APT Position Paper

Role of Play Therapists in a Disaster Response (Postvention)

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INTRODUCTION

This position paper was created by the Association for Play Therapy to assist and guide play therapists who wish to offer assistance in post-disaster events. In order to be deployed as a clinician or mental health worker, most organizations will require that you have a Master's degree or doctorate, or some type of certification or license to be eligible. Play therapists may not self-deploy and must go through an approved organization to provide services. Volunteer clinicians should have some training in Psychological First Aid which helps to guide the interventions.

APT DOES *NOT* HAVE A DEPLOYABLE CRISIS TEAM

Play therapists are urged to contact appropriate organizations which specialize in disaster response such as, at the national level, the American Red Cross, National Organization for Victim Assistance, World Vision, as well as many states, municipalities and school systems who have their own crisis teams. Each organization will have their own training requirements, response protocols, and procedures specific to their mission and may utilize Psychological First Aid or the FEMA Incident Command model.

DEFINING DISASTERS AND CRISES

A disaster can be defined as a serious event or series of events (small or large) that take place over a short or extended period of time which overwhelms the individual, family, school and/or community and may be perceived as life threatening (Chatterjee, 2018). They can produce severe disruption, ecological or psychological, which greatly exceeds the coping capacity of a community (e.g. physical death, destruction, basic needs cannot be met, psychological, security, interpersonal relationships and meaning to one's life). Disasters range from environmental/natural (e.g., floods, tornadoes, wild/residential fires, hazardous, toxic waste events, building collapse) to human-caused (e.g., school/community shootings, bombings, war, terrorism, aviation/mass transportation accidents, hostage taking). Disasters vary in size and scope, and may affect single or multiple family dwellings, neighborhoods, states, regions, and even a nation as a whole (American Red Cross, 2011; Shelby and Smith, 2020).

ETHICAL CONCERNS

As in all our clinical endeavors, we must honor critical ethical and professional concerns. A fundamental consideration in a crisis situation is to make sure that you do NOT work outside your scope of practice or knowledge (American Counseling Association, 2014; American Psychological Association, 2016; American Red Cross, 2011; Halpern & Vermeulen, 2017; Shelby & Smith, 2020).

It is important to become familiar with Psychological First Aid (PFA; an online and free training developed by the National Child Traumatic Stress Network and National Center for PTSD). This is a program "designed to reduce the initial distress caused by traumatic events and to foster…adaptive functioning and coping," and it is widely used by the Red Cross and other disaster response organizations.

You are bound by your licensed or certified profession's codes of ethics. Maintain a confidential client-practitioner relationship and do not disclose to others without consent and only on a need-to-know basis. Find a private space to talk. Be aware of your surroundings and who is nearby hearing your conversation. Know the laws and regulations of the state you are in for mandated reporting.

It is important that you inform the survivor you are a mental health worker or disaster counselor/psychologist, social worker, etc. or a "licensed social worker with the Red Cross team," if appropriate, before beginning any intervention (American Red Cross, 2011).

BEFORE DEPLOYMENT

Deployment is under the auspices of disaster relief programs (such as the Red Cross, Pastoral Counselling, local agencies, etc.). You CANNOT self-deploy to go to a disaster relief setting, even if it is close to where you live or work. You MUST go through a recognized organization in order to get assigned to a disaster site (American Red Cross, 2011; Lomas & Denino, 2018; Stewart, et al., 2016).

Before volunteering to be deployed to a disaster relief location, you need to consider your own emotional and physical ability in very stressful environments for that particular time in your life. You also need to consider whether or not to serve if you (and/or your family) are impacted by the disaster. Disaster volunteer work can be very fulfilling and rewarding, but it can also be emotionally and physically taxing and draining.

Disaster responding involves working long hours in uncomfortable and often disorganized environments, witnessing extreme emotional responses, living in a staff shelter with little privacy or space, dealing with a lack of 'creature comforts' (caffeine, familiar foods, air conditioning, reliable phone and internet, etc.), and handling shifting responsibilities and staff conflicts (American Red Cross, 2011; NASP, 2017; Shelby, 2022). You will also be directly impacted by leaving family members and loved ones or pets, discouraged by lack of progress, and perhaps not getting regular work pay (Mochi & VanFleet, 2009; Ohnogi & Drewes, 2016).

