Practice Challenges in Using Psychological First Aid in a Group Format with Children: A Pilot Study

Carol A. Plummer, PhD
Daphne S. Cain, PhD
Rakinzie M. Fisher, MSW
Toni Q. Bankston, MSW

Using pilot data and practice experiences, this paper reports on an attempt at a controlled postdisaster intervention. The authors discuss use of Psychological First Aid (PFA) with children in a group format, focusing on the challenges inherent in responding to distress subsequent to a hurricane disaster. Difficulties in providing services in a timely manner are explored, and the value of PFA, even months and years after experiencing a natural disaster, is discussed. The pilot study included 27 African-American children aged 6–15 years, but due mostly to mobility, only 12 completed the entire set of six sessions and were included in the analysis. The small sample that resulted did not show positive gains with respect to reduction in trauma symptomatology but did show positive results in terms of participant satisfaction. Challenges in providing timely and relevant services included access to children, timing difficulties, multiple and ongoing sources of stress, and developmental considerations. Lessons learned are provided for others providing postdisaster services with children, as well as suggestions for subsequent research. [Brief Treatment and Crisis Intervention 8:313–326 (2009)]

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Service providers following disaster events seek the best approaches to help people who have been harmed. Although postdisaster reactions or behaviors may appear to be symptoms of psychopathology, in fact, normal reactions in a crisis state may include shock, exhaustion, disorientation, irrationality, uncontrollable emotions, and racing thoughts (Garvin & Seabury, 1997; National Child Traumatic Stress Network and National Center for PTSD, 2006). Thankfully, most people recover from the effects of disaster with little or no formal psychological intervention (Norris et al., 2002). Other people may initially appear to have no special needs only to develop symptoms later as they realize the full impact of the loss and pain (van der Kolk, 1996; Wilson, Raphael, Meldrum, & Bedosky, 2000).
Matching disaster survivors’ needs with appropriate and effective services continues to be a major challenge to responders. Because a goal of recovery is to draw on strengths and coping mechanisms so that victims can recover and move forward in their lives (Bussey & Wise, 2007), clarity regarding individual needs and matching needs to services has become centrally important in disaster work.

The literature on disaster work demonstrates a widespread recognition that specific groups are particularly vulnerable to experiencing disaster-related adverse reactions (Wisner, Wisner, Piers, & Cannon, 2003). Children are one high-risk group (National Child Traumatic Stress Network and National Center for PTSD, 2006; Norris et al., 2002). Children have intense and sometimes unrealistic fears, may lose their routines as well as objects of comfort, develop sleep problems, and be separated from familiar people (Vogel & Vernberg, 1993). Moreover, as adults address children’s physical needs, the treatment of psychological needs may be indefinitely deferred. Indeed, these needs may even be entirely ignored so as not to retraumatize already vulnerable children (Norris et al., 2002). Because children often lack options and choices, they may feel particularly out of control during and after a crisis event, and children may lack the ability to articulate their distress and to seek help independently (LaGreca, Silverman, Vernberg, & Roberts, 2002).

Currently, approximately 66.5 million children are affected by disaster every year (Penrose & Takaki, 2006). Immediately following a crisis, there is both a sincere concern for the well-being of children and confusion as to how best to respond to them. Children are “supposed” to be protected: they are given few choices and may be descended upon by many strangers—including professionals unknown to the children—or, conversely, ignored by overwhelmed adults. Additionally, erroneous assumptions may include the idea that children are not impacted significantly or that they will “bounce back” readily (Norris et al., 2002).

This article reports on use of a Psychological First Aid (PFA) model with children following their experience of hurricane Katrina in a gulf coast community. It describes the theoretical and practical aspects of the use of the program and reports the results of a pilot study. The facilitators’ and researchers’ experience implementing this program—including the challenges in its use with children in the aftermath of disaster—is explored. Finally, recommendations and conclusions are provided.

Postdisaster Interventions

Different populations may need different responses applied at different times during response and recovery (Kaul & Welzant, 2005). Although the roles of mental health (MH) professionals subsequent to disaster are growing in importance (Keane & Piwowarczyk, 2006), it is not easy to determine who should deliver what kind of support or services to whom and at what time after disaster. In fact, it may seem absurd to address psychological issues when lives are still threatened. Indeed, even after the immediate crisis, survival needs may demand the highest priority (Reyes, 2006). However, research shows that psychological support is also crucial during and after a disaster (Vernberg & Vogel, 1993). In fact, these needs are widespread and serious enough to lead some to advocate the training of non-MH professionals to provide basic crisis-oriented services, like PFA, and to leave more acute or severe service delivery to professionally trained MH clinicians (Parker, Everly, Barnett, & Links, 2006).

