselves. Oaklander (1978:58) states that children will do anything to survive. This explains why the participants in the case studies struggled to speak to their foster carers about their past. It is the researcher's view that, while denial, withdrawal and the ability to distance were forms of survival for the refugee children in the study, it can also lead to an impasse and prevent self-support (see 2.8.2.1).

children gain closure with their unfinished business. It is the researcher's opinion that making sense of their traumatic experiences, loss and grieving is part of the refugee child's unfinished business. It is because of unfinished business that children are not able to establish organismic self-regulation. Schoeman (2004:177) is of the opinion that when the child owns the projection or when the emotions he has projected are his own or the child can find alternatives and solutions.

It is the opinion of the researcher that because the refugee children in the study have been separated from their families and country of origin, they may not have the same support structures as British children, nor equal access to supportive services, due to social exclusion, discrimination and racial harassment. It is the opinion of the researcher that a Gestalt play therapy approach gives consideration to these experiences of refugee children because of the principles of field theory. It is the researcher's opinion that refugee children's needs have to be viewed in the context of their environment (see 2.8.2.1). Exile involves such huge changes that any intervention should be at a more holistic level and priorities should be the importance of rebuilding the social world of refugees (Harris, 2007:81).

It is therefore the researcher's view that seeking alternatives and solutions for unaccompanied refugee children needs to be done in a way that respects their present way of surviving while exploring other ways of existing meaningfully. The researcher believes that this is possible with a Gestalt approach to play therapy by applying Schoeman's working model. It is the researcher's opinion that the *alternatives* stage in Schoeman's working model facilitates problem-solving.

5.7.1.4 Alternatives

Being able to talk about ongoing problems, problem-solving in collaboration with others and the ability to ask for help from appropriate adults are seen as characteristics of resilient children by Woodcock (2002:275) and Lampert (2003:176). The researcher is of the opinion that these characteristics are forms of self-support in refugee children. Healthy self-support is when the person is self-supported, yet also able to recognise when they need help from environmental support (Joyce & Sills,

For these children, this is vital in order to rebuild the social networks that are so applicable to refugee children who not only need to have social networks of support rebuilt, but also cultural networks of support. The researcher believes that the findings of this research study indicate that all the participants were able to draw the therapist's and other adults' attention to the necessity for more support in their lives.

Refugee children, by their very nature of being children, are dependent on adults for survival. They also have the status of being a refugee and all the experiences of a refugee. In addition, they may face further hostility in the country they have fled to and may need to be secretive about their identities as a refugee and their cultural identity.

The secrets that some refugee children need to keep for ensuring their own and their family's safety is a big responsibility. This erodes trust in relationships and in the view that the world is a safe place. Some may have arrived in the UK by trafficking. This makes them vulnerable to exploitation and complicates the building of relationships as they may not know whom to trust, yet in order for them to be resilient, their survival depends on asking appropriate adults for help and working alongside others to solve their ongoing problems.

According to Lampert (2003:176), the best prevention of abuse is to learn to recognise who is trustworthy and who is not. The researcher therefore agrees with Lampert(2003:9) that the Gestalt therapeutic relationship is ideal because of the I-Thou principles. Lampert (2003:175), states that being in a relationship with someone who is consistent, respectful and trustworthy carries the message, "If there is one person in the world like this, there is probably another one somewhere."

The researcher believes that Gestalt play therapy facilitates problem-solving through self-regulation and self-support (see 2.8.2.1). In Gestalt a person is seen as having a natural or organismic tendency to regulate themselves. In order to grow and develop, people strive to maintain a balance between need gratification and tension elimination. The healthy person differentiates this meaningful need and responds to it appropriately, thereby restoring the balance, releasing more energy and allowing the

(Clarkson, 1999:21). The criticism levelled against

this does not necessarily bring about health, but just

leads the person to make the most of what is available to them. It is the view of the researcher, however, that the aim of the Gestalt therapist is to enhance the self-regulating process of the child so that he can choose to take responsibility for regulating himself. The Gestalt approach helps them to meet their needs in a way that is right for themselves as well as their environment (Oaklander, 1988:291). The researcher believes that this is the crucial difference between non-directive play therapy and play therapy from a Gestalt perspective. It is the researcher's view that this is the reason why play therapy with a Gestalt approach is effective with refugee children, as it enhances their self-regulation.

It is also the researcher's opinion that Schoeman's working model encourages appropriate self-support, where the child is able to meet his needs in a way that it is not destructive to himself or those around him. This is done through the *awareness continuum* which occurs throughout the process. This describes the process of Gestalt formation where the greatest concern of the child comes to the foreground, so that it can be fully experienced, coped with in order for it to be forgotten, assimilated or integrated. This then leaves the child's foreground free for the next Gestalt.

