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ABSTRACT

Major natural and human-caused disasters deeply affect children, and they have a special vulnerability to such events. The importance of providing crisis counseling recovery assistance within the context of their special world cannot be over emphasized. The information in this manual provides both theory and guidance to individuals concerned with the mental health needs of children who experience major disasters. It is designed as a supplement to the Manual for Mental Health and Human Service Workers in Major Disasters. At the time of the disaster, children are often left to the care of unfamiliar persons and provided limited explanations about what occurred. Specifics of how the many aspects of a disaster affect children are explained, and particularly how their reactions differ from adults. Chapters include: (1) "The World of Childhood and the Developing Child"; (2) "Reactions of Children to Disasters"; (3) "Helping the Child and Family"; and (4) "Guidelines for Caregivers, Mental Health and Human Service Workers." Appendix A is Agency Assistance in Disasters and Appendix B is Web Sites for additional resources. (Contains 30 references.) (JDM)

PSYCHOSOCIAL ISSUES FOR CHILDREN AND ADOLESCENTS IN DISASTERS

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

This publication was produced under an Interagency Agreement between the Federal Emergency Management Agency and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. This publication was previously published under the title *Manual for Child Health Workers in Major Disasters.* The first edition, printed in1981, was written by Norman L. Farberow, Ph.D., and Norma S. Gordon, Ph.D. The second edition revises and updates the first edition. Portland Ridley served as the CMHS publications and editorial coordinator.

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SECOND EDITION

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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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FOREWORD

This manual is a second edition and is intended to reaffirm and extend the concepts expressed in the first edition written by Norman L. Farberow, Ph.D., and Norma S. Gordon, Ph.D., and published in 1981 under the title *Manual for Child Health Workers in Disasters*. Since 1981, the nation has experienced many major, natural disasters and several devastating, human-caused disasters. In all cases, these events deeply affected children. The collective experience of individuals involved in disaster work over two decades has repeatedly demonstrated the special vulnerability of children to the impact of traumatic events and the importance of providing crisis counseling and recovery assistance within the context of their special world. An extensive review of the professional literature, materials developed through various Federal Emergency Management Agency (FEMA) and Center for Mental Health Services (CMHS) funded Crisis Counseling Program grants and contracts, and personal communications with numerous crisis counseling and outreach workers contribute to the substantive additions to the original volume.

This manual provides information and guidance for individuals concerned with the mental health needs of children who experience major disasters. This background, training, and experience will vary and may include health and mental health professionals, professional and paraprofessional social service personnel, school and daycare personnel, clergy, volunteers, and parents.

Responding to the disaster-related needs of children is unlike any other type of work with children. It is distinct because it always involves helping children and their support systems cope with the emotional impact of a traumatic event. FEMA provided CMHS funding to develop this publication as part of a continuing effort to disseminate knowledge gained from previous crisis counseling programs. These two Federal agencies serve as conduits of information to others responsible for planning and implementing disaster mental health services.

The information in this manual is intended as a supplement to the *Training Manual for Mental Health and Human Service Workers in Major Disasters, Second Edition* (CMHS, 2000), which provides an

overview of essential information for training disaster mental health workers. It is our hope that the material presented in this manual serves as an effective resource in the tool kit for disaster workers.

Mary Elizabeth Nelson, M.S.W., Chief
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Anthony H. Speier, Ph.D.
March 2000

INTRODUCTION

Following a disaster of such magnitude that the President has declared it as eligible for Federal assistance, communities are often in chaos and individual survivors are undergoing their own feelings of disbelief and shock. It is within this context communities must respond to the emotional needs of their residents: adults and children. Adults living in the impacted area must balance their roles as survivors, responders and caregivers during this time of turmoil. They are often overwhelmed with the responsibility and immediate tasks of crisis response and recovery and must take time to meet the physical and emotional needs of themselves and family members and respond to the needs of the larger community. Consequently, children may be left in the care of unfamiliar persons or provided with limited explanations of what has actually happened.

Disaster response workers, who are providing crisis counseling and emotional recovery assistance, need to be sensitive to the emotional vulnerability of children. The materials discussed herein will give crisis response workers essential information about the impact of disasters on individuals, how the trauma associated with such events impacts children, the unique world of children, and the diversity of family structures in which children reside.

A special emphasis is placed on assisting child health workers to understand children as uniquely different from adults, and childhood as distinct from adulthood. Child health workers must engage children in the ever changing and qualitatively distinct world of emotional and cognitive stages of development in which children find themselves. The purpose of the manual is to achieve a better understanding of the world of children and the nature of disaster response.

The manual also provides information and guidance for the broader group of individuals concerned with the mental health needs of children who experience major disasters, and may include the following:

- Experienced mental health professionals who specialize in working with families and their children who experience serious emotional disorders;

- Other health professionals such as physicians, physician assistants, nurses, and rehabilitation specialists who are experienced in working with children;
- Professional and paraprofessional workers who provide crisis and suicide intervention services, case managers, and other public health and social service personnel who work with children on a regular basis;
- School and licensed day care center personnel, including teachers, teachers' aides, guidance counselors, school social workers and psychologists, and administrators;
- Nonprofessional volunteers from the community who have little or no training, but who have had personal experience with their own and neighbors' children; and,
- Adults who routinely work with children either as volunteers, or as paid service providers or caregivers who have a strong commitment to helping children in times of crisis.

1

THE WORLD OF CHILDHOOD AND THE DEVELOPING CHILD

Children are one of the most vulnerable groups during and following a disaster. A disaster is a strange event that is not easily understood. It is emotionally confusing and frightening and results in children needing significant instrumental and emotional support from adults. Children, parents, and whole families in need of assistance are found at shelters, recovery centers, and other locations. A review of some basic principles and reminders from child developmental theory show how a child's current stage of development influences their behavior and their understanding of traumatic events associated with the disaster. Below is a list of basic principles that may be helpful as we, the helpers, are rapidly trying to determine the best strategy for providing assistance to children in both the early stages of crisis response and the later stages of emotional recovery from the disaster:

- Be a supportive listener.
- Be sensitive to the child's cultural, ethnic, and racial experiences.
- Respond in a way that is consistent with the child's level of development.
- Be aware of the child's emotional status. Is the child actively afraid or withdrawn?
- Determine if the child is comfortable/secure about his/her current surroundings and those of his or her parents, and other significant persons/pets,
- Assist the child in normalizing his/her experiences.
- Seek assistance from a child specialist or mental health professional, if necessary. Assistance is needed when the helper does not know what to do or think or if he or she is making things worse.

THEORIES OF CHILD DEVELOPMENT

An abundance of popular press is available on the subject of children. Topical areas of interest include how to raise, parent, educate, and discipline children. It is important, especially when one is in a period of stress and turmoil, to step back from the issues at hand and assess the current situation from the perspective of life during non-crisis routine times. This is especially true when engaging children.

The most important concept to remember is that children are different from adults; childhood is different from adulthood. As trained child health workers or disaster mental health outreach workers who encounter children as survivors of a disaster, the preceding statement seems with a moment's reflection as obvious. In fact, the reality is so obvious that it is often overlooked.

Jean Piaget, renowned for his elegant theory of child development, formulated much of his theory from simply observing how his own children responded to their environment. Piaget, the scientist-observer, systematically confronted his children at different chronological ages with various mental challenges and recorded his observations of their responses. Classic examples from his work illustrate how children perceive the world differently at various chronological ages.

