International Journal of Play Therapy, 15(2), pp. 59-81 Copyright 2006 APT, Inc.

Current Practices

PREPARING PLAY THERAPISTS FOR DISASTER RESPONSE: PRINCIPLES AND PRACTICES

Jennifer Baggerly
University of South Florida

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Abstract: *In the wake of numerous recent natural disasters such as the 2004 tsunami and 2005 hurricanes, play therapists have been asked to provide disaster response. However, the role of disaster response interventionists is vastly different from the typical role of play therapists. In order for play therapists to be prepared for disaster response, an explanation of disaster response principles and procedures is needed. This article will help educate play therapists about how to use their play therapy skills and knowledge in a disaster response environment. Specifically, this article will (a) explain basic principles such as following the Incident Command Structure; (b) discuss the play therapist's role in disaster response in light of the phase of disaster; and (c) recommend disaster response procedures. Examples from APT members' response to the tsunami and Hurricane Katrina are provided.*

The U.S. Federal Emergency Management Agency (FEMA, 2005) registered 48 major disaster declarations including Hurricane Katrina, Hurricane Rita, severe floods, tornados, and landslides in 2005 and 68 major disaster declarations in 2004. A 70% increase in U.S. major disasters has occurred in the last decade from 319 disasters between 1986

Jennifer Baggerly, Department of Pyschological and Social Foundations, University of South Florida. Correspondence concerning this article should be addressed to Jennifer Baggerly, University of South Florida, Counselor Education, 4202 E. Fowler Ave., EDU162, Tampa, FL 33620. Email: Baggerly@tempest.coedu.usf.edu.

and 1995 to 545 disasters between 1996 and 2005. Worldwide natural disasters have increased 56% from 1,735 disasters between 1994 and 1999 to 2,699 disasters between 2000 and 2005 (Centre for Research on the Epidemiology of Disasters [CRED], 2005). With natural disasters on the rise, play therapists may ask "how do natural disasters impact children and how should play therapists respond?"

Children are one of the most vulnerable populations during and after natural disasters (Speier, 2000). Most children experience temporary symptoms, such as nightmares, fears, or disruptive behavior in school, after a disaster (Speier, 2000). Some children with risk factors, such as limited intellectual ability, female gender, younger age, unstable family life, and intense exposure to frightening events, may experience ongoing symptoms (Yule & Canterbury, 1994). Vernberg, LaGreca, Silverman, and Prinstein's (1996) found 55% of elementary school children in their study exhibited moderate to very severe symptoms three months after Hurricane Andrew in Dade County, Florida.

Due to children's unique vulnerability after disasters, play therapists are often asked to provide disaster response. For example, in 2005, Association for Play Therapy (APT) members were recruited to join Operation U.S.A., a California-based disaster relief agency, in providing disaster response to Sri Lankan children and their caretakers who were affected by the tsunami. Later that year, several APT branches and members provided disaster response to children affected by Hurricane Katrina. Although play therapists are well established in working with traumatized children (Boyd-Webb, 1999; Gil, 1991; Shelby, 2000), the role of disaster response interventionists is vastly different from the typical role of play therapists. In order for play therapists to understand their role in disaster response, an explanation of disaster response principles and procedures is needed. The purpose of this article is to help prepare play therapists for disaster response by (a) explaining basic principles such as following the incident command structure and normalization, (b) discussing the play therapist's role in disaster response in light of the phase of disaster, and (c) recommending evidenced-informed procedures.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

DISASTER RESPONSE PRINCIPLES

Incident Command Structure

The first principle in disaster response is to submit to the Incident Command Structure (ICS) that is established to manage personnel and resources in a disaster area. ICS is paramilitary and brings structure to chaos by identifying team leaders who follow predetermined procedures (FEMA, 2003). An Incident Commander will identify a Safety Officer to establish safety; an Operations Director to arrange for food services, bedding, etc.; and a Medical Services Coordinator to organize doctors, nurses, and mental health providers. (For details on Incident Command Structures, please see http://www.fema.gov/rrr/conplan/conpln4c.shtm).

It is imperative that play therapists do not respond to a natural disaster without having a specific call by a specific organizational leader to a specific place. When called, play therapists must check in with the Incident Commander or designated person. For example, after the 2004 tsunami, APT members were called by Richard Walden, President of Operation U.S.A. to particular refugee camps in Sri Lanka. After Hurricane Katrina, APT members were called by Kit O'Neil, Red Cross Mental Health Coordinator, to particular Red Cross shelters in Opelousas, Louisiana. Play therapists should always work in teams rather than alone to ensure their safety.

