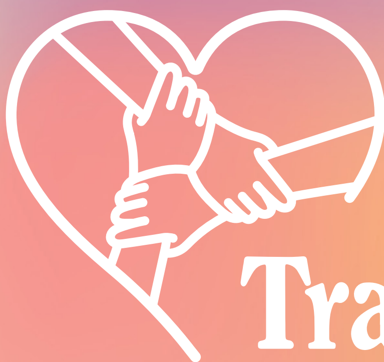


Trauma-informed Mental Health and Psychosocial Support for Children during Disasters

A Training Manual for Counsellors

August 2024

By

RAHBAR, A FIELD ACTION PROJECT OF THE SCHOOL OF HUMAN ECOLOGY, TATA INSTITUTE OF SOCIAL SCIENCES

In Collaboration With

NATIONAL DISASTER MANAGEMENT AUTHORITY

Contents

FOREWORD 3

PREFACE 4

A. ABBREVIATIONS 6

B. AUTHOR BIOS 7

C. ABOUT THE MANUAL 10

SECTION 1: DISASTERS, TRAUMA AND CHILD MENTAL HEALTH 14

SECTION 2: TRAUMA RESPONSES IN CHILDREN DURING DISASTERS 38

SECTION 3: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) FOR CHILDREN AFFECTED BY DISASTERS 65

SECTION 4: TRAUMA-INFORMED MHPSS INTERVENTIONS FOR CHILDREN DURING DISASTERS. 90

राष्ट्रीय आपदा प्रबंधन प्राधिकरण
National Disaster Management Authority
भारत सरकार
Government of India

Foreword

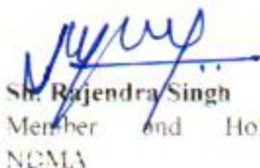
The National Disaster Management Authority (NDMA) is pleased to present the manual, *Trauma-Informed Psychosocial Support for Children Experiencing Natural Disasters*, developed in collaboration with Rahbar, a field action project of the Tata Institute of Social Sciences (TISS), Mumbai. This manual reflects a shared commitment to addressing the psychosocial needs of children, one of the most vulnerable groups affected by natural disasters, through a structured and trauma-informed approach.

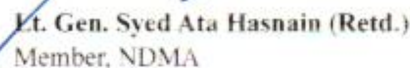
Natural disasters profoundly disrupt lives, and children are particularly susceptible to the psychological and emotional consequences. Providing effective support requires interventions that are scientifically grounded, contextually relevant, and delivered with empathy. This manual is designed to equip mental health professionals with the necessary tools and frameworks to address these challenges, combining global best practices with local insights for a robust and effective response.

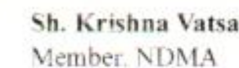
NDMA has long recognized the critical importance of integrating mental health and psychosocial support (MHPSS) into all stages of disaster management. This collaboration with Rahbar has produced a resource that serves as both a guide and a call to action, advocating for the prioritization of children's mental health within disaster response frameworks. The manual not only highlights theoretical underpinnings but also provides practical strategies to empower professionals in supporting children during and after disasters, fostering resilience and safeguarding their rights.

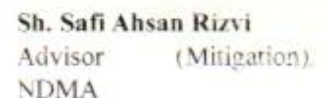
Special acknowledgment is extended to the team at Rahbar, under the leadership of Dr. Chetna Duggal, whose expertise and dedication have been pivotal in the development of this manual. Their contributions exemplify a commitment to advancing the field of psychosocial care in disaster contexts.

This manual is intended to be a resource for professionals and organizations working at the nexus of mental health and disaster response. NDMA remains steadfast in its mission to ensure that psychosocial care becomes an integral part of disaster management, contributing to a more resilient and inclusive future for all.









Sh. Rajendra Singh
Member and HoD, NDMA

Lt. Gen. Syed Ata Hasnain (Retd.)
Member, NDMA

Sh. Krishna Vatsa
Member, NDMA

Sh. Safi Ahsan Rizvi
Advisor (Mitigation), NDMA

टाटा सामाजिक विज्ञान संस्थान
Tata Institute of Social Sciences
मुम्बई Mumbai | तुळजापुर Tuljapur | गोवाहाटी Guwahati | हैदराबाद Hyderabad

भविष्य की पुनर्कल्पना RE-IMAGINING FUTURES
TISS
Estd. 1936

PREFACE

Over the past century, India has faced a relentless series of natural calamities and disasters. Between 1995 and 2020 alone, the country endured nearly 400 floods and cyclones, followed by the unprecedented challenges of the COVID-19 pandemic. These events have had devastating repercussions, profoundly impacting millions of lives. As we look to the future, experts predict an intensification of natural disasters, including severe floods, prolonged droughts, extreme heatwaves, and potential global pandemics. These crises are anticipated to cause widespread disruptions, exacerbating pre-existing vulnerabilities and leading to significant challenges such as loss of livelihoods, forced migration, social instability, and collective trauma.

In the aftermath of such disasters, mental health repercussions emerge as a critical concern. The interplay of local cultural and social dynamics often shapes the mental health needs of affected communities. Disrupted access to basic necessities, social and economic instability, isolation, and stigma underline the urgent need for effective mental health and psychosocial support (MHPSS) services tailored to the unique challenges faced by disaster-affected populations.

Recognizing this urgent need, the National Disaster Management Authority of India (NDMA) partnered with *Rahbar*, a field action project of the School of Human Ecology at Tata Institute of Social Sciences. This collaboration seeks to bridge the gap in training and knowledge for delivering MHPSS during disasters. The partnership began during the COVID-19 pandemic, when *Rahbar* provided supportive supervision to mental health professionals offering psychosocial support through NDMA's reverse helpline. A pivotal outcome of this collaboration was the development of the training manual, *Psychosocial Support during the COVID-19 Pandemic: A Training Manual for Counsellors*.

Building on this foundation, NDMA and *Rahbar* extended their efforts post-pandemic, culminating in the updated *National Guidelines on Mental Health and Psychosocial Support during Disasters*, released in December 2023. Continuing this vision, two comprehensive manuals have now been created to enhance best practices in delivering MHPSS to adults and children in disaster-affected communities.

These manuals integrate international best practices with valuable field insights and are deeply rooted in the principles of community care, trauma-informed approaches, and social justice. They provide actionable guidelines and strategies to empower mental health professionals, enabling them to respond effectively and compassionately to the mental health needs of disaster-stricken populations.

.... 2/-

वी.एन. पूरव मार्ग
देवनार, मुम्बई 400 088.
V. N. Purav Marg,
Deonar, Mumbai 400 088.

दूरभाष Telephone: 022 2552 5000
फैक्स Fax: 91 22 2552 5050
वेबसाइट Website: www.tiss.edu

A Deemed to be University established under Section 3 of the UGC Act, 1956, vide Notification No. F11-22/62-U2, dated 29th April, 1964, of the Government of India, Ministry of Education

पूरक पत्र
Continuation Sheet

I commend the *Rahbar* team, led by Dr. Chetna Duggal, Associate Professor at the School of Human Ecology, for their tireless efforts in developing these manuals. I extend my gratitude to NDMA for its visionary leadership in embedding trauma-informed approaches into disaster response frameworks and for emphasizing the importance of training and supervision for counsellors.

It is my sincere hope that these manuals and guidelines will serve as invaluable resources for mental health professionals across the country, equipping them to address the profound mental health challenges that disasters leave in their wake.

Prof. Shankar Das
Pro Vice-Chancellor

List of Abbreviations

ACA- American Counselling Association

ACE- Adverse Childhood Experiences

ANS- Autonomic Nervous System

APA- American Psychiatric Association

CAMH- Center for Addiction and Mental Health

DMA- Disaster Management Act

DSM- Diagnostic and Statistical Manual of Mental Disorders

FEMA- Federal Emergency Management Agency

IEC- Information, Education and Communication

IFRC- International Federation of Red Cross and Red Crescent Societies

MHCA- Mental Health Care Act

MHP- Mental Health Professionals

MHPSS- Mental Health and Psychosocial Support

NCTSN- National Child Traumatic Stress Network

NDMA- National Disaster Management Authority of India

NGO- Non-Governmental Organization

NIMH- National Institute of Mental Health

PTSD- Post Traumatic Stress Disorder

SAMHSA- Substance Abuse and Mental Health Services Administration

TISS- Tata Institute of Social Sciences

UNCRC- United Nations Convention on the Rights of the Child

UNDRR- United Nations Disaster Risk Reduction

UNICEF- United Nations Children's Fund

USDVA- United States Department of Veterans Affairs

WHO- World Health Organization

Author Bios

Dr. Chetna Duggal

is Associate Professor at the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. She has completed her Ph.D. from TISS, Mumbai and her M.Phil. in Clinical Psychology from NIMHANS, Bangalore. She is a psychotherapist with over 20 years of experience and has worked with children, adolescents, couples and families. She teaches courses on psychotherapy and counselling in the Masters programme and supervises trainee counsellors and practitioners. She is the Project Director for Rahbar, an initiative to promote training, supervision and professional development for mental health practitioners in India. She also heads the School Initiative for Mental Health Advocacy (SIMHA), an initiative that endeavours to promote well-being of young people in schools through advocacy, research and capacity building. She is the trustee of Apnishala, an organisation working towards making life skills education accessible to children from underprivileged contexts. She has a keen interest in psychotherapists and counsellors training, supervision and reflective practice, and has conducted research and authored book chapters and papers on the same.

Ms. Bakul Dua

is a Clinical Psychologist based in Bengaluru. She has over 16 years of experience in clinical practice, research and advocacy and has worked in clinical and community contexts across Delhi, Mumbai and Bengaluru. She comes from a multidisciplinary background in the humanities, having completed her M.Sc. in Cultural Studies from at the London School of Economics, M.A in Counselling Psychology from the Tata Institute of Social Sciences (Gold medalist) and M.Phil. in Clinical Psychology from the National Institute of Mental Health and Neurosciences (Gold medalist). She is currently a doctoral scholar at the School of Human Ecology at TISS. She is the Project Coordinator of Rahbar – a field action project at TISS which provides training and supervision to mental health professionals across India. She works as a psychotherapist in independent practice in Bengaluru and also leads programming at the India Mental Health Alliance.

Ms. Mrinalini Mahajan

is a Clinical Psychologist working as a private practitioner in New Delhi. She has experience of working with individuals with psychiatric difficulties as well as children who are survivors of sexual abuse. Her special interest is in working with individuals with histories of trauma which also aligns with her research interest. She has an MPhil in Clinical Psychology from NIMHANS (Bangalore), an MA in Clinical Psychology from TISS, Mumbai (Silver Medalist) and a BA (Hons.) Psychology from Delhi University (Gold Medalist). Her therapeutic work is a reflection of her beliefs about acknowledging and appreciating the role of social justice, intersectionality and socio-political frameworks in the sphere of mental health.

