Module IV Special groups: Children and adolescents

Children, especially the very young, are particularly vulnerable in disasters. It is widely recognized in the literature that a certain degree of distress is observed in children under 5 years old and in the elderly. This vulnerability becomes significant when normal healthy development is absent or distorted as a result of the traumatic experiences associated with different forms of loss, as commonly occurs in disasters and complex emergencies. Forced interruption of the normal developmental processes makes a child more prone to developing levels of emotional distress that border on mental illness. However, not all children experience such negative reactions. Some show remarkable resilience, which acts as a protective factor. Younger children are more vulnerable than older ones since they have not yet developed effective coping strategies to survive the whole spectrum of disasters. Thus, they have a high mortality in disasters. For example it has been documented that after a sequence of natural disasters in the disaster-prone region of the Bay of Bengal (a cyclone followed by floods and famine in 1970 and 1971), approximately 30% of those who died were children under five; researchers of the 1991 cyclone, which hit coastal Bangladesh, reported the same trend; similarly the 1999 cyclone in Orissa India.

This module is intended to provide health and mental health personnel with some guidance on a **non-disease oriented** approach to psychosocial disaster response. Disaster stress should be understood as a **normal reaction to an abnormal disaster event**. Mental health and other psychosocial personnel can assist most survivors to get back to their normal lives as soon as possible without specialized care and at the primary health care level using a combination of both psychological and community-based approaches. More specifically this module has as its aim and objectives the following:

Aim

To provide an overview of special groups affected by disasters and emergencies and to reach an understanding of their behaviour after disasters; to address general and specific stressors and to examine the consequences of these experiences in order to better help victims come to terms with their experiences

Objectives

By the end of this module the user should be able to:

- Describe the broad psychosocial needs of children and adolescents in disasters and complex emergencies.
- Understand the complexity of intervention models concerning children.
- Understand and identify appropriate models of intervention.

Children in disasters and complex emergencies

Approximately 540 million children in the world - one in four - live in dangerous and unstable conditions.

- Children and women are the majority of the civilians who suffer, physically and psychologically, when their country is ripped apart by war and conflict.
- Children, some as young as 10 - are forced or coerced into services by governments and armed opposition groups.
- Environmental catastrophes, such as floods, hurricanes and earthquakes, also have grave ffects on children *(17, p. 78).*

Children exposed to the aftermath of sudden disasters will probably experience intense feelings of anxiety and fear. The fear of death, injuries, of being left alone and separated from family members, is expressed in different ways depending on their ages; for example separation is less stressful for infants once the necessary care is provided by caregivers**.**

While there is some difficulty *(18)* in assessing children's responses to disaster trauma there is now a consensus that teachers report less psychopathology among child survivors than parents do; and both parents and teachers report far less than the children themselves. One reason may be that children try to protect their parents from the full extent of their distress.

In this type of appraisal, screening instruments should be used together with detailed interviews with the child. These reveal post-disaster stress among affected children *(19)*. Regressive behaviours, with clinging to parents and heightened dependency, are frequent findings.

Mental health: a human right

The *United Nations Declaration of Human Rights* asserts that most people want to live in a society that offers protection against natural disasters, famine, violence and war. Each person should be free to develop his/her talents and capacities and to seek happiness in ways that do not further harm or injury to others.

Children in disasters

In disaster situations the human rights of children of all ages must be addressed. Rescue workers, health and social workers concerned with the consequences of stress in children should bear in mind the following points:

- No harm should result from their interventions.
- The focus should be on identifying children's needs and helping them to resolve their problems.
- The children themselves should be enabled to participate actively in restoring their own well-being.
- The local culture must be respected.
- Children should be helped to re-establish their self-esteem.
- The focus on trauma in conflict should be replaced by psychological and practical reconciliation with the fighting factions.

Children under six

Because young children are not highly verbal, they express their fears and anxieties through regressive behaviours, reverting temporarily to "childish" actions such as bed-wetting, sucking thumbs, asking to be fed or dressed, fear of being left alone or in the middle of crowds *(20)*.

Understanding children's behaviour

- Do not be alarmed: reactions are usually normal and of short duration.
- Do not become over-concerned and punish the child, this would only prolong the reaction.
- Spend extra time giving attention, assuring love and care, and explaining that reactions are normal.
- Children who cling need to know that caregivers will come back and be reassured about security and safety.
- Keep the family together in the early days of the aftermath.
- Include children in the recovery activities.
- Return to regular family routine as soon as possible.
- Provide comfort to very young children.