Several models for intervention have been proposed and utilized, both for children and adults. Crisis intervention is one well-acknowledged approach to working with people immediately postdisaster (Garvin & Seabury, 1997). Crisis
debriefing (CD), also referred to as Critical Incident Stress Debriefing, has also been used for postdisaster services, particularly in areas where many people have needed services after the shared experiences of disaster (Mitchell, 1983). More recently, a recommended form of postdisaster relief has been the use of “PFA,” an approach that combines the best of prior approaches and attempts to eliminate their adverse components (Everly & Flynn, 2005).

Crisis intervention has five basic steps: offer hope, promote catharsis (allow emotional expression), stay event focused, reconnect with support systems, and reactivate client coping mechanisms (Garvin & Seabury, 1997). Crisis intervention as a method expects a very active role for the social service/MH professional because in the aftermath of a severe crisis, people may literally be unable to “think straight” (Turner, 1996). Those intervening work quickly to ensure physical safety and that other basic needs are attended to, such as hunger, or being wet or cold (Turner, 1996). People are also assessed for the level of their distress, support/family resources that may be accessed, and often given small directive tasks to start to reclaim some agency in a life that may feel out-of-control (Turner, 1996). This intervention has been used most extensively with potentially suicidal clients, where listening, empathy, and being directive is critical (Sommers-Flanagan & Sommers-Flanagan, 1999).

In the recent past, CD was a preferred form of group intervention when a shared disaster affected large numbers of people (Gard & Ruzek, 2006). Using this method, people revisit and discuss their experiences explicitly. However, a variety of concerns have been raised about this method, most specifically its potential for retraumatizing the victims (McNally, Bryant, & Ehlers, 2003). It is now believed that discussing one’s own trauma in detail and listening to stories of others who were traumatized may create more problems than it solves for some individuals (McNally et al., 2003). Raphael (2003) suggests that postdisaster services need the following components: assuring safety, security, and survival and providing shelter. He asserts that debriefing may not be effective as a one-on-one early intervention and argues those at highest risk need more specialized counseling.

PFA, supported by disaster MH experts as the “acute intervention of choice” when responding to individuals affected by disaster (National Child Traumatic Stress Network and National Center for PTSD, 2006, p. 1), is an alternative form of early intervention aimed at reducing initial distress and fostering adaptive functioning in both the short and long term (National Child Traumatic Stress Network and National Center for PTSD, 2006). Using this framework, the informal delivery of support must fit seamlessly into the provision of basic services (medical, nutritional, educational, etc.), must not conflict with the priorities of service organizations, must consider the cultural values of the beneficiaries, and be grounded in community-based psychosocial supports (Reyes, 2006). PFA is comprised of eight core actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connecting with social supports, informing about coping, and linkages with collaborative services (Gard & Ruzek, 2006). This psychoeducational service is utilized to assess needs and coping skills quickly so as to help identify individuals at risk and needing more resources. The aim is to bolster the coping of participants and to refer those who need more substantial treatment. Most studies show that there is no justification for PFA to be delayed until weeks after a disaster happens and that there is an urgent need to have more evidence-based PFA interventions (Yule, 2006). The relative lack of research on the value of PFA (McNally et al., 2003; Nagae & Kim, 2005; National Child Traumatic Stress Network and National Center for PTSD, 2006) prompted this pilot study.
PFA after Hurricane Katrina

PFA has been adapted from prior work with disaster victims, borrowing from other theories and techniques (Leach, 1995; McNally et al., 2003; Vernberg & Vogel, 1993). Some development of these constructs came from debriefing survivors of life-threatening situations (Leach, 1995). The behaviors of those who coped well were compared with those who did not and distilled into principles for PFA (Leach, 1995). This model describes three phases of coping: period of impact, period of recoil, and period of posttrauma (Leach, 1995). The goal of this intervention is to return participants to functional behavior as quickly as possible (Leach, 1995).