Piaget (Flavell, 1963) noted young children have difficulty observing objects from more than one perspective. For example, a seven-year-old is shown two glass containers: one is short, wide, and filled with water; the other is empty, tall, and slim in shape. The child is convinced that when the liquid from the short container is transferred to the tall one, the volume of the contents actually changes as well. Similarly, when a child of ten or eleven is asked to solve a problem that requires abstract reasoning, such as a problem of logical inference (i.e., a>b and b>c; therefore, a>c), the child is often baffled by the solution. However, when the same problem is presented with solid objects, it is easily solved. Because the objects are concrete and readily visible, he or she easily recognizes the relationship. An adolescent, on the other hand, can solve this problem in the "abstract" by creating mental images of a, b, and c and then solving the problem in his or her head.

Piaget was trained as a biologist and based much of his theory of development on the notion that organisms seek homeostasis or a steady

state of balance or equilibrium. With respect to humans, he postulated that as we grow we change internally and thus, our capacity to engage the environment changes as well. Throughout our development we experience states of disequilibrium and seek to return to a state of equilibrium. The mechanisms he proposed are two active processes of assimilation and accommodation. Simply put, assimilation is the process of interpreting new information within the context of our existing cognitive structure, while simultaneously accommodating to the new information or demands of our environment. Through the tension of these two ongoing processes we develop our cognitive knowledge and capacities. Thus, we develop from an infant who responds primarily to sensations to an adult who is capable of complex abstract reasoning.

All of us can recall conversations with friends who related their frustration as parents, complaining that their children are disobedient and refuse to do their chores. Is this refusal to behave and do the chores simply because the child is disobedient? Or is it because the parent is issuing commands in a manner that requires the child to translate the "abstract" orders into concrete actions, when they have not yet developed the necessary cognitive skills? While a comprehensive discussion of cognitive developmental theories is beyond the scope of the subject at hand, it is important to recognize that children think and construct their responses to the world in different ways depending on their current level or stage of cognitive development.

In summary, we should be aware when we meet a child that they are operating in the world with a different set of cognitive structures than adults and are interpreting information from the environment in a different fashion. In the next chapter, there are a number of illustrations of how this actually works.

Cosario (1997) recently reasserted that when trying to understand children, we must remember that childhood is not simply an apprenticeship to the "real" world of adulthood, but is the current world in which children operate. It is the environment in which cognitive, social, and emotional development occur for individual children. "Children create and participate in their own unique peer cultures by creatively taking or appropriating information from the adult world to address their own peer concerns" (p.18). Hartup (1979) suggests that children really experience two worlds: the world of adult-child interactions, such as with teachers and parents, and the world of peer interactions with children of

similar age. We must be aware of the simultaneous presence of both these environments to understand and relate to children as developing individuals.

The emotional development of children parallels, complements, and interacts with their cognitive development. Kagan (1982) has shown in studies of normal infant development that when confronted with new and different information infants may smile if the information is successfully integrated, and they show fear by crying or withdrawing if they cannot make sense of the information. The study of emotional development affirms that emotions are central to survival. Through emotional expression the infant expresses distress (a soiled diaper or hunger), pleasure (being comfortable and having a full stomach), and fear of strangers. As children in middle school and high school, we learn to respect the social standard of non-aggression toward peers and acquire the skills necessary to problem solve conflicts and modulate emotional expression accordingly. By adolescence we are well skilled in expressing empathy, pride, shame, guilt, and other emotions. Thus, throughout normal development we learn more sophisticated strategies of emotional expression.

Closely tied to emotional development is the development of attachment. Attachment theory as originally developed by John Bowlby (1982) integrates psychoanalytic concepts of child development with parts of cognitive psychology, ethnology, and human information processing. He defines attachment theory as a way of conceptualizing ". . . the propensity of human beings to make strong affectional bonds to particular others, and of explaining the many forms of emotional distress and personality disturbance including anxiety, anger, depression, and emotional detachment to which unwilling separation and loss give rise" (Bowlby, 1982, p. 39). Attachment refers to the affectional bond that forms between a nurturing figure, usually the mother, and her child in the course of time and in response to consistent care. Bowlby states that there is an innate tendency within the human baby to seek and maintain proximity to the attachment figure. This behavior has the function of protecting children from the risk of harm.

Mary Main (1996) recently reviewed the field of attachment research. In the years since Bowlby's original formulation, the concept of attachment has been extended beyond infancy to account for behavior throughout the life span. Main has affirmed that the development of the

attachment relationship is based on social interaction. In the overwhelming majority of instances children become securely attached to a nurturing caregiver. Children also become attached to maltreating parents and the resulting attachment bond is expressed as an insecure attachment. The quality of the attachment bond is usually established by seven to eight months of age and is characterized as secure or insecure. Secure attachment is the result of an infant being able to rely on the caregiver as consistently available and nurturing. Infants who have incompetent, uncaring, or inconsistent caregivers express insecure attachment behavior. Insecure attachment behaviors related to separation and reunion with the caregiver range from ignoring the caregiver to excessive and disquieting expressions of distress.

Being securely attached to a nurturing caregiver is further expressed by using the caregiver as a "secure base" for exploring one's immediate environment. For example, a small child playing in the park will run and play far away from his or her mother as long as he or she is in visual proximity. The child will wander farther and farther away only to spontaneously return to his or her mother and soon wander off again in spirited play. Just as the child displays organized and confident behaviors while in the comforting presence of the caregiver, he or she can also appear disorganized and highly anxious or fearful upon separation or loss of the caregiver. Brief separations from one's parents is a common event in disasters.

Upon separation and loss of proximity to the caregiver, the child will express fear and anxiety until again secure in the knowledge of the availability of the caregiver. As discussed earlier, infants and very young children must be able physically to see objects to keep them psychologically available. However, with time, children can build psychological representations of objects, people, and relationships. Recent research suggests that through maintenance of mental models of caregivers, children are influenced in their formation of relationships with peers and in the development of successful interactions with friends. In a similar vein, adolescents are influenced by models of adult caregivers as they begin developing long-term relationships with significant others.

To better understand normal and abnormal child development, much research has been conducted comparing the behavior of securely attached and insecurely attached children. Carlson and Sroufe (Main, 1996) have reported ". . . in peer and school settings, children who felt

secure as infants with their mother exhibit greater ego resilience as well as social and exploratory competence than insecure infants . . . Security with fathers also contributes favorably to outcome" (p. 240).

Disasters are events postulated with separation and loss. Irrespective of the quality of the child's attachment to the caregiver as secure or insecure, unexpected separation and disruption of one's secure environment results in fear, anxiety, and disorganization of one's own behavior. Children who have experienced secure attachment relationships with a nurturing caregiver are the most resilient in reconciling the disruption and recovering from traumatic events. The disruption and loss experienced will most likely be more difficult to resolve for children who have experienced insecure attachment relationships.

Cassidy (1996) summarized some basic findings from the study of attachment relationships:

- Linkages exist between family and peer systems.
- Children's daily experiences with parents affect their concept of self and relationships with others.
- Children with more positive relationships with peers express more positive behaviors.
- More positive behaviors result in being better liked by peers.

In summary, the quality of parents' caregiving behavior initiates a process linked with the quality of peer relationships throughout childhood and early adolescence.

Erik Erickson's theory of psychosocial development (Santrock and Yussen, 1987) offers a perspective on a child's social development. Erickson proposed that social development is the result of the interaction between internal biological forces and external cultural pressures. As such, he proposed eight stages of development throughout the life span. The conflicts one experiences at each stage can be resolved in either a positive (adaptive) or negative (mal-adaptive) way. For Erickson, the development of a psychologically healthy adult required the successful resolution of conflict at each developmental stage. He accounted for variation of emotional expression and behavior among individuals on their resolution of conflict along a continuum of healthy to unhealthy outcomes. The eight stages of psychosocial development coincide

loosely with eight life stages. Five of these stages occur from infancy through adolescence.