Six C's of Disaster Mental Health

The second principle is to follow the "six C's" of disaster mental health (Mitchell & Everly, 2003; World Health Organization, 2003). Calmness must be exhibited by play therapists at all times. In the midst of chaos and distress, play therapists can maintain a calm, non-anxious presence by eliciting the dominance of the parasympathetic nervous system over the sympathic nervous system, (i.e. taking slow deep breathes to lower heart rate and relaxing pelvic muscles) (Rank &

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Gentry, 2003; Sapolsky, 1998). Common sense must be enacted because many survivors react in a "fight or flight" mode, which hinders their higher order reasoning (Schwarz & Perry, 1994). Play therapists may need to offer common sense suggestions such as placing cold water on the face to stay cool or staying away from dangerous elements. Compassion is a familiar skill that play therapists can provide. Reassuring words and gentle physical touch may ease children's minds. Collaboration is paramount due to the incident command structure and many other professionals involved. Communication of children's needs and play therapy procedures to staff and families is also essential. Finally, control of self is needed so that play therapists can effectively fulfill their roles. Taking a break, contacting a comforting family member, eating, or resting are all expected self-care strategies that play therapists can enact so they can maintain self-control while interacting with families and staff.

Hardiness and Flexibility

The third principle is to maintain hardiness and flexibility (National Institute for Mental Health, 2002). Disaster response requires play therapists to have the hardiness of a strong, healthy body that can endure harsh conditions such as sleeping on the floor or working in 95º heat for long hours. They must have physical and emotional stamina along with resoluteness to do whatever is asked of them whenever it is needed. For example, after Hurricane Katrina, some APT members were asked to serve meals after working with children outside in the heat for hours. Flexibility to change locations and interventions frequently and immediately is also needed. Play therapists should be accommodating to all requests and aware of needed cultural adaptations. For example, in Sri Lanka after the tsunami, APT members had to improvise children's activities for an hour until a translator arrived and then had to stop the program abruptly so the translator could take a tea break. Play therapists may also need to be flexible by functioning as case managers (e.g., connecting people with the social security office, advocating for traveler's aid funds, or driving families to the bus stop).

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Expectation for Normal Recovery

The fourth principle is having an expectation that children and their families will have a normal recovery (NIMH, 2002). Rather than seeing all symptoms as pathological, play therapists should hold the view that most children are simply having normal responses to abnormal experiences. In disaster response situations, parents often indirectly ask play therapists if their children are alright. Play therapists should reflect parents' feelings of concern, reassure them that most children experience a normal recovery, identify signs of resilience in their children, and provide written information on children's typical responses and coping strategies (National Child Traumatic Stress Network [NCTSN], 2005). Reminding adults of developmentally appropriate expectations such as "children are not miniature adults" and "children's natural language is play" is also helpful (Landreth, 2002, p. 54).

Safe Space

The fifth principle is that a safe space is essential in order for stabilization and trauma recovery to occur. According to Maslow (1968), safety is the most basic need of humans after physiological needs of food and shelter. Children and families usually receive physiological needs of food, bedding, and medical attention at disaster shelters but not necessarily a sense of safety due to chaotic environments and people who are behaving in an out-of-control manner. For example, after Hurricane Katrina, one play therapist reported that children were being stepped on as people pushed through shelter lines (S. Bratton, personal communication, September 15, 2005). In addition, the author observed an intoxicated man trying to play with young children in a Hurricane Katrina shelter. Reports of sexual predators residing in disaster shelters with children have been made. Therefore, play therapists should be advocates for children in creating a safe space for children to play and learn within the shelter. A separate room with open space for toys is ideal; however, creating a circle in an open area with chairs as

boundaries will suffice. Safety can also be established by making sure all adults approved to work with children wear name badges that specify their area of expertise (e.g., emotional/behavioral health). Throughout the disaster recovery process, play therapists should consult with parents and shelter administrators to identify strategies to keep children safe.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

PLAY THERAPISTS' ROLE BASED ON PHASES OF DISASTER

Play therapists have essential knowledge and skills that many disaster responders lack. Play therapists know child development principles, can build rapport with children through toys and puppets, communicate empathy and unconditional acceptance to children, and understand children's language of play (Nalavany, Ryan, Gomory, & Lacasse, 2005). Their skills of tracking play behavior, reflecting feelings, setting therapeutic limits, and enlarging the meaning of children's play are also valuable in disaster response situations (Baggerly, 2004a). However, play therapists must first understand their role in each phase of the disaster in order to judiciously apply their skills without harming children in their recovery process (Baggerly, 2004b). Regardless of differing theoretical models (e.g., Child Centered, Jungian, Adlerian, Cognitive Behavioral, Prescriptive, etc.), play therapists must adhere to the described role during each phase of the disaster.

