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Counseling Children After Natural Disasters: Guidance for Family Therapists

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After natural disasters, most children exhibit typical symptoms, which can be mitigated when parents and teachers provide emotional support and facilitate adaptive coping strategies. However, some children may experience clinical symptoms, which require professional counseling. This article guides family therapists in (a) identifying children's typical and clinical symptoms after a natural disaster, (b) training parents and teachers in basic interventions, and (c) implementing developmentally appropriate clinical interventions that integrate play. A multimodal, three-phase approach of Cognitive Behavior Therapy, Play Therapy, and Family Play Therapy is described.

COUNSELING CHILDREN WHO HAVE SURVIVED NATURAL DISASTERS

Natural disasters are a persistent threat to families in North America. In 2005, the Federal Emergency Management Agency (FEMA, 2006) declared 48 federal disasters such as hurricanes, tornados, floods, and fires. The most prominent natural disaster of 2005, Hurricane Katrina, was identified as the costliest hurricane in United States history with over $81 billion in damage and the deadliest in 77 years with approximately 1,833 fatalities (Knabb, Rhome, & Brown, 2005). A 70% increase in U.S. major disasters has occurred in the last decade from 319 disasters between 1986 and 1995 to 545 disasters between 1996 and 2005. Unfortunately, scientists are predicting high numbers of storms in the next ten years (National Oceanic and Atmospheric Administration [NOAA], 2006). These natural disasters will cause fear and disruption in the lives of countless children and families.

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During natural disasters, children are one of the most vulnerable populations because their neuro-physiological systems are subject to permanent changes and their coping skills are not developed enough to manage catastrophic events (Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Speier, 2000). Most children exhibit typical, temporary symptoms during and after disasters; yet these symptoms can be mitigated when parents and teachers provide emotional support and facilitate adaptive coping strategies. However, some children may experience clinical symptoms, which require developmentally appropriate counseling interventions that integrate play (Baggerly, 2004b, 2004c).

Family therapists must be prepared to provide developmentally appropriate interventions to children who experience distress after natural disasters. However, the literature for family therapists on this topic is sparse. Miller (1999) described treatment for Post-Traumatic Stress Disorder (PTSD) for children and families but does not incorporate developmentally appropriate approaches of play. Wittenborn, Faber, Harvey, and Thomas (2006) discussed integrating play therapy techniques into family therapy but did not address natural disasters. The purpose of this article is to guide family therapists in (a) identifying children's typical and clinical symptoms after a natural disaster, (b) training parents and teachers in basic interventions, and (c) implementing developmentally appropriate clinical interventions that integrate play. A multimodal, tri-phase approach of Cognitive Behavior Therapy, Play Therapy, and Family Play Therapy is described.

TYPICAL SYMPTOMS OF CHILDREN AND ADOLESCENTS

Children's typical symptoms after natural disasters include fear, depression, self-blame, guilt, loss of interest in school and other activities, regressive behavior, sleep and appetite disturbance, night terrors, aggressiveness, poor concentration, and separation anxiety (Speier, 2000). However, symptoms vary from minimum to severe based on a child's developmental level, personal experiences, emotional or physical health, and the responses of parents to the incident (Vogel & Vernberg, 1993). For children 5 years old and younger, typical symptoms include separation anxiety, excessive clinging, crying, whimpering, screaming, and regressive behavior such as thumb sucking and fear of the dark (National Institute for Mental Health, [NIMH], 2001). For children 6 to 11 years old, typical symptoms include extreme withdrawal, increased fighting and aggression, hyperactivity and inattentiveness, irrational fears, irritability, sleep disruption, school refusal, complaints of stomachaches, and emotional numbing (NIMH, 2001). For adolescents 12 to 17 years old, typical symptoms include flashbacks, nightmares, emotional numbing, avoidance of reminders of the trauma, substance abuse, and depression (NIMH, 2001). They may also experience headaches, stomachaches,

risk-taking behaviors, lack of concentration, decline in responsible behavior, apathy, and rebellion at home or school.