The task of a Gestalt play therapist is also to help children realise that they cannot take responsibility for choices that don't exist for them. It is the opinion of the researcher that this concept of responsibility in Gestalt therapy is important for refugee children because of the limited control and choices they have in their lives, seeing that many children were forced to flee their country of origin and did not choose to live in the UK of their own accord. In the case of the participants in the case studies, their family had arranged for them to come to the UK, fearing for their safety. Gestalt play therapy is aiming to help the child see the world as it really is and therefore feel strong within himself (Yontef & Simkin, 1993:139).

It is the opinion of the researcher that this is an ongoing process throughout the Schoeman working model but specifically in the *alternatives* stage. In this stage, the therapist discusses alternatives for problem-solving. The child's process is considered important, and the therapist works in confluence with the child. Past, present and

ns are thought about. By making the child aware of
ceptable, the child becomes able to think of sound
solutions. The therapist facilitates this process and the child begins to take
responsibility for choices. In this way, the young people have found ways in which to
meet their needs.

5.7.1.5 Empowerment

According to Schoeman (2004:179), empowerment is about giving the child power and control. This can be done by making the child aware of the choices available and that they can take responsibility for those choices. Oaklander (1978:61) believes that children cannot take responsibility for choices that do not exist for them. It is the opinion of the researcher that empowerment is a most important concept for refugee children. The researcher is in agreement with Lampert (2003:178) who states that giving children choices in play therapy gives them the message that sometimes you do have control, even though you feel that you don't. The researcher's view is that this is what empowerment for refugee children is all about. According to Alayarian (2007a: xx), refugees need to feel empowered in order to deal with their problems and reduce their social exclusion. The researcher has discussed how the Gestalt therapeutic relationship can empower refugee children (see 5.1).

Woodcock (2002:275), believes that in order for refugee children to be resilient they need some degree of choice over major decisions. According to Lampert (2003:174), resilient children have a talent and special interest which brings pleasure and a sense of competence. It is the opinion of the researcher that refugee children need to be empowered to feel that they have a choice over major decisions. They have experienced not only the loss of relationships, culture and a familiar way of life, but also a loss of identity. This would make it difficult for them to believe that they have a special talent and interest which could bring them pleasure and a sense of competence. They need to be made aware that they have this talent and interest.

It is the researcher's opinion that the 'empowerment' stage in Schoeman's working model allows the therapist to give the child some power and control by making them aware that they are not helpless, that they are able to make decisions, that they have choices, and that they have talents and abilities which make them unique. Lampert

aware of their special talent brings pleasure and a characteristic of the resilient child. In addition, the researcher is in agreement with Hyder (2005:19) who states that play in itself offers refugee children opportunities to gain control and have some power (see 2.9).

The researcher was able to make all the participants in the case studies aware of their uniqueness in being able to speak several languages, as well as how competent they were in being able to adjust to British culture and a new educational system. According to Rutter (2001:97), bilingualism should be seen as an asset, not as a problem. Three of the case study participants were initially embarrassed about their lack of fluency in English. Rutter (2001:97) further states that their skills in their first language should be valued and encouraged.

English

The Gestalt approach to play therapy allowed the researcher to value the first language of each participant. This was facilitated by applying Schoeman's working model, specifically when thinking about empowerment.

According to Alayarian (2006:12), psychoanalysts wish to offer patients their expertise, capacity for listening and interpreting, and ideas about intrapsychic processes. According to Daniell (2007:66), the therapist will feel greatly inadequate by the separation from the language, culture and life experience of the client. It is the researcher's opinion that the fact that some participants could not speak English fluently and the therapist could not able to speak their first language created a shared experience which empowered the child. By teaching the play therapist a few words in the child's first language, the child was empowered. This occurred, because it gave the child the opportunity to be in control and feel competent, as well as to value his first language. Play therapy is also an opportunity for children to try out new skills.

It is the researcher's view that play therapy with a Gestalt approach empowers the refugee child, because it gives him the opportunity to experiment in speaking English. It also gave the refugee child the opportunity to become aware of how valuable his first language was, by teaching some of it to the researcher. According to Yontef (1993:7), "Gestalt therapy is based on the power of experimentation, of trying something new and letting awareness emerge from the new experimental behaviour." Zinker (1978:123) agrees by saying that the experiment is the cornerstone of learning

about into doing. The participants were able to
without fearing rejection or criticism.

It is the researcher's opinion that being able to speak English while valuing their first language is very important for refugee children. This enhances their resilience and thus their ability to integrate into British society. According to Zinker (1978:125), if the creative experiment works well, it pushes the person to his boundaries, where his growth needs to take place. It is the researcher's view that this was possible in the research by applying Schoeman's working model because the 'empowerment' stage focuses specifically on empowering the child.

Cultural Identity

Cultural identity refers to the culture that an individual will identify with. According to Eleftheriadou (2006:37), culture is a flexible construction of the world to which a certain group of people belong, and which is geographically and historically specific. This includes observable as well as subtle communication and relationship patterns, religion and spirituality.