Phases of Disaster

According to NIMH (2002), there are five phases of a disaster. First is the pre-incident phase in which communities plan and improve coping strategies. Play therapists' role in this phase is to (a) join local or national disaster relief organizations, such as the American Red Cross, community crisis support teams, or faith-based groups, (b) help them develop children's protocol that include play therapy techniques, (c) receive disaster mental health training, and (d) familiarize themselves with NCTSN existing protocols and literature available at www.nctsnet.org (Baggerly, 2004b).

Second is the impact phase, in which 0 to 48 hours after the event people focus on survival and communication. Play therapists' role in this phase is to maintain their own safety and make their disaster response availability known to disaster response organizations with which they are affiliated. Play therapists should also prepare for deployment by packing essential personal items and play therapy toys. For example, during Hurricane Katrina, the author packed balloons, bubbles, beach balls, puppets, small dolls, animal families, toy soldiers, toy medical kit, rescue vehicles, small stuffed animals, play dough, crayons, markers, paper, story books (Holmes, 2000; Moser, 1988; Sheppard, 1998), bottled water, and individually wrapped snacks.

Third is the rescue phase, in which 0 to 7 days after an event people are rescued by first responders (e.g., police, firefighters, EMS) and adjust to changes. If play therapists are deployed by a credible organization, their role in this phase is to stabilize children by conducting initial disaster interventions, such as the Child C^{3}ARE model (Baggerly & Mescia, 2005) which will be described in detail below. Another initial disaster intervention is Psychological First Aid (National Center for PTSD [NCPTSD], 2005), which is "designed to reduce initial distress caused by traumatic events, and to foster short- and long-term adaptive functioning" (p. 4). Play therapists can also help stabilize children during standard shelter informational meetings by using puppets to convey information and toys to comfort children. Play therapists can stabilize children in small groups by using stuffed animals, art materials, and story books to reduce children's trauma reactions and normalize their responses (Baggerly, 2004b).

Fourth is the recovery phase, in which 1 to 4 weeks after an event people conduct appraisal and plan for the future. Play therapists' role in this phase is to infuse play therapy techniques into standard individual and group disaster response interventions. For example, some disaster response professionals use Mitchell and Everly's (2003) Critical Incident Stress Debriefing (CISD), a seven-step small group protocol. Play therapists can help adapt this approach to children by using play therapy techniques such as "news broadcast" during the fact

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

phase, "puppet sentence completion" during the thought phase, and "color your feelings" during the reaction phase as well as numerous other play therapy techniques (Baggerly, 2004b; Kaduson & Schaefer, 2003; McPherson, 2003). Another role for play therapists is to provide parents emotional support, handouts on children's typical trauma responses and helpful responses (Lazarus, 1998), parent and child coping workbooks such as *After the Storm* (La Greca, Sevin, & Sevin, 2005), as well as referrals to local play therapists. Play therapists should explain to parents that children who have prior mental health history and/or trauma issues may have extreme responses and may need play therapy.

Fifth is the return to life phase, in which two weeks to two years after an event, people reintegrate and try to return to pre-event level of functioning or better. However, for some children and families, a more realistic goal may be reorganization (Bowlby, 1994) or accommodation (i.e., readjusting to the new world without forgetting the old world) (Rando, 1993). Play therapists' role during this phase is to provide typical play therapy sessions that assist children in (a) establishing safety, (b) reconstructing their trauma story, and (c) reconnecting with their community (Baggerly, 2004a). Play therapists should also be familiar with evidenced-based concepts and interventions such as Trauma-Focused Cognitive-Behavioral Therapy (Cohen, Deblinger, & Mannarino, 2006). TF CBT web-training is available at http://tfcbt.musc.edu/ (TF CBT, 2006). Play therapists' role also entails consultation with school staff and community leaders to provide information and training in play therapy procedures that will promote children's recovery. It should be noted that the timing for these phases varies vastly based on the event and individual responses. Play therapists should assess individual's needs and intervene accordingly.

DISASTER RESPONSE PROCEDURES

Given that play therapists will most likely be deployed during the rescue and/or recovery phases, they should be familiar with disaster

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

response procedures appropriate for these phases. In every situation, play therapists must keep their focus on the people, not just the procedures. It is essential to make adaptations based on children's individual, cultural, and/or situational need.

Child C³ARE model – Initial Individual Intervention

An initial individual intervention that helps children stabilize after a disaster is the Child C³ARE model (Baggerly & Mescia, 2005). In this six step procedure, play therapists will **C**heck, **C**onnect, **C**omfort, **A**ssess, **R**efer, and **E**ducate as follows:

1. Check the scene to ensure it is safe to enter; the structure to identify the head authority on scene; self to ensure you are prepared; and the survivor to ensure the child is physically safe.