Generally, PFA, like other crisis responses, aims to provide intervention in the immediate aftermath or at least within the first weeks, following the disaster event (National Child Traumatic Stress Network and National Center for PTSD, 2006). Yet, the fact that services often cannot reach all those in need in such a short time raises questions of PFA’s feasibility and usefulness after those first weeks have passed. Vernberg and Vogel (1993) note “long-term adaptation phase interventions”—those interventions designed for three or more months postdisaster. These include individual psychotherapy, behavioral and cognitive-behavioral approaches, family therapy, and memorials, rituals, and gathering of survivors (Vernberg & Vogel, 1993). Moreover, Vernberg and Vogel state that children may have persistent adjustment difficulties for months or even years subsequent to disaster and long-term interventions may be warranted (1993).

What is clear is that in the case of hurricane Katrina, where many did not receive any immediate services, PFA may continue to be appropriate due to the ongoing nature of the event. As many noted on the second and third anniversaries of hurricane Katrina, there was a natural disaster, then flooding due to manmade errors and miscalculations, and then years of inadequate response and betrayal of the people most harmed by agencies and government at all levels (Bohrer, 2008; CBS News, 2007). In fact, it could be argued that many remain in the “disaster impact phase” because they have not seen the end of the disaster nor been able to return home or to their normal life.

PFA: Groups Format with Children

Johnstone (2007) suggests that group intervention is a valuable way to present PFA. Indeed, groups can have an immediate positive impact and lasting consequences in reducing the degree of posttraumatic stress disorder (PTSD) symptomatology (Foy et al., 2000). Johnstone (2007) recommends that PFA groups be present centered, include acute debriefing, be supportive, and use principles of both cognitive behavioral and psychodynamic approaches.

Although the rationale for group interventions with adults has been established (Everly, Phillips, Kane, & Feldman, 2006), little has been published regarding group use of PFA with children (McNally et al., 2003; National Child Traumatic Stress Network and National Center for PTSD, 2006). The field lacks information on its process, unique problems, and efficacy. Clearly, there are times that a group setting is preferable for children and youth primarily for practical reasons given the fact that many more children can be reached with this method using less expenditure of time and money. Moreover, there are also clear theoretical and experiential justifications for a group approach: these include shared experience, normalization of reactions, helping others as a way of empowerment, and mutual support (Johnstone, 2007).

Pillay (2005) defines PFA for children more specifically as providing psychosocial care by listening and being supportive and taking
care to not be probing or intrusive. Pillay also suggests that having survivors take on active roles, and the use of spirituality may be beneficial. However, little is actually known about the use of PFA with children, especially in a group context, and particularly, when PFA services were provided later than in the immediate crisis period. Although little is written about actual group PFA approaches, recommendations and guidelines for its implementation have been developed (National Child Traumatic Stress Network and National Center for PTSD, 2006). Key components for PFA include engagement and stabilization, providing needed information, providing comfort and support, promotion of MH and self-care, reinforcement of positive coping skills, and providing resources for deciding if additional help is necessary and where it can be accessed (National Child Traumatic Stress Network and National Center for PTSD, 2006). Although few details on children’s group PFA are published, it is recommended that four standards be met in providing PFA: (a) Be consistent with research evidence on risk and resilience following trauma; (b) be applicable and practical in field settings; (c) be developmentally appropriate; and (d) be culturally informed and flexible (National Child Traumatic Stress Network and National Center for PTSD, 2006).

Hurricane Katrina and Relocation

Just before hurricane Katrina made landfall, August 28, 2005, New Orleans Mayor Ray Nagin ordered the first-ever mandatory evacuation of New Orleans (Katrina Heads for New Orleans, 2005). It has been estimated that the majority of New Orleans residents (approximately 80%) were able to evacuate (Brown, 2005). For those who were not fortunate enough to leave, the government established several “refuges of last resort,” including the Louisiana Superdome that sheltered approximately 26,000 individuals for several days following the storm (26,000 Shelter at Superdome, 2005). Within days, the storm surge caused several breaches in the levees protecting the city leaving approximately 80% of the city underwater (Knabb, Rhome, & Brown, 2006; Murphy, 2005). The rushing water destroyed nearly 100,000 homes (Meitrod, 2005) and countless businesses.

Following Katrina, residents of New Orleans and the southern Gulf Coast were redistributed across the country. The most significant evacuations were to Houston, TX (approximately 35,000 people), Mobile, AL (24,000 people), and Baton Rouge, LA (15,000 people) (Knabb et al., 2006). In response, area shelters, food banks, universities, and churches (Cain & Barthlemy, 2008) began to fill auditoriums, halls, dining areas, and sanctuaries with physically, mentally, and spiritually exhausted individuals. The multiple traumas associated with the initial hurricane, the levee breaches and flooding, the evacuation process, and prolonged relocation called for immediate and long-term MH care.