Bedtime problems are the most common difficulties encountered by caregivers following disasters. Children have difficulties sleeping alone or falling asleep because of nightmares.

How can caregivers help?

- Spend more time with children, providing a sense of security when night falls.
- Provide physical exercise and vigorous play.
- Establish a comforting routine at bedtime (story-telling, quiet play).
- Acknowledge their fear and listen to their experiences with dreams and nightmares.
- Put a night light in the room.

Supporting children, parents and communities

For children *(2)*:
- Re-establish safety, security and protection
- secure their physical well-being through proper nutrition and health care
- encourage them to continuous normal activities
- help them to understand their experiences by giving more information, and
- help them to process their sensory impressions and emotions.

For parents *(2)*:
- Give them information about normal behaviour problems of children exposed to violence
- provide information on appropriate methods of behaviour management
- help them to overcome their own loss and grief
- support and guide them to provide their children with appropriate care and education, and
- give practical assistance in restoring basic household functions.

For communities *(2)*:
- Maintain or restore basic public services
- include all members of the communities in reconstruction activities
- offer community meetings and facilitate mutual support
- foster cultural traditions that strengthen people's sense of identity and belonging
- promote communication between community groups
- facilitate political understanding, and
- encourage religious practices.

Older children – six to eleven

Fear and anxiety are also prevalent in this age group although there is an increasing awareness of real danger by children themselves, their families and friends. Loss of possessions has special meaning. Other emotional reactions are expressed through irritability, disobedience and depression, headaches and visual or hearing problems.

Understanding children's behaviour

- Take children's fears seriously, respect their feelings and try to understand them.
- Listen to what children have to say about their emotions and what happened.
- Do not force them to be brave and face what has frightened them.
- Explain the disaster in a clear way.
- romote talking about their fears at home and in school.

Other reactions include school avoidance, difficulties in concentrating, and reactions to death and grieving.

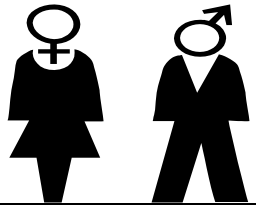
How can caregivers help?

- Provide security, indicating that the caregiver will be at home when they return from school.
- Tell children about the death of a loved one; do not try to protect them by not sharing what has happened in an honest way.
- Answer their questions.
- Include them in funeral rituals.
- Provide family reassurance and support.
- Encourage strenuous sports and games to deal with anger.
- Help them to process guilt by reassuring that the death was not their fault.

Pre-adolescence and adolescence: twelve to seventeen

Disaster effects upon this age group will depend on the degree of disruption of both family and community. Fear of loss of family, of losing the acquired independence from family so characteristic of adolescence (disasters make families pull together again) among others, may revive old fears of earlier development.

Common reactions are withdrawal and isolation, psychosomatic reactions such as headaches and stomach-aches, suicidal thoughts, anti-social behaviours (stealing, aggression, acting out), sadness, decline in school performance, sleep problems including night terrors.



Most of these behaviours are temporary and subside over time. Adolescents often express emotional distress through physical complaints, as do many adults. If this occurs, teachers at school will notice and should respond quickly. Other reactions relate to death and grieving, confusion and boredom, and isolation. Older adolescents may find themselves as head of the household and they should allow themselves to grieve.

Feelings of helplessness, hopelessness and worthlessness are strong indicators of suicidal thoughts.

School and life routine are severely affected by disasters and life in the adolescent view becomes boring, particularly when one takes in both the isolation from peers and separation of family.

To overcome boredom it is critical to involve the adolescents in clean-up activities. Getting them involved in the reconstruction process - building shelters or recreation areas, assisting the elderly and assisting young children. This strategy was used by an experienced NGO when schools were reopened after the war and famine in Baidoa, Somalia.

Additional intervention guidelines are available from other NGOs and disaster relief organizations. Some have been successfully used in developing countries facing disasters *(21)* and can be used for both adults and children. These programmes are proactive and are popular because they access directly the affected populations in real need. They use a variety of community-based techniques that include:

- outreach counselling
- distribution of booklets, facts sheets, coloring books
- parent guidance
- crisis telephone
- support groups
- songs
- plays
- art expressions
- story telling
- puppet play
- drama and theatrical representation
- free writing
- self-calming exercises
- school and church programmes
- field trips
- media presentations.