Early infancy is the stage of 'trust versus mistrust' in which the infant learns to view the world as a place where one can trust others to be supportive and caring, or a place where the infant cannot consistently rely on the support and nurturing of others. Late infancy is the stage of 'autonomy versus shame and doubt'. In this stage autonomy is the ability to control one's own actions, such as successful toileting. An inability to learn such control may result in feelings of shame and doubt. Early childhood is the stage of 'initiative versus guilt'. The child is confronted with the conflict of relationships with parents and unresolved feelings of love and hate. Taking the initiative and engaging in positive social activities resolves conflict; failure to do so results in unresolved guilt. Middle childhood is the stage of 'industry versus inferiority'. During this stage, the child's cognitive knowledge, physical abilities, and social relationships are expanded. Upon comparison of self with others, the child ultimately measures how he or she compares to peers. If the child feels incompetent and inferior, as opposed to competent and adequate, his or her interactions with others will differ than if the child feels confident in how he or she compares with peers. During the storm and stress of adolescent years, the child is confronted with the universally known stage of Erickson's theory 'identity versus identity confusion'. It is during this period that the child resolves the conflict between "who I am and what I want to be" and struggles to decide the direction of his or her life. Resolution of the conflict associated with identity marks the end of childhood and the emergence of adult role-taking in society. The remaining three stages continue to deal in a similar vein with issues of role performance and development throughout adulthood.

In summary, normative development throughout childhood is generally viewed as an active and complex process. It involves the ongoing maturation of the child and how he or she engages people and events, attachment to significant adults, social relationships with peers, intellectual and emotional development, and the actual world in which he or she lives. Childhood is the culture in which individual development occurs. The quality and characteristics of their environment also directly influence the healthy development of children. Is it a setting where basic needs are a struggle to meet, where danger and fear of personal safety are daily concerns? Or is it a world that is predictable in its organization

and resources? Is it a nurturing place with companionship or one of disregard and isolation?

When a natural or human-caused disaster invades the world of the child, the impact disrupts the normalcy of the environment and normative functioning. Fortunately, most children enjoy successful and normal childhoods surrounded by adults and peers who can help them adjust to the impact of the disaster. Traumatic events can be successfully assimilated into their worlds within the context of their own individual development. For those children who are experiencing childhood as a negative environment and are actively developing maladaptive survival strategies, recovery from traumatic events will be a complex and time-consuming process. This can result in sustained and significant alterations in how successfully children are functioning in their world. For example, children may experience a drop in academic performance at school and disruptions in their social interactions with friends, siblings, or parents. Children who are experiencing such significant disruptions in their routine social and cognitive functioning may be at risk for developing Post Traumatic Stress Disorder (PTSD) or another form of emotional disorder.

2 REACTIONS OF CHILDREN TO DISASTERS

NORMAL REACTIONS TO DISASTER INDUCED STRESS

Most parents recognize when their children's behavior indicates emotional distress. During routine, non-crisis times parents are tuned-in to the nuances of their children's behavior. Most mothers can tell immediately if their young son or teenage daughter had a bad day at school or a fight with their best friend. A very common sign indicating distress is the sudden appearance of a very busy child, who just suddenly decides he or she will watch TV with his or her parents, and is not even particular about what they are watching. For most parents, this is when their antennae go up and somehow they know it is time to give that extra hug and just be available. Typically, a few words eventually pass between the parent and child. The parent smiles, the child looks relieved, and as quickly as the child appeared he or she vanishes back into his or her now somewhat reorganized and normal world. Under normal circumstances in the majority of nurturing families, they play this scene over and over and without really thinking anything of it. It is just a slice of daily life.

Disasters are not normal or routine and therefore, impose a significant abnormality on our daily routines. Everyone is affected. Typical modes of interacting with each other are strained. All of us are trying to get a grip on things and as a result focus less on supporting each other. It is within this context that children experience the aftermath of disasters.

The American Academy of Child and Adolescent Psychiatry (AACAP, 1998) suggests that a child's reaction to a disaster, such as a hurricane, flood, fire, or earthquake, depends upon how much destruction is experienced during or after the event. The death of family members or friends is the most traumatic, followed by loss of the family home, school,

special pets, and the extent of damage to the community. The degree of impact on children is also influenced by the destruction they experience second hand through television and other sources of media reports.

Generally, most children recover from the frightening experiences associated with a disaster without professional intervention. Most simply need time to experience their world as a secure place again and their parents as nurturing caregivers who are also again in charge.

Studies of how children have reacted to catastrophic events are limited. However, in the available work done on this topic there emerges a consistent pattern of responses and factors that influence the difficulty children may have in returning to their pre-disaster state. Yule and Canterbury (1994) reviewed a number of studies concerning children exposed to traumatic events. The types of reactions experienced by many children reported include feeling irritable, alone, and having difficulty talking to their parents. Many experience guilt for not being injured or losing their homes. Adolescents are prone to bouts of depression and anxiety, while younger children demonstrate regressive behaviors associated with earlier developmental stages. Many children who have difficulty reconciling their feelings will engage in play involving disaster themes and repetitive drawings of disaster events. It has also been demonstrated that children as young as two or three can recall events associated with disasters. The child's level of cognitive development will influence their interpretation of the stressful events. Some studies reviewed by Yule and Canterbury suggest that the intellectual ability of the child, their sex, age, and family factors influence their recovery. Girls experience greater stress reactions than boys, bright children recover their pre-disaster functioning in school more rapidly, and families who have difficulty sharing their feelings experience greater distress. As expected, there also appears to be a direct relationship between the degree of exposure to frightening events and the difficulty in emotional adjustment and returning to pre-disaster functioning.

Other researchers have attempted to explain what factors influence children's reactions to traumatic or stressful events. In their review of the emotional effects of disaster, Lewis Aptekar and Judith Boore (1990) report that one's belief as to who or what caused the disaster and the degree of destruction are major factors influencing children's reactions. These authors have also identified five additional factors that influence recovery from the traumatic event:

- child's developmental level
- child's premorbid mental health
- community's ability to offer support
- parents' presence or absence during the event
- significant adults' reaction

A more recent review by Vogel and Vernberg (1993) also suggests the influence of children's developmental level on their ability to comprehend traumatic events, their coping repertoire, and their involvement with other groups of people beyond the immediate family.

In a longitudinal study, Vernberg, LaGreca, Silverman, and Prinstein (1996) provided a thoughtful account of how elementary school children responded to the disastrous impact of Hurricane Andrew in Dade County, Florida. These researchers concluded that many symptoms experienced by these children could be understood using an integrated conceptual model first discussed by Green et al. (1991). Green et al. investigated four factors:

- exposure to traumatic events during and after the disaster
- pre-existing child characteristics
- post-disaster recovery environment (social support)
- coping skills of the child

The model suggested by Vernberg, et al. (1996) increased the number of factors from four to five:

- exposure to traumatic events during and after the disaster
- pre-existing demographic characteristics
- occurrence of major life stressors
- availability of social support
- type of coping strategies used to manage disaster-related stress

The primary focus of this study was to ascertain what factors influence the lingering symptoms and subsequent identification of children experiencing PTSD. The authors conclude that symptoms associated with PTSD could represent normal adaptive reactions and that for many children

the effects of a disaster may still be observed beyond one to two years after the event. In trying to determine what made the various symptoms persist in these elementary age children, the researchers found the daily hassles of routine life in the weeks and months following the incident interacted with the severity of the trauma experienced making it difficult to recover. The strains of ongoing life events (e.g., loss of employment by a parent, divorce, or other stressors) also impact the availability of a supportive environment. Other factors identified by the authors were the overall loss of essential support from the community and schools given the respective impact of the disaster on these social systems.