CLINICAL SYMPTOMS OF CHILDREN AND ADOLESCENTS

Although many children will recover from these typical symptoms with basic family and school support after a natural disaster, some children experience ongoing symptoms that disrupt their daily functioning. Vernberg, LaGreca, Silverman, and Prinstein (1996) found 55% of elementary school children in their study exhibited moderate to very severe symptoms three months after Hurricane Andrew. In contrast, McDermott, Lee, and Judd (2005) found 22.6% of children in their study had abnormally high emotional symptoms six months after exposure to a wildfire disaster.

Children's clinical symptoms may result in a diagnosis of Acute Stress Disorder (ASD), Post Traumatic Stress Disorder (PTSD), other anxiety disorders, or depression disorders. Indicators of childhood PTSD include the following symptoms that persist longer than 30 days after the event: persistent re-experiencing of the event through intrusive memories, frightening dreams (with or without recognizable content), repetitive play in which themes or aspect of the disaster are expressed, increased arousal such as irritability or hypervigilance, and avoidance of things related to the disaster (American Psychiatric Association, 2000). Rates of PTSD in children after natural disasters vary. Evans and Oehler-Stinnett (2006) found 41% of children in their study who experienced a severe tornado had PTSD symptoms that meet DSM-IV-TR criteria. Vernberg et al. (1996) found 30% of children in their sample who experienced Hurricane Andrew had severe symptoms of PTSD. Conversely, Shannon, Lonigan, and Finch (1994) found 5% of 5,687 school-aged children surveyed who experienced Hurricane Hugo met criteria for PTSD.

Children's development of PTSD is influenced by the following five factors: (a) exposure to traumatic events during and after the disaster, (b) pre-existing demographic characteristics, (c) occurrence of major life stressors, (d) availability of social support, and (e) type of coping strategies used to manage disaster-related stress (Vernberg et al., 1996). These researchers also found that children's symptoms persisted due to interactions between daily life hassles and the severity of the disaster, stressful life events, e.g., parent's divorce or loss of employment, and loss of support from overburdened community systems and schools. In addition, McDermott, Lee, and Judd (2005) found that younger children and children with higher levels of exposure and threat had higher prevalence of PTSD than older children and children with lower levels of exposure and threat.

When diagnosing children, counselors should ask parents, other relatives, and teachers whether children's behaviors would be considered "normal" for a given child prior to the disaster. To assess the impact of trauma

in children, Ohen, Myers, and Collett (2002) suggest several different assessments. When a diagnosis of PTSD is the goal, they suggested the clinician-administered scales of the *Children's PTSD Inventory [CPTSDI]* (Saigh et al., 2000) or the *Clinician-Administered PTSD Scale for Children [CAPS-C]* (Nader et al., 1996). If clinician administered assessments are too time consuming, then Ohen et al. (2002) recommended the self-reported *Child PTSD Symptom Scale [CPSS]* (Foa, Johnson, Feeny, & Treadwell, 2001) for a quick first screen or the culturally sensitive *Children's PTSD-Reaction Index [CPTS-RI]* (Frederick & Pynoos, 1998) or the *Impact of Event Scale-Revised [IES-R]* (Weiss & Marmar, 1996). The *Trauma Symptom Checklist for Children – Alternative* [TSCC-A] (Briere, 1996) assesses for trauma and more general psychopathology, which provides for helpful follow along over time. For younger children, the *Angie/Andy Cartoon Trauma Scales [ACTS]* (Praver, DiGiuseppe, Pelcovitz, Mandel, & Gaines, 2000) for ages 6 to 12 or the *Pediatric Emotional Distress Scale [PEDS]* (Saylor, Swenson, Reynolds, & Taylor, 1999) for ages 2 to 10 were recommended. Since accurately diagnosing children with PTSD is very difficult due to their limited cognitive and expressive skills (Cohen, Berliner, & March, 2000), counselors are advised to provide treatment even if symptoms do not meet a formal diagnosis of PTSD.