According to Woodcock (2002:275), resilience in refugee children means being connected to networks which offer some degree of social and cultural familiarity. The present research indicates that the resilient refugee children all maintained their culture. It is the view of the researcher that this research finding is consistent with the statement by Hyder (2005:63) that refugee children need opportunities to value their own language and culture in order to be resilient. It is the researcher's view that this enabled the participants to better integrate into British society. Refugee children need to maintain their own cultural identity. It is the opinion of the researcher that by working with the *polarities*, the refugee children were able to become aware of their own cultural identity as well as British culture, and to deal with the dichotomy of two cultures where they could integrate both. The refugee children were given the opportunity in the play therapy sessions to talk about their culture and how they maintained their cultural identity. It is the view of the researcher that they became aware of how important their cultural identity and links with their cultural community were.

at maintaining cultural links as well as their cultural
refugee children, especially after their experiences of
loss, including the loss of cultural identity. According to Rutter (2001:64), refugee
community organisations can offer children long-term support and help them gain
control in their lives by making contact with people who share the same cultural
values.

It is the researcher's view that especially by applying Schoeman's working model,
refugee children can be empowered to build the social and cultural networks
necessary for their resilience. Rutter (2001:124) is of opinion that social and cultural
networks are very important in view of the refugee experience of children having
been stripped of their normal support networks. The cultural and social networks
therefore need to be supported and rebuilt as soon as possible. The researcher is of the
opinion that field theory in Gestalt therapy is very relevant to working with refugee
children, as it takes into consideration their need for social and cultural support
networks. A Gestalt play therapy approach views the child holistically in relation to
his socio-cultural background and ecological environment, and not in isolation.

5.8 Integration of Polarities

It is the opinion of the researcher that refugees experience two cultures, their own and
British culture. This, at times, causes internal conflict within the child, as well as his
family, community and society (Rutter, 2001:167). The field is often differentiated
into polarities, parts of a whole that are opposite to each other. Dichotomous thinking
splits the field into two polarities and does not view the field as a whole made up of
interlocking parts. This interrupts organismic self-regulation as it prevents
understanding paradoxical truths about a subject. Organismic self-regulation leads to
integrating parts into a whole (Yontef & Simkin, 1993:143).

According to Zinker (1978:196), when brought into awareness with clarity, conflicts
tend to allow the person the sense of his internal differentiation and, at the level of
creativity, hold the possibility for integrative behaviour ó behaviour which is highly
adaptive because it spans the full range of responses between formerly experienced
polar extremes. The person is able to respond flexibly to a wide range of responses
while polar responses are restrictive and unimaginative (Zinker, 1978:196).

refugee children may appear to be caught in such an internal conflict where they view their own culture and way of life as being in conflict with the British way of life. This represents the dichotomous thinking as described by Yontef and Simkin (1993:143). This is one of the major internal conflicts which interrupts self-regulation in refugee children. According to Schoeman (2004:177), the therapist needs to make the child aware that polarities do exist and that they are acceptable. This will lead to the child integrating these polarities. By integration of the polarities, they will be able to find flexible and new ways of meeting their needs, new ways of viewing themselves and ways of self-support.

According to Alayarian (2007:82), social integration involves active engagement in a wide range of social activities and relationships and a recognition of the social roles that defines the person. It is the researcher's opinion that by helping refugee children integrate the polarities in their lives, their resilience is being enhanced. For refugee children, this means maintaining their own cultural identity while integrating into British society.

In the following chapter the researcher discusses the final conclusions and the limitations of the research. Recommendations are also made which could enhance resilience in refugee children, based on the conclusions of this research study, as well as recommendations for further research.

6. Conclusions, Recommendations and Limitations

6.1 Summary of Chapters

The focus of this research study was on resilience in refugee children's lives. A Gestalt play therapy approach was used to explore resilience in refugee children. This meant that the researcher was guided by Gestalt theory and therapy. The research revealed that despite the trauma, loss and many changes that refugee children experience, they are able to be resilient. The conclusions from the research will be discussed as well as the recommendations and limitations. The researcher will also summarise the research process.

The literature study in Chapter Two highlights refugee children's experiences and their outcomes. Refugee children have to deal with trauma, loss and many changes in order to adapt to British society. There are protective and adverse factors that impact on children's resilience. The protective factors are those which protect children's development, and the adverse factors those which make it likely that children would suffer long-term psychological harm. In the course of the literature study it is indicated that a Gestalt play therapy approach could effectively address the therapeutic needs of refugee children by enhancing their resilience.

In Chapter Three the researcher discusses the research strategy and how this was implemented. In Chapter Four the research findings are presented and discussed. In Chapter Five these findings are analysed and integrated.

6.2 Main Conclusion

The main conclusion of the research study is that a Gestalt play therapy approach is able to enhance resilience in refugee children by applying the Schoeman working model.

6.3 Research Problem

In this research project, the results indicate that enhancing resilience in refugee children means increasing the protective factors in their lives and reducing the adverse

is mostly limited to describing risk and protective factors on how these protective factors can be increased in refugee children's lives is very scarce.