Ms. Sarika Bapuji

is a Clinical Psychologist and Psychotherapist in private practice, based out of Bengaluru. She began her journey in the field of mental health 13 years ago and has a keen interest in providing psychological care and support at the community level. Sarika has experience of working with adolescents, young and middle aged adults across settings including hospitals, schools and corporate organisations in Chennai, Bengaluru and Mumbai.
She completed her professional training in Clinical Psychology at the National Institute of Mental Health and Neurosciences, Bengaluru (MPhil) and Tata Institute of Sciences, Mumbai (M.A.).
Sarika uses a Relational and Attachment-first lens in her practice and is passionate about creating awareness about and access to mental health care and support at the community level.

Introduction

About the Manual

BACKGROUND

This manual has been developed with the aim of being a resource for mental health professionals working with children experiencing trauma such as natural disasters. It has been developed by Rahbar, in collaboration with the National Disaster Management Authority (NDMA). Rahbar is a field action project of the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. Rahbar was founded in 2019, as a platform for promoting supervision and training in mental health practice, with a focus on resource constrained contexts. Ever since its inception, Rahbar has collaborated with the NDMA through multiple initiatives. Between 2019 and 2021, Rahbar partnered with NDMA to provide training and supervision support to volunteer counsellors leading NDMA's psychosocial helpline for persons diagnosed with Covid-19. The sessions informed the development of the training manual titled 'Psychosocial Support during the COVID-19 pandemic: A training manual for counsellors' (https://ndma.gov.in/sites/default/files/PDF/covid/RAHBAR_%20NDMAmanual.pdf). NDMA and Rahbar also documented this work through the research titled 'Psychosocial Support for Individuals Diagnosed with Covid-19: Experiences of Volunteer Counsellors from India' (https://ndma.gov.in/sites/default/files/PDF/covid/Psychosocial-Support-forIndividuals-Diagnosed-with-Covid-19.pdf). Following this, in 2023 Rahbar worked on updating the National Disaster Management Guidelines on Mental health and Psychosocial Support Services in Disasters. The updated guidelines provide a pathway to integrate and mainstream psychosocial care in every stage of the disaster management cycle using a whole-society and trauma-infomed approach in line with global best practices and contextual realities.

Most recently, the NDMA and Rahbar collaborated to provide psychosocial work following the landslide in the state of Sikkim. It included creating resources for community sensitization and facilitating awareness programs for school students to identify emotional responses during disasters and sharing strategies for

managing distress. Tele-Manas counsellors from the state were trained in trauma-informed practices for working with traumatic responses commonly seen in the aftermath of disasters. A reverse helpline was started in which the counsellors contacted those most severely affected by the landslide to provide psychosocial support. Rahbar provided supervision and debriefing support to the counsellors during this time.

This collaboration culminated in preparing a manual titled ‘Trauma-informed approach to Mental health and Psychosocial Support During Disasters: A Training Manual for Counsellors’. The manual with a trauma-informed framework of psychosocial support to equip counsellors in addressing the mental health concerns of adults that arise in the context of disasters. The manual integrated international best practice guidelines with practice-based insights of trainers and supervisors, as well as counsellor education frameworks and it aimed to be a resource for mental health professionals not only in India, but across the world). As a part of this project, Rahbar also conducted a Training of Trainers (ToT) for 30 mental health professionals from Andhra Pradesh, Delhi, Gujarat, Kerala, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh, Uttarakhand and West Bengal. The training aimed to provide participants with an overview of mental health and psychosocial support (MHPSS) during disasters. Participants were given an overview of mental health during disasters and the responses they might come across. The neurobiological and theoretical basis of trauma-informed care and takeaway key strategies to help counsellors provide mental health and psychosocial support during disasters were discussed.

In continuation of this work, Rahbar recognised a similar need for a trauma-informed framework of psychosocial support to equip counsellors working with children in disaster affected regions. The current manual was developed with the sole focus of being a resource for the psychosocial support of children experiencing distress in relation to natural disasters.

OVERVIEW

Provided below is an overview of the four chapters in this manual.

CHAPTER 1: The introductory chapter provides an overview of the concept of trauma in the context of natural disasters. It focuses on introducing the rights of children and trauma-informed care. Readers will be introduced to risk and protective factors influencing children's experience of trauma.

CHAPTER 2: The second chapter focuses on children's response to trauma. Readers will be introduced to the psychological impact and manifestations of trauma in children who have expereinced natural disasters.

CHAPTER 3: The third chapter focuses on the principles, values and ethics of providing mental health and psychosocial support to children. Readers will be introduced to the therapeutic frameworks which inform interventions for children proposed in this manual.

CHAPTER 4: In the last chapter, we discuss specific trauma-informed interventions for providing MHPSS to children during and in the aftermath of the disasters. Readers will be introduced to these interventions to support children in disaster settings

CHAPTER 1

Disasters, trauma and child mental health

1

WHAT IS TRAUMA?

Trauma has been defined in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013), as "exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event(s) occurred to a close family member or close friend (in case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (DSM 5, APA, 2013). This definition focuses on the traumatic event.

The American Psychological Association (2015) highlights the experience of trauma where it is seen as an emotional response to a difficult event like an accident, rape or natural disaster. Immediately after the event, shock and denial are usually present. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea (APA, 2015).

The definition of trauma by Substance Abuse and Mental Health Services Administration (SAMHSA) highlights the effect that a traumatic event can have on those who experience it. SAMHSA has specifically defined trauma as resulting "from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p.7). This definition of trauma is sometimes used to define "psychological trauma" to help differentiate it from other types of trauma such as physical trauma like having a fractured limb or meeting with a road traffic accident. Psychological trauma can therefore be understood in terms of the event, the individual's experience of the event and the adverse long-lasting effects of this experience.

Thus, the 3 Es of trauma are (SAHMSA, 2014):

Events	These are the single, multiple or extended situations and circumstances posing an actual or extreme threat of physical or psychological harm.
Experience	The subjective experience that determines if the event is traumatic for the individual. This may include feelings of humiliation, guilt, shame, horror, betrayal, or silencing. These are influenced by the individual's developmental stage, cultural beliefs, and access to social support.
Effects	These refer to the impact of the experience on the person. Effects of the event may be immediate, or delayed; short term, or long term.

2 WHY ARE DISASTERS CONSIDERED TO BE TRAUMATIC EVENTS?

Disasters can be naturally occuring, man-made or deliberately caused. The Disaster Management Act (2005) defined natural disasters as "a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man made causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of property, or damage to, or degradation of environment and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area" (DMA, 2005, p.4). The impact of natural disasters on affected communities can be devastating and have long lasting repercussions (UNDRR, 2015).

The common elements across different definitions of trauma suggest that trauma involves a deeply disturbing event or series of events that make a person feel like their resources are thoroughly exhausted. It leaves them with a significant amount of distress and can negatively affect their functioning. A traumatic event may be "caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge

an individual's view of the world as a just, safe, and predictable place" (American Psychological Association, 2015, p. 1104; DSM, APA, 2013).

3

WHY FOCUS ON THE IMPACT OF DISASTERS ON CHILDREN?

Childhood is a crucial and vulnerable period in human development. In comparison to the fully developed adult, a child's mind, body, and brain are rapidly growing and developing, making for an extremely sensitive period in one's life. From infancy to late adolescence, the child moves through various stages of development. In each phase the child experiences unique physical, cognitive, social and emotional changes, and requires different levels of support from the environment to thrive and flourish. For instance, an infant relies on caregivers to be fed, clothed, soothed and so on, but an eight year old may be able to do all of these tasks independently. Similarly a 4 year old would require a lot of active engagement from caregivers to manage overwhelming emotions, while a teenager who experiences overwhelming emotions may require privacy and guidance while learning to manage stress.

Due to these considerations, mental health support for children needs to be relevant and sensitive to the individual characteristics of a child, their family and social contexts.

Natural disasters can directly or indirectly impact children (Kousky, 2016; Pfefferbaum et al., 2015). Some examples of direct impacts include physical injuries or physical illnesses, loss of loved ones, loss of one's home and so on. Indirect impacts are those that do not affect the child directly but impact the environment of the child instead. Examples of indirect impact include the destruction of community properties such as schools or hospitals. Both direct and indirect impacts of disasters affect a child's well-being and mental health. Hence it is important for us as MHPs to be mindful of the impact of disasters on children, how they may affect a particular child and address them in our MHPSS interventions.

Reflective Exercise

- When we see children and their caregivers in the aftermath of a disaster, how can we decide whose needs to address first?
- How can our role as MHPs be different when working with the direct and indirect effects of disasters?

4

WHAT ARE THE IMPORTANT CONSIDERATIONS FOR UNDERSTANDING THE IMPACT OF DISASTERS ON CHILDREN?

4.1 ADULTS PLAY A SIGNIFICANT ROLE IN CHILDREN'S EXPERIENCE OF DISASTERS.

While the degree of support may vary with age, all children are dependent on adults for their needs (Shaw, 2000). Parents, school teachers and close family make significant contributions to the way in which children understand the world around them. Parents tend to be a primary form of emotional support for children and the quality of the bond they share plays an important role in the child approaching their parents for support (Pfefferbaum et al., 2015). How parents respond to traumatic events can significantly influence the nature of their children's responses too. For example, if a parent is highly stressed or anxious after an incident, the child may also respond with significant distress, whereas if the parent evaluates the situation as manageable and feels hopeful about dealing with it, the child may also be more likely to feel more positive about the situation (Shaw, 2000; North et al., 2018).

4.2 CONDITIONS OF THE FAMILY BOTH PRE AND POST THE DISASTER WILL IMPACT CHILDREN'S EXPERIENCE OF DISASTERS.

When it comes to the context of the family, the family's socio-economic status, their overall community support, and educational levels of family members are some important factors that affect the family's ability to cope with traumatic events (Koenen et. al, 2010, Pfefferbaum et al., 2015). How severely a family's functioning is affected by a traumatic event affects the child's experience of

it too (Shaw, 2000). For example, after a flash flood an affected family may be forced to rebuild their house and may have suffered severe financial losses as a result. Families may experience severe financial problems such as loss of jobs, property, dilution of assets, debt accumulation and so on during disasters. These financial issues may have short-term or long-term repercussions. The socioeconomic status of the family prior to the exposure of the natural disaster will influence their experience of the disaster. Children from families belonging to lower SES backgrounds which may have experienced chronic financial instabilities are likely to experience significant psychological stress (Kreimer, 2001; Kousky, 2016; FEMA, n.d.; Reiss, 2013; Hawkins, 2009).