PARENT AND TEACHER INTERVENTIONS

Due to the large number of children that will experience typical symptoms after a natural disaster, family therapists can maximize their efforts by training parents and teachers to provide supportive responses and basic interventions for their children (Harper, Harper, & Stills, 2003). In a study by Wolmer, Laor, Dedeoglu, Siev, and Yazgan (2005), children exposed to the 1999 earthquake in Turkey who received teacher led interventions had significantly higher functioning compared to a matched control group. These researchers concluded that teachers may become efficient clinical mediators due to the central role in the lives of children. Parents also play an important role in their children's recovery because children take their cues on how to respond to the disaster from their parents (FEMA, 2004a). If parents are out of control of their feelings and behavior, then children will feel more helpless and scared. If parents are appropriately upset but maintain optimism and control of their feelings and behavior, then children will feel more secure. Therefore, it is important to teach parents and teachers how to maintain a non-anxious presence by enacting self-soothing strategies such as relaxing their body (Rank & Gentry, 2003).

Family therapists should help parents and teachers focus on maximizing children's protective factors of good communication skills, strong self-efficacy, and positive coping skills (Vernberg et al., 1996). To maximize good communication skills, encourage parents and teachers to schedule

regular times to talk with their children about their emotions, concerns, and plans for the future. Since young children may not be able to verbalize their feelings, other communicative modes, e.g., playing, drawing, or singing, may be more effective (Webb, 2004). Coloring books and free flow drawings are also useful ways for children to express themselves (Corder and Haizlip, 1996). A hurricane coloring book that helps children express their own story, feelings, thoughts, and behaviors is available on the web at http://www.state.sc.us/dmh/schoolbased/hurricane.htm . A parent and child coping workbook, entitled *After the Storm* (La Greca, Sevin, & Sevin, 2005), also offers playful activities.

To maximize children's sense of self-efficacy, parents and teachers should reassure children that symptoms of nightmares, crying, etc. are typical and usually temporary. Providing a handout of typical children's cognitive, emotional, physiological, behavioral, and spiritual symptoms will help parents and teachers focus on the normalcy of children's responses, rather than seeing them as pathological. (Please see Figure 1). Children's self-efficacy can also be enhanced by quickly re-establishing a routine that is stable and manageable (FEMA, 2004a). During the early phases of a natural disaster the normal rules, expectations, and responsibilities at home and at school are usually relaxed (Haizlip, 1999). However, parents and teachers should remember that they do need to reestablish normal structure as much as possible. For example, parents could re-establish routines of reading bedtime stories or saying nightly prayers to comfort and reassure their children. Teachers can resume regular classroom routines of readings, projects, and limited homework. In addition, parents and teachers can promote children's self-efficacy by encouraging them to participate in social and school activities as well as community rebuilding activities.

Parents and teachers should help children identify or learn positive cognitive, emotional, physiological, behavioral, and spiritual coping strategies that fit their unique coping style (Please see Figure 2). Felix, Bond, and Shelby (2006) recommend playing a game of "Go Fishing for Coping Skills" in which children discern adaptive from maladaptive coping skills by matching categories of cards with adaptive coping skills and discarding maladaptive coping skills. For teenagers, positive coping strategies will include group interventions that process emotions through expressive arts, drama, and rapping/singing. Teens can also write letters to encourage survivors, first responders, and political leaders and participate in recovery efforts such as cleaning a park or reading to younger children.

Disturbing Dreams

Counselors may need to train parents and teachers how to respond to their children's disturbing nightmares related to the natural disaster. Younger children's dreams related to the distressing event may change into generalized

Thoughts	**Feelings**
Confused Can't think Can't remember Mean thoughts Scary thoughts Always thinking about it Always remembering what happened Always looking around 	Scared Sad Mad Don't feel anything Crying Guilty Embarrassed Don't want to feel Really, really angry Too much all at once 
Things We Do	**Body and Brain**
Sit alone Always looking around Can't trust anyone Yelling Hitting Fighting Crying Can't do homework anymore Not hungry or always hungry Can't sleep or always sleep Clumsy Can't sit still	Staring off in the distance Stomachache Headache Dizzy Sweaty for no reason Cold for no reason Jumpy Nightmares
God	
Think God left Confused with God	Mad at God Don't want to pray, sing, or go to church

Developed by Jennifer Baggerly, 2004; Adapted from Jim Norman, 2001.