There is research available on the characteristics and attributes of resilient children, including refugee children; however, research was needed on how these attributes can be realised and enhanced in refugee children. There is little information on intervention programmes or approaches on enhancing resilience in refugee children, although play therapy had previously been used by a researcher in the UK. Yet, although play therapy had been used, there was little or no research done on Gestalt play therapy with refugee children, or on a Gestalt approach to understanding resilience.

Because many therapeutic approaches are based on the individual, services for the refugee child have become fragmented and the child is not viewed holistically. This leads to refugee children's needs not being addressed holistically. The problem can therefore be formulated as: how the therapeutic needs of refugee children can be addressed by focusing on their resilience.

The goals of the research were based on the research problem. There was limited research available on resilience in refugee children and on a Gestalt play therapy approach with refugee children. Research on children's experiences of trauma and loss had indeed been done, but the experiences of refugee children appear to be more complex than previously realised. Not only do they have to deal with the reasons why they had to flee their home country, but they also have had to adjust to living in their host country. In the case of this research, the refugee children have had to adjust to living in the UK. There was limited research available on therapeutic intervention with refugee children, despite the huge numbers of refugee children worldwide. Part of the problem is that refugee children and their families have a limited understanding of therapeutic services, as many of the countries they originate from do not have any therapeutic services available. This impacted on their accessing therapeutic services in the UK. It is the researcher's view that also within the Social Welfare system and the Child and Adolescent Mental Health Service in the UK there is a limited understanding of the emotional needs of refugee children. Along with the dearth of

There was limited research available on intervention programmes for refugee children's resilience, as well as on therapeutic intervention with refugees, including children. Intervention programmes aimed at promoting refugee children's resilience were even more limited. Given the large numbers of refugee children in the UK as well as worldwide, and their complex needs, there is an urgent demand for a refugee child specific programme of intervention. While undertaking this research project, the researcher was approached by several professionals to consult on work with refugee children. The researcher was also offered a job developing a programme for refugee children. This is indicative of the demand for an effective approach to working with refugee children. In addition, there was very little information available on refugee children who had successfully adapted to life in the UK. It was, and still is, the view of the researcher that many aid and development programmes mainly focus on meeting the primary needs (food and shelter) of refugee children, while the emotional needs of these children are largely overlooked.

6.3.1 Research Questions

In this study, the following research questions are addressed:

- *What were refugee children's needs and experiences?*

The literature study indicates that refugee children had to flee their country of origin for various reasons: they may have been forced to flee because they were forced to take part in military activities; they may have been orphaned, or their parents may have been unable to keep them safe due to civil war; they may have been forced to take part in religious activities or to refrain from doing so, thus persecuted because of their religious beliefs; or persecuted due to their race or ethnicity. Refugee children have therefore been exposed to a wide range of traumatic events: some have been tortured; others witnessed the killing of friends, family and siblings; still others may have been protected from this by being sent away to keep them safe; in their host country, they may be separated from their family for ever, or for a period of time; some parents may be missing, imprisoned or believed to be dead. Refugee children therefore need to cope with their past experiences while struggling to adjust to a new country, culture and life, thus having to cope with trauma, loss and radical changes. In the research results, these are indicated as the number and nature of adverse factors

posed to (see Figures 1 (i), (ii) and (iii), and sections

The literature study also indicates that resilient children are better able to cope with trauma and loss and, in general, the experience of being a refugee and of integrating into British society. Others, indicated as the non-resilient group, are psychologically fragile, suffering from symptoms of post-traumatic stress disorder (see Figure A and Figure 1.2).

- *Could play therapy enhance resilience in refugee children?*

Research was available on the benefits of play therapy with refugee children to help them make sense of their traumatic experiences. It is the researcher's opinion that the results of such (previous) research prove that play can be a natural form of healing in refugee children, given that play is a universal protective factor in children's lives, promoting their cognitive and social development. Play can also be used to help children become aware of their environment, promoting their resilience. The benefits of play for refugee children are important, as they may not have had ample opportunities to play, due to war or poverty or both. It is the researcher's opinion that this research indicates that play therapy can enhance refugee children's resilience, because it helps them make sense of their trauma, cope with separation and loss, and helps them rebuild their relationships and to value their cultural identity (see section 5.1.1, Figure 4.2 and Tables A, B, C and D).

- *How does a Gestalt play therapy approach enhance resilience in refugee children?*

Gestalt therapy is based on the idea that the therapeutic relationship is the most effective tool in helping children to heal. The I-Thou principles of the relationship promote resilience and empower refugee children, because it give them a sense of safety, help them gain some control, and make them aware of having choices. In addition, it empower refugee children because it encourages responsibility and self-support. The researcher is of the opinion that the research results clearly indicate this, thereby addressing the research question satisfactorily (see Tables A, B, C and D).

refugee children to make sense of their traumatic experiences and to grieve and work through of their loss. This took place during the play therapy sessions which the researcher conducted. It is the researcher's opinion that working with the polarities in refugee children's lives helped them to integrate their conflicting emotions and experiences (see 5.7.1.5 and 5.8). Play therapy takes place in the phenomenological experience of the child and therefore enhances organismic self-regulation. A Gestalt play therapy approach can therefore increase the protective factors in refugee children's lives, thereby enhancing their resilience. The researcher believes that this has indeed occurred in this research project (see Figure 4.2).