TYPICAL REACTIONS OF CHILDREN

FEARS AND ANXIETIES

Fear is a normal reaction to disaster, frequently expressed through continuing anxieties about recurrence of the disaster, injury, death, separation, and loss. Because children's fears and anxieties after a disaster often seem strange and unconnected to anything specific in their lives, the child's relationship to the disaster may be difficult to determine. In dealing with children's fears and anxieties, accepting them as very real to the children is generally best. For example, children's fears of returning to the room or school they were in when the disaster struck should be accepted at face value, and interventions should begin with talking about those experiences and reactions.

Before the family can help, however, they must understand the children's needs; this also requires an understanding of the needs of the family. As discussed throughout this manual, families have their own unique pre-disaster profile of beliefs, values, fears, and anxieties. Frequently, dysfunction in the family is mirrored in the child's malfunctioning. The disaster mental health worker may need to talk with the family as a whole to better understand the role the whole family can play in responding to its own set of fears and anxieties that may exacerbate the fears expressed by the children. Sometimes, the pre-disaster level of dysfunction in the family may be so severe that referral for more formal mental health services may be necessary.

A parent's or adult's reaction to children makes a great difference in the children's recovery. The intensity and duration of children's symptoms

decrease more rapidly when families can show that they understand their feelings. When children believe their parents do not understand their fears, they feel ashamed, rejected, and unloved. Tolerance of temporary regressive behavior allows children to redevelop those coping patterns that had been functioning before the disaster. Praise offered for positive behavior produces positive change. Routine rules need to be relaxed to allow time for regressive behaviors to run their course and the reintegration process to take place.

When children show excessive clinging and unwillingness to let their parents out of their sight, they are expressing their fears and anxieties of separation or loss. They have experienced the harmful effects of being separated from their parents and in their clinging are trying to prevent a possible recurrence. Generally, the children's fears dissolve when the threat of danger has dissipated and they feel secure again under the parent's protection.

Children are typically most fearful when they do not understand what is happening around them. Every effort should be made to keep them accurately informed, thereby alleviating their anxieties. Adults frequently fail to realize the capacity of children to absorb factual information and do not share what they know. Consequently, children receive only partial or erroneous information.

Most important to resolving disaster related fears and anxieties in children is the quality of safety and security present in the family. The family should make every effort to remain together as much as possible, for a disaster is a time when the children need their caregivers around them. In addition, the model adults present at this time can be growth enhancing. For example, when parents act with strength and calmness, while maintaining control and sharing feelings of being afraid, they serve the purpose of letting the children see that acting courageously even in times of stress and fear is possible.

SLEEP DISTURBANCES

Sleep disturbances are among the most common problems for children after a disaster. Behaviors associated with sleep disturbances are likely to take the form of resistance to bedtime, wakefulness, unwillingness to sleep in their own rooms or beds, and refusal to sleep by themselves. Children will also express a desire to be in a parent's bed or to

sleep with a light on, insist that the parent stay in the room until they fall asleep, or may begin to rise at excessively early hours. Such behaviors are disruptive to a child's well-being. They also increase stress for parents, who may themselves be experiencing some adult counterpart of their child's disturbed sleep behavior. More persistent bedtime problems such as sleep terrors, nightmares, continued wakening at night, and refusal to fall asleep may point to deep-seated fears and anxieties that may require professional intervention.

In working with families, exploring the family's sleep arrangements may be helpful. Long-term adjustments in sleeping arrangements, such as allowing children to sleep routinely in the parent's bed, will inhibit the child's recovery process. However, temporary changes following a disaster may be in order. For very young children, it may be especially reassuring to have close contact with their parents during those times when disaster fears are most prominent. After a brief period of temporary changes, the parents should move toward the reinstatement of pre-disaster bedtime routines. Thus, the family may need to develop either new or familiar bedtime routines, such as reinstating a specific time for going to bed. The family may find it helpful to plan calming, pre-bedtime activities to reduce chaos in the evening. Teenagers may need special consideration for bedtime privacy. Developing a quiet recreation in which the whole family participates is also helpful.

Besides the above descriptions of fears, anxieties, and sleep disturbances, children's reactions to a disaster can be expressed in many different forms. Below are some more common reactions. (For convenience, the reactions are presented for three age groups: preschool or early childhood, latency age, and pre-adolescence and adolescence.)

PRESCHOOL, FIVE YEARS OLD AND YOUNGER

Most of the symptoms appearing in this young age group are nonverbal fears and anxieties expressed as the result of the disruption of the child's secure world. These symptoms include:

- crying in various forms, with whimpering, screaming, and explicit cries for help
- becoming immobile, with trembling and frightened expressions
- running either toward the adult or in aimless motion

- excessive clinging

Regressive behavior, that is, behavior considered acceptable at an earlier age and that the parent had regarded as past may reappear. This includes the following:

- thumb sucking
- bed-wetting
- loss of bowel/bladder control
- fear of darkness or animals
- fear of being left alone or of crowds or strangers
- inability to dress or eat without assistance

Symptoms indicative of fears and anxieties include:

- sleep terrors (i.e., child abruptly sits up in bed screaming or crying with a frightened expression and autonomic signs of intense anxiety. The child is unresponsive to the efforts of others to awaken or comfort him/her. If awakened, the child is confused and disoriented for several minutes and recounts a vague sense of terror usually without dream content.)
- nightmares (i.e., frightening or anxiety producing dreams)
- inability to sleep without a light on or someone else present
- inability to sleep through the night
- marked sensitivity to loud noises
- weather fears – lightning, rain, high winds
- irritability
- confusion
- sadness, especially over loss of persons or prized possessions
- speech difficulties
- eating problems

The symptoms listed above may appear immediately after the disaster or after the passage of days or weeks. Most often they are transient and soon disappear. Parents can help diminish the above symptoms in their

children through understanding the basis for the behaviors and giving extra attention and caring. If the symptoms persist for longer than a month, parents should recognize that a more serious emotional problem has developed and seek professional mental health counseling.

LATENCY AGE, SIX YEARS OLD THROUGH 11 YEARS OLD

Fears and anxieties continue to predominate in the reactions of children in this age group.

However, the fears demonstrate an increasing awareness of real danger to self and to the children's significant persons, such as family and loved ones. The reactions also begin to include the fear of damage to their environment. Imaginary fears that seem unrelated to the disaster also may appear.

Regressive behaviors may appear in this age group similar to those in the preschool group. Problem behaviors include the following:

- bed-wetting
- sleep terrors
- nightmares
- sleep problems (e.g., interrupted sleep, need for night light, or falling asleep)
- weather fears
- irrational fears (e.g., safety of buildings, or fear of lights in the sky)

Additional behavior and emotional problems include:

- irritability
- disobedience
- depression
- excessive clinging
- headaches
- nausea
- visual or hearing problems

The loss of prized possessions, especially pets, is very difficult for children in this age group. As noted in the previous section, the school environment and relationships with peers is central to the life of latency age children. School problems begin to appear and may take the form of:

- refusal to go to school
- behavior problems in school
- poor school performance
- fighting
- withdrawal of interest
- inability to concentrate
- distractability
- peer problems (e.g., withdrawal from play groups, friends, and previous activities or aggressive behaviors and frequent fighting with friends or siblings)

PREADOLESCENCE AND ADOLESCENCE, 12 YEARS OLD THROUGH 17 YEARS OLD

Adolescents have great need to appear competent to the world around them, especially to their family and friends. Individuals in this age group are struggling to achieve independence from the family and are torn between the desire for increasing responsibility and the ambivalent wish to maintain the more dependent role of childhood. Frequently, struggles occur with the family, because the peer group seems to have become more important than the parental world to the adolescent child. In the normal course of events, this struggle between adolescents and family plays itself out and depending on the basic relationships between the child and his or her parents, they resolve the trials and problems.