4.3 DIFFERENT SOCIAL IDENTITIES OF THE CHILD WILL AFFECT THEIR EXPERIENCE OF DISASTERS.

All children have different 'social identities' based on their belonging to a certain gender, age, caste, class and so on. These identities come together or intersect to create a unique social location for each child. The combination of each child's unique social position is referred to as Intersectionality. Intersectionality can be defined as "..a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles….." (Crenshaw, 1989, p.8). Intersectionality lens looks at different social factors such as gender, race, class, caste, nationality, sexuality and so on, that make us all have different social standings in society. It proposes that based on our social demographics, some of us have more power in society than others (Runyan, 2016). For example, in our Indian context some castes have been historically more advantaged in society, than some other castes. This is particularly difficult for women from certain historically marginalised castes who would then be even more at risk following disasters. Even within this subgroup, adolescent girls might be more at risk as their needs may be significantly neglected or stay unacknowledged. Following a disaster, the need for sanitation pads for adolescent girls may remain unheard particularly if, historically, the elders do not have the knowledge to use or buy them due to their unavailability

Reflective Exercise

When a person is "exposed to multiple and varied traumatic stressors", they can experience what is referred to as **Polyvictimisation** (Ford & Delcker, 2018, p1). As the name suggests, when a child is in a situation in which they are faced with different types of stressors simultaneously, they may be at the risk of experiencing much higher levels of trauma, compared to another child who is not dealing with multiple stressors simultaneously.

> *Jothi is a 12 year old child survivor of a cyclone-stricken fishing village, who has lost both her grandmother and her home to the calamity. Her father is a fisherman, her mother a day-wage labourer, while Jothi studies at the public school in her village. Most children in the community she hails from have lost a family member, homes or shops to the disaster. In this way her experiences are similar to other children and families in the community. It's been a few months since the cyclone occurred, but their community is yet to receive aid from the relevant local bodies or NGOs around the area. The school has been shut, most of their houses destroyed and the nearest hospital four bus stops away. Now consider that a few months before the cyclone occurred, she lost her brother in a hit-and-run road accident. Apart from dealing with his loss, she has also been dealing with severe anger and distress due to the injustice around the circumstances of his death. Her parents have spent most of their money on filing a police complaint and paying for a local lawyer. Now they do not have any money to reconstruct their home. Jothi has been severely distressed and has been constantly anxious about how her family will make ends meet. She cannot stop crying about her brother and feels very guilty about thinking about the cyclone a lot more than she has been able to think about him.*
>
> 1. What are the different kinds of stressors faced by Jothi and her family?
> 2. What are some factors that could make Jothi more vulnerable to stress than other children in the community?
> 3. What are some aspects we must account for in our intervention plan for Jothi?

Reflective Exercise

Here is the story of another child from Jothi's community.

> *Consider the story of Vicky, a 16 year old male child who is visually impaired and as a result does not go to school. He belongs to a single-parent family and was fortunate enough not to lose his father to the disaster. However their house was severely damaged and Vicky's father was injured badly on the day of the cyclone. His father is unable to function due to the injuries and has been in bedrest for several weeks. Vicky is having significant fears about another cyclone occurring and has been hearing the voices of people screaming every night in his sleep. He wakes up with a racing heart and drenched in sweat almost every night. He also keeps having vague dreams about death and constantly worries about his father's health. He is severely stressed during the day because he is unable to assist his father in recovery, nor is he able to help around his community or participate in ways that he'd like to. Not many people visit their home or support them because Vicky and his father have more or less kept to themselves for many years now.*
>
> **Compare Jothi's story to Vicky's.**
>
> 1. What are the unique social factors to consider in each of their stories?
>
> 2. In our plan to support them, what can we do to address some of these concerns?

While analyzing the uniqueness of the circumstances that Vicky and Jothi are situated in after the disaster, factors such as their age, the ways in which the cyclone impacted each of their families, the social support and financial situation of the families are all important to consider. Vicky at 16 years of age might have more developed psychological abilities to cope with this situation, compared to Jothi at 12 years of age. However, as a child who is visually impaired, the subjective manner in which the disaster affects Vicky needs to be factored in; which may be significantly different from how it impacts a neurotypical child such as Jothi.

5

WHAT ARE THE RISK AND PROTECTIVE FACTORS THAT INFLUENCE THE EXPERIENCES OF CHILDREN WHO HAVE BEEN EXPOSED TO DISASTERS?

Some children may be at higher risk than others to experience more severe mental health concerns after being affected by natural disasters. Some of these risk factors are discussed below:

NATURE OF THE NATURAL DISASTER

When natural disasters are sudden and unpredictable, people suffer more losses and damages because they do not have sufficient time to prepare for it. Children belonging to communities that have experienced severe disaster related damages, tend to experience higher levels of disaster related trauma (Du et. al, 2023).

FREQUENCY OF EXPOSURE

When children are exposed to repeated occurrences of natural disasters, they may be at a higher risk of developing more severe post-traumatic stress reactions (FEMA, n.d.). For example, living in a flood prone region or at a border-conflicted region could mean repeated exposure to disasters.

AGE

The age and stage of development of the child at the time of exposure to the natural disaster are crucial factors. The child's physical, psychological, social or cognitive abilities at the time of disaster exposure influence how severely they are impacted by it (Pfefferbaum, 2015; Masten & Narayan, 2012).

GENDER

Girls and women may be at more risk than boys or men to develop post-traumatic stress with higher severity following exposure to natural disasters (Du et. al, 2023; Masten & Narayan, 2012).

PRIOR TRAUMA EXPOSURE

Children who have had pre-existing mental health concerns or have been exposed to other forms of trauma prior to encountering a natural disaster, are at a higher risk of experiencing more severe post-traumatic stress

following the same (La Greca & Silverman, 2006; Masten & Narayan, 2012).

POST-DISASTER TRAUMA EXPOSURE

Children who continue to experience some form of trauma, long after the natural disaster has occurred are at a higher risk of developing post-traumatic stress responses. Some examples of post-disaster trauma could include poverty, death or chronic illnesses in the family (Hawkins, 2009; Kelley et al., 2010).

BELONGING TO MARGINALISED COMMUNITIES

Children belonging to marginalised communities may be at a higher risk of experiencing long lasting post-traumatic stress because they may not get timely or sufficient access to essential resources or facilities needed for recovery (Flanagan et al., 2011).

MENTAL HEALTH CONCERNS IN PARENTS

Children belonging to families wherein parents develop mental health concerns such as Depression or Post-traumatic Stress Disorder after a natural disaster, are at a higher risk of developing mental health concerns themselves (Kilic et al., 2003).

PRE-EXISTING DEVELOPMENTAL CONCERNS

Exposure to disasters may exacerbate the difficulties associated with the pre-existing conditions such as neurodevelopmental concerns (including autism, intellectual disability, speech and language impairments) or physical disabilities (NDMA, 2023).

Protective factors may be understood as elements such as a child's individual strengths or important factors in the child's environment such as family, friends or community, that help protect the child from or reduce the overall level of adverse impacts of the disaster on the child. Some of these protective factors are discussed below:

QUALITY OF RELATIONSHIP BETWEEN PARENTS AND CHILDREN

The parent-child relationship and the parenting style are both important factors that influence the child's mental well-being during a natural disaster. Positive relationships with parents and the experience of one's parents as supportive or accepting prior to the exposure of a natural disaster, have been linked to better coping skills in children post exposure to a natural disaster (Wickrama & Kasper, 2007; Costa et. al, 2009). When parents respond to children consistently by reassuring them and supporting them through their grievances post disasters, children are able to cope with their stress more easily (Masten & Narayan, 2012).

ACCESSIBLE SOCIAL SUPPORT

Children with strong social connections and networks within their community may find it easier to cope with stress after they have been exposed to natural disasters. Such social support helps children feel a sense of belonging and provides them with opportunities for shared healing with other members of the disaster affected community (Prinstein et al., 1996).

RESPONSE TO THE DISASTER AND EFFORTS TO RE-ESTABLISH SAFETY AND STABILITY

When children experience disasters, their sense of safety and stability tend to get shaken significantly. This can be deeply anxiety provoking and disturbing for them. When a sense of safety is reestablished either by being provided a safe physical space, a consistent daily routine or by any other means to reduce the sense of chaos experienced, children can slowly and steadily start to feel protected post disasters (Silverman & La Greca, 2002).

EFFECTIVE COMMUNICATION WITH THE CHILD POST DISASTER

Children are perceptive and may be able to understand the severity of their circumstances after a disaster has occurred. Clear and honest communication in an age appropriate manner about the disaster, or how it might impact one's family or community can help children feel prepared and experience a sense of control in an otherwise uncertain and stressful time (Pfefferbaum et al., 2001).

ACCESS TO RESOURCES

How fast children are able to access helpful and important community resources after disasters significantly influence their recovery. This could include healthcare, school or community centers. Access to these facilities could help them connect with other survivors, help establish that they are not alone or help slowly reestablish a routine or a sense of normalcy after the disaster (Masten & Obradovic, 2008).

COPING SKILLS

Children may differ from one another in their coping mechanisms and skills. This may be dependent on their age, the way in which they cope with stress or handle their emotions. Children who have some established ways of regulating their emotions or problem-solving are better equipped in managing stress associated with surviving natural disasters (Vernberg et al., 1996).

6

WHAT PERSPECTIVES CAN GUIDE US IN WORKING WITH CHILDREN DURING DISASTERS?

In helping children navigate disasters, it is important to ensure we keep their rights in mind and that we protect their rights to the best of our abilities as responders and caregivers. Adults providing for and caring for children through disasters must ensure that they are not further abused, neglected, exploited or exposed to any form of violence in times of crises such as natural disasters and related emergencies. Literature shows evidence that traumatic experiences such as abuse, neglect or violence are reported more frequently in children after disasters (Seddighi, et al, 2021). Hence it becomes even more imperative that the rights of children during such experiences are prioritised.

The following principles may help guide adults to work in the best interest of a child during natural disasters (Hyams, 2012). These principles are also in alignment with the United Nations Convention on the Rights of the Child (UNCRC, 1989):

DO NO HARM

Ensuring we do not directly or indirectly expose children to further harm is important. For example, two adults having a conversation about some disturbing events that occurred during the disaster in the presence of the child, may trigger disturbing memories or emotions in the child. Care should be taken to avoid such occurrences.

ENSURE EQUITABLE ACCESS

All children who have survived disasters have equal rights to avail resources and assistance provided by a community or respondents. This may include access to healthcare support or other forms of basic aid such as food, shelter or clothing. Children who live on streets or who have lost their parents may be at a high risk of being marginalised, excluded or discriminated against because they may be unaccompanied by caregivers or adults while trying to access such resources. Care should be taken to ensure this does not happen and that all children are equally and fairly provided for.