A further basic concept in Gestalt therapy and theory is that of field theory, which does not see the child in isolation, but considers the family, community and socio-political context. This is vital for refugee children who experience racism and xenophobia. (see Figure 3.1(iv)).

- *How do refugee children gain access to therapeutic and supportive services which promote their resilience?*

Previous research indicated that refugee children do not always have access to therapeutic and supportive services due to their refugee status and the fact that refugees form part of a social group in society who is subjected to institutional racism, along with black and minority ethnic people. In this study, this was true for all the case study participants; neither of them was able to access therapeutic services (see Figure 3.3).

It is the view of the researcher that this research project shows that despite the trauma of war and civil conflict, and all the loss and change entailed, unaccompanied refugee children have a natural instinct to survive and if given the right support may go on to lead productive and healthy lives. The literature study revealed that in intervention with refugee children it is simply assumed that they have access to the services and that the services are appropriate in meeting the needs of refugee children. It is the researcher's opinion, however, that this research indicates that, due to the particular experiences of refugee children such as exposure to civil war, separation and many losses, they may not have the capacity to take up the opportunities for supportive

...ss affect children's contact functions. This causes
... withdrawal as a means of protection. This situation
is compounded when living in a society where they may have to psychologically
defend themselves against the real threat of racism (see Table A, Case Studies C and
D).

6.3.2 Goal Formulation

The goals for the project focused on resilience in refugee children. The literature study gave an indication that most refugee children are resilient despite the adversities they have experienced. Resilience serves to release the natural flow of recovery and development that might have been paralysed by negative experiences. It also appears that resilient children do not necessarily possess unique qualities, but that they have access to supportive and protective resources. These may be attributes related to the individual child, his family and community. In the case of unaccompanied refugee children this is vital, in order for them to be able to overcome trauma and loss, and to re-build their supportive networks, as unaccompanied refugee children were separated from their primary carers, whether parents or family or friends of the family. Unaccompanied refugee children are therefore dependent on adults who may be unknown to them, making them quite vulnerable.

The aim of the research study was to explore how play therapy from a Gestalt approach could promote resilience in refugee children. The researcher was able to do this by identifying resilience in the control group of the research study and analysing their developmental outcomes. Inferences were made from this group in order to undertake play therapy with the participants of the multiple case study. Schoeman's working model was used as a guide in applying a Gestalt play therapy approach. Schoeman's working model was used, because the researcher made the assumption that this model would be appropriate for refugee children, due to its focus on the therapeutic relationship, the sensory modalities, alternatives and empowerment. The literature study as well as the document analysis concerning the control group indicated that refugee children need a kind of therapeutic intervention that is empowering, so that they are able to rebuild their support network and overcome their experience of trauma and loss.

Research

was to understand resilience in refugee children by using a Gestalt play therapy approach. Previous research on resilience only explored and identified resilience in children. There was little research available on programmes or intervention that would enhance resilience in children. It is the researcher's opinion that this research project addresses this gap. In addition, there is little research on therapeutic approaches with refugee children, focusing on enhancing their resilience. The researcher believes that this research project can contribute to intervention aimed at doing this with refugee children. Finally, this project also brings together the basic concepts of Gestalt therapy with the issue of resilience about which there exists little or no research.

6.3.3.1 Objectives

The researcher identified three objectives for the research study. The researcher's view is that these objectives were met. The researcher will discuss how these objectives were met.

1. *To do an extensive literature review on the topic, including the following:*

- *To document the experiences of refugee children. In doing this, the researcher would raise an awareness of the needs of refugee children.*

The researcher was able to find information on refugee children. Previous research indicated that refugee children may have been exposed to traumatic experiences such as: civil war, including bombing and shelling; destruction of their homes; the violent death of family and friends; getting separated from family and friends; being arrested, detained or tortured; hostility in the new homeland; and extreme poverty. Refugee children may also have been forced to flee, or they may have been sent away from their family for their own safety. Parents may have paid agents to accompany their children to safety, while some children got smuggled into the UK. Their journeys may also have been traumatic and life threatening. Some unaccompanied children have been assaulted, and in 1999 three Iraqi children were found dead in a refrigeration truck in Belgium.

l change were discussed, specifically as experienced

The impact of trauma on refugee children is well documented in the available literature. The literature indicates that some children may be suffering from post-traumatic-stress disorder, yet the majority of children, although having been traumatised, do recover from trauma. The impact of war on children was also included, as many refugee children had been exposed to war or civil or ethnic conflict. The impact of trauma on children's resilience was also discussed.