Assignments may change. Flexibility is a critical skill for all disaster volunteers. Workers may be asked to assume responsibilities that are not consistent with their preferences or expectations (e.g. helping serve food, taking out trash, helping to clean bathrooms). Workers' assignments are subject to the needs of the disaster operation (American Red Cross, 2011; Mochi, 2022).

ENTERING THE SUPPORT SITE

Observe the setting, noting environmental stressors and the general emotional tone of the population. Disaster relief settings usually have an onsite supervisor and technical supervisor who oversee the mental health services. But, on occasion, you might be the one assigned a supervisory role. You must follow appropriate lines of authority at all times. Know the chain of command.

Use your clinical judgements and observations to gauge the person's readiness before you begin to engage with colleagues and survivors. Use PFA guidelines for the initial engagement by asking practical questions, such as, "Can I get you a bottle of water?" (American Red Cross, 2011; Baggerly & Green, 2017).

ROLE OF THE PLAY THERAPISTS

Traditional play therapy is NOT appropriate or even possible during times of disaster as work is time-limited. Therapeutic play and emotional support along with psychoeducation is the focus. Play therapists can advocate for and help establish a safe place for children to engage in familiar and regulating play. You may need to be flexible and nimble in helping to create space for play (e.g., use of a blanket, taped off floor/areas, or circling chairs to create a boundary).

Our role is to make a connection, be kind, compassionate and calm, meet people's basic

needs, listen, give realistic reassurance, encourage good coping, help people to connect, be safe, give accurate and timely information, and make a referral where necessary, as well as take care of ourselves (good self-care).

Additional roles can include coordination with relief organizations, physical and emotional support, helping with survival needs, identifying local resources, conducting need assessments, training/supervising local helpers in play interventions, conducting child, family or community interventions and helping organize play activities (Baggerly, 2015; Echterling & Stewart, 2015; Halpern & Vermeulen, 2017; Mochi, 2022; Mochi & VanFleet, 2009). Any intervention must acknowledge and include existing relationships and organizations (e.g. school connections) and be considered for the impact on trauma and need to avoid re-traumatization.

WORKING WITH PARENTS/CAREGIVERS

Check with parents before helping children. Support parents/caregivers to help cope and consequently support their children by creating a safe environment, provide familiarity, routines and predictability, and minimize media exposure. Help them to understand developmental issues and ways children may express distress through physical symptoms and play. Assist parents in determining ways they can effectively provide reassurance, respond to questions, and encourage expression of emotions.

Children's reactions (e.g., regression, acting out, clingy or needy, not sleeping) can be difficult for parents/caregivers. Reassure them it is likely to be temporary and offer specific advice based on children's developmental stages. Foster self-efficacy in parents by emphasizing their competence and ability to respond to their children's needs (Harris, et al., 2010; Shelby, 2022; Shelby & Smith, 2020). Also recognize if parents are overwhelmed or are having their own trauma responses and offer to play with their children within sight of their parents.

Reactions to distress will vary by individual and by age/developmental stage. Remind parents that efforts to shield children from the truth rarely helps and may make them feel betrayed or confused. Encourage parents to give developmentally attuned, honest, accurate information. Use concrete language, give children an opportunity to ask questions and tailor responses to developmental level, allow children to express their feelings and offer them choices to provide control over appropriate decisions (Chatterjee, 2018).

WORKING WITH CHILDREN

Crisis workers focus on helping children recover a sense of emotional and physical safety and enhancing protective factors to diminish the traumatic responses to the event. This includes connecting to support systems (e.g. schools, faith-based organizations or teams), enhancing affect and behavioral regulation, and teaching relaxation and cognitive coping skills (American Red Cross, 2011; Ohnogi & Drewes, 2016).

DISASTER REACTIONS

Reactions to a disaster are unique to each person and not all children and families develop long-term symptomatology requiring treatment. Children may become confused and overwhelmed with feelings and in response to the reactions of those around them. They may have feelings of guilt and responsibility for the disaster (Ohnogi & Drewes, 2016) with a wide variety of behaviors in their efforts to cope, such as somatic complaints, difficulty sleeping, over activity, aggression, irritability, angry outbursts, withdrawal, separation anxiety, heightened startle response, regression and numbness (Perry, 2000). High level exposure, extensive disruption and devastation can create feelings of hopelessness and helplessness in children and families (Mochi, 2022; Mochi & Van Fleet, 2009). These feelings may be especially heightened in communities with few resources and where oppression and discrimination already exist, as they will be disproportionately negatively impacted.