HELP BUILD RESILIENCE

Children may be taught skills that can help them cope better with the adverse effects that natural disasters have on their well-being. It is essential for adults to empower children by teaching them essential skills, helping them identify their strengths and to build on them. For example, a child may feel startled or deeply frightened after hearing loud noises that remind them about the disaster. They can be taught breathing or relaxation techniques to soothe themselves momentarily.
While these skills may be taught to children and help equip them to respond to situations better, the responsibility to oversee a child's well-being ultimately falls on the adults responsible for the child.

WORK TOWARDS REBUILDING A SENSE OF SAFETY

Helping children understand what safety may mean to them could help them immensely, while navigating the period after a disaster. It is important to remember that the onus of establishing safety for children is on adults. Children will need access to safe spaces as well as people who can ensure the safety of the child. We can then help children to give them options about who

to reach out to and how to reach them when needed. Depending on the age of the child, ensuring they have a basic understanding of their neighborhood could be beneficial. If a child has to get around their community for any assistance from others outside their home, they should know safe routes to use around their community and trusted adults to reach out to.

INCREASE CHILDREN'S AWARENESS OF THEIR RIGHTS

Part of responding to children during disasters involves empowering them with the knowledge about their rights in emergencies or disasters. Some of these rights include access to safe spaces, community support and relief networks or healthcare and sanitation. If a child is being denied access to any of these on any account, they should be aware of their rights, so they may ask for support through such discrimination or exclusion.

WORK WITH PARENTS AND COMMUNITY RESOURCES

Parents and other external stakeholders such as siblings, peers or the school must be involved and engaged in catering to a child's recovery after a disaster. Parents may be encouraged to involve children in discussions and decisions concerning them, should the child be old enough to comprehend or participate in such conversations. Schools could be used as centers to bring affected children and their families together in support initiatives or community building exercises to encourage community healing. All these efforts could positively support children's recovery after a disaster has occurred.

ADVOCATE FOR THE NEEDS OF CHILDREN

In order to ensure that children's rights are respected, it is important that systems around them are responsive to their needs. It is imperative that all adults, children may engage with during and in the aftermath of disasters respond to them in ways that are respectful about their rights and aligned with this approach. Doing awareness-building and sensitization programs about the rights of children for government officials, police officers and other important stakeholders who may interact with children can be helpful in this context.

Reflective Exercise

- Are we familiar with the United Nations Convention on Rights of Child? In your experience, which rights of children are more likely to be respected? Which ones are the most likely to be compromised in the context of disasters?
- How can we assure that we are upholding the rights of children in our workspaces?
- How can we spread awareness about the rights of children in our communities before and after the disasters occur?

6.1 TRAUMA-INFORMED APPROACH

Being trauma-informed can mean shifting our lens to "What happened to this person?" from "What is wrong with this person?" (Butler et al., 2011)

Trauma-informed care is an umbrella term referring to a service delivery approach where the focus is on understanding and responding to the impact that a traumatic event has on the individual. It is aimed at improving outcomes of care by focusing on ensuring physical, psychological, and emotional safety. This helps to empower people to define and work towards fulfilling their needs, achieving their goals and exercising choices about their care and services. Trauma-informed approach focuses on increasing awareness about trauma and encouraging service providers to work actively to discourage processes and practices that have the potential to re-traumatize survivors.

Four principles that trauma-informed approaches are rooted in include, to realise, recognise, respond and resist re-traumatisation. "A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and

responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**" (SAMSHA, 2014).

4Rs

Realisation

Realisation that trauma is wide-spread and that traumatic events impact individuals, families, groups, organizations, as well as communities. These experiences, behaviours and coping strategies are contextualised in the framework of adversity and overwhelming circumstances that people may have faced in the past or are currently facing either directly or indirectly.

Recognition

Recognition of signs and symptoms of trauma while keeping in mind the intersectionality of gender, age or settings of the individual.

Responding

Responding to the presence of trauma by using the key principles of a trauma-informed approach in all areas of functioning. It involves incorporating the understanding that traumatic experiences impact all people involved directly or indirectly. Policies of the organization, budget, and leadership endorse a culture based on resilience, recovery, and healing from trauma.

Resisting Retraumatization

Lastly, it involves taking precautions against replicating the traumatic experiences in the life of survivors, that is, by resisting retraumatization (SAMHSA, 2014). These principles are considered to be essential to the context of care (Brave Heart et al, 2011; Ford et al, 2009).

6.1.1 PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach is guided by six key principles. These principles can be generalized across different settings and adapted to become setting or sector-specific. These key principles are crucial in linking and promoting resilience and recovery of children or adults or families affected by trauma (Elliot et al., 2005; Harris & Fallot, 2001).

Safety: Safety for the child and anyone associated with trauma-informed care is of utmost importance. Establishing safe spaces in disaster settings where children can feel secure and supported is important during the disasters as well as in its aftermath (National Child Traumatic Stress Network & National Center for PTSD, [NCTS], 2005). This may start with policy planning where children's view of safety is taken into consideration, extend to establishing physical safety (for example, settling in relief camps, away from the site of disaster) and then towards psychological safety (providing interventions to bring the child back to the present following a disaster).

Trustworthiness and transparency: The aim is to build a relationship based on trust and transparency by creating a system of honesty, honouring the commitments made by people providing trauma-informed care and maintaining an atmosphere of trust between the child and MHP. We can try to establish trustworthiness by checking in with them about the effectiveness of the process and techniques used with them, actively listening to and amplifying the voices of the children whenever they want to be involved in the healing process. We can also promote transparency by acknowledging the limitations of the MHPs in the disaster situation and knowing when the concerns of the children are beyond the scope of the MHP and facilitate a referral when the need arises (Rosenberg et al, 2022)

Peer support: It is important to provide and receive support from peers both for the people who have experienced traumatic events and the MHPs who support them. In the disaster context, it is imperative that children get the support from their peers in the community. This translates into involving children, their peer groups, families and communities into the healing process. This can be actively encouraged by promoting

local resources by partnering with local practitioners on projects, and with mental health providers and public health practitioners as well as local leaders whom children trust and look up to (Rosenberg et al, 2022).

Collaboration and Mutuality: Collaboration with the child is a key component of trauma-informed care. There is an active effort to recognise power differences and reduce them between the child and the MHP by emphasising on a collaborative approach. It helps demonstrate that healing in trauma is possible when power and decision-making are shared, thereby increasing agency and control that children have in their paths of recovery. This may be done by ensuring that children's voices and concerns are heard, discussed, and their ways of coping with the disaster situation are heard and incorporated in the plans for interventions.

Empowerment, Voice and Choice: This principle highlights the importance of recognising and celebrating the strengths of children and keeping them central in all our endeavours. This translates into believing in the resilience of children and trusting in their ability to heal during traumatic events such as disasters. It also involves sharing decision-making processes with them, finding out and bringing their choices in the foreground and keeping their goals as the priority of the work. For example, asking children to identify safe spaces for them to speak with the MHPs, helping children reclaim spaces for play and learning and giving children choices about what kind of work they would like to engage in. The aim is to nurture within us the importance of the privacy of the child, their resilience and their ability to set goals for their healing journey. This promotes their self-advocacy and agency.

Cultural, Historical and Gender Issues: It is important to acknowledge the unique socio-cultural, historical and gender backgrounds of the children after they have experienced disasters and be congruent in responding to them. For example, culturally congruent practices may include identifying those communities who get marginalised during disasters and improving their access to facilities and engagement in decision-making processes; acknowledging and accounting for caste or class tensions, unequal land use, forced immigration, etc.; and, fostering community strength and pride (Rosenberg et al, 2022).

6.1.2 WHY IS IT IMPORTANT TO ADOPT A TRAUMA-INFORMED APPROACH?

Children and families may have survived or been impacted by disasters which can potentially change the course of their development (Butler et al., 2011). Disasters may lead to difficulties such as making sense of the event, bouncing back from it and focusing on constructing relationships with significant others or their community at large (SAMHSA, 2014). During disasters, people with a prior trauma history are more vulnerable to experiencing mental health concerns, than people who have not lived through traumatic experiences. Thus, the impact of traumatic experiences whether in the past, ongoing or in its aftermath cannot be left unacknowledged. Failing to use a trauma-informed approach increases the risk of misunderstanding or wrongly understanding and addressing the child's mental health concerns when faced with disaster situations. When providing mental health and psychosocial support, in the absence of a trauma-informed lens, children may be misdiagnosed, may fail to get trauma specific interventions that they may need and worse could be re-traumatised in the process (Ishola et al., 2022). Thus, it may cause more harm to the child (Butler et al., 2011).

6.1.3 HOW IS A TRAUMA-INFORMED APPROACH DIFFERENT FROM A TRAUMA-SPECIFIC INTERVENTION?

"Trauma-specific interventions" and "trauma-informed care" are occasionally thought to be the same as they are oriented towards providing care for those with histories of traumatic stress. However, these are different. Trauma-specific interventions refer to the clinical interventions for individuals and groups which aim to prevent or intervene for trauma-related symptoms, PTSD and other co-occurring disorders.

Trauma-informed care, on the other hand, focuses on creating a universal framework for helping people and organizations develop awareness, knowledge, and skills to provide a supportive environment for survivors of trauma (Hopper et al., 2010). Thus, it includes trauma-specific assessment, treatment and building support systems for recovery. Being trauma-informed means acknowledging the possibility that whether or not people explicitly show signs or symptoms of trauma

they could have experienced traumatic events. Being sensitive to this and approaching people with this possibility leads to trauma-informed practice (Butler et al., 2011).

Practice Exercise

A 14-year old child, Billu was brought to a community medical center. He had sustained an injury to the head when he fell from his bed in his sleep and was bleeding a lot. As a result he was feeling light headed and his mother who brought him in, mentioned that he had not spoken a word ever since the accident had happened. The doctor on checking with the mother realised that he was mumbling about floods that had happened last year in their city in his sleep. He was also thrashing around in his sleep and during one of those incidents had fallen down and injured his head.

After they stopped the bleeding, finished preliminary medical care and other medical evaluations, the child was discharged. When the mother asked if it was safe for him to go, they said that there was no neurological damage and he was physically fine. The mother was worried about him not speaking since the last few days and expressed this to the doctor. However, he told her it will become alright in a day or two, and sent the child back home.

Let's reflect.

1. Was the doctor's approach trauma-informed?
2. What could this child's experience suggest about his emotional state?
3. If we could speak to the mother, what could be some details we can try to ask for?
4. If we had a chance to speak with this child, what would be some things we could do in an attempt to engage him?
5. If the child was willing to speak to us, what are some questions we could ask him to understand his concerns?

Let's avoid...

Understanding traumatic events as unidimensional. It is important to remember that traumatic events such as disasters can be understood better using 3Es- event, experience and effect. This helps us in gaining a holistic understanding and planning for more wholesome ways of helping.