The effects of a major disaster on adolescents will vary depending on the extent to which it disrupts the functioning of the family and the community. The impact of the disaster may stimulate fears related to loss of family, peer relationships, school life, and even concern over the intactness of their own bodies. Adolescents struggling to achieve their own identity and independence from the family may be set back in this personal quest with reactivated fears and anxieties from earlier stages of

development. The trouble signs to watch for in pre-adolescents and adolescents include:

- withdrawal and isolation
- physical complaints (e.g., headaches or stomach pain)
- depression and sadness
- antisocial behavior (e.g., stealing, aggressive behavior, or acting out)
- school problems (e.g., disruptive behavior or avoidance)
- decline in academic performance
- sleep disturbances (e.g., withdrawal into heavy sleep, sleep terrors, or sleeplessness)
- confusion
- risk taking behavior
- alcohol and other drug use
- avoidance of developmentally appropriate separations (e.g., going to camp or college)

Most of the above behaviors are transitory and disappear within a short period. When these behaviors persist, they are readily apparent to the family and to teachers who should respond quickly. Teenagers, who appear to be withdrawn and isolate themselves from family and friends, are experiencing emotional difficulties. They may be concealing fears they are afraid to express. Just as many adults do, adolescents often show their emotional distress through physical complaints.

3 HELPING THE CHILD AND FAMILY

This section of the manual focuses on helping children and their families deal with the emotional aftermath of a disaster. Major disaster events irrespective of their origin impact all persons who experience the event. Evidence from numerous disasters clearly demonstrates that persons who are impacted by the event either directly or indirectly will experience a range of feelings and emotions regarding the effect of the disaster and its consequences.

While everyone interprets life events within the context of their experiences, children interpret their personal experiences within the limited context of their current stage of psychological development. As mentioned in the previous sections, the world of the child is defined by his or her stage of intellectual and emotional development, experiences with siblings and parents and extended family including grandparents, uncles, aunts, and cousins, the child's history and culture, and his or her school, peers, neighborhood, and community within which he or she lives. It is within the structure of these relationships that a child must cope with the impact of the disaster event.

Understanding the definition(s) of family for a child is essential to understanding the complexity of their emotional reaction to the disaster. Family in its most common definition is a group of persons consisting of parents and their children. However, in its broadest interpretation it can be defined as any class or group of related things. Thus given the appropriate context, a child's family can be as broad as their neighborhood, community, or school, or as narrow as their relationship to their parents. Considering the various definitions of family when trying to assess the depth of impact of a disaster on children is important and necessary to determine appropriate crisis counseling and disaster mental health recovery strategies.

Below are examples of some potential relationships that comprise the notion of family for children:

- children to natural parent, direct caregiver, or guardian

- children to brothers and sisters, living in the same and other households
- children to grandparents (maternal and fraternal)
- children to uncle, aunts, and cousins, within and distant from the impact area
- children to significant non-related adults
- children to the world of their school (teachers, staff, and students)
- children to school friends and neighborhood friends — from their inner circle of very close confidants to casual acquaintances
- children to community of worship (church, synagogue)
- children to persons in the communities of reference, (e.g., local neighborhood, village, town, city, county)

GENERAL STEPS IN THE HELPING PROCESS

A basic principle of working with children in disasters is that they are essentially normal children who have experienced great stress. Most of the problems that appear are likely therefore to be directly related to the disaster and transitory in nature.

The process recommended for helping children and families often starts with "crisis intervention," which trained and supervised paraprofessionals and volunteers can provide. The primary goal in crisis intervention is to identify, respond to, and relieve the stresses resulting from the crisis (disaster) and to reestablish normal functioning as quickly as possible. Sometimes the reaction is mild, but other times it is severe. Also, the workers must be trained to recognize when the condition is mild and can be handled by the families (with guidance), when referral to a helper, such as a school counselor is warranted, and when it is severe and requires intervention by a mental health professional.

The general steps in the helping process are:

1. ESTABLISHING RAPPORT

- Let the children know you are interested in them and want to help.

- Check with the children to make sure that they understand what you are saying and that you understand them.
- Display genuine respect and regard for the children and their families.
- Communicate trust and promise only what you can do.
- Convey acceptance of the children and their families.
- Communicate to the children and their families that you are an informed authority.

2. **IDENTIFYING, DEFINING, AND FOCUSING ON THE PROBLEM**
   - Identify and prioritize specific problems with the children, parents, and family.
   - Select a specific problem, define its characteristics, and focus on solving it first.
   - Achieve a quick resolution to the problem so that the members of the family experience a sense of success and control.
   - Evaluate the seriousness of each of the identified problems and the capacity of the family to deal with them.

3. **UNDERSTANDING FEELINGS**
   - Demonstrate your ability to see and feel as others do.
   - Display patience in trying to understand children's feelings, for children are frequently unable to express their fears.
   - Respond to the children's stories frequently by commenting on the events and affirming their feelings.
   - Express a nurturing positive regard for the children, to convey an appreciation for the kind and intensity of their feelings.

4. **LISTENING CAREFULLY**
   - Understand the disaster concerns from the point of view of the children.
   - Listen to the children's account of the disaster many times, in order to help children "work through" their feelings associated with the disaster.

- Refrain from interrupting the children as they tell their stories.
- Affirm children's feelings by giving them time to express themselves.

5. **COMMUNICATING CLEARLY**
   - Communicate in a language children understand.
   - Talk with children in groups or with siblings or other family members.
   - Seek the presence of family members to interpret code words used by the children.
   - Communicate with children in their dominant language.

THE ROLE OF THE FAMILY

As discussed earlier, many factors can influence the child's psychological definition of family. However, for purposes of the current discussion, the child's family is defined in terms of significant persons providing caregiving and support, who are also members of the child's nuclear and extended family structure. Since children live in family systems, both the experience of the disaster and recovery from its aftermath are most often mutually experienced. Consequently, children will share common aspects of the disaster event experience. The retelling of these experiences between the adults and children in the family can normalize the overwhelming rush of feelings associated with the disaster. For many families, the role of the outreach worker is simply to give them permission to share their feelings with each other and to communicate that having disaster related feelings is normal and sharing these feelings with each other is appropriate and healthy.

A function of the crisis counseling program is to convey information to parents about the common reactions of families to trauma and loss following a disaster. Often parents deny the need for this type of information for themselves, but will gladly participate in programs or gatherings where this type of information is provided for helping support their children. Typically parents will recognize stress reactions and accompanying behavioral changes in their children, before they recognize them in themselves. The disaster mental health worker helps all members of

the family unit by sensitizing parents to the signs of stress in their children and suggesting strategies for helping their children.

Outreach workers can remind parents of these simple facts:

- Parents should acknowledge the parts of the disaster that were frightening to them and other adults.
- Parents should not falsely minimize the danger as it will not end a child's concerns.
- The child's age affects how he or she will respond to the disaster. (A six-year-old may express his or her concerns by refusing to attend school, while an adolescent may express his or her concerns by arguing more with parents.)
- The way the child sees and understands his or her parent's response is very important.
- Parents should admit their concerns and also stress their abilities to cope with the situation.

Often the role of the family is simply to learn to work together to solve problems and actively recognize the needs and feelings of both the children and the adults. The identification of concrete issues that are problematic for the family unit, as well as for individuals within the family, is often the first step in the emotional recovery of the family. This is followed by crafting solutions to problems, resolving problems by implementing solutions, and celebrating the successes of positively resolving problems. Through this process, family members begin to reestablish mastery over their environment and bring back into equilibrium the role of each of the family members. By routinely repeating this process throughout the various stages of recovery, the family members will become closer as a unit and individually more autonomous, thus helping all members of the family reestablish their identity and proceed with their normal developmental roles.

In working with families of diverse backgrounds, outreach workers must be sensitive to language differences and cultural needs. Children are often thrust into the role of interpreter if their parents and relatives are not fluent in English. This responsibility may require skills beyond the child's current stage of development and be too stressful for the child. The outreach worker can relieve the child of this responsibility by seeking out adult interpreters for the family.