These programmes also contain an important psychosocial component, including information on the following: overall expected psychological reactions and symptoms and how to normalize these reactions; the danger of drug abuse including alcohol; the increased incidence of interpersonal conflicts and how to cope effectively.

Children's Drawings

Children are able to deal with complex psychological difficulties through play. Children's play, especially drawing, cuts across all cultures and generally illustrates the same themes, notably those of family and nurturing, and the roles played within the family. Painting and drawing is a spontaneous activity for children and represents the child's perception of his/her world.

Children's drawings reflect both a child's reality and the historical moment. For example, children who live in war zones illustrate elements of conflict in their drawings. Drawing and painting are thus an important component in assessing and treating children, especially young children where verbal communication is limited. They are also an important tool in cross-cultural studies and in research on children in disasters generally.

However, along with drawings of real events, children also draw fantasies. For example, children who lived in the Terezin concentration camp during World War II drew both executions and princesses.

Activity 2

What special psychosocial child issues should be taken into account when dealing with child survivors of a large-scale natural disaster such as an earthquake?

Distress is a normal reaction to a traumatic event, but when it is particularly intense or continues over a prolonged period of time, physiological and mental coping strategies can begin to take their toll on the individual's well-being *(24)*. Vulnerable children are viewed as more susceptible: no single factor in a child's life determines vulnerability but some groups, for example unaccompanied children, those already sick or injured, and the physically or mentally impaired, are often singled out for developing pathology *(25)*.

Resilience

Children's coping strategies are considered more likely to fail when there is inadequate protection at either the individual or community levels, with other factors such as:

- extreme poverty
- low parental education
- authoritarian parenting style exacerbating the problem.

However, even when coping strategies are lacking or poor, some children still show resilience in the face of these extreme factors.

The resilient child has been defined as one who shows a positive outcome despite being at significant risk of developmental problems.

The absence of previous pathology, and proactive positive behaviour are two of the protective factors in resilient children.

A physically healthy child is more likely to be emotionally and psychologically resilient. The relative cognitive maturity of older children can enhance expression and coping. Resilient children are active, affectionate, good-natured, easy to manage, adaptable and flexible, able to ask for help and to tolerate frustration and anxiety. Consistent and secure relationships with a primary caregiver foster resilience. Resilient children have parents who are "models of resilience". The extended family can lessen stress by providing additional adult nurturing and being positive role models. A socially coherent community can do much to enhance the resiliency of children. Friends, neighbours and teachers can provide emotional support and promote self-esteem and competence. The community also indirectly supports the child by supporting the child's parents. A strong ideology, for example political or religious views, can bring stability and meaning to a family during times of hardship.

However, almost all children in disasters show some evidence of distress in their behaviour. Consequently there is no totally resilient child. There is at the same time a great variation in children's vulnerability thresholds.

Traumatic experiences when experienced alone by children are the worst to cope with, a cross-cultural finding *(26)*.

Shelter and protection from caregivers is one way that children use to mediate this stress.

Other strategies, used by older children are:

- use of own individual resources to cope with the fear generated by the situation
- use of coping resources acquired in previous experiences.

Children who have been repeatedly exposed to intense traumatic experiences can develop vulnerability. While control over any situation builds resilience, the lack of control and constant fear and threat, heighten vulnerability.

Suggested psychosocial interventions

There are various methods of intervention for both short and long-term. In the short term these may include family interventions such as outreach and/or educational materials, and in the long-term adjustment phase, individual psychotherapy.

Interviewing children

Interviews should be kept simple, informal and friendly. It is also important that affection, care and comfort should be somehow conveyed. Key principles are *(4)*:

1. **The child's belief.** Make sure that the child has a clear idea of the purpose of the interview. You may include in the interview someone that the child already trusts, eliminating a potential source of misunderstanding leading to distorted response.