The research results indicate that refugee children may experience the loss of parents, family and their broader support network. They may go through a period of mourning and grieving which can manifest itself in different ways. A refugee child's grieving and mourning is compounded by additional losses and the manner in which they may have been separated from their families, for example through death or forced separation. Losing family and friends through death is already traumatic, in addition refugee children have to cope with dislocation which involves the loss of their broader support network, community, cultural identity and way of life. For these children there is also the loss of education, play and other social activities which impact on their cognitive and emotional development (see Figure 1 (i), (ii), (iii) and section 5.2.1.1).

- *The researcher explored refugee children's adjustment to and integration into British society.*

Research on the experiences of refugee children in their country of origin was well documented. There was, however, little research available on refugee children's adjustment and integration in the new country they were living in. When refugee children arrive in the UK they have to deal with the trauma and loss of the refugee experience. This would include loss of cultural identity, a familiar way of life, loss of supportive relationships and family. On arrival in the UK, refugee children will then need to go through the process of claiming asylum so that they can legally remain in the country. This involves repeatedly proving that they will be unsafe if they were to be returned to their country of origin. This process takes some time, and even when they obtain legal status to remain in the UK, they may still fear deportation. In addition, refugee children need to adjust to living in a new country, having to cope

their education, social status, learning a new language
values, and re-building their supportive relationships.

Due to their legal status of being a refugee, they may also have difficulty to gain access to supportive and essential services. This is due to racism and discrimination that refugees experience as part of a minority ethnic group. Also, supportive services, including therapeutic services, may not be appropriate to meet refugee children's needs. They also have to face hostility in the media who portray refugees as "beggars" and "scroungers". They may also be vulnerable to racist attacks; many attacks on refugees, including some killings, have been reported. Research on refugee children indicate that many experience racist bullying at school. This was the experience of two of the case study participants (see Table A, Case Studies A and C). In this respect as well, this project confirms previous research (see 2.1.5.7).

All these adversities impact on their ability to adjust and integrate into British society. Still, the literature study indicates that refugee children are nonetheless able to integrate and adjust to living in the UK.

- *Resilience as a concept and how it impacts on children, including refugee children.*

Research studies on resilience in children were readily available, but almost none on resilience in refugee children. Resilience can be described as how well a child can cope with damaging experiences, or the ability to overcome adverse circumstances. It has also been described as children's natural healing ability and adaptation. The literature study indicates that resilient children were able to recover from trauma and loss and adapt to changes. Research on the attributes of resilient children also indicates that resilient children were able to cope with stress, they could ask for help and they had a sense of competence.

The results of this research indicate that there are protective factors which served to protect children's development and therefore promote their resilience. There are also adverse factors which, in many cases, cause children to be psychologically fragile. The protective and adverse factors were discussed extensively (see 2.1.4, 2.1.5 and 2.1.6). The research results also indicate that children who have more protective than adverse factors are resilient, but that these protective factors may need to be different

meet their particular needs (see Figure 2 and section

- *The researcher discussed Gestalt play therapy and how it could promote resilience in refugee children.*

There was limited research available on promoting resilience using Gestalt therapy. It is the researcher's opinion that the research results of her study confirms the assumptions of Lampert that Gestalt play therapy is able to promote and enhance children's resilience because of the principles that Gestalt therapy and theory are based on. These are organismic self-regulation, the I-Thou relationship, the paradox of change, self-support and responsibility (see Table D and section 5.7.1.1).

The researcher's view was that these aspects were particularly relevant to refugee children who have to deal with traumatic experiences, loss and change, while integrating into a new society. In view of refugee children's experiences and the literature available on their therapeutic needs, the researcher hypothesised that Schoeman's working model, being a Gestalt model of play therapy, would be particularly relevant for refugee children. The reason for this hypothesis was that literature on the experiences and therapeutic needs of refugees indicates that they need an approach which is empowering. The Schoeman working model has a specific stage which focuses on empowering the child. The Schoeman working model was then applied, with the hypothesis that as a Gestalt play therapy approach it could promote resilience in refugee children.

2. *To explore how play therapy with a Gestalt approach can promote resilience in refugee children.*

The researcher was able to achieve this objective by applying play therapy to refugee children. The researcher had made the hypothesis that applying Schoeman's working model as a Gestalt play therapy approach would be likely to promote resilience in refugee children. This was based on the literature study and a critical analysis of Gestalt therapy and theory. The researcher proceeded to do this by linking Gestalt principles with the concept of resilience. This was duly

research process involved testing this hypothesis. This chapter Three.