COMMON FEELINGS AND BEHAVIORS

Children and adults express signs and symptoms to stressful events along four dimensions: cognitive, emotional, physical, and behavioral. Common reactions expressed by children along each of these dimensions include the following:

COGNITIVE

- trouble concentrating
- preoccupation with the event
- recurring dreams or nightmares
- questioning spiritual beliefs
- inability to process the significance of the event

EMOTIONAL

- depression or sadness
- irritability, anger, resentfulness
- despair, hopelessness, feelings of guilt
- phobias, health concerns
- anxiety or fearfulness

BEHAVIORAL

- isolation from others
- increased conflicts with family
- sleep problems
- avoiding reminders
- crying easily
- change in appetite
- social withdrawal
- talking repeatedly about the event
- refusal to go to school
- arguments with family and friends
- repetitive play

PHYSICAL

- exacerbation of medical problems
- headaches
- fatigue
- physical complaints with no physical cause

CASE EXAMPLES

Below are examples of the situations that confront children in the aftermath of a disaster event. These examples are from ice storms in Maine, tornadoes in Texas and Arkansas, and floods in Louisiana and Texas.

1. Separation Anxiety

Katy, an eight-year-old girl, and her father were returning home from the video store one Saturday afternoon when a tornado struck. Katy and her father hunched down in the car, when suddenly the windows blew out and a tree fell across the hood. They crawled out of their demolished car shaken but miraculously unhurt. Katy's mom and two older brothers, who were in the home when the tornado struck, survived with only bumps, bruises, and one broken arm, but their two-story home was a pile of rubble.

The next few weeks after the tornado were difficult for Katy. She did not want to go to school and had difficulty sleeping at night. She had dreams about the tornado and feared leaving her mom, dad, and brothers. The teachers at school were supportive and understanding of Katy's needs. The first few weeks after the tornado Katy felt anxious and worried about her parents. School personnel allowed Katy to call and "check-in" with her parents at recess so she was assured that they were okay. Katy's family also held a family meeting and discussed what they should do to be safe at home, school, or work in the event of another disaster. After a few weeks, Katy could sleep in her own room again and go to school without much anxiety.

2. Acting Out

Tommy, an eleven-year-old fifth grader, had been receiving mental health treatment for disruptive behavior and defiance in the classroom prior to the tornado. He was responding well to treatment and receiving positive reports from his teacher. Tommy, who had never experienced any kind of disaster, was at a friend's house when the tornado struck and several trees came smashing through the windows. Tommy was not hurt physically by the tornado, but both his teachers and parents reported an increase in his disruptive and defiant behavior even though he continued in treatment. Upon review of Tommy's situation with the school and an interview with his parents, it became clear that no one had offered Tommy any opportunity to deal with his disaster related experience and with the subsequent stress he was trying to manage due to fears associated with the occurrence of another tornado. A series of visits by the disaster outreach workers to Tommy's home and school helped Tommy normalize his experience and feel more open about discussing his fears. Both his parents and teacher reported a lessening of Tommy's disruptive and defiant behavior.

3. Anxiety

Jill, a six-year-old, was at home with her mother and father on the afternoon when the tornado struck. The family escaped with no injuries. Jill started having problems within the next few days, scared that another tornado would strike. Jill would frequently question her parents about the weather and often became tearful.

Jill's mother called the 1-800 tornado coping line and asked for advice. The crisis counselor suggested that Jill's parents explain tornadoes to her, discuss the warning signs for a tornado in their community, and develop and practice its own family safety plan. The crisis counselor sent the family some informational materials about tornadoes. The crisis counselor called Jill's parents several days later to see how they were doing. Jill's parents reported that her fears had lessened by learning about tornadoes and knowing how to protect herself.

4. Disruptive Behavior at School

Following a major ice storm, Jason, age eight, was displaced from his home to a Red Cross shelter for eleven days waiting for power to be restored to his home. Greg, age eleven, was displaced from his family for thirteen days and spent this time with relatives in a very crowded house. Both children exhibited disruptive behaviors upon returning to school. Jason was constantly talking and appeared very anxious. Greg was inattentive in class and presented an angry and defiant manner. The outreach crisis counselor spoke with the teacher and offered to come to the weekly health class to talk about the ice storm and to tie the conversation with the classroom material about the five senses. The crisis worker first encouraged the children to share their personal experiences with the storm (i.e., What did you see? What did you smell? What did you hear? What did you feel?). This was a creative way of discussing the effects of the storm, providing assurance and information, and for the students to hear from their peers that they shared many of the same feelings. Within a few days both Jason and Greg settled back into their daily routines.

5. Adolescent Aggression

Patrick, a sixteen-year-old, became verbally aggressive and threatened other youths after only one night in a large urban shelter following a major flood. Patrick had a history of petty crimes, homelessness, and drug use, and was well known to the local police. Given Patrick's history and current behavior, the shelter manager and local police seriously considered removing him to a juvenile detention center. His mother met with the crisis counselor, the shelter manager, and a law enforcement official to work out an alternative plan. They asked Patrick to assist the National Guard in their duties distributing water and other food supplies. He readily agreed, helped the community, and with this more structured level of adult guidance was able to maintain good behavioral control and remain at the shelter.

6. Reactions Three to Six Months Post-Disaster

Several months following the floods, many children remained in temporary living situations. Roger, an eight-year-old third grader, continued to struggle with school work, became increasingly withdrawn from friends, and non-responsive at school. As the school year was nearing the end, his teacher became concerned he would not advance to the fourth grade. Consultation with the school guidance counselor and the crisis counseling outreach workers revealed that many children displaced from the same trailer park as Roger were still feeling anxious and tense and doing poorly in school. In some cases, the pressures of the long disruption had affected the relationships of the parents, and separations and divorces were occurring within the families of his peers.

The crisis counselors became more involved with Roger's class, assisting with field trips and performing skits about floods and the lengthy time it takes to return families to pre-disaster status. The counselors also began encouraging the families in the trailer park to get together with their neighborhood friends over potluck suppers to talk about common issues and plans to get things "back to normal." The school helped Roger's parents find a retired teacher to tutor Roger with his school work, so that he would be ready to advance to the fourth grade.

7. Anniversary Reactions of Children and Families

A crisis counseling team assisting the community to recover worked with schools and the local unmet needs committee to arrange a number of commemorative events to assist survivors during the anniversary of the disastrous floods. Some families were still waiting for financial assistance, while others were rebuilding their homes. Since many families had returned to their daily routines, there was some degree of community impatience with those still struggling with the impact of the flood. During the commemorative week of the anniversary, many children expressed lingering fears and a remaining sense of loss. The anniversary events focused on individual and community healing, celebrating their survival, and the accomplishments of the last

year. At several schools, outreach workers visited the younger children and distributed coloring books depicting the recovery and return to daily routines experienced by Andy and Allie, two young alligator characters who had lived through the storms. Through human interest stories revealing the ongoing needs of survivors, additional resources were donated to assist in their recovery.

4

GUIDELINES FOR CAREGIVERS, MENTAL HEALTH AND HUMAN SERVICE WORKERS

Disaster work almost always requires training, supervision, and consultation of human service workers, many of whom have little or no training in disaster issues. This section is directed to the various roles professionals, parents and caretakers of children may be called upon to serve during and following a disaster event. Side by side, professionals and paraprofessionals alike can work together to utilize basic skills in responding to the special needs of children who have experienced a disaster.