2. Connect with the child by being calm, getting on the child's eye level, and using a puppet to establish rapport; with the child's guardian by introducing yourself; and with specialized services that are needed immediately such as Emergency Medical Services. For example, play therapists could say, "*Hello, my name is ________, and I'm helping out here today. This is my puppet _______. Is this your family member or friend? Is it O.K. if I visit with you? Does anything hurt or feel bad? What do you need right now?*"

3. Comfort the child with calm, reassuring words; provide food, drinks, and blankets; guide in body relaxation through deep breathing, blowing bubbles, and progressive muscle relaxation; and encourage them to draw a safe, happy place. For example, say "*You've been through a difficult time but you are safe right now. Would you like something to eat or drink? I know some ways to help you be calm. Blow these bubbles. Now tense your muscles like*

a tin-man and relax like a rag-doll. Draw a safe and happy place on this paper."

4. **A**ssess (informally through observation) child's coping and functioning; monitor physical and behavioral status; identify child's risk and resiliency factors; and determine current and potential needs. Play therapists can ask, *"What do you think you need right now and in the future to help you get along? In a little while, I'll help your family find out how to get those things."*

5. **R**efer the child and guardian to needed services and resources; connect with indigenous helpers and safe peers; and provide written handouts of typical trauma symptoms and coping strategies. Say *"You said you needed _____. This information may help you and your family. What questions do you have? Let me know when you have other questions or need help with something."*

6. **E**ducate children and guardians about typical trauma responses; normalize these responses; and encourage positive coping strategies such as thought stopping, distraction techniques, singing, praying/meditating, and playing with other children. Play therapists can say, *"Many children notice changes in their body or in the things they do after something scary happens. Some have bad dreams or cry a lot or don't like to play outside. Here is a paper with different changes that happen to some kids. What changes have you noticed in you? These are normal changes that happen in normal kids like you when something different and scary happens. What do you usually do to feel better when you feel bad? I know some other things you can do. Would you like to learn? Try this . . .Here's a paper that tells you lots of things you can do. I'm going to get kids together later to play*

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

games. Would you like to come? I'm going to visit some other kids now. I'll come back later to let you know when the games start. Thank you for visiting with me. It was nice to meet you. Bye."

Throughout this intervention, the play therapist should use basic skills of listening carefully, reflecting feelings, communicating clearly, focusing on concerns, and keeping confidentiality (Speier, 2000). Play therapists can learn details on how to implement stabilization and trauma recovery tools from Baranowsky, Gentry, and Schultz (2005).

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Cognitive Behavioral Interventions for Individuals and Groups

Given that crisis intervention requires a more active directive stabilization approach than typical counseling and play therapy (Kanel, 1999), play therapists need to integrate play therapy techniques into individual and group psycho-educational sessions. Teaching children cognitive behavioral skills will help them establish safety and stabilization in their body, cognitions, behavior, emotions, and social relationships (Baranowsky, et al., 2005). In preparation for the APT tsunami disaster response in Sri Lanka, Shelby, Bond, Hall, and Hsu (2004) adapted several strategies from NCPTSD (2005) Psychological First Aid protocol for preschool and elementary school children.

Normalize Symptoms. Many children may be embarrassed of their disaster reactions, such as bed wetting, while adults may be distressed by children's reactions, such as aggressiveness or avoidance of disaster reminders. Play therapists should normalize children's responses to disasters by informing adults and children of typical reactions. This information can be conveyed through children's storybooks (Holmes, 2000; Moser, 1988; Sheppard, 1998) and puppet shows created to address local concerns. For example, Sri Lankan teachers were distressed that some children refused to play outside for fear that another tsunami

would come. Play therapists developed a puppet show that explained this as a normal response and reminded them how to look at physical evidence to determine when another tsunami is imminent.

Manage Hyper-Arousal. Some children experience ongoing hyper-arousal in their bodies because they are unable to deactivate their "fight or flight response" after a disaster (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). As a result, many children have general agitation and may avoid reminders of the disaster, such as being near the water, in an attempt to manage their anxiety. Play therapists should teach children self-soothing, relaxation techniques to calm their bodies. These procedures include (a) taking deep breathes through playful activities, such as blowing soap bubbles or pinwheels; (b) progressive muscle relaxation by tensing like a tin man and relaxing like a rag doll; (c) focusing on positive images by drawing happy places, engaging in mutual story telling with a positive ending, or meditating on peaceful places; and (d) teaching parents and guardians to conduct soothing sessions that might include massaging, rocking, and singing to their children (Shelby, et al., 2004). For example, in Sri Lanka, many children were afraid to go to the beach after the tsunami. Play therapists taught children and teachers deep breathing and positive images through the following song, which is to the tune of "Twinkle, Twinkle, Little Star." *"I am safe and I am strong. Take a breath and sing this song. I'm growing stronger every day. I know that I'll be O.K. I am safe and I am strong. Take a breath and sing along."* Gradually, children returned to the beach to help with chores of fishing and clothes washing.