Thinking of the child's experiences in isolation. The effect of disasters on children is complex and mediated by the experiences of the adults around them. Hence it is imperative that the role of socio-economic and political environment around the child is kept in consideration. Important social identities of the child also need to be given due importance in understanding the best way to respond to the child's needs and difficulties.

Negating the protective factors for children. It is important to remember that not all children who witness a disaster will experience difficulty. Some may show adaptive and resilient responses as well provided they have access to support and resources.

Ignoring the rights of children. It is important to recognise that all children have basic rights that need to be respected and followed by all members of society including the MHPs.

Not considering the key principles of trauma-informed care while working children. The key principles of trauma-informed care help us in realising the presence of traumatic events, recognising their effects on people, respond holistically to these experiences and resist re-traumatization. This aligns with the rights of children where the emphasis is on not doing something which may harm the child.

Tips for Supervisors

- It may be helpful for supervisees to understand traumatic events such as disasters in the 3E format, that is, to focus on the event, experience and effect of the disaster on the child. We can design case examples to enhance their understanding and help them better.

- It may also be important to emphasise on the concept of intersectionality in supervision. Helping supervisees identify the different identities of children and how these identities may make them vulnerable to different consequences of the disaster is a key skill in working with children affected by disasters.

Self-care Exercise

Why should self-care be prioritised in our work?

As MHPs working in the area of providing care to people with histories of trauma, we may experience what is referred to as Secondary Traumatic Stress. "Secondary traumatic stress...is the direct result of hearing emotionally shocking material from traumatized clients" (Canfield, 2003). It is only natural for us to feel overwhelmed or affected by the stories we hear and hence we must ensure not to ignore our own mental health in this process.

What can we do to address this?

- We can take time after sessions to reflect on how we felt about it
- We can reach out to peers, colleagues or mentors when we feel overwhelmed and share our experiences with them
- We can ensure to have sufficient space between sessions, so we do not feel overworked
- We can try to build some breaks in our work day, for example a short walk or a quick tea break between sessions

This chapter focused on defining trauma and highlighting how disasters can be understood as traumatic events. Children's unique experiences and vulnerabilities during disasters are highlighted. The chapter also discusses key considerations we have to keep in mind when understanding and responding to children's experience of disaster using a trauma informed approach. The next chapter focuses on how children respond to disasters.

References

American Psychiatric Association. (2013). Diagnostic and statistic manual of mental disorders (5th ed.). Washington, American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). American Psychiatric Association.

American Psychological Association. (2015). APA Dictionary of Psychology (2nd ed.). American Psychological Association.

Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011).Trauma-informed care and mental health. Directions in Psychiatry, 31, 197-210.

Canfield, J. (2003). An exploratory study of secondary traumatic stress and vicarious traumatization among child psychotherapists. Smith College School for Social Work.

Costa, N. M., Weems, C. F., & Pina, A. A. (2009). Hurricane Katrina and youth anxiety: The role of perceived attachment beliefs and parenting behaviors. Journal of anxiety disorders, 23(7), 935-941.

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. In University of Chicago Legal Forum (Vol. 1989, No. 1, p. 8)

Du, Y. Z., Kao, T. F., Yang, L., Li, C., & Wang, X. (2023). The Psychological Effects of Disasters on Children and Adolescents. In 2023 9th International Conference on Humanities and Social Science Research (ICHSSR 2023) (pp. 813-820). Atlantis Press.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. Journal of community psychology, 33(4), 461-477. Federal Emergency Management Agency (FEMA), & American Red Cross. (n.d.). Helping Children Cope with Disaster.

Flanagan, Barry E.; Gregory, Edward W.; Hallisey, Elaine J.; Heitgerd, Janet L.; and Lewis, Brian (2011). A Social Vulnerability Index for Disaster Management. Journal of Homeland Security and Emergency Management: Vol. 8: Iss. 1, Article 3.

Ford, J. D., & Delker, B. C. (2018). Polyvictimization in childhood and its adverse impacts across the lifespan: Introduction to the special issue. Journal of trauma & dissociation : the official journal of the International Society for the Study of Dissociation (ISSD), 19(3), 275–288. https://doi.org/10.1080/15299732.2018.1440479

Harris, M. and Fallot, R. (2001). Using trauma theory to design service systems. New Directions for Mental Health Services, 89. Jossey Bass.

Hawkins, R. L. (2009). Same as it ever was, only worse: Negative life events and poverty among New Orleans Katrina survivors. Families in Society, 90(4), 375-381.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homeless service settings. The Open Health Services and Policy Journal, 3, 80–100.

Hyams, J. (2012). CHILD PROTECTION IN DISASTERS AND EMERGENCIES. Child Protection Working Group.

Ishola, O. V., Jaiyeola, B. O., & Esere, M. O. (2022). Trauma-Informed Counselling And Mental Health: Implications For Counselling. Journal of Professional Counseling, 5(1), 1-13.

Kelley, M. L., Self-Brown, S., Le, B., Bosson, J. V., Hernandez, B. C., & Gordon, A. T. (2010). Predicting posttraumatic stress symptoms in children following Hurricane Katrina: A prospective analysis of the effect of parental distress and parenting practices. Journal of traumatic stress, 23(5), 582-590.

Kiliç, E. Z., Özgüven, H. D., & Sayil, I. (2003). The psychological effects of parental mental health on children experiencing disaster: The experience of Bolu earthquake in Turkey. Family Process.

Koenen, K. C., Roberts, A. L., Stone, D. M., & Dunn, E. C. (2010). The epidemiology of early childhood trauma. The impact of early life trauma on health and disease: The hidden epidemic, 1.

Kousky, C. (2016). Impacts of natural disasters on children. The Future of children, 73-92.

Kreimer, A. (2001). Social and economic impacts of natural disasters. International Geology Review, 43(5), 401-405.

La Greca, A. M., & Silverman, W. K. (2006). Treating children and adolescents affected by disasters and terrorism. Child and adolescent therapy, 356.

Lubit, R., Rovine, D., DeFrancisci, L., & Eth, S. (2003). Impact of trauma on children. Journal of Psychiatric Practice®, 9(2), 128-138.

Masten, A. S., & Narayan, A. J. (2012). Child development in the context of disaster, war, and terrorism: Pathways of risk and resilience. Annual review of psychology, 63, 227-257.

Masten, A. S., & Obradović, J. (2008). Disaster preparation and recovery: Lessons from research on resilience in human development. *Ecology and Society, 13*(1), Article 9. https://doi.org/10.5751/ES-02282-130109

National Disaster Management Authority (NDMA) (2005) Disaster Management Act.

National Disaster Management Authority (NDMA), Government of India. (2023). National disaster management guidelines: Mental health and psychosocial support services in disasters. Ministry of Home Affairs, Government of India.

North, C. S., Mendoza, S., Simic, Z., & Pfefferbaum, B. (2018). Parent-reported behavioral and emotional responses of children to disaster and parental psychopathology. Journal of loss and trauma, 23(4), 303-316.

Pfefferbaum, B., Jacobs, A. K., Griffin, N., & Houston, J. B. (2015). Children's disaster reactions: the influence of exposure and personal characteristics. Current psychiatry reports, 17, 1-6.

Pfefferbaum, B., Jacobs, A. K., Houston, J. B., & Griffin, N. (2015). Children's disaster reactions: the influence of family and social factors. Current psychiatry reports, 17, 1-6.

Pfefferbaum, B., North, C. S., Flynn, B. W., Reyes, G., & Kuykendall, A. (2001). The impact of the 1995 Oklahoma City bombing on the mental health of adolescents: Initial findings from the terrorism and disaster branch. *Journal of Traumatic Stress, 14*(1), 7-18. https://doi.org/10.1023/A:1007824724484

Prinstein, M. J., La Greca, A. M., Vernberg, E. M., & Silverman, W. K. (1996). Children's coping assistance: How parents, teachers, and friends help children cope after a natural disaster. Journal of Clinical Child Psychology, 25(4), 463-475. https://doi.org/10.1207/s15374424jccp2504_11

Reiss, F. (2013). Socioeconomic Inequalities and Mental Health Problems in Children and adolescents: a Systematic Review. Social Science & Medicine, 90(1), 24–31.

Rosenberg, H., Errett, N. A., & Eisenman, D. P. (2022). Working with disaster-affected communities to envision healthier futures: A trauma-informed approach to post-disaster recovery planning. International journal of environmental research and public health, 19(3), 1723.

Runyan, A. S. (2016). What Is Intersectionality and Why Is It Important? | AAUP. Aaup.org.

Seddighi, H., Salmani, I., Javadi, M. H., & Seddighi, S. (2021). Child abuse in natural disasters and conflicts: A systematic review. Trauma, Violence, & Abuse, 22(1), 176-185.

Shaw, J. A. (2000). Children, adolescents and trauma. Psychiatric Quarterly, 71, 227-243.

Silverman, W. K., & La Greca, A. M. (2002). Children experiencing disasters: Definitions, reactions, and predictors of outcomes. *Prevention Researcher, 9*(3), 7-10

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach Prepared by SAMHSA's Trauma and Justice Strategic Initiative.

UNDRR. (2015). Disaster. Undrr.org; United Nations Office for Disaster Risk Reduction.

United Nations (UNCRC). (1989). Convention on the Rights of the Child.

Vernberg, E. M., La Greca, A. M., Silverman, W. K., & Prinstein, M. J. (1996). Prediction of posttraumatic stress symptoms in children after Hurricane Andrew. *Journal of Abnormal Psychology, 105*(2), 237-248. https://doi.org/10.1037/0021-843X.105.2.237

Wickrama, K. A. S., & Kaspar, V. (2007). Family context of mental health risk in Tsunami-exposed adolescents: Findings from a pilot study in Sri Lanka. Social Science & Medicine, 64(3), 713-723.

CHAPTER 2

Trauma responses in Children During Disasters

In the previous chapter we looked at how natural disasters can impact children, through the lens of trauma. In this chapter we take an in-depth look at how trauma is experienced by the brain and the body and how it impacts the overall functioning of the child. This requires us to understand the basic neurobiological process of typical childhood brain development and the impact of trauma on this process.

1

HOW DOES EARLY CHILDHOOD DEVELOPMENT OCCUR ?

Knowing how early childhood development unfolds is very important as it can help us understand why and how to support children after disasters. We have listed some key features of brain development that can inform our understanding.

1. **The brain's structure and functioning are impacted by early childhood experiences.** Early childhood experiences are very important for the growing brain. The brain's structure and its functioning are determined to a large extent by the quality of the environment in which the child grows. The child's experiences guide which neuronal connections are strengthened and which ones are lost. They also help in determining if the genes (what we inherit from our parents) are expressed and the manner in which they will be expressed (Szyf, 2009). For example, if the child experiences a loving relationship with a caregiver and a safe environment, even if they have a gene for developing a mental health concern, it may not get expressed.