RESILIENCE

Psychological First Aid (Brymer et al., 2006) is based on the assumption that most people are resilient. However, a significant minority are at risk of developing a new or aggravated clinical disorder. Services should alleviate immediate emotional distress and mitigate long-term consequences. Most individuals and families function adequately during and after a disaster, but their effectiveness in daily activities may be diminished, especially vulnerable populations (Chatterjee, 2018; Stewart, et al., 2016).

Services should augment the community's mental health resources, not replace them. Survivors will be individuals, families, neighborhoods, community groups and others who are experiencing stress related to the impact of the disaster (American Red Cross, 2011; Halpern & Vermeulen, 2018).

Resilience and recovery depend on the nature of the traumatic experience, personality factors, developmental timing, pre-disaster traumatic experiences, dose of exposure to the disaster, levels of caretaker and community supports, and events and treatment following the disaster (Baggerly & Green, 2017; Harris, et al., 2010; Mochi & VanFleet, 2009). It is important to note that, similar to other crises, reactions to disasters are idiosyncratic, meaning a situation that overwhelms coping for one person may not overwhelm coping for another person (James & Gilliland, 2017).

The play therapist crisis worker focuses on helping children recover a sense of emotional and physical safety and enhancing protective factors to diminish the traumatic responses to the event. These include connecting the child to support systems, helping the child experience coregulation and regulation of affect, and inviting them to practice relaxation and cognitive coping skills with your guidance (American Red Cross, 2011; Ohnogi & Drewes, 2016).

INTERVENTIONS

The Red Cross (2011) defines disaster intervention as occurring in three phases: 1) assessment of the situation and triage using exposure-based risk factors; 2) promotion of resilience and coping skills; 3) interventions to mitigate psychological complications as a result of the disaster.

Phase I: Assess, address and support those who “saw/heard death or serious injury” and survivors. Safety and regulation are primary.

Phase II: Help people to feel safe, meet basic needs, listen, encourage good coping, and help people connect.

Phase III: Interventions include advocacy, crisis intervention, grief support, family support and referrals. The goal is to protect, support and restore systems that provide the capacity for resilience (American Red Cross, 2011).

THERAPEUTIC PLAY

Play-based opportunities allow children and families to experience and enhance their ability to cope with the aftermath of the disaster. Interventions should be tailored to the unique disaster circumstances, to the overall principles of a strength-based, time-sensitive, practical and present/future orientation approach. Play therapy-informed interventions

should reflect the goals of promoting a sense of safety and calm, encouraging, and supporting self-efficacy, enhancing social connections and strengthening hope. Play therapists DO NOT conduct “traditional” play therapy during post-disaster (Baggerly, 2015; Shelby, 2022; Shelby & Smith, 2020).

TYPES OF PLAY

While the nature and scope of the disaster (whether natural or human caused, the amount of destruction, etc.) may influence play themes and activities, there are several universal goals of therapeutic play in disaster responding:

1. Play that enhances felt sense of safety and regulation. Use of sensory and grounding materials and activities such as soothing sensory materials listed in Shelby’s Coping Box (Shelby & Smith, 2020), low-stress physically regulating activities such as Red Light-Green Light and Butterfly Hugs, and child-directed play.
2. Play that encourages social connections. Constructing a group mural, playing games, singing and dancing, etc.
3. Play that allows for sharing of disaster narratives (in play or with words) and coping skills: cardboard boxes for houses that can be rebuilt, water bottle “fire hoses” for battling wildfires, sock puppets who can “say” what cannot be said, etc.
4. Play that facilitates hope and imagination: written messages or pictures of hope hung on the wall (Shelby, 2022), t-shirt superhero capes and pipe cleaner magic wands, etc.

PLAY MATERIALS

Create your own kit of items that are sturdy and portable and selected with a play-therapy informed purpose. Ideas include: miniatures, flexible dolls of diverse ethnicity and generations, a pack of men’s white socks, scissors and markers to create puppets, deflated beach ball for interactive physical and social play, a deck of cards, soap bubbles, non-drying clay for pounding release of stress, and colored pencils and white paper. Typical play therapy toys NOT appropriate for a disaster site include dart guns, rubber knives, and bobo punching dolls as these can be triggering for some people.

Make creative use of supplies that are readily available in disaster sites. Such as, Styrofoam cups, coffee stirrers, and plastic spoons can be used for puppets; crumbled paper towels and masking tape for balls; water bottles for bowling; cardboard boxes for creating imaginary castles and hideaways, duct tape for roads and to “rebuild” cardboard towns, etc.