Manage Intrusive Re-experiencing. Some children experience intrusive thoughts of disaster related events because brain alterations during a trauma encode indelible pictures in their implicit memory (Perry, et al., 1995). Play therapists should teach children methods of containing these images and grounding themselves. These procedures include (a) "changing the tape" by replacing the thought with a predetermined song, story, or sayings such as "I'm safe right now and I know it because I have . . ." and (b) grounding activities such as their rubbing stomach or hands together (Shelby, et al., 2004). Play therapists

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

can also amend Baranowsky's, et al., (2005) 5-4-3-2-1 sensory grounding and containment procedure by asking children to play a 3-2-1 game. For this game, ask children to identify three objects above eye level, three sounds everyone can hear, and three things they can touch; then two things they see, hear, and touch; followed by one thing they see, hear, and touch. Implementing this activity with children in Hurricane Katrina shelters helped them refocus on the here and now as well as realize their surroundings were safe.

Increase Accurate Cognitions. Due to their egocentric and concrete cognitions, some children may have misattributions of the cause of disasters, such as their bad dreams or someone's bad behavior. Play therapists should assess misattributions and give accurate information. These procedures include (a) making a Q-sort of possible reasons for the disaster and asking children to sort by true and untrue; (b) creating a blame box for younger children to put in drawings of who or what they blame and then drawing the correct reason together; (c) developing a puppet show in which puppets ask about misattributions and another puppet gives accurate reasons; and (d) acting out a radio show of people calling in with questions and an expert giving correct information (Shelby, et al., 2004). In Sri Lanka, play therapists performed a puppet show in which a small puppet timidly asked if the tsunami was caused by bad dreams or by someone putting something in the ocean while a larger puppet calmly explained that an earthquake under the water caused the tsunami.

Increase Effective Coping. Young children have not had the life experience to develop a wide range of coping strategies and do not have the cognitive ability to accurately evaluate the effectiveness of their coping strategies. Since negative coping strategies of social withdrawal and self-blame have been correlating with increased depressive symptoms (Jeney-Gammon, Daugherty, Finch, & Belter, 1993), play therapists should help children differentiate between effective and ineffective coping strategies and develop numerous adaptive coping strategies. Matching children's preferred coping style ("attenders" who focus on the stimulus vs. "distractors" who focus away from the

stimulus) with corresponding interventions has been shown to be more effective in decreasing symptoms (Fanurik, Zeltzer, Roberts, & Blount, 1993).

Procedures to increase effective coping include (a) writing or drawing maladaptive coping strategies on cards and telling children to "pass the trash"; (b) playing card games in which children find pairs of adaptive coping strategies and throw out maladaptive strategies; (c) playing coping charades in which children act out positive coping strategies; and (d) organizing developmentally appropriate, cooperative play or games such as "duck, duck, goose" and relay races (Shelby, et al., 2004). For example, after the tsunami and Hurricane Katrina, play therapists guided children in making a coping bracelet of five colorful cards on which they drew effective coping strategies.

Seeking Social Support. Many young children socially withdraw or cling to their parents after a disaster. Some older children withdraw from healthy social support by engaging in disruptive behavior with peers. Play therapists should teach children appropriate ways of seeking healthy social support and decrease unhealthy social withdrawal. These procedures from Shelby, et al., (2004) include (a) role playing how to ask for social support from four different sources such as peers, parents, staff, and teachers; (b) making support coupons by writing or drawing a request for help on paper and giving it to a trusted peer or adult when help is needed; and (c) creating a paper doll support chain in which linked images of dolls are labeled with names of people who provide support. For example after Hurricane Katrina, some children were angrily demanding that adults play with them so play therapists helped the children role play ways to ask politely for adults to play with them.

Foster Hope. When disasters destroy homes, schools, communities, and lives of loved ones, children lose their framework for safety, order, and meaning. Consequently, many children lose a sense of hope. Play therapists can be a part of the compassionate humanitarian response that reignites children's hope and positive images for the future (Shelby, et al., 2004). Procedures from Shelby, et al., (2004) to increase hope include (a) role playing family and community rebuilding efforts;

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

(b) creating stories, poems, or songs that express hope; and (c) identifying community support projects that children can participate in, such as making thank you cards for police officers or building a rock garden. For example, in Sri Lanka, play therapists guided children in finding natural objects on the beach and placing them in a sandbox to symbolize the rebuilding of their community.