FIGURE 1 Normal things that happen to normal kids after something scary.

nightmares of monsters or of rescuing others. Children in middle to late childhood are more likely to experience sleep disturbances as they begin to understand the finality of loss (NIMH, 2001).

To help children effectively process disturbing dreams, parents and teachers can learn Dahlen's (1999) Traumatic Dream Defusing Process (TDDP) of creating a safe sleeping environment and giving voice to specific details, feelings, and thoughts from the dreams. Parents and teachers help children defuse the strength of the dream and regain sense of control by helping them record the dream in a journal. For younger children, parents and teachers encourage children to draw or color their dreams and then bury them in a structured ceremony. This symbolic burial gives children the power to bring an end to the significance of the dreams. Another method is

<table>
<tr>
<td><u>Thoughts</u>
Write things down
Decide to do one thing at a time
Ask for help
Think about what you need
Think of a plan
Ask questions
Think of a nice place to be
Think of nice people
Yell stop when you have bad thoughts
  </td>
<td><u>Feelings</u>
It is O.K. to cry
It is O.K. to feel angry
Say what you feel
Talk about your feelings to your family and friends
Laugh
Remember happy feelings
  </td>
</tr>
<tr>
<td><u>Things We Do</u>
Play with others
Cuddle with family
Help others
Ask for help
Have fun
Relax, relax, relax
Go outside
Read books
Sing and dance</td>
<td><u>Body and Brain</u>
Run and jump
Ride bike
Don't eat to many sweets
Drink water
Take deep breathes
Blow bubbles
Tense like a tin man, relax like a rag doll</td>
</tr>
<tr>
<td colspan="2"><u>God</u>
Pray Read spiritual books
Sing Go to church or synagogue or mosque
Talk to your parents and priest, minister, or Rabbi about God</td>
</tr>
</table>

Developed by Jennifer Baggerly, 2004; Adapted from Jim Norman, 2001.

FIGURE 2 Things you can do to feel better.

to ask children to blow their fearful dreams into a balloon and then release the inflated balloon. This activity helps children feel more in control as they see their dreams disappear.

COUNSELING INTERVENTIONS

For children who experience typical symptoms after a natural disaster, family counselors should provide parent and teacher consultation as described above along with supportive counseling, crisis intervention, and resources and referrals to meet basic needs (Harper et al., 2003). However, if children continue to experience persistent symptoms that disrupt their functioning weeks after the natural disaster is over, then more intensive counseling is warranted. Herman (1997) recommends a three phase trauma recovery approach of (a) establishing safety, (b) retelling the trauma story, and (c) reconnecting

with others. When working with children after natural disasters, we recommend applying Herman's approach via a multimodal three-phase approach as follows: (a) establish safety and manage symptoms through Cognitive Behavior Therapy, (b) facilitate the child's retelling of their trauma story through play therapy, and (c) reconnect the child with others through family play therapy.

Cognitive Behavioral Therapy

Cognitive Behavior Therapy (CBT) has been proven to decrease children's symptoms related to ASD, PTSD, other anxiety disorders, and depression (Cohen et al., 2000; Compton et al., 2004). When working with children after natural disasters, CBT procedures that incorporate play therapy techniques can be used to establish safety and manage symptoms (Knell, 2000; Shelby, 2000). To increase children's sense of safety, family therapists should create a child friendly environment by providing toys. In addition to inviting children to play with the toys, family therapists can ask children to (a) play a game of identifying indicators that they are safe at the present time, (b) draw a picture of a safe place, and (c) develop a safety plan for future disasters.