Weathering the Storm PFA Groups for Children

In January 2006, Weathering the Storm (WTS) PFA groups were launched in Baton Rouge, LA.
The WTS PFA groups were developed using guidelines found on the United States Department of Veterans Affairs (n.d.), National Center for Posttraumatic Stress Disorder, PTSD Information Center (http://www.ncptsd.va.gov/ncmain/information/). Originally, the university approved a pilot study of up to 60 middle school-aged children (fourth—sixth grades) displaced by hurricane Katrina. A middle school in the area was interested in the services and the researchers planned to conduct a classic experimental design (pretest—posttest control group design) over the course of 1 year.

All middle school-aged children displaced by hurricane Katrina at the identified school were given a letter of invitation and consent forms to take home to caregivers. Researchers planned to accept the first 60 children with completed consent to participate in the study, with 30 children randomly placed in the intervention group and 30 randomly selected for the control group (i.e., a wait list for the WTS PFA groups). Children in both the intervention and control conditions were to be pretested using a researcher-created educational/skills measure, a response/coping style questionnaire (How I Cope With Things That Happen, n.d.), and the reaction index, a questionnaire that was based on the PTSD reaction index for children (Frederick, Pynoos, & Nader, 1992) and that was customized with permission to be specific to hurricane disaster.

Primary caregivers in both the intervention and control conditions were to be pretested using a researcher-created educational/skills measure, a response/coping style questionnaire, a symptom-level questionnaire, and two measures rating children’s symptom levels and coping abilities. Additionally, caregivers would be asked to complete a demographic questionnaire.

Middle school-aged children in the intervention condition were to receive the WTS PFA groups in their school for 6 weeks. One week following the completion of the first round of intervention, children and caregivers in both conditions (intervention and control) would be posttested using the same measures as pretest, excluding the demographics form. One week following posttest, children and caregivers in the control condition would receive the intervention. These participants were to be posttested 1 week after the 6-week intervention using the same measures as pretest and posttest 1.

Two licensed clinical social workers were hired to conduct the psychoeducational PFA children’s groups in the school. Procedures were arranged so that if any child or caregiver needed or requested additional or more thorough MH services, those individuals would be referred to the school counselors and MH partners in the health care center within the school.

The Necessity for Change: The Program as Implemented

The initial protocol was not feasible, mostly due to disaster-related reasons. With few caregivers providing consent for PFA groups for their children (perhaps due to the overwhelming nature of their life circumstances and the volume of paperwork they were required to complete), in August, 2006, the researchers eliminated the control condition and random assignment in order to serve children as they were identified. The target age range was expanded to all elementary school-aged children to increase sample size and to expedite services. Additionally, PFA groups were opened up to children who were having disaster-related emotional and behavior reactions but who had not been evacuated from New Orleans (i.e., children originally from the Baton Rouge area). And, data requested of caregivers were reduced as part of an effort to streamline the process and increase caregiver compliance.
The Intervention

**WTS: A PFA Intervention**

Elementary and middle school-aged children (aged 5–12 years) affected by hurricane Katrina received the *Weathering the Storm Psychological First Aid Wellness Groups* in their schools. A local clinician, and coauthor on this paper, developed the 6-week group intervention for children affected by hurricane Katrina that utilizes Marge Heegaard’s illustrated children’s workbook entitled, *After Hurricane Katrina: Helping Children Cope with Traumatic Loss*. Learning objectives for the 6-week intervention (1 hr per session) followed PFA guidelines associated with work with children subsequent to disaster (National Child Traumatic Stress Network and National Center for PTSD, 2006) and included increased knowledge about disaster and dispelling myths, recognizing emotional responses and coping strategies in the aftermath of disaster, expressing emotions using appropriate verbal and written communication and art, asserting personal needs in appropriate ways, dealing with negative and intrusive thoughts related to traumatic experiences, coping with anxiety associated with the recall of painful experiences and stress related to being displaced, identifying “triggers” associated with stress and using relaxation techniques and imagery exercises to cope, increasing feelings of self worth, understanding anger and techniques to resolve conflict, and reexperiencing joy in life. Although sequential information was provided on each of these topics, input and questions from the children also determined the order and content of the sessions, and concepts were reinforced from one session to the next. Skill building was achieved through practice and repetition, including controlled breathing, identification of support persons, and identification of a range of emotions.