Before administering these interventions, it is important to be aware of children's prior mental health history and/or trauma issues, which may become salient after a natural disaster. For example, when play therapists provided interventions after the tsunami, some Sri Lankan children stated their parents were killed by landmines during the civil war. While working with families after Hurricane Katrina, some parents indicated their children's ADHD symptoms were more pronounced. Play therapists should use discernment in implementing interventions during the short-term recovery phase so prior trauma issues are not triggered. Again, the goal during disaster response is stabilization. If prior mental health history and/or trauma issues are salient, the play therapist should focus on grounding and containment interventions to stabilize the child and give a referral to a local mental health professional for follow up.

Compassion Fatigue Resiliency Planning

Even when play therapists follow these principles and protocol, the physical and emotional difficulty of disaster response will make them susceptible to compassion fatigue. According to Figley (1995), compassion fatigue is defined as "a state of tension and preoccupation with the traumatized clients by re-experiencing traumatic events, avoidance/numbing of reminders, and persistent arousal (e.g., anxiety) associated with the client" (p. 1435). Before deploying to a disaster, play therapists should develop a compassion fatigue resiliency plan that includes strategies for self-regulation, self-validated caregiving, connecting with social support, and physical and spiritual self care (Baranowsky, et al., 2005). Daily team debriefing and supervision is essential to ensure that each play therapist continues to be fit for duty.

For example, in Sri Lanka, this author conducted daily team debriefings to (a) identify things that went well; (b) things that needed improvement; (c) experiences that "stuck-out"; (d) prominent thoughts and feelings; and (e) self-care strategies.

RECOMMENDATIONS

Play therapists' participation in disaster response is needed to help ensure children receive developmentally appropriate interventions that promote their stabilization and disaster recovery. In order to develop a cadre of prepared and effective play therapists for disaster response, recommendations for training, service, and research are offered.

Training. Play therapists need in-depth training in these disaster response principles and procedures. High stress situations of disaster response require play therapists to have a procedural memory of these principles and procedures, which only comes through ongoing training and practice. Offering disaster response trainings for play therapists at national and statewide conferences will be helpful. Play therapists can also view demonstration videotapes such as *Disaster Mental Health and Crisis Stabilization for Children*, available at www.emicrotraining.com (Baggerly, 2006). Team building among trained play therapists is needed as well. Logging team members' strengths, needs, and characteristics will help ensure leaders develop a well-balanced team. Team-building exercises will increase trust and communication in high stress situations.

Service. Play therapists can provide service to children after disasters by joining an emergency relief organization. There are numerous options. The American Red Cross (ARC) provides mental health services teams and needs children's specialists for local disasters, such as house fires and national disasters such as hurricanes. (Contact ARC at www.redcross.org). Church of the Brethren (CB) provides Disaster Child Care teams at disaster recovery sites and incorporates play therapy principles in their procedures. (Contact CB at http://www.brethren.org/genbd/ersm/dcc.htm). Community Emergency

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Response Teams need children's specialists to provide services. (Contact information available at http://www.citizencorps.gov/programs/cert.shtm). Emergency Operations Centers or Emergency Management departments may have more local options.

Research. Research is needed to determine the effectiveness of play therapists implementing these principles and procedures with children during disaster response. Researchers should measure children's anxiety and trauma symptoms pre- and post-intervention to determine if play therapy techniques decrease children's symptoms more than interventions without them. Assessment instruments that should be considered include *Trauma Symptom Checklist for Children – Alternative* (TSCC-A; Briere, 1996), *Post-Traumatic Stress Reaction Index for Children* (PTSRIC; Frederick & Pynoos, 1998), *Revised Children's Manifest Anxiety Scale* (RCMAS; Reynolds & Richmond, 1985), *Children's Depression Inventory* (CDI; Kovacs, 1982), and the *Child Behavior Checklist* (CBCL; Achenbach & Rescorla, 2001). Sample research questions may include the following:

- Do trauma symptoms as measured by TSCC-A and PTSRIC decrease significantly more in children who receive disaster interventions with play therapy techniques when compared to children who receive no disaster interventions?
- Do anxiety, depression, and behavior symptoms as measured by RCMAS, CDI, and CBCL decrease significantly more in children who receive disaster interventions with play therapy techniques when compared to children who receive only disaster interventions without play therapy techniques?
- Do trauma symptoms as measured by TSCC-A and PTSRIC decrease significantly more in children who receive disaster interventions from mental health professionals trained in play therapy and disaster response when compared to children who received

disaster interventions from mental health professionals not trained in play therapy or disaster response?