3. *To draw conclusions and make recommendations to all those involved in delivering services to refugee children.*

This objective was achieved by analysing all the research findings, comparing the empirical results with the relevant literature. The following conclusions and inferences could be drawn:

- It is the researcher's opinion that the application of Schoeman's working model enhances resilience in refugee children, because it empowers them to make sense of their traumatic experiences, and severe loss, and to help them maintain their cultural identity, rebuilding support networks and links with their community of origin, while integrating into British society.
- Through integration of the polarities that exist in the lives of refugee children their resilience is enhanced. Particularly challenging is the polarity of having to live in a society which is not always welcoming to refugees, as well as having to adjust to a new culture, while maintaining their own cultural identity. For refugee children, resilience also means integrating into British society.
- It is the researcher's view that refugee children who have experienced trauma may not be able to make effective use of all their contact functions. A Gestalt play therapy approach can succeed in restoring their contact functions through engaging with different sensory modalities.
- The researcher concludes that the application of Schoeman's working model improves self-regulation (choosing to take responsibility for what is in your control) and self-support (meeting your needs in a way that is not destructive to yourself and others) in refugee children, and therefore enhances their resilience.
- The researcher further concludes that a Gestalt play therapy approach can enhance refugee children's resilience by increasing the number of protective factors in

the researcher's view that the protective and adverse
the children themselves.

- A Gestalt approach to play therapy takes into account field theory. In this way, refugee children's needs and behaviour are not viewed in isolation but rather in response to the field, where the field is a totality of mutually influencing forces which together form a united interactive whole. It is a holistic approach which is essential for enhancing resilience in refugee children. In the opinion of the researcher, a Gestalt approach to play therapy accepts refugee children's reality, as well as the limitations of therapy in meeting their needs, the aim being to help refugee children achieve self-support and responsibility.
- The nature and number of adverse factors, as well as the length of exposure to them mean that some refugee children will not be resilient.
- It is also the opinion of the researcher that because of the limited choices existing for refugee children, decreasing the numbers of adverse factors may not be possible. This is due to the social exclusion of minority groups in the UK and the legal status of refugee children. By the very nature of being refugee children, both in British society and in general, they would have been and may still be exposed to adverse factors over which they have only limited control. This means that there will always be refugee children who will not be resilient, on account of the nature and number of adverse factors they experience.
- It is the opinion of the researcher that language barriers appear to be a problem in therapeutic work with refugees. However, the researcher found that this can be effectively used in play therapy as an opportunity to empower the child.
- It is the opinion of the researcher that unaccompanied refugee children may always be in transition due to their legal status or by not being able to gain access to therapeutic resources due to social exclusion. They therefore need a non-intrusive therapeutic model which is effective over a short period of time. Play in itself is healing, and positive changes can therefore take place within a few sessions of play therapy. The researcher's view is that Schoeman's working model

work, as changes can take place over a short period of

- A Gestalt play therapy approach enhances resilience of refugee children by giving them opportunities to feel competent and in control. This can best be done by applying Schoeman's working model which includes a stage focused on empowering the child.
- In assessing, a Gestalt therapist is more interested in *what* and *how* than *why* the child displays certain forms of behaviour. It is the researcher's view that this explains why a Gestalt play therapy approach can produce significant changes within a few sessions. The researcher believes that this could also be an explanation for the significant changes that occurred in some areas of the participants in the case study. This is particularly relevant, given the circumstances that refugee children find themselves in.
- Resilience is a value judgement, and what may be viewed as resilience in one culture may not be viewed as resilience in another culture. Therefore, what protects children in one country or culture may be different from what protects them in another culture. A phenomenological approach allows different opinions.
- Nonetheless, in all societies play features as a protective factor. The types of play may vary, but they all serve the same purpose. For this reason, a play therapy approach is more effective, as its aim is not to fix or change the child but to facilitate self-healing through awareness.
- Differences in language between the therapist and child may be seen as a barrier. In this research, however, the language barrier was successfully used to give the child some control and power and a feeling of competence. The researcher was able to do this because of the experimental nature of Gestalt play therapy. Play therapy does not only take place verbally, but non-verbally as well.

that refugee children are in can affect their ability to
thereby affecting their resilience. Adolescence can be a
difficult time with all the developmental changes that take place.

- The lack of resilience in some refugee children can be attributed to circumstances and adverse factors which they have little or no control over, like war, poverty, racial harassment, social exclusion, or needing to keep secrets to protect themselves and their family.
- Refugee children's grieving process is complicated, and this can make them appear as if they are clinically depressed. A certain behaviour or a lack of resilience may be a 'normal' response to grief. This is especially relevant to certain cultures where children may have been socialised to deal with loss and grief in a certain way.
- Refugee children and their families should be made aware of therapeutic services available.

6.4 Recommendations

It is the opinion of the researcher that previous literature and research on refugee children mostly focus on specific issues relating to refugee children, such as trauma and adverse and protective factors, while giving little attention to a holistic approach to helping refugee children. For instance, adverse and protective factors are mentioned often enough, with the suggestion of reducing the adverse factors and increasing the protective ones. But, in the researcher's experience in perusing the literature, there is little information as to how this can be achieved with unaccompanied refugee children who may have limited access to services and may be fearful and disempowered through their past experiences. There is an assumption that refugee children will have access to the services and will be able to take up the opportunity, forgetting the environmental impact on refugee children.