To manage hyper-arousal symptoms, family therapists can teach children self-soothing relaxation techniques to calm their bodies and deactivate their "fight or flight response" (Perry et al., 1995). These procedures include (a) taking deep breathes through playful activities such as blowing soap bubbles or pinwheels; (b) progressive muscle relaxation by tensing muscle groups like a toy soldier and relaxing like a rag doll; and (c) focusing on positive images by drawing happy places, engaging in mutual story telling with a positive ending, or meditating on peaceful places (Baggerly, in press).

Family therapists should teach children methods of managing intrusive thoughts of disaster related events that are encoded in their implicit memory (Perry et al., 1995). These procedures include (a) "changing the tape" by replacing negative thoughts with a predetermined positive song, story, or saying such as "I'm safe right now and I know it because I have . . ." and (b) grounding activities such as rubbing stomach and hands together (Shelby, Bond, Hall, & Hsu, 2004). Family therapists can also amend Baranowsky, Gentry, and Schultz's (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.

To help children manage avoidance of disaster related stimuli, family therapists should implement systematic desensitization procedures of pairing relaxation with a step-by-step hierarchy of exposure to the stimuli (Wolpe, 1969). For example, a child may be afraid to take a bath after a hurricane because of the association that occurred when the family sought shelter in

the bathtub during the hurricane. The family counselor should teach the child to relax and then ask him to wipe his face with a wet wash clothe, gradually progressing to washing in a sink, then near the tub, etc. (Baggerly, Green, Thorn, & Steele, in press). Parents will need to be involved with these procedures and provide positive reinforcements for each accomplished step.

Due to their egocentric and concrete cognitions, some children may misattribute the cause of natural disasters to their bad dreams or someone's bad behavior. Family therapists should identify their misattributions and give accurate information. Procedures to correct misattributions include (a) making a Q-sort of possible reasons for the disaster and asking children to sort them as true or 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). Many of the play-based procedures described above are demonstrated in a video by Baggerly (2006) available at http://www.emicrotraining.com/child.html#038

Play Therapy

After helping children establish a sense of safety and manage symptoms, family therapists should help children retell their trauma story. Since children ages two to ten years old are still in the cognitive developmental stage of pre-operations or concrete operations, the most developmentally appropriate way for young children to communicate their trauma story is through play (Kottman, 2001; Landreth, 2002). Landreth stated "Play is the child's symbolic language of self-expression. . . . Play is children's way of working out balance and control in their lives . . . that is essential to children's emotional development and positive mental health" (Landreth, 2002, p. 18).

Children often repeatedly reenact a specific traumatic event in their play in an attempt to create a concrete narrative of traumatic events so they can master frightening images (Baggerly, 2005c; Terr, 1990). For example, a 5-year-old boy who experienced Hurricane Katrina named a toy dinosaur "the sea monster." He spun the sea monster in circles and repeatedly knocked down the doll family and furniture in the doll house. Later, he used the army men to kill the sea monster. Clearly, the boy was re-enacting his hurricane experience in order to gain mastery of a scary situation.

Play therapy helps children process their trauma narrative, aids in resolving symptoms, builds resiliency, and resumes the process of normal development (Gil, 1991; Shelby, 2000). During play therapy, the family counselor should provide selected toys such as bendable doll families, zoo animals, rescue vehicles, medical kits, etc., as recommended by Landreth (2002), so children can express their trauma narrative through play. While children are

playing, family therapists should provide therapeutic responses of reflecting content and feelings, facilitating decision making, encouraging, enlarging the meaning, and facilitating accurate understanding (Baggerly, 2005c; Landreth, 2002). These play therapy procedures are demonstrated in a video by Baggerly (2005a) available at http://www.emicrotraining.com/playtherapy.html. After each play session, consult with parent and provide them helpful responses to their child's concerns. If the child wants to play out their resolved trauma story for their parents, instruct the parents to reflect their child's feelings and strengths and provide reassurance of their support.