2. It is also important that these experiences described above **happen at the right time as the capacity to develop brain structures is highest during childhood.** Imagine the developing brain as a house under construction. Just like the house has to be built in a predictable sequence and its foundation has to be strong enough to support the other structures, the brain also develops sequentially and if the foundation is disturbed, it will have consequences for the further growth of the child. If the material to build the house is unavailable at the right time, it will change the

blueprint of the house. Similarly, if a child does not have appropriate experiences, it can lead to alterations in brain structure. Thus, the right environment and stimulation at the right time helps to develop the required cognitive, social, and emotional skills needed for the child (Shonkoff & Phillips, 2000).

3. **Brain development takes place in a sequential manner.** It is important to note that there is a sequence to the process of brain development. For example, the ability to perceive simple aspects of the world develops first. Then using this as a basis we develop emotions around these perceptions and use these to make social judgments. It is only later that we gain the ability to make well-thought out reasoning arguments and decisions. This ensures that we build on the previous information. Thus, higher-level skills such as attention, goal-setting, rule-following, problem-solving and impulse control are gradually developed. This process is congruent to the development of the prefrontal cortex (the large part of the brain behind the forehead). The more the prefrontal cortex develops from infancy into early adulthood, the better we are able to acquire these skills (Rothbard & Posner, 2005). Majority of the early development of the prefrontal cortex occurs during childhood and then is refined during adolescence and the early adult years (National Scientific Council on the Developing Child, 2007).

4. **These higher-level capacities are called executive function and self-regulation and serve as the brain's " traffic control system."** Executive functions refers to the abilities of the brain that help in planning, monitoring, and managing information that is received by the individual at the same time. These are not in-born in children; rather children are born with the potential to acquire them when responsive relationships with others are present. Along with these abilities, children also develop their abilities to experience and express different emotions. They also develop the capacity to cope with and manage a variety of feelings (Thompson & Lagattuta, 2006). The development of these executive functions and abilities to self-regulate their emotions, is accompanied with other developments such as increased mobility (motor control), thinking (cognition), and communication (language). This development is a

result of emergence of some new neural connections and maturation of the old ones across different areas of the brain, including the prefrontal cortex (Davidson et al, 2002). We see that when children learn to use both emotional skills and executive functions, they are able to regulate themselves. If the emotional skills are not developed completely, emotions may interfere with attention and decision-making (Bush et al, 2000).

5. **Quality of relationships during childhood plays a role in adult relationships.** Child development begins in the family but also involves other adults who play significant roles in their lives. This can include extended family members, teachers, coaches, and neighbors. These relationships impact the intellectual, social, emotional and physical development of the child (Sweatt, 2009). The quality and stability of these relationships in the early years lays the foundation for building self-confidence, motivation to learn and capacity to build relationships as an adult (National Scientific Council on the Developing Child, 2004). Young children naturally reach out to adults for interaction through babbling, facial expressions, gestures, and words and responsive adults engage in similar ways emotionally, verbally and non-verbally. This continues in a back and forth way, like a game of tennis or passing of a ball. These experiences need to be attuned to the child's unique personality by following their cues. For example, attuned adults will acknowledge the child's interests, be mindful of their capabilities and support the child's initiative. This helps the child develop awareness of their sense of self. However, if the adults behave in ways which are unreliable, not appropriate to the child's age or capabilities, or are simply absent, this has an adverse impact on brain development. (Reis et al., 2000).

6. **A growth promoting environment that is able to give a healthy diet and good social interactions with responsive caregivers helps children adjust to a variety of circumstances.** We have to remember that brain development takes place in the context of both brain and body development. The development of other physiological systems such as the cardiovascular (heart), immune, neuroendocrine (hormones), and metabolic regulatory systems help and aid in the process of child development. For example, when children learn words they need adequate hearing,

the ability to differentiate sounds, and the capacity to link meaning to specific words. On the other hand, an adverse environment where children are not well-nourished, and/or are deprived of appropriate sensory, emotional, and social experiences will weaken this association and hence brain development through the process of hearing will be hampered.

7. **Brain development is flexible.** The brain's capacity to learn from experience, called *plasticity*, is the highest during early childhood. This capacity decreases with age as the process of pruning takes place. Positive early experiences, support from adults, and the normal development of the child helps in protecting them from adverse effects even later in adulthood. The presence of even one stable and responsive relationship with a parent, caregiver, or other adult helps mitigate the effect of adversity such as disasters.

2

THE MIND-BODY CONNECTION: HOW DO CHILDREN'S BODIES AND BRAIN RESPOND TO TRAUMA?

Physical impact: Children's bodies are significantly different from those of adults. They may be more vulnerable to sustaining injuries when the disaster strikes. Children's bodies contain less fluid as compared to adults, making them significantly more likely to experience dehydration. These differences may leave them being more vulnerable to experience negative physical effects after exposure to a disaster. For these reasons, children require specialised physical care and nutrition during the disaster and in its aftermath. In the absence of quality nutrition or food supplies, they may experience deficits in calorie intake and nutritional imbalance. This can significantly affect the development of the child. Lack of access to quality medical care may also negatively affect the development of the child as they may not receive timely medical help (Kousky, 2016).

Significant difficulties during or even after the disaster such as extreme poverty or child maltreatment may adversely affect brain structures and capacities such as learning, behavior and health in children (Centre on the Developing Child, Harvard, 2016).

During the acute phase of disaster, a helpful bodily emergency response system called the 'fight-flight-freeze' response system gets activated. It helps us survive a major threat, is deployed immediately, and does not require any thinking (it is automatic). This emergency

response is carried out by the autonomic nervous system (ANS) which activates certain changes in the body and brain which help us to immediately survive the threat. Thus, during this phase, bodies respond by increasing the heart rate, blood pressure, and blood sugar levels and decreasing the immune system's responses.

When supportive caregivers who provide strong, stable and responsive relationships in the earliest years of life are present, this emergency response is 'switched off' after the immediate danger has passed and the acute phase of disasters ends. However, if the threat is extreme and long-lasting, and the emotional protection from a caring adult is not available, the stress response of the body may continue beyond the actual emergency and may lead to a more adverse response. This long-term response to trauma may be observed in later phases of disasters in those for whom psychosocial care has not been addressed.

In such circumstances, the body may start to show rapid fear, react strongly even when danger is not present. Alternatively, the body may 'freeze' or potentially shut down completely because of the constant wear and tear (National Scientific Council on the Developing Child, 2014). When we are exposed to extreme threats in the aftermath of the disaster, these short term, adaptive responses become chronic and long term such that even when children transition into a physically safe environment, these survival mechanisms do not turn off. Thus, the brain gets stuck in the survival state and very little information can get passed up to the other parts of their brain that control learning, memory and motivation. Whilst the brain is stuck in this situation, it is difficult to feel safe, form secure attachments; manage emotions or behaviour, think, learn or reflect because the brain is simply trying to help the child stay alive in a world that is highly dangerous.

3

WHAT IS THE IMPACT OF DISASTERS ON THE MENTAL HEALTH OF CHILDREN?

Children who have been exposed to traumatic events such as disasters may express or communicate their distress in different ways. These expressions of distress depend on various factors; some of these include their age, stage of development, or the physical, emotional, cognitive or social skills and milestones they have achieved, at the time of exposure to the disaster (APA,

2013; NIMH, n.d.; USDVA, n.d.; Zero to three, 1994; 2005). Other factors such as a child's individual characteristics, health status or cultural background also play an important role. (Pine & Cohen, 2002; Shaw, 2000).

Children may show increased fearfulness, irritability or an intense desire to stay close to a parent. Sometimes they may repeatedly speak about, draw or play in ways that portray aspects of the disaster. They may also make active efforts to avoid being reminded of the disaster or may refuse to attend school. This is particularly true for younger children as they may feel scared to be separated from their parents (North et al., 2018).

Older children may experience difficulties in concentration or keeping up with the demands of school when they may still be concerned about the disaster (FEMA, n.d.). Even during the recovery phase, they may experience difficulties as they may be living with consistent stress and a sense of insecurity, without certainty around when their lives will go back to normal. Children may also experience stress as a result of the socio-economic impact of the disaster. For example, after losing their house during a disaster, children may have to relocate temporarily. They may lose access to their friends and peers (FEMA, n.d.).

Traditionally, mental health concerns in children have been broadly understood on the spectrum of "Internalising" and "Externalising" concerns. Internalising mental health concerns usually include experiences like sadness, anxiety or psychosomatic concerns. As the name suggests, these concerns are usually experienced internally by a child and there may not be externally recognisable signs for others to notice. For example, a child who is experiencing sadness may not always cry or show any noticeable signs of sadness in their behaviour, so others may not recognise this. In the present manual, the use of externalising or internalising language has not been used. This is because literature has highlighted that these are not mutually exclusive categories; children may show both externalising and internalising behaviours at the same time (Lilienfield, 2003). For example, a child who has first hand witnessed the loss of a loved one during an earthquake may not 'appear' sad or anxious to others in the days following the event, but may very well be. They may be having some anger outbursts in comparison to before the earthquake. If we focus only

on addressing these behavioural concerns, we may miss out on helping them with other parts of their trauma experiences that may not be clearly externally observable.

It is also important to note that experiencing distress after a traumatic event such as a disaster is completely natural and expected. Therefore signs of mental and emotional distress in children following a disaster must be normalised and catered to sensitively, viewing such distress as a normal, expectable reaction to an abnormal and deeply distressing situation.

4 HOW DO TRAUMA RESPONSES MANIFEST IN CHILDREN ACROSS DIFFERENT AGE GROUPS?

Taking a developmental perspective helps us understand the different ways in which children respond to trauma and the support they may require.

4.1 TRAUMA IN INFANTS AND TODDLERS POST DISASTERS (0-5 YEARS)

Infants and toddlers are at greatest risk when experiencing traumatic events such as disasters (Finkelhor et. al, 2009). As seen above, infancy is the critical period during which most rapid growth and development takes place. Experiencing disasters during this stage could interfere with the infant's development as they may not have access to food, clean air and water during the chaos of the disaster and the recovery period. This may interfere with the acquiring of new skills that the infant is supposed to gain at this stage. It may also cause the infant to regress or lose some of the skills that they have already acquired. Regression is a common response in children who have experienced disasters (NIMH, n.d.; NCTSN, 2018). They may also experience difficulties in sleeping and feeding routines as these may get neglected in the chaos of the disaster and its aftermath. Infants may express their distress during disasters by becoming generally less responsive to their caregivers, compared to before the disasters. This may be referred to as numbing of responsiveness towards caregivers. Some infants may also appear to show the opposite response by clinging to the caregivers, not wanting to be separated from them and are difficult to soothe if the separation occurs (Zero to three, 2005).Thus,

infants are especially at risk for developmental problems in short-term as well as at risk for hampered long-term growth.