It is the researcher's view that intervention with refugee children requires a holistic approach which integrates all aspects of their lives. This includes their past, present

ir needs. Gestalt therapy focuses on a holistic and therefore be ideal in helping professionals address the needs of refugee children, especially when their needs may seem overwhelming. The principle of organismic self-regulation in Gestalt theory can also help professionals keep in mind that refugee children can be resilient despite all their experiences.

The researcher therefore recommends that:

- a holistic approach be adopted to promote resilience in refugee children, with inclusion of the family and the community;
- play therapy from a Gestalt perspective be considered for refugee children;
- Gestalt play therapists become involved in community services and other organisations offering support to refugees;
- more play therapists be trained in Gestalt therapy;
- play therapy with a Gestalt approach be made available at schools;
- a Gestalt approach to play therapy be used to identify and facilitate resilience in refugee children;
- refugee children be assisted in gaining access to supportive services which will provide them with opportunities to increase the protective factors in their lives.

6.4.1 Recommendations for further research

- Because of differences in the age, gender and nationality of refugee children in the UK, this research project was limited to unaccompanied minors in foster care in Essex. Further research in other areas of this study can therefore be considered.
- The pilot study revealed that parents were reluctant to involve their children with those they did not know; thus, they may prefer a therapist from the same culture.
- Separating the protective and adverse factors in refugee children's country of origin and those in their host country may be considered.
- Establishing the impact that the broader community's response to refugee children may have on them.

assessments and social exclusion have on the resilience

- Research on resilience in children is linked to measuring their developmental outcomes. This research focused on the immediate and short-term impact of Gestalt play therapy. Further research is therefore needed on the long-term impact of a Gestalt approach to play therapy on the resilience of refugee children.
- Community resources and opportunities impact on children's resilience. Refugee children come from different countries and cultures. The scope of this research does not include the impact of cultural factors on children's resilience. Further research on whether children from a particular country or culture are more resilient than others, needs to be done.
- The limited access that refugee children have to services that could promote their resilience may also impact on their resilience. It is the opinion of the researcher that this research has indicated that refugee children may have limited access to supportive resources that could impact on their resilience. This research has a limited focus on refugee children's access to therapeutic services; it did not focus on any particular service. Further research could therefore explore this aspect. Research indicates that basing play therapists at schools where children have easy access may be helpful.
- The research was undertaken with individual children. Given the limited resources and access that refugee children may have to therapeutic services, further research could look at play therapy groups for refugee children, based on Gestalt group work.
- Further research is needed to explore the connection between resilience and educational support for refugees, including those who did not have any formal education in their country of origin.

6.5 Closing Remarks

The researcher's opinion is that this research study integrates the concept of resilience with a Gestalt play therapy approach. The researcher believes that resilience is similar to organismic self-regulation in Gestalt therapy, thus resilience and Gestalt play therapy could be integrated. The use of play therapy to promote resilience in refugee

has only come to the fore in the last five years, since brought refugee children in contact with health and social care services. This is problematic in itself, as mental health including play therapy, has different meanings in different cultures. However, resilience and play are universal features of all cultures, and this is what makes play therapy ideal.

Models of resilience in terms of developmental outcomes focus on increasing those factors which protect children's development. However, there has been limited research on actual programmes which have been implemented to increase these protective factors in children's lives or programmes aimed at promoting children's resilience. It is the researcher's view that this research study may help to address this gap in the research.

In addition, there has been very little research on using Gestalt therapy for refugees. There are several international organisations that provide Gestalt therapy for refugees but because this has only occurred as a result of recent world events, research is limited and just emerging. It is the opinion of the researcher that a Gestalt play therapy approach could be particularly relevant to refugee children because of the principles of organismic self-regulation, holism and integration.

Refugee children's lives contain many polarities which cause inner conflict and hamper their adjusting to life in the UK. Unaccompanied refugee children may have been subjected to persecution or war in the country where they were born. They are sent away for their own safety or their best interest by the people who love them. They may be sent away for their own safety, yet what they may experience in reality is insecurity, racism, abandonment or exploitation. In order to be safe, they may need to lie and keep secrets. This means that they cannot readily trust people, yet their very survival depends on people whom they may not know. In order to integrate in and adjust to a new way of life, they may need to maintain their own cultural identity while integrating their new identity. It is the opinion of the researcher that integrating these polarities in unaccompanied refugee children's lives will enable them to be resilient. Gestalt play therapy offers refugee children the opportunity to make sense of these polarities, and that, in turn, empowers them. It is the opinion of the researcher that these particular polarities make refugee children unique, and without addressing



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... way, refugee children will not become resilient. For
... model, being a Gestalt approach to play therapy with
its specific focus on empowerment, may be particularly successful in promoting and
enhancing refugee children's resilience.

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