There is a long history of using play therapy to treat traumatized children, beginning with Anna Freud's work with children after London was bombed in World War II (Freud & Burlingham, 1943). The effectiveness of play therapy was revealed in Bratton and Ray's (2000) comprehensive literature review of 82 play therapy research studies and a meta-analysis of 94 play therapy outcome research studies, which showed a large positive effect of .80 on treatment outcomes (Ray, Bratton, Rhine, & Jones, 2001). Recently, Shen's (2002) research with Chinese children who experienced earthquake related trauma symptoms revealed that children who received 10 sessions of child-centered play therapy had significantly lower anxiety and suicide risks than did control group children. Given these positive results of play therapy and its unique developmentally appropriate approach, family therapists are encouraged to obtain play therapy training. Play therapy training information is available at www.a4pt.org and www.cpt.coe.unt.edu.

Family Play Therapy

The final phase in trauma recovery is reconnecting children with others. To accomplish this, family therapists can integrate play into family therapy so that parents can enter their children's world and develop emotional connectedness (Gil, 1994; Wittenborn et al., 2006). "Play techniques can engage parents and children in enhanced communication, understanding, and emotional relatedness" (Gil, 1994, p. 42). Play in family therapy can also help children and parents make sense of their lived traumatic experience, solve problems, and build resilience as a family unit.

These goals can be facilitated through family play activities that utilize a variety of mediums. If a sand tray and numerous miniatures are available, ask the family to use these to create their world before the disaster, after the disaster, and how they hope it will be in the future. Afterwards, the family counselor should ask each family member to share their thoughts and contributions to their sand tray world (Carey, 1999). If puppets are available, ask each family member to choose and name two puppets. Then ask the family to make up a story that has a beginning, middle, and an end. Afterwards, the family counselor should interview each puppet to process feelings, perceptions, strengths, and problem solving strategies (Gil, 1994).

Family art activities accomplish the above described goals in a medium that is available to most family therapists (Gil, 1994). Provide three large, poster-size pieces of paper, crayons, and markers and ask families to make a mural of their life before the natural disaster, afterwards, and in the future. Family members can enhance the murals by pasting images from magazines, if available. After the mural is complete, lead the family in processing feelings, perceptions, strengths, and problem solving strategies. Another art activity is to provide one large piece of paper and ask each family member to draw a special place where they would like to live (DeTrude, 2003). Ask them not to talk until everyone is finished. Then ask each family member to describe the sights, sounds, and smells of their special place. Finally, ask family members to make one positive comment about each person in the family. This activity helps families focus on hopes and dreams, giving them a sense that there is life after a disaster.

CONCLUSION

Recognizing children and adolescents' typical and clinical traumatic stress symptoms after natural disasters will guide family therapists in providing needed therapeutic interventions. Since most of the recovery takes place at home and at school, family therapists must teach parents and teachers to understand symptoms and intervene with reassurance of normalcy, extra attention and nurturance, re-establishing routine, open communication, and facilitating adaptive coping strategies. If children experience clinical symptoms, family therapists are encouraged to follow the model of (a) establishing safety and managing symptoms through Cognitive Behavior Therapy, (b) facilitating the child's retelling of the trauma story through play therapy, and (c) reconnecting the child with others through family play therapy. In doing so, counselor will help children, families, and communities develop resilience after natural disasters.

REFERENCES

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th Ed. Text Revision)*. Washington, DC: Author.

Baggerly, J. (in press). International interventions and challenges following the crisis of natural disasters. In N. Boyd Webb's *Play Therapy with Children in Crisis* (3rd ed). New York: Guilford Publications

Baggerly, J., Green, C., Thorn, A., & Steele, W. (in press). He blew our house down: Natural Disaster and Trauma. In S. Hobson's *Critical Incidents in Counseling Children*. Alexandria, VA: American Counseling Association Press.

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

Baggerly, J. N. (2005a). *Play therapy: Bouncing into the Basics* (Video). Framingham, MA: Microtraining Associates.

Baggerly, J. N. (2005b). 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* (pp. 93–96). Alexandria, VA: American Counseling Association.