PROVIDING DISASTER MENTAL HEALTH SERVICES

The hallmark of a disaster mental health operation is to assist persons in dealing with their emotional response and recovery following the trauma of a major disaster event. The intended outcome is to return persons affected by the disaster to their pre-disaster level of coping. Since most disaster survivors do not perceive themselves as ill or in need of mental health services, crisis counseling programs emphasize outreach to communities, neighborhoods, churches, schools, and existing social networks to help persons who typically would not seek assistance from mental health service agencies. Hundreds of crisis counseling programs across the nation have repeatedly demonstrated that paraprofessionals indigenous to the affected community perform most effectively in the role of providing basic crisis counseling services. In these programs, it has been demonstrated that special services and programs for children have been developed within schools, extended school programs, communities, youth organizations, and summer recreational programs.

Children may have an extensive support system, but usually do not have the life experiences or coping skills that would assist them in responding to the dramatic changes in their lives caused by disaster. Knowing what kind of assistance is available in the community, through government, religious and private agencies, is critical in responding to the needs of children and families in disasters. Most services will be found in local government and private agencies. Professionals, paraprofessionals and caretakers such as teachers need to learn as much as practicable about the community resources specifically offering services to children. Examples are family services agenices, child guidance agencies, child care centers and after school programs.

However, due to the unpredictable nature of outreach work and the potential for engaging persons who may significantly benefit from professionally delivered mental health services, it is crucial that outreach workers are provided with sufficient levels of supervision from trained mental health professionals.

SUPERVISION OF HUMAN SERVICE WORKERS

The FEMA/CMHS Crisis Counseling Assistance and Training Program (commonly referred to as the Crisis Counseling Program) that follows a Presidentially declared disaster employs intervention models that mobilize a broad spectrum of persons with a great diversity of experience and training. Crisis Counseling Programs emphasize outreach to communities, neighborhoods, schools, and other networks to help persons who typically would not seek assistance from mental health service agencies. Hundreds of Crisis Counseling Programs across the nation have repeatedly demonstrated that paraprofessionals indigenous to the affected community perform most effectively in the role of outreach workers. Outreach workers must have certain communication skills and other attributes necessary for successfully conducting their roles, which are discussed in other CMHS publications. However, due to the unpredictable nature of outreach work and the potential for engaging persons who may significantly benefit from professional mental health services, it is crucial that outreach workers are provided with sufficient levels of supervision from trained mental health professionals. Below are

examples of the broad range of supervisory roles mental health professionals provide:

- **Supervision Through Didactic Training** – Increasing the knowledge base of workers through brief in-service sessions explaining the basics of human behavior and development, assessing survivor needs, and providing tips on engagement.
- **Group Supervision** – Team building through weekly review of current events and activities of the outreach workers. This includes discussing recent interactions with disaster survivors, problem-solving unique situations, and stimulating innovative thinking among outreach team members.
- **Individual Supervision** – Supporting each individual team member with strategies for managing administrative workload, emotional/professional commitment, personalization of outreach experiences, development of dependency relationships, and issues of transference and counter transference.

PROVIDING MENTAL HEALTH TRAINING

Crisis Counseling Programs often engage mental health professionals to provide specific information about working with special populations. After a disaster, persons in a community who would have little reason to meet each other now find they share a bond through the common challenge of post-disaster recovery. Outreach workers, volunteers, unmet needs committee members, emergency operations personnel, clergy, housing specialists, and others may be confronted with situations and persons with special needs with whom they have little or no experience. Children with serious emotional or behavioral disorders and their families are an example of a special population that disaster recovery personnel may encounter in shelters, disaster recovery centers, and other sites. Brief training sessions for operations staff by mental health professionals can alleviate much apprehension of personnel and equip them with information and strategies that will result in successful outcomes for all involved parties. Mental health professionals may be called upon to provide ongoing training on specific topics to crisis counseling staff. Examples include the following: specialized information topics about case finding techniques of in-home intervention, working with

children with developmental disabilities, issues related to family interventions, child abuse, and recognizing maladaptive patterns of alcohol and drug use.

SYSTEMS CONSULTATION

Mental health professionals also play a significant role as consultants to Crisis Counseling Programs. A common role of consultants is to provide orientation and ongoing project development training to the crisis counseling staff. In the context of children and their recovery, the main purpose of the consultant is to sensitize project staff to the mental health needs of children and families in their recovery from the disaster and to assist project staff to integrate their services through interagency collaboration with other child-serving agencies. Many communities throughout the country have developed Child and Adolescent Services System Programs (CASSP). These children oriented systems of care are designed for at-risk children with serious emotional disorders. In a time of a disaster, these agencies may represent significant resources to crisis counseling recovery programs. Often the child mental health professionals in a community play an important role in this network. They can provide consultation on how interagency collaboration is done in a specific community, as well as which combined community and agency resources may be available to disaster survivors. Consultants can also assist staff with issues of organizational boundaries, working with school administrators, referral criteria for various community services, and role clarification.

ASSISTING CRISIS COUNSELING STAFF TO MANAGE STRESS

Responding to the needs of children and families who are coping with the aftermath of a major disaster is physically demanding and emotionally charged work. This is true even for the seasoned mental health professional who is accustomed to the fast paced, often chaotic environment of mental health crisis intervention work. A distinguishing characteristic of disaster mental health work is that often the worker identifies on a personal level with survivors and cannot find a quick method for establishing psychological distance with the persons seeking assistance.

Additionally, the disaster mental health worker may also be a survivor of the disaster and must deal with issues concerning his or her own recovery and that of family members.

Acknowledging the high stress load of this work and implementing an array of stress reducing strategies is an important role for mental health professionals. Examples of typical stress management activities linked to Crisis Counseling Programs are: routine defusing and debriefing sessions during all phases of recovery operations, identifying a stress management counselor outside the project's administrative chain of command, offering ongoing stress management training sessions, providing auto-relaxation techniques, and assisting staff to recognize the signs and symptoms of burnout in survivors and staff.

Burnout is the normal result of increased demands and overwork after a disaster and may appear as persistent physical and emotional exhaustion, unrelieved feelings of fatigue, marked irritability, and a decrease in the individual's desire and ability to work effectively. With respect to staff working with children and families, burnout is often the result of overwork and over commitment. Burnout among project staff may be very harmful not only to the worker, but also to the disaster survivors who are seeking assistance. Project staff may become irritable with survivors and make promises they cannot possibly keep. CMHS strongly recommends that staff responsible for implementing disaster mental health services seek consultation on the development of a comprehensive stress management program as an integral part of their disaster recovery operations.

CONCLUSION

Most parents are capable of assisting their children in overcoming fears and anxiety related to a disaster event. However, when the situation seems beyond their reach, assistance can easily be provided through pediatricians, family physicians, or mental health and school counselors. Understanding and helpful intervention can reduce a child's fears and prevent more serious problems from developing. The manner in which adults, caregivers and mental health professionals help children to resolve their emotional turmoil at uncertain times may have a lasting effect on the child. Knowing the type of assistance that is available in a community is necessary in responding to the needs of children after a disaster.

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CHILDREN IN GRADES K-3:

Walton, W. *Weather or Not: Riddles for Rain and Shine.* Lemer Publications, 1990. ISBN# 0822523299.

CHILDREN IN GRADES 4-6:

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Stolz, M. *Storm in the Night.* Harper and Row, 1988. ISBN# 0060259124.

CHILDREN IN MIDDLE/JUNIOR SCHOOL:

Arnold, C. *Coping with Natural Disasters.* Walker and Co., 1988. ISBN # 0802767168.

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Wignell, E. *Escape by Deluge.* Holiday House, 1989. ISBN# 0823408027.

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Greenburg, K. *Hurricanes & Tornadoes (When Disaster Strikes).* Twenty First Century Books, (9-12), 1995. ISBN # 0805030956.

Mark, B. S., Layton, A., and Chesworth, M. *I'll Know What to Do: A Kid's Guide to Natural Disasters*. Magination. (Ages 9-12). 1997. ISBN # 0945354762.