Think through any potential consequences of your play activities. For instance, glitter glue and paint may be great fun for the children, but not welcomed by parents with limited access to laundering facilities. Energizing, exciting play can reduce stress and enhance social connections, but in a crowded disaster setting may present an additional challenge to others nearby or create safety issues (Echterling & Stewart, 2008; Lomas & Denino, 2018; Mochi & VanFleet, 2009; Stewart, et al., 2016).

IMPORTANT CONSIDERATIONS

Our role is to normalize reactions (feelings and thoughts no matter how extreme are understandable), assess coping, modify cognitive distortions, decrease panic symptoms and isolation, increase self-soothing, instill hope, reinforce social support, build resiliency, and facilitate coping skills.

Your services will not always be welcome. There may be bias and cultural taboos against mental health services and help. You may encounter anger, hostility or avoidance to your offer to talk or receive support. You may be dealing with different languages, races, and religions that may inadvertently stir up personal biases and prejudices.

Speak in a calm voice. Be flexible. Maintain your own regulation. Provide your own structure daily as there may be chaos, lack of support and limited sleep and private space. Acknowledge your limits, set boundaries, assert yourself, and get help if needed (Karkashian, 1994).

VICARIOUS TRAUMA

Play therapists are at significant risk as they work to promote the safety of the victims, survivors, and responders. Psychological safety is as critical as physical safety in a disaster response.We are impacted just as the people who are experiencing the disaster. We may live or work in the same community as where the disaster has occurred. Witnessing

emotional responses of others, including those of friends and family, and seeing the results of the disaster, devastation and losses as the survivors you are helping will have an emotional impact on you.

You may be facing extreme emotional reactions to witnessing catastrophic destruction, feeling as if your life was in danger (e.g. aftershocks, wildfires nearby, flood waters rising), and stories of death, loss, and grief that may challenge and stir up your own unresolved emotional reactions to past personal events and may create feelings of helplessness. You may also be dealing with the added worry about family and friends dealing with the disaster or your worry about tending to your own home.

Stress reactions can vary widely and can occur in all domains of functioning: emotional, cognitive, physical, behavioral, spiritual. It can activate your own personal history of trauma or mental health issues. Be attentive to your own stress symptoms and those of your coworkers. You may find yourself exhibiting the same stress reactions as those of survivors (children and adults): rage, anger, irritability, resentment, anxiety and fear, despair, hopelessness, numbness, terror, guilt, sadness, helplessness, loss of control, disinterested, and overwhelmed. Difficulty thinking and concentrating, making difficult decisions, being forgetful, confused, distortion of sense of time, intrusive thoughts, memories and flashbacks, worry, a sense of being cut off from reality, and lowered self-esteem may happen to you, as well as clients.

You may find yourself feeling fatigued, having difficulty sleeping, feeling agitated and easily startled, developing physical symptoms such as appetite disturbance, craving for caffeine, lightheadedness, or a sense of weakness. Our coping mechanisms and beliefs about the world can become challenged, and we may neglect our own physical, social-emotional health and self-care.

Self-care as a disaster volunteer is a critical piece of effective responding. Stay connected with family and friends (Ohnogi & Drewes, 2016; Shelby, 2022; Stewart, et al., 2016). If possible, work with a team and have daily team debriefings as well as one-on-one check ins (Baggerly, et al., 2019). Give yourself permission to take breaks, both physical and emotional. Pack your journal, craft supplies, photos of your favorite place or people, music playlist, favorite books, sand tray miniatures, or whatever helps keep you grounded.

CONSULTATION

Play therapists need to seek consultation and supervision related to disaster responses. Do not work outside your scope of practice. Disaster mental health workers are more directive with clients in the disaster situation, as opposed to reflective in therapy, in an effort to provide problem-solving and task-centered activities to address basic needs and the reduction of stress.

SPECIAL CONSIDERATIONS:

Need for Culturally Competent Orientation

Without a culturally competent orientation, we can run the risk of misinterpreting culturally mediated emotional responses, mislabeling culturally normative behaviors, decreasing survivor participation, or inadvertently harming the very people we seek to assist. Cultural competence and cultural humility in disaster situations improves access to care, helps to build trust and promotes engagement and retention in care. Cultural perspectives help us differentiate between normative and maladaptive behaviors (Gil & Drewes, 2021; Harris et al., 2010).