Children’s anxiety reactions and negative feelings associated with the disaster were ascertained through discussion and art and normalized where appropriate and possible. Children’s strengths and positive coping strategies and abilities were highlighted. Children learned and practiced relaxation techniques and imagery exercises to help them cope with negative emotions. Additionally, children were encouraged to identify a trusted adult to whom they could turn when they needed to talk about their feelings.

Just one example of a child who shifted from a focus on the horrors of the past to the hope of the future during the group process was that of a 12-year old boy who drew an elaborate picture about evacuation that included people drowning, being lifted into helicopters, crying for help, and on roofs. His “safe place” drawing was of his club house. When he talked about Katrina toward the end of the 6-week period, he talked not only about anger and sadness but also about the opportunities and happiness in a new and apparently better home in Baton Rouge. He expressed finding some level of peace and joy in his new hometown and school.

**WTS PFA: Preliminary Findings.** The WTS PFA intervention and evaluation tools were pilot tested from March to May, 2006. A total of 27 children (aged 6–15 years; all African-American) completed pretests and began group. Due to school expulsions, families moving back to New Orleans, and families moving within the Baton Rouge area, only 44% of the children (aged 6–13 years) completed the group and posttesting.

Among the 12 children who participated fully in the 6-week intervention and completed postmeasures, there were no statistically significant differences in PTSD symptoms (tested using the reaction index—Frederick et al., 1992) among the children from
pre- to postintervention ($t = 0.32(9), p = .756$), but there were slight mean improvements in symptoms (from $M = 28.4$ to $M = 27.4$) (this indicates that the average child in the group suffered from moderate PTSD symptoms). Additionally, there were no statistical differences in children’s coping skills from pre- to post-intervention ($t = -0.29(11), p = .780$), but again, we found a slight mean improvement in coping (from $M = 21.67$ to $M = 21.92$) (How I Cope with Things that Happen, n.d.). More favorably, 75% of the children who completed the group reported that the group helped them “lots.”

Although these findings are statistically insignificant, this result and the perceived benefits are consistent with findings from other PFA research (Regehr & Hill, 2000). Regehr and Hill (2000) studied the efficacy of CD with 164 Australian firefighters following a critical incident. The majority of the firefighters attending the CD group perceived the intervention to be beneficial in reducing their level of stress; however, there was no significant association between attending the group and scores of depression (Regehr & Hill, 2000).

In the current study, the statistically insignificant findings may be due to the poor reliability of the measures with this sample (Cronbach’s alpha = .62 pretest and .75 posttest for the reaction index and alpha = .65 pretest and .43 posttest for the Coping scale). Additionally, the very small sample size ($N = 12$) produced poor power to detect differences between groups. Moreover, the non-significant results may be due in part to the multiple challenges encountered during intervention implementation.

A weakness of this pilot was the selection bias, both focused on those who were available and had parental permission, as well as eliminating those with more severe problems who had been expelled from school.

### Identified Challenges

#### Implementation Challenges

**Parental Permission.** Creating and implementing groups for children involves multiple challenges in a real-world setting. First, children are not the ones to determine whether or not they will participate, although in most cases, their assent is required in both practical terms as well as for any program that is being empirically evaluated. Thus, the process of obtaining parental permission, particularly when parents are overwhelmed with multiple adjustments, is a primary barrier to service delivery, especially when a hierarchical assessment of needs demands immediate attention for such things as food, housing, and basic medical care.

Additionally, an unexpected difficulty resulted from the fact that many children we hoped to serve did not live with parents, at least temporarily (perhaps while parents sought work in another city). Further, kinship arrangements, often accomplished informally, meant permission (even for school attendance) was a challenge if the “guardian” held no legal rights. Because most families’ possessions were totally devastated in the floods following the storm, access to this kind of documentation was rare, and thus, getting informed consent and parental permission was both time consuming and difficult. Indeed, these two issues caused considerable time to lapse before groups could begin. Informed consents were initially presented to caregivers in January 2006, just 5 months postdisaster. However, the first groups were not initiated for another 2 months, in March 2006.