Toddlerhood is an important time for learning new skills, attending to stimuli, engaging in play and learning interpersonal skills necessary for adult social relationships. The chaos of disasters may lead to neglect of the basic needs of the toddlers and opportunities for their growth and development. For example, during a disaster, parents may be busy with arranging for basic needs of the family and may not be able to engage with the toddler in play and teaching social skills. They may not be able to pay attention required to learn new skills. In fact, some toddlers may also show regression, that is, they may not be able to showcase the skills they had already learnt such as toilet training. They may also experience sleep disturbances after they have been exposed to disasters. This could be due to nightmares related to the disaster. Nightmares may exacerbate sleep difficulties as they may fear falling asleep, have broken sleep or express significant distress around bedtime (APA, 2013; Zero to three, 1994).

Toddlers may not be able to understand, identify and soothe their distress. When faced with disasters, toddlers can experience overwhelming feelings of helplessness especially in the absence of a strong relationship with their caregiver. They may also show changes in their behaviour such as increased clinginess, temper tantrums, and social withdrawal (Osofsky, 1997). Those who were found to be trusting and friendly in general, with unfamiliar children or adults, may show significant changes in their behaviours towards others after they have experienced disasters. This may be because they start to feel unsafe with unfamiliar people or situations since they feel anxious in new situations as a result of their experiences during the disaster (Ainsworth et al., 1978; Zero to three, 2005; FEMA & American Red Cross, n.d.). There might be an increase in aggression towards others (SAMHSA, 2011). Another way in which toddlers and young children express their distress after disasters is by expressing it in their play or in the stories they tell others. They may reenact parts of the disaster or may include violent or disturbing elements from it in their play. For example, a child who has witnessed death during a flood may re-enact the scene by getting a doll to drown in the water. Children may also share stories

of the disasters. They may narrate them as if they are happening as they speak (NIMH, n.d; Hamblen & Barnett, 2022). Such reenactments may also be seen in the drawings of young children wherein they may create drawings with violent or dark themes related to the disaster they encountered, such as death or destruction of property. They may not externally appear distressed during such reenactments, but it may be evident while we observe such play, stories, drawings or verbalisations (Zero to three, 1994).

Reflective Exercise

- How can we identify signs of distress in toddlers and infants?
- Asking the caregivers about their infants and toddlers responses may elicit fears and worries in them? What can we do to make this process easier and more comfortable for the parents and caregivers?

What are some ways in which these responses can be assessed?

1. *Interference with developmental momentum*
   We can assess if the child is at the same developmental level as expected. We can even ask the caregiver if they have noticed any activity or skill that the child was able to perform earlier and cannot do now.

2. *Abrupt changes in attachment and temperament*
   We can assess if the infants have become more clinging to the parent or are they crying more often or easily as compared to earlier interactions. We can ask the caregivers for these changes and also ask about their sleep patterns.

3. *Numbing of responsiveness*
   Another change that we can be careful about is the interaction of the child with the environment. We can see if the child is being curious about their environment and ask the caregivers if they have noticed any change in their behaviours. These changes can be noticed in their interactions with others as well as in play.

4.2 TRAUMA IN PRE-ADOLESCENT SCHOOL-AGED CHILDREN POST DISASTERS (6-12 YEARS)

Children in the age group of 6-12 years are in the process of acquiring skills for language development and interpersonal development. They also have a relatively higher capacity to make meaning and understand circumstances around the traumatic event (Shaw, 2000). Thus, they may respond to disasters in ways which are different from toddlers.

Children in this age group may have difficulties in falling asleep. They may also have nightmares which may further exacerbate the sleep-related difficulties. They may also show changes in appetite; some children may have reduced appetite while others may feel more hungry (APA, 2013). The disaster and its aftermath may also lead to changes in the routine for children as school timings and play timings which usually anchor their routines are disrupted. Children may also express aches and pains such as stomach ache and headaches which may not be explained by any underlying physical cause. These unexplained aches and pain may further exacerbate the difficulties in maintaining their routines.

They may also express concerns over their own safety and that of others in their school or family. They may experience intrusive, strong mental recreations of scenes from the day of disaster. They are more likely than younger children to report feelings of reliving the disaster and difficulty with expressing feelings, such as sadness or anger in words (SAMHSA, 2011). There could be a distress around reminders or significant efforts made to avoid any reminders that could trigger such disturbing disaster-related mental imagery. While actively experiencing a flashback, a child could feel very scared and panicked (APA, 2013). Disasters could also distort the way in which they are registered in the child's memory. This could affect the sense of time around the event, particularly when they try to recollect details around it and may lead to misremembering of the sequence of events while retelling details or stories around it. This is referred to as Time Skew. (USDVA, n.d.). They may also experience shame and guilt regarding their responses to the disasters.

They may regress to earlier developmental stages, that is, start demonstrating responses similar to that of younger children. They may also go back to earlier modes of relating to parents. This may be manifested through increased struggles over food, self-care, and schoolwork. Decline in school and academic performance are also commonly seen. There might be a marked change in academic functioning and it may be attributed to higher levels of stress and anxiety as a result of preoccupation with disaster-related thoughts and feelings. It could also be reflective of decreased attention and concentration post the disaster (APA, 2013; NCTSN, 2018; USDVA, n.d.; Shaw, 2000). At school, children may find it difficult to focus or may be aggressive. Other children and adults around them may not understand these changes and become withdrawn or critical towards the child. This may result in further isolation and consequent academic, social, and emotional difficulties.

Reflective Exercise

- What makes these responses different from the responses mentioned for infants and toddlers?
- What are our views about the comprehension and communication skills of children in this age group? How may this influence our interactions with the children?
- Children use different modalities to express themselves such as language, play or art. What is our level of comfort in using these different modalities to connect to children's experiences?

What are some ways in which these responses can be assessed?

1. *Traumatic reenactment in play or storytelling.*
   We can play with the child and ask them to tell us some stories after we think the child is comfortable with us. Once we engage them in these activities, carefully observe if you can hear or see elements of the traumatic events. We can ask the parents about the same as well.

2. *Reenactment in verbalisations and drawings.*
   We can also observe these repetitions in the words they use and drawings that they are drawing. It is possible that the drawings have violent or dark themes. They may not appear to be distressed when this happens. We can also ask the caregivers to observe the same.

3. *Regression.*
   It is important to ask the parents and observe if the child has gone back to a younger behaviour. For example, we can say, "Have you noticed that your child is unable to do something that they could previously do before the disaster? Or we may ask them if they have seen their child behaving as if they were younger.

4. *Nightmares and disturbed sleep*
   Children frequently report disturbed sleep and nightmares post trauma exposure. We can ask the children or their parents about how they have been sleeping and how they feel once they wake up.

5. *Flashbacks and intrusive memories*
   Children may experience intrusive, strong mental recreations of scenes from the traumatic event. We can use the same questions as mentioned in the parent manual to understand these.

6. *Decline in school and academic performance*
   Decline in school and academic performance are well cited signs of trauma in school age children. We can ask these questions to parents in a non-stigmatising way. We can frame a decline in school performance as a consequence of trauma and then ask if they have noticed a similar pattern in their child.

4.3 TRAUMA IN ADOLESCENTS POST DISASTERS (13-17 YEARS)

Adolescence is a time of fast-paced physical and social changes which emphasise the desire to establish their own identity and gain independence from their families. Their experiences may differ from younger children. Adolescents may experience sleep related difficulties.

They may also have nightmares related to the disaster context which may further exacerbate the sleep-related difficulties. (APA, 2013). They may also experience significant differences in their appetite, causing marked changes in their eating habits. It may include binge eating, on one hand or starving on the other. This could have a cascading effect and may contribute to the development of other difficulties such as body image issues (NCTSN, 2018; Shaw, 2000). The chaos of the disaster situation may make it difficult for the adolescents to follow a routine. External anchors of routine such as school timings, play timings or study timings get disrupted during and after the disaster. This might make it difficult for the adolescents to set-up a routine of their own and regain a sense of consistency for themselves. Adolescents may also experience some unexplained aches and pains which cannot be medically explained. It is possible that adolescents may complain of stomach aches and headaches. This may further exacerbate the disruptions of their routines.

Adolescence is also the stage of development where peer relationships become important. Experiencing traumatic events such as disasters may lead to changes in their relationships. Disasters can lead to the displacement of families, causing adolescents to lose contact with their peers and disrupting established social networks. This may result in feelings of isolation, loneliness, and difficulties in forming new friendships (Rose et al, 2019). In the aftermath of a disaster, adolescents may increasingly rely on digital communication to maintain contact with their peers and support networks. While this can be a vital coping mechanism, it may also lead to issues related to digital overuse and a decrease in face-to-face interactions (Lai, et al, 2020).

Disasters can disrupt adolescents' academic progress and social relationships, leading to long-term consequences for their educational attainment and social skills. Displacement and loss of school infrastructure often exacerbate these challenges (Betancourt et al, 2019). They may experience school-related difficulties such as reduced concentration, memory-related difficulties, and impairments in decision-making. These can hinder academic performance and daily functioning (Pfefferbaum et al, 2019).

Adolescents are more likely than middle-aged children to express feelings of fear, and anxieties related to self during and after disasters (SAMHSA, 2011). They may start doubting and questioning their capabilities in dealing with difficult circumstances. They may also feel guilty about surviving and not being able to help others. This may hamper their sense of self and lead to difficulties in their beliefs about their efficacy (APA, 2013; NCTSN, 2018; Eckes & Radunovich, 2007). In order to overcome fear, they may be likely to develop new habits or risky behaviours that may compromise their safety. For example, they may begin using substances in order to cope with their feelings of distress which places them at risk of developing substance use disorder later (Jones et al, 2020).

They may also experience significant changes in their perception of the world in the aftermath of a disaster. This might significantly alter how they approach situations. They might begin to have a higher threat perception, and show skepticism about people or situations than before. Some adolescents may even show aggressive behaviors (NCTSN, 2018; USDVA, n.d.; Eckes & Radunovich, 2007). Certain personality characteristics such as being agreeable, ability to take others' perspectives and empathise, may be significantly reduced. In addition, they may start avoiding school or becoming involved with other children who are aggressive in order to gain a sense of safety. All these behaviors are an attempt to guard against feelings of helplessness and overwhelming fear (Osofsky, 1997). It is also possible that some adolescents may also experience some of the signs experienced by younger children. Older adolescents may be more likely to experience trauma signs similar to those experienced by adults (Shaw, 2000).

Reflective Exercise

- Interactions with adolescents may elicit some biases in our understanding of autonomy and discipline. How can our views influence our interactions with adolescents?
- Adolescents are also likely to challenge the power dynamic in the relationship. What can be some ways in which power dynamic within the relationship is addressed?