Participant recruitment in research studies is difficult during disasters. Quick approval from Institutional Review Boards and disaster shelter operations managers or child care facilities is essential. Some parents or guardians may be hesitate to sign informed consent forms because they already feel vulnerable and may view research as insensitive or suspicious. Random selection for treatment or control groups may create resentment among families who do not receive treatment. Hence, a convenience sample of "first come, first serve" with a waiting list control group may be more practical.

CONCLUSION

Play therapists have valuable skills and knowledge that can benefit children after natural disasters. However, before responding to a natural disaster, play therapists must adhere to disaster response principles of submitting to the ICS, following the "six C's" of disaster mental health, maintaining hardiness and flexibility, holding expectations of normal recovery, and establishing a safe space. Play therapists must also distinguish their role in differing disaster phases of pre-incident, impact, rescue, recovery, and return to life. Play therapist should practice initial individual interventions such as the Child C^{3}ARE model and cognitive behavioral interventions of normalizing symptoms, managing hyper-arousal and intrusive re-experiencing, increasing accurate cognitions and effective coping, seeking social support, and fostering hope. Compassion fatigue resiliency planning is also essential for play therapists. Due to the increasing number of natural disasters, play therapists should pursue training, service, and research in facilitating children's disaster recovery. By doing so, play therapists will expand their role to communities that need healing for children devastated by natural disasters.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

REFERENCES

Achenbach, T. M., & Rescorla, L. A. (2001). *Child behavior checklist.* Burlington, VT: Child Behavior Checklist University Medical Education Associates.

Baggerly, J. N. (2004a). Ring around the rosie: Play therapy for traumatized children. In J. Webber (Ed.), *Terrorism, trauma, and tragedies: A counselor's guide to preparing and responding* (p. 93-96). Alexandria, VA: American Counseling Association.

Baggerly, J. N. (2004b). Systematic trauma interventions for children: A 12 step protocol. In J. Webber (Ed.), *Terrorism, trauma, and tragedies: A counselor's guide to preparing and responding* (p. 97-102). Alexandria, VA: American Counseling Association.

Baggerly, J. N. (2006). *Disaster Mental Health and Crisis Stabilization for Children* [Video]. Framingham, MA: Microtraining Associates.

Baggerly, J. N., & Mescia, N. (2005). *Disaster behavioral health first aid specialist training with children: C-FAST.* Tampa, FL: Florida Center for Public Health Preparedness.

Baranowsky, A. B., Gentry, J. E., & Schultz, D. F. (2005). *Trauma practice: Tools for stabilization and recovery.* Ashland, OH: Hogrefe & Huber Publishers.

Bowlby, J. (1994). Pathological mourning and childhood mourning. In R. V. Frankiel (Ed.), *Essential papers on object loss* (pp. 185-221). New York: New York University Press.

Boyd-Webb, N. (1999). *Play therapy with children in crisis, second edition: Individual, group, and family treatment.* New York: Guilford Press.

Briere, J. (1996). *Trauma symptom checklist for children.* Odessa, FL: Psychological Assessment Resources.

Centre for Research on the Epidemiology of Disasters (CRED). (2005). EM-DAT: The international disaster database. Retrieved December 29, 2005, from http://www.em-dat.net/index.htm

Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2006). *Treating trauma and traumatic grief in children and adolescents: A clinicians' guide.* New York: Guilford Press.

Fanurik, D., Zeltzer, L. K., Roberts, M. C., & Blount, R. L. (1993). The relationship between children's coping styles and psychological interventions for cold pressor pain. *Pain, 53,* 213-222.

Federal Emergency Management Agency. (2003). Concept of operations. Retrieved April 30, 2004, from http://www.fema.gov/rrr/conplan/conpln4c.shtm

Federal Emergency Management Agency. (2005). Annual major disaster declarations totals. Retrieved December 29, 2005, from http://www.fema.gov/news/disaster_totals_annual.fema

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* Bruner/Mazel: New York.

Frederick, C. J., & Pynoos, R. S. (1998). *The child post-traumatic stress disorder (PTSD) reaction index.* Los Angeles: University of California.

Gil, E. (1991). *The healing power of play: Working with abused children.* New York: Guilford Press.

Holmes, M. (2000). *A terrible thing happened: A story for children who have witnessed violence or trauma.* Washington, DC: Magination Press.

Jeney-Gammon, P., Daugherty, T. K., Finch, A. J., & Belter, R. W. (1993). Children's coping styles and report of depressive symptoms following a natural disaster. *Journal of Genetic Psychology, 154,* 259-267.

Kaduson, H., & Schaeffer, C. (2003). *101 favorite play therapy techniques, volume III.* Northvale, NJ: Jason Aronson.