**Timing Issues.** Closely related to implementation challenges are those involving timing. Although there is a desire to respond quickly, schools, families, and service providers have many demands during a crisis that slow
implementation of PFA groups. Infrastructures and systems may be compromised, making the addition of new programs, even if needed, difficult. Additionally, at first, there may be numerous competing programs or needs that may create a lag time in service delivery. Moreover, there are clear challenges to accessing children in schools, an environment rightfully designed to protect the privacy and safety of children. Thus, what has been designed for immediate responses to crisis needs may be set aside for months, or even more than a year, as more basic physical needs take priority.

The post-Katrina situation in Louisiana developed in this way in many communities. By the time, schools were organized, families were settled, children were attending schools, providers were hired and properly trained, and numerous levels of permission seeking were accomplished, actual services for children were 6 months postdisaster.

It might be questionable if the same needs existed or the same services should have been provided, given the time lag. However, difficulties that might have been solved more readily festered, and misinformation, fears, and behavior problems did not dissipate or go away on their own. In fact, this article contends that the necessity of services, with some adaptations, continues and that those who did not receive information, support or skill building regarding coping, were as much or even more in need of it as the months passed.

Developmental Considerations. Third, methods of intervention with children require more awareness of developmental levels, and approaches are likely to need more than one application and different approaches than purely didactic presentations or talk-focused programs. We found, for example, that children need more time for distractions, repetition, testing the safety of the group, and integration of group experiences than did most adults.

Although initially groups were formed with children of the same age, groups eventually included students of mixed ages (grades 1–6)—a group policy that initially changed due to practical concerns. In fact, this policy change resulted in some unanticipated benefits. The older children enjoyed assisting the younger children, and the younger children had support and role models for group participation and coping skills.

Another unanticipated issue related to children’s developmental levels was the conflicts between Baton Rouge youth (where the groups were conducted) and those who had previously lived in New Orleans. This was referred to in shorthand as the “225—504 conflicts,” using the phone area codes from each area. Although this cultural and geographical tension did not occur with regularity in the PFA groups, school administrators and teachers informed us that it was a major problem, resulting in fights, exclusion, and fear. Given that children and youth gave up their peer groups, their school affiliations, and their distinctive cultures in the relocation, New Orleans youth were seeking the identity formation required at this age/stage. Similarly, youth from the local schools were “invaded” by large groups of children who challenged the school norms and culture by their presence, creating new competition in sports, academics, and popularity. Indeed, age-appropriate concerns were frequently discussed in relation to hurricane-related topics. An example comes from an oversized and athletic 10-year-old boy who discussed how he “longed” for “the good old days” in New Orleans where he played football. He strongly identified with sports and worried because he was not currently playing due to the relocation. He feared that his skills would diminish due to lack of practice. In addition, this child’s age-appropriate worries were complicated by intrusive memories of his hurricane experience. His artwork depicted the Hyatt in New Orleans.
crowded with people and “lots more people coming.” He also drew people in the water along the streets but stated that they were “not drowning.” And, he complained of nightmares of being shot.

**High Levels of Need.** The levels of need for many children were quite high due to conditions of distress and ongoing transitions. Although PFA was aimed as a preventive measure for the development of problems (PTSD, depression, etc.), even this long post-disaster, the needs were greater than anticipated. For some, regressive behaviors were a reaction to their situations. For others, aggressiveness and self-protection were the reaction. Others lived with misconceptions but showed no external problems. Therefore, the children served in the groups surpassed the estimated level of behavioral difficulty originally anticipated, both because of the level of the original trauma and multiple ongoing stressors. For this reason, PFA group size had to be reduced to behaviorally contain the children. This ultimately reduced the final number of children served in our project from a goal of 60 children to just 27 children served, with 12 completing all aspects of group intervention.

Additionally, the “no tolerance” for violence school policies adopted by most school systems were thoroughly problematic for these traumatized children. Common childhood behavioral reactions to trauma associated with natural disaster include irritability, loud or aggressive behavior, acting out behaviors, depression, inability to concentrate, defensiveness, and unreasonable fears associated with being alone and/or of the weather (LaGreca, Vernberg, Silverman, Vogel, & Prinstein, 2001; MacLean, 2005; Spier, 2000). Many children were suspended and expelled due to emotional and behavioral problems interrupting not only their education but also the provision of our PFA group services. Due to the extreme stress associated with their recent past and current living situations, many children also developed symptoms of separation anxiety and subsequent school refusal and truancy. Moreover, some children never returned to school and may have been lost for the academic year due to the confusion associated with the mass relocation and school enrollment processes (Hurricane Help for Schools, 2005; NASP Resources, 2005). Indeed, it appeared that school officials were caught between trying to empathize and accommodate troubled children and obligations to the education, safety, and protection of students. For example, an 11-year-old girl in the group was eventually expelled from school due to behavior problems. In group, she reported that her family had to seek refuge on the roof of their home during the flooding. She discussed being separated from her father and sister (they were missing for a while) and how distressed she felt about not knowing where they were. She reported having nightmares about someone killing her. When asked to draw her safe place as part of an art therapy component of the group, she drew a two-storey pink house and depicted all the residents on the second floor (above the flood waters). There is little doubt that this young girl’s acting out behaviors, which subsequently led to her expulsion from school, were associated with the trauma she experienced due to the hurricane and relocation process. Though referrals were made, we cannot be confident that the student received services outside the school system.