Cultural Sensitivity

When responding to natural disasters and mass trauma incidents, play therapists have a professional and ethical responsibility to provide meaningful, strength-based, culturally and racially attuned care that is grounded in local sociocultural, structural, political, and historical contexts. Play therapists need to regard community members as valuable partners, coordinating play therapy services with local providers and organizations who live within these cultures and subcultures. Play therapists should ensure that play therapy materials and techniques are adapted to local cultural norms (Baggerly et al., 2019), thus respecting the safety, dignity and rights of individuals and communities affected by the disaster.

We should receive training in both cultural humility and cultural competency to have as much information on the cultural differences encountered in working with survivors of a disaster, including how traumatic stress reactions may manifest for a particular cultural group, and appropriate ways to intervene. Be aware of cultural differences in customs, greetings, language, local toys, socio-political issues, religion, and worldviews so you can make adaptations (Baggerly et al., 2019). Find a local leader who will orient you to these cultural issues. See if the site leader serves as or has identified a cultural broker to consult with (it may be a colleague or survivor). Always approach people with cultural humility with an attitude of learning about and honoring their culture.

Be aware of your own cultural beliefs, values and prejudices; how these may differ with those of the survivors you are servicing; and how you can avoid letting your values and beliefs interfere with providing culturally appropriate services to the survivors. Encountering unfamiliar cultural or ethnic populations whose primary language may not be English may inadvertently bring out personal biases and prejudices (Gil & Drewes, 2021; Mochi & VanFleet, 2009; Ohnogi & Drewes, 2016).

Do Not Make Assumptions

Do not make assumptions about the individuals with whom you work based on their culture, race, ethnicity, SES, gender, etc. There is a great deal of within-group behavioral variations in any cultural group. Do not assume the individual is a member of a particular cultural/ethnic group and follows or holds the generalized norms, values, or behaviors associated with that group. Focus on connecting people to existing supports, including religious and faith-based systems.

Pay attention to cultural appropriateness of physical proximity, eye contact, touch, and gestures. Do not take for granted that it is okay to address the person by their first name. Ask how they would like to be addressed.

Many ethnic or cultural groups have their own indigenous interventions that may help them deal with individual or community level trauma. Ask if you can help find a religious advisor of their faith.

Know that you do not have all the (cultural) awareness, knowledge, and skills to adequately address the needs of culturally different survivors. Give yourself permission to be “ignorant” and ask for clarification on how to assist (Gil & Drewes, 2021).

Neurodivergent and Special Needs Populations

Children with special needs, special populations, and neurodivergent individuals are particularly sensitive to separation from familiar surroundings, people and possessions, loss of familiar community providers and supports, disruption of routines, and excessive noise and confusing environments. Talk with the parent or caregiver to determine the child’s unique needs and how best to effectively interact and share information with shelter staff. Emotional reactions may become magnified, with regressive, aggressive, defiant, disruptive or withdrawal behaviors occurring. Provide assurance, support and attention as quickly as possible when responses to triggers and cues occurs and offer ways to help.

If the child’s environment has to be changed (e.g., an evacuation, the absence of a parent) try to maintain as much of the normal routine (e.g., meals, play, bedtime) as possible, even

in the new environment. Try to bring concrete elements from the child's or adult's more routine environment (e.g., a toy, blanket, dolls, eating utensils) into the new environment to maintain some degree of "sameness" or constancy (Halpern & Vermeulen, 2017; James & Gilliland, 2017; Lomas & Denina, 2018).

Things to Watch For

There may be misinterpretation of behaviors made by other survivors and staff due to lack of awareness and knowledge on how to support children with special needs. Be aware that some people with special needs may lack fear of real danger. For example, a neurodivergent child might be attracted to water nearby (from flooding, lakes, etc.) and be at risk of drowning. Be aware that sensory sensitivity issues may produce a fight or flight reaction. Your role is to remain vigilant to ensure the physical and psychological safety of the persons in your charge. In times of crisis there may be 'bad actors' who will take advantage of the disorganization, lack of supervision, etc. and do harm (abduct, abuse, etc.). This vigilance should be applied to yourself as well, so having a buddy to trust, go places in groups of three, etc. for safety purposes.

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Additional resources and references have been compiled to support professionals involved in disaster response. They include guidelines, practical tools, and additional readings to enhance preparedness, response, and recovery efforts in crisis situations. These materials are intended to serve as supplemental information to aid professionals in delivering informed, effective care during times of emergency.