Baggerly, J. N. (2005c). 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* (pp. 97–102). Alexandria, VA: American Counseling Association.

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

Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal Play therapy, 9*, 47–88.

Briere, J. (1996). *Trauma Symptom Checklist for Children*. Odessa, FL: Psychological Assessment Resources.

Carey, L. (1999). *Sandplay therapy with children and families*. Northvale, NJ: Jason Aronson Inc.

Cohen, J. A., Berliner, L., & March, J. S. (2000). *Treatment of children and adolescents*. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective Treatments for PTSD* (pp. 106–138). New York: Guilford Press.

Compton, S. N., March, J. S., Brent, D., Albano, A. M., Weersing, V. K., & Curry, J. (2004). Cognitive-behavioral psychotherapy for anxiety and depressive disorders in children and adolescents: An evidence-based medicine review. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(8), 930–959.

Corder, B., & Haizlip, T. (1996) *A coloring book after the hurricane for children and their parents or helpers*. Raleigh, NC: NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; and the Department of Public Instruction.

Dahlen, P. (1999). Follow-up of counseling after disaster: Working with traumatic dreams toward healing. *Traumatology, 5*, 18–30.

DeTrude, J. A. (2003). The family art project. In H. Kaduson & C. Schaefer (Eds.), *101 Favorite Play Therapy Techniques. Volume III*. Northvale, NJ: Jason Aronson Inc.

Evans, L. G., & Oehler-Stinnett, J. (2006). Structure and prevalence of PTSD symptomology in children who have experienced a severe tornado. *Psychology in the Schools, 43*(3), 283–295.

Federal Emergency Management Agency. (2004a). *Helping children cope with disaster*. Retrieved November 2, 2004, from http://www.fema.gov/rrr/children.shtm

Federal Emergency Management Agency. (2006). *Federal Declared Disasters*. Retrieved August 15, 2006, from http://www.fema.gov/news/disaster_totals_ annual.fema

Felix, E., Bond, D., & Shelby, J. (2006). Coping with disaster: Psychosocial interventions for children in international disaster relief. In C. Schaefer & H. Kaduson (Eds.), *Contemporary Play Therapy: Theory, Research, and Practice* (pp. 307–329). New York: The Guilford Press.

Foa, E. B., Johnson K. M., Feeny, N. C., & Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*, 376–384.

Frederick, C. J. & Pynoos, R. S. (1998). *The Child Post-traumatic Stress Disorder (PTSD) Reaction Index*. Los Angeles: University of California.

Freud, A., & Burlingham, D. (1943). *War and Children*. New York: Medical War Books.

Gil, E. (1994). *Play in family therapy*. New York: Guilford Press.

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

Haizlip, T. (1999, October). *Dealing with the emotional aftermath of a disaster: Helping the helpers and the victims*. Presentation. East Carolina University School of Medicine, Brody Medical Sciences Building, Greenville, North Carolina.

Harper, F. D., Harper, J. A., & Stills, A. B. (2003). Counseling children in crisis based on Maslow's hierarchy of basic needs. *International Journal for the Advancement of Counseling, 25*(1), 10–25.

Herman, J. (1997). *Trauma and recovery*. New York: Basic Books.

Knabb, R. D., Rhome, J. R., & Brown, D. P. (2005*). Tropical Cyclone Report Hurricane Katrina, 23–30 August 2005*. National Hurricane Center. Retrieved August 15, 2006, from http://www.nhc.noaa.gov/pdf/TCR-AL122005_Katrina.pdf

Knell, S. (2000). Cognitive-behavioral play therapy for childhood fears and phobias. In H. G. Kaduson & C. E. Schaefer's (Eds.), *Short-term play therapy for children* (pp. 3–27). New York: The Guilford Press.

Kottman, T. (2001). *Play therapy: Basics and beyond*. Alexandria, VA: American Counseling Association.

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

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.