Kanel, K. (1999). *A guide to crisis intervention.* Pacific Grove, CA: Brooks/Cole.

Kovacs, M. (1982). *Children's depression inventory.* Pittsburgh: Western Psychiatric Institute.

La Greca, A. M., Sevin, S. W., & Sevin, E. L. (2005). *After the storm: A guide to help children cope with the psychological effects of a hurricane.* Coral Gables, FL: 7-Dippity.

Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). Bristol, PA: Accelerated Development.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Lazarus, P. J. (1998). *Trauma and children: A parent handout for helping children heal.* Bethesda, MD: National Association of School Psychologists.

Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). Princeton, NJ: Van Nostrand.

McPherson, K. F. (2003, October). *Critical incident stress management (CISM) and play therapy.* Paper presented at the meeting of the Association for Play Therapy, Norfolk, VA.

Mitchell, J. T., & Everly, G. S. (2003). *Critical incident stress management (CISM): Basic group crisis intervention* (3rd ed.). Ellicott City, MD: International Critical Incident Stress Foundation Inc.

Moser, A. (1988). *Don't pop your cork on Mondays!: The children's anti-stress book.* Kansas City, MO: Landmark Editions, Inc.

Nalavany, B. A., Ryan, S. D., Gomory, T., & Lacasse, J. R. (2005). Mapping the characteristics of a "good" play therapist. *International Journal of Play Therapy, 14*(1), 27-50.

National Center for PTSD. (2005). Psychological first aid: Field operations guide. Retrieved November 2, 2005, from http://www.nctsnet.org/nccts/nav.do?pid=typ_terr_resources_pfa

National Child Traumatic Stress Network. (2005). Age-related reactions to a traumatic event. Retrieved December 29, 2005, from http://www.nctsnet.org/nccts/nav.do?pid=ctr_aud_prnt_what

National Institute of Mental Health. (2002). *Mental health and mass violence: Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices.* (NIH Publication No. 02-5138). Washington, DC: U.S. Government Printing Office.

Perry, B., Pollard, R., Blakely, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiological adaptation and 'use-dependent' development of the brain: How "states become traits." *Infant Mental Health Journal, 16*(4), 271-291.

Rando, T. (1993). *Treatment of complicated bereavement.* Champaign, IL: Research Press.

Rank, M. G., & Gentry, J. E. (2003). Critical incident stress: Principles, practices, and protocols. In M. Richard, W. Hutchinson, & W. Emener (Eds.), *Employee assistance programs: A basic text* (3rd ed.) (pp. 208 - 215). Springfield, IL: Charles C. Thomas Publisher.

Reynolds, C., & Richmond, B. (1985). *Revised children's manifest anxiety scale.* Los Angeles: Western Psychological Services.

Sapolsky, R. M. (1998). *Why zebras don't get ulcers: An updated guide to stress, stress-related diseases, and coping*. New York: W. H. Freeman and Company.

Schwarz, E., & Perry, B. D. (1994). The post-traumatic response in children and adolescents. *Psychiatric Clinics of North America, 17*(2), 311-326.

Shelby, J. S. (2000). Brief therapy with traumatized children: A developmental perspective. In H. G. Kaduson & C. E. Schaefer's (Eds.), *Short-term play therapy for children* (pp. 69-104). New York: The Guilford Press.

Shelby, J., Bond, D., Hall, S., & Hsu, C. (2004). *Enhancing coping among young tsunami survivors: Cultural approved interventions*. Los Angeles: Authors.

Sheppard, C. (1998). *Brave bart*. Groose Pointe Woods, MI: TLC.

Speier, A. H. (2000). *Disaster relief and crisis counseling: Psychosocial issues for children and adolescents in disasters*. Rockville, MD: Center for Mental Health Services.

Trauma-Focused Cognitive Behavioral Therapy (TF CBT). (2005). TF-CBT web: A web based learning course for trauma-focused cognitive behavioral therapy. Retrieved November 1, 2006, from http://tfcbt.musc.edu/

Vernberg, E. M., LaGreca, A. M., Silverman, W. K., & Prinstein, M. J. (1996). Prediction of posttraumatic stress symptoms in children after hurricane Andrew. *Journal of Abnormal Psychology, 105*(2), 237-248.

Vogel, J., & Vernberg, E. M. (1993). Children's psychological response to disaster. *Journal of Clinical Child Psychology, 22*, 470-484.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

World Health Organization (WHO). (2003). Mental health in emergencies: WHO Geneva. Retrieved November 2, 2005, from http://www5.who.int/mental_health

Yule, W., & Canterbury, R. (1994). The treatment of posttraumatic stress disorder in children and adolescents. *International Review of Psychiatry, 6,* 141-151.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.