2. **Observation.** Make sure to record omissions and any other non-verbal form of communication.
3. **Physical signs.** Record any physical signs within the context of child's culture particularly any form of body language.
4. **Listening.** Resist giving advice, relating stories, passing judgment. All these will intimidate child's reporting.
5. **Questioning.** Use the open-ended format when asking questions, do not try to have a narrative in the middle of long periods of silence.
6. **Talking.** Limit your comments to those ones that makes the child comfortable, or encourages a positive behaviour by repeating a key phrase.
7. **Trust.** The child should trust you and that you respect his story.
8. **Objective experience/Subjective response.** Understand the relationship between the experience and the internal subjective response to it.
9. **Know yourself.** Do not impose any of your prejudices on the child.
10. **Judging.** Do not judge the actions being reported to you.
11. **Role of the interviewer.** By touching many subjective reactions that affect the child's feelings and lead to fear, anger and hope, avoid exerting power (even subjectively) over the child's future.
12. **Honesty.** The more consistent you are, the greater the trust the child will have for you. This will affect your work with other children in the camp. Be consistent with your role and provide accurate information.
13. **Public image.** An ethical public and professional behaviour will contribute to the improvement of children's well-being. Children form impressions easily and base their roles on these impressions.

Conducting interviews

Interviews, whenever possible, should be conducted privately. In the case of young children who are easily frightened, an adult should be included. Adults are not allowed to answer questions addressed to the child.

Outline of interview

I. **Introductions. E**xplain why the interview, what kinds of questions and why.
II. **Interpreter. F**ocus on child by directing the questions to child.
III. **Difficulty in talking about an event. D**o not force talking, move on to other questions, and later come back, allowing time for child to regain control of emotions raised by painful memories. Another alternative is to ask some person that the child trusts to obtain the answers and then pass on to the interviewer later.
IV. **Questions**. The child should be encouraged to ask questions during the interview.
V. **Accuracy**. Make sure that the child understands that there is no right or wrong answer, and the information provided at any point is accurate. This reduces anxiety.
VI. **Time to stop.** The caregiver can often provide a sign indicating when to stop. Signs of anxiety are often good indicators of when to stop an interview (e.g. restlessness, body signs).
VII. **Ending the interview.** This should be done in a positive way, discussing the routine of the camp to boost security. Child can ask questions to feel in control of the situation. A

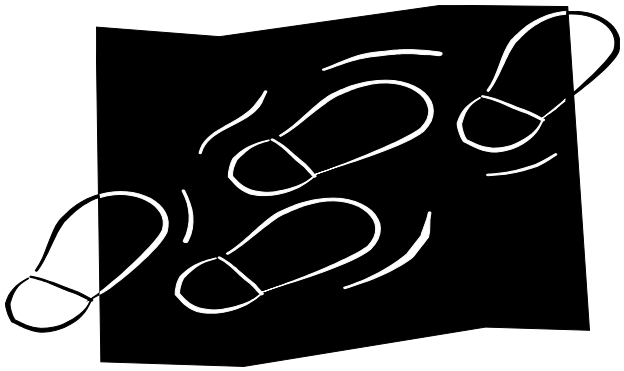
caregiver should follow up with a visit to monitor any possible distress reactions. Interviews should be made in morning hours never, before the child goes to bed at night.

Other approaches

Because young children have no previous experience of coping with trauma, an individual approach may be better, especially when dealing with those children who are "stressed" rather than "traumatized".

It has been suggested that a two-stage model, such as Psychological First Aid with Clinical Debriefing, may be of more use than the psychological debriefing used in classrooms or groups, and that in fact psychological debriefing for children should be used with caution. Experience with child soldiers in the Sudan shows that routine debriefing (they had the opportunity to talk about their experiences) performed when boys arrived at the transient camp was not well taken; they rejected routine and structured talk. Also the worst traumatic part of their experiences was left out of their narratives.

Sharing traumatic experiences among other members of the group with similar experiences helps to normalize stress reactions.



Empowerment through psychosocial training addressing the normality of these abnormal experiences is one of the effective ways of dealing with large groups of children affected by the violence of wars. However it should be noted that most models of intervention are "western" in design and may not therefore be suitable for all cultures. Culturally sensitive interventions should be aimed for whenever possible.

- A safe and secure environment and the re-establishment of close relationships with caregivers is one effective community-based psychosocial strategy.
- Depending on the children's age and maturity, these difficult experiences cannot necessarily be overcome through only art therapy, play and dance. Play, stimulated by adults, may be a healing tool for some children once a secure environment is established, but not for others.

When children spontaneously engage in play, it is a good sign towards emotional healing and recovery.

Psychosocial projects are not usually designed with these concepts and, in some instances, the conceptual framework is structured around the mistaken notion that all children are equally traumatized by war effects. Programme responses need to take into account the individual needs of children and their families.

Notes

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