McDermott, B. M., Lee, E. M., & Judd, M. (2005). Posttraumatic stress disorder and general psychopathology in children and adolescents following a wildfire disaster. *Canadian Journal of Psychiatry, 50*(3), 137–143.

Miller, L. (1999). Treating posttraumatic stress disorder in children and families: Basic principles and clinical applications. *American Journal of Family Therapy, 27*(1), 21–34.

Nader, K., Kriegler, J. A., Blake, D. D., Pynoos, R. S., Newman, E., & Weather, F. W. (1996). *Clinician Administered PTSD Scale, Child and Adolescent Version*. White River Junction, VT: National Center for PTSD.

National Institute of Mental Health. (2001). *Helping children and adolescents cope with violence and disasters*. Bethesda, MD: Author. Retrieved August 22, 2006 from http://www.nimh.nih.gov/publicat/violence.cfm

National Oceanic and Atmospheric Administration. (2006). *NOAA continues to predict above-normal hurricane season*. Retrieved August 15, 2006, from http://www.noaanews.noaa.gov/stories2006/s2678.htm

Norman, J. (2001). The brain, the bucket, and the schwoop. In E. Gentry's (Ed.), *Traumatology 1001: Field traumatology training manual* (pp. 34–37). Tampa, FL: International Traumatology Institute.

Ohen, J. L., Myers, K., & Collett, B. R. (2002). Ten-year review of rating scales. IV: Scales assessing trauma and its effects. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(12), 1401–1422.

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.

Praver, F., DiGiuseppe, R., Pelcovitz, D., Mandel, F. S., & Gaines, R. (2000). A preliminary study of a cartoon measure for children's reactions to chronic trauma. *Child Maltreatment, 5*, 273–286.

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.

Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy, 10*(1), 85–108.

Saigh, P., Yaski, A. E., Oberfield, R. A., Green, B. L., Halamandaris, Ph. V., Rubenstein, H. et al. (2000). The Children's PTSD Inventory: Development and reliability. *Journal of Traumatic Stress, 30*, 369–380.

Saylor, C. F., Swenson, C. C., Reynolds, S. S., & Taylor, M. (1999). The Pediatric Emotional Distress Scale: A brief screening measure for young children exposed to traumatic events. *Journal of Clinical Child Psychology, 28*, 70–81.

Shannon, M. P., Lonigan, C. J., & Finch, A. J. (1994). Children exposed to disaster: I. Epidemiology of post-traumatic symptoms and symptom profiles. *Journal of the American Academy of Child & Adolescent Psychiatry, 33*, 80–93.

Shelby, J. S. (2000). Brief therapy with traumatized children: A developmental perspective. In H. G. Kaduson & C. E. Schaefer (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*. Los Angeles: Authors.

Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression, and adjustment. *International Journal of Play Therapy, 11*, 43–63.

Speier, A. H. (2000). Disaster Relief and Crisis Counseling. *Psychosocial Issues for Children and Adolescents in Disasters*. Rockville, MD: Center for Mental Health Services.

Terr, L. (1990). *Too scared to cry: Psychic trauma in childhood*. New York: Harper & Row.

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.

Webb, N. B. (Ed.) (2004). *Mass trauma and violence. Helping families and children cope*. New York: Guilford Press.

Weiss, D. S., & Marmar, C. R. (1996). The Impact of Events Scale-Revised. In J. Wilson & T.M. Keane (Eds.), *Assessing Psychological Trauma and PTSD* (pp. 399–411). New York: Guilford.

Wittenborn, A. K., Faber, A. J., Harvey, A. M., & Thomas, V. K. (2006). Emotionally focused family therapy and play therapy techniques. *American Journal of Family Therapy, 34*(4), 333–342.

Wolpe, J. (1969). *The practice of behavior therapy*. New York: Pergamon Press.

Wolmer, L., Laor, N., Dedeoglu, C., Siev, J., & Yazgan, Y. (2005). Teacher-mediated intervention after disaster: A controlled three-year follow-up of children's functioning. *Journal of Child Psychology and Psychiatry, 46*, 1161–1168.