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APPENDIX A

AGENCY ASSISTANCE IN DISASTERS

SERVICES FOR CHILDREN AND FAMILIES

When a disaster strikes a community, it temporarily disrupts the infrastructure of community services on which many children and families rely. It is essential for disaster mental health workers to become familiar with the remaining available post-disaster resources. Most communities have developed resource guides describing the available community services in their area. Seeking out information from community resource guides is always a good place to find what pre-disaster assistance is available for children and their families. Health and social services are provided through municipal, county (parish), non-profit, and private agencies in most communities. Direct services are usually not provided by the state government; however, in some areas of the country state government is directly involved in the delivery of services.

Assisting persons to cope with the aftermath of a major disaster requires access to traditional mental health services and to basic social and physical health services. The role of disaster mental health workers is to be aware of resources that can be useful to families and children as they go through the recovery process. Below is a partial listing of the types of organizations that are actively involved with children and families. These organizations are potential sources of information about existing and new resources that may be developed following a disaster:

- Area church /religious organizations
- Community mental health centers
- Case management agencies
- Child Adolescent Services System Program (CASSP) local teams
- Children's hospitals
- Family service agencies

- Foster care providers
- Home health agencies
- Local/county public health agencies
- Local professional associations for mental health professionals
- Local funding organizations such as the United Way and non-profit foundations
- School counselors
- Social service (welfare) and child protection agencies
- Support groups for child-related disorders such as attention deficit disorder or support groups for various learning disabilities

HUMAN SERVICES PROGRAMS

Below is a listing of current programs administered through the Federal Emergency Management Agency (FEMA) and other related federal agencies. These programs are authorized under the Robert T. Stafford Emergency Assistance and Disaster Relief Act or other federal legislation.

❖ *CORA BROWN FUND*

These funds are used to assist survivors of Presidentially-declared major disasters for disaster-related needs that have not or will not be met by governmental agencies or other organizations which have programs to address such needs. Disaster survivors do not apply directly for these funds. The FEMA Regional Director, with assistance from other governmental agencies and disaster volunteer agencies, identifies potential recipients. This fund may not be used in a way that is inconsistent with other Federally mandated disaster assistance programs. A verification of the facts of each case must be conducted by the FEMA Regional Director, who then prepares a memorandum of recommendation and decision to the Deputy Associate Director, Response and Recovery Directorate.

❖ *CRISIS COUNSELING ASSISTANCE AND TRAINING PROGRAM*

This program is designed to provide supplemental funding to states for short-term crisis counseling services to people affected by Presidentially-declared disasters. There are two separate portions of

the Crisis Counseling Program which can be funded: immediate services for up to sixty days of assistance following the disaster declaration date and regular services for an additional nine months. The program is available to State Mental Health Authorities through the State Office of Emergency Services and is administered by FEMA with technical assistance and collaboration from the Center for Mental Health Services.

❖ *DISASTER HOUSING ASSISTANCE PROGRAM*

The Disaster Housing Assistance Program makes temporary housing and funds available to individuals whose home is uninhabitable because of a disaster.

❖ *DISASTER LEGAL SERVICES*

Through an agreement with the Young Lawyers Division of the American Bar Association, free legal advice is available for low-income individuals regarding cases that will not produce a fee (i.e., those cases where attorneys are paid part of the settlement which is awarded by the court). Cases that may generate a fee are turned over to the local lawyer referral service.

❖ *DISASTER UNEMPLOYMENT ASSISTANCE (DUA)*

Unemployment benefits may be available through the State unemployment office and are supported by the U.S. Department of Labor. The benefit period begins with the week (as defined by State law) following the disaster incident or date thereafter that the individual becomes unemployed and can extend for up to 26 weeks. The DUA benefit amount may not exceed the maximum weekly amount authorized under the unemployment compensation law of the State in which the disaster occurred. Individual eligibility is dependent on other available unemployment benefits to the victim/survivor. Individuals should contact a local office of the agency that administers the UI program in their State. It should be listed in the State government section of the telephone directory under such titles as Unemployment Insurance, Unemployment Compensation, Employment Security, or Employment Service.

❖ *INDIVIDUAL FAMILY GRANT PROGRAM (IFG)*

The purpose of the IFG is to provide funds for the necessary expenses and serious needs of disaster survivors. IFG funds are for

expenses that are not met through other means of federal or private assistance (e.g., Small Business Administration loan or private insurance). The maximum grant amount is adjusted annually in accordance with changes in the Consumer Price Index (CPI). IFG eligible categories include: real and personal property, medical, dental, funeral, and transportation. Ineligible costs are: improvements or additions to real or personal property, recreational property, cosmetic repair, business expenses, and debts incurred before the disaster. Home inspections are normally conducted before a check is issued. The IFG program is administered by the state.

❖ ***STRESS MANAGEMENT PROGRAM***

This program is intended to ameliorate, to the extent practicable, the stresses experienced by its disaster workers as a result of the demands of working directly in a disaster operation. The Center for Mental Health Services works in collaboration with FEMA on the implementation of this program.

❖ ***DEPARTMENT OF VETERANS AFFAIRS (VA)***

The VA provides death benefits, pensions, insurance settlements, and adjustments to home mortgages for veterans.

❖ ***INTERNAL REVENUE SERVICE (IRS)***

The IRS can allow certain casualty losses to be deducted on Federal Income Tax returns for the year of the loss or through an immediate amendment to the previous year's return.

❖ ***U.S. SMALL BUSINESS ADMINISTRATION DISASTER LOANS (SBA)***

Most, but not all, federal assistance is in the form of low interest loans to cover expenses not covered by the state or local programs, or private insurance. Loans are available to individuals, businesses, and farmers for repair, rehabilitation, or replacement of damaged and real personal property and some production losses not fully covered by insurance.

❖ ***SOCIAL SECURITY ADMINISTRATION (SSA)***

The SSA provides no special benefits during a disaster, however SSA staff are provided to the Federal Coordinating Officer and Disaster Recovery Centers to process SSA benefit services such as:

processing survivor claims, obtaining eligibility evidence for claims processing, resolving problems with lost or destroyed Social Security checks, and redevelopment of lost/destroyed pending claims.

APPENDIX B

SOURCES FOR ADDITIONAL INFORMATION

ADMINISTRATION FOR CHILDREN AND FAMILIES, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
http://www.acf.dhhs.gov/

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
http://www.aacap.org/web/aacap/

AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN
http://www.cwla.org/mentalh/mentalhealth.html

CHILD, ADOLESCENT AND FAMILY BRANCH, THE CENTER FOR MENTAL HEALTH SERVICES
http://www.mentalhealth.org/cmhs/ChildrensCampaign/index.htm

CONNECT FOR KIDS
http://www.connectforkids.org/index.htm

FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH
http://www.ffcmh.org/

GEORGETOWN UNIVERSITY CHILD DEVELOPMENT CENTER
http://www.dml.georgetown.edu/depts/pediatrics/gucdc/

KIDS COUNT
http://www.aecf.org/aeckids.htm

NATIONAL ASSOCIATION FOR THE MENTALLY ILL
http://www.nami.org/

NATIONAL MENTAL HEALTH ASSOCIATION
http://www.nmha.org/children/index.cfm

PARENT ADVOCACY COALITION FOR EDUCATIONAL RIGHTS (PACER)
http://www.pacer.org/

PARENTS PLACE
http://www.parentsplace.com/

RESEARCH AND TRAINING CENTER ON FAMILY SUPPORT AND CHILDREN'S MENTAL HEALTH
http://www.rtc.pdx.edu/

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Rockville, Maryland 20857

Official Business
Penalty for Private Use $300

DHHS Publication No. ADM 86-1070R
Substance Abuse and Mental Health Services Administration
Revised 2000

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