**Multiple and Ongoing Stressors.** When children finally received interventions, the original precipitant for the PFA may have occurred months previously, so that additional adjustment difficulties presented themselves at the same time. Indeed, purposeful resolution of the original disaster for most children has never occurred, and the original trauma has been exacerbated by prolonged dislocation. Therefore,
the disaster experiences have been compounded, and confounded, by additional life losses and difficulties. One enthusiastic and talkative 6-year-old girl talked often in group about the loss of her 1-month-old baby sister who apparently drowned. She stated that her mother was pregnant again, and she was worried about this baby, a fear directly associated with the loss of her sister in the hurricane.

Children in the groups were responding to several types of traumas: the hurricane, the subsequent flooding, mandatory evacuation, forced change of schools, separation from family, and witnessing violence. Indeed, some children seemed to struggle most with images associated with the threat of violence including images of police officers holding guns, and screaming demands. A 13-year-old boy, with a good sense of humor, told a funny story during group about sneaking his dog in his backpack during the evacuation by the ARMY. However comical this child presented outwardly to group, his artwork depicted intrusive and scary thoughts about shootings that he would not discuss in group. Obviously, this child had learned to cope with his haunting memories with humor.

**Compromised Infrastructure and Support Services.** Displaced individuals discovered that finding all types of services in an unfamiliar environment took a great deal of time and energy. One challenge was related to the lack of access to transportation services for most of the evacuees. Indeed, evacuees moved from a city with good public transportation to a place with sporadic and inadequate public transport. Transportation services were set up on-site at the Federal Emergency Management Agency trailer parks, but services were irregular and many stopped providing services without much forewarning to the recipients. The Baton Rouge Children’s Health Project sponsored by the Children’s Health Fund and operated by the Pediatric Department of LSU Healthcare Sciences Center was one of the few remaining mobile service providers in the area 1-year post-Katrina. The impact of the withdrawal of mobile services cannot be highlighted enough. Most residents of the trailer parks did not have adequate transportation to access care outside the park and relied heavily on on-site mobile services.

**Discussion**

PFA has usually been defined as *early* assistance in the immediate aftermath of disaster and the acute intervention of choice (National Child Traumatic Stress Network and National Center for PTSD, 2006). And yet, it may have broader uses and may be an intervention of choice even beyond the immediate aftermath, particularly in areas where few children are receiving interventions. However, as this article has argued, there are many challenges to providing such a service to children shortly following a natural disaster such as hurricane Katrina. These include the fact that parents, children, schools, and social service providers are all overwhelmed during and following such an event. Further, developing and implementing a group PFA for children may involve challenges that inevitably take time to resolve. Thus, beginning the treatment takes longer than expected, and reinforcement of concepts is needed for longer than a one-session experience. Some implementation challenges include the logistics of parental permission, timing issues associated with infrastructure and system development, developmental issues, heightened levels of need, the multiple and ongoing stressors on families, and compromised infrastructures and supports.

The pilot data from this study, although collected with a smaller sample and different design than planned, indicate no significant
gains for children as a result of their participation in groups. Certainly, the sample of 12 limits conclusions drawn, as do the fact that there was no control group and unreliable measurement. However, there was self-reported satisfaction by the children, and it is possible that a larger study may result in different outcomes. Further research is required to examine gains in each of the goals of PFA, especially as administered to children in a group setting. This preliminary report indicates that many disaster-related factors must be considered when planning for service delivery or research with children in the aftermath of a disaster. The difficulties faced in the present study, however, are less a reflection on the PFA methodology itself and are more of a reflection on the real-world circumstances post-disaster and the flexibility demanded of anyone engaging in disaster research.

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