What are some ways in which these responses can be assessed?

View of self.
It is possible that adolescents may respond by developing significant self-doubt, and may begin to question their capabilities in dealing with difficult circumstances. We can gently assess this by asking them questions such as, "Do you notice any change in the way you view yourself, your confidence, after this incident?". A broader question about how they are feeling may not elicit all emotions. It may be important to try to reflect and validate their emotions. These skills are covered in the previous manual.
We can use the question about the changes that could be due to their changed perception of the world. In some adolescents, personality traits pre-existent to the traumatic event may get significantly undermined or change completely. In this context, we can even check with their caregivers if they have noticed any changes in their behaviour.

Risk for harm
Adolescents may be more prone to developing new habits or high-risk behaviours that may be seen as self-destructive or those that compromise their safety. Some children may experience significant differences in their appetite, causing marked changes in their eating habits, including but not limited to binge eating or starving themselves due to marked increase in/ loss of appetite. A gentle, non-judgemental enquiry is required in this context. It is important that we do not let our personal perceptions and biases interfere in this process. We can

ask the adolescents about their habits and curiously ask them about their daily routines. We can also ask if they take any substance and understand their quantity to help us understand their intake. Additionally, we can ask them, “How do you cope when you experience distressing emotions?”

4.4 CHILDHOOD TRAUMA AND THE IMPACT ON ADULTHOOD

There is a lot of research evidence that links trauma exposure in early life to physical, emotional, and mental health problems in adulthood. The Adverse Childhood Experiences (ACE) Study (1998) showed a strong link between childhood abuse or household dysfunction as risk factors for physical health concerns such as heart disease and cancer (Felitti et al., 1998). Experiencing disasters in childhood can have profound and long-lasting impacts that persist into adulthood. These effects can manifest in various ways, including mental health challenges, altered stress responses, difficulties in relationships, and impacts on physical health. It may lead to altered stress responses in the body during adulthood, such as heightened cortisol levels or atypical ANS responses increasing the risk for developing chronic stress-related conditions (Danese & Wisdom, 2020) and adverse physical health outcomes in later life (Schnurr & Greene, 2018). Experiences of disasters during childhood may also lead to difficulties in building trust, intimacy, and attachment to others which may cause problems in maintaining stable relationships or even isolation (Tyrka et al, 2019). Disasters and their aftermath can cause disruptions in a child’s educational and developmental trajectories. As adults, they may have lower educational qualifications and subsequently, limited opportunities to have fulfilling careers (Nurius et al, 2019). It is also seen that being exposed to disasters during childhood is associated with a higher likelihood of developing mental health concerns in adulthood such as PTSD, anxiety, and depression. It may also make them more vulnerable to future stressors and other traumatic events (Shonkoff et al, 2018). However, the severity of these concerns is mitigated by other factors such as the intensity of the disaster and the support children received afterwards (DiGangi et al, 2018).

4.5 CHILDHOOD TRAUMA AND RECOVERY

Multiple factors may influence the time taken by children to navigate and recover from psychological trauma following a disaster. As we have discussed previously, some of these factors could include the nature, severity or impact of the disaster, the support systems available to the child as well as the child's coping skills and resilience.

Children have the capacity to bounce back from adversities such as disasters, return to their level of functioning prior to the disaster and can gradually achieve a sense of well-being despite surviving a traumatic event such as a disaster. Most children may recover in a few weeks or months following a disaster, while some others may take longer periods of time to fully recover. The intensity of their trauma responses may tend to reduce over time. Gradual improvements may be seen in a child's functioning and significant reductions in their distress levels may also be seen as time passes and they begin to feel safe or regain a sense of control over their situation (APA, 2016).

It is important to note that recovery is never linear. Even within the process of recovery there are ups and downs. There may be times when adults and children feel that their 'healing' has slowed down or that they have taken a few steps backward when something reminds them of their trauma and feels overwhelming. It is important to normalise these ups and downs in the journey of recovery and sustain hope for children.

5 MORE SEVERE PRESENTATIONS OF TRAUMA IN CHILDREN

While a large number of children who are exposed to trauma and natural disasters are able to resume their functioning with support, we also need to understand that some children may experience distress which may be clinically significant. It is important to note that these clinical signs have to be understood in the unique context of a child, rather than simply be used to diagnose, label or pathologise the child. Some children may also experience distress that does not warrant a diagnosis. These responses are called sub-threshold responses (APA, 2013). So it is pertinent for us to carefully understand the child's experiences and trauma

responses before concluding whether they are clinical or sub-threshold responses as this will also guide how we help the child and plan our interventions.

5.1 WHAT ARE SOME CLINICALLY SIGNIFICANT SIGNS OF TRAUMA IN CHILDREN?

Clinical signs of trauma in children who have survived a disaster could be experienced in various ways. Responses could include intrusive and repetitive flashbacks, repeated thoughts or memories about the disaster. Flashbacks refer to vivid and intrusive images of the disaster that the child may abruptly be disturbed by when they think of or are reminded of the disaster. Children may also engage in repetitive play or reenactments of something traumatic witnessed during the disaster or they could have disturbed sleep due to frightening nightmares about the disaster. Children may also feel the need to avoid distressing disaster related thoughts, reminders or memories and as a result may fear going to places associated with the disaster or talking about the disaster.

Another way in which children could respond following a disaster, is the inability to experience safety even while they are out of danger. This constant perception of danger causes disturbances in a child's nervous system and can cause the child to experience significant ups and downs in their **arousal** levels. There are two ways in which a child's arousal levels may be impacted. When a child's nervous system is on high alert all the time, it is referred to as a state of **Hyperarousal**. Hyperarousal causes the child to be overly vigilant, expecting a threat or dangerous situation to occur any moment. In this state, the child is ready for the threat and one's body is prepared to respond to the threat by fighting, fleeing or freezing. Hyperarousal could include signs such as constantly feeling anxious or overwhelmed, having anger outbursts or constantly checking for safety. The other way in which the child's nervous system may respond when it perceives a threat or danger is by entering into a state of **Hypoarousal**. Hypoarousal refers to responses that are similar to a 'shutdown'. When children respond by experiencing numbness, appear frozen or have difficulties speaking or moving, or experience a

significant amount of fatigue, these may be considered signs of hypoarousal.

Children may also experience signs of dissociation in response to a traumatic event such as a disaster. These could include severe disorientation or confusions in what has really occurred and what has not, gaps in their memories around the disaster, experiencing their surroundings in an altered way, or feeling disoriented when they are reminded about the disaster. Lastly, children may experience significant distress as a result of a persistent negative mood following a disaster. This could include significant sadness, anxiety or anger and may cause the child to feel constantly disturbed and could lead to significant interferences in their attention and concentration levels (APA, 2013).

5.2 WHAT ARE THE CLINICAL MENTAL HEALTH CONDITIONS RELATED TO TRAUMA IN CHILDREN?

Children who have experienced traumatic events such as disasters may experience severe traumatic stress amounting to a clinical diagnosis. Some or all of the signs of trauma discussed above could be seen in children following a disaster. Discussed below are well-documented clinical conditions of trauma in children.

Acute Stress Disorder: When a child is directly exposed to a traumatic event or multiple traumatic events simultaneously such as a disaster, death of loved ones, loss of one's home and so on, they may begin to experience highly distressing signs of trauma, immediately after the event occurs. If children begin to respond with signs of trauma within a few days of being exposed to the disaster and also recover from it within a month, it may be considered an 'Acute stress' response or disorder.

Post-traumatic Stress Disorder (PTSD): When a child experiences significantly distressing signs of trauma, which lasts for longer periods of time, such as more than a month or for several months, it may be considered as Post-traumatic stress disorder. In addition to the signs of trauma discussed above, it is also common for some children to cling to their parents or experience significant separation anxiety from their loved ones. So

it is essential to note that different children experience PTSD differently and we must be watchful of children's subjective experiences of trauma. Some children may not show any signs of trauma for as late as six months after the disaster and may have a delayed post-traumatic stress response. The duration for which the signs of trauma are experienced is what sets Acute Stress Disorder and Post-traumatic Stress Disorder apart. The signs of trauma experienced in both disorders could be similar (APA, 2013).

Reflective Exercise

- How would clinical representations differ for children as compared to adults?
- What could be the possible reasons for these differences in presentations?
- How will these difference influence the way in which we assess and understand the concerns of children?

6

HOW DO WE UNDERSTAND RESILIENCE IN CHILDREN?

It is important to acknowledge that when faced with disaster, many children also show the capacity to thrive and overcome their circumstances. The American Psychological Association (2022) defines resilience as the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (APA, 2022, p. 375). Resilience helps children face, and overcome difficult circumstances and environments. However, this ability is not formed in isolation. It is affected by various factors.

Three main factors interact to determine a child's level of resilience:

1. **Individual characteristics:** such as a child's temperament or nature that influences their behaviour, their intelligence and sense of humour.

2. **Family and community characteristics:** These include understanding how involved the parents are in the everyday life of the child, how safe children feel with them and how positively do parents feel about their role in the child's life.

3. **Coping with natural disasters is a collective process.** Children heal and experience resilience and strength from their communities.

4. **External supports:** employment opportunities and support systems for the whole family (Condly, 2006).

5. **Some other protective factors** include resilience or the ability of the parents to bounce back, their social circles, support of basic needs in times of need, and the child's own ability to regulate their emotions and form social connections. The presence of one or more of these positive supports in the family, community, and larger context helps overcome the negative outcomes for the child and support the development of resilience (Felitti et. al, 1998). The interaction between individual characteristics and supportive relationships in both the family and the community help children show resilience (Masten 2012; Rutter, 2012).

Reflective Exercise

- How can we identify protective factors which contribute to resilience in children and adolescents?
- What questions can we ask their caregivers about the resilience of the child?
- How can acknowledging the child's resilience impact the relationship between the caregiver and the child?

Let's avoid...

Negating the unique way in which children experience traumatic events vis-a-vis adults. It is important to remember that trauma is experienced differently by children as compared to adults and can be their unique expression of the same.

Looking at children without the developmental lens. The responses of children have to be understood in the context of their age. What might look like a trauma response at a particular age may be considered age-appropriate response for some other age-group.

Not understanding the developmental history of children. It is possible that even though the child may have attained a particular age in years but may not have been able to attain a particular developmental milestone. It is important to know if the child has been able to learn the skill already before considering it as a trauma response.

Believing that development is predetermined. There are a number of factors that can help the child's development. This includes having supportive caregivers and developmental opportunities.

Negating the protective factors for children. It is important to remember that not all children who witness a disaster will experience difficulty. Some may show adaptive and resilient responses as well.

Tips for Supervisors

- For supervisees, it might be helpful to learn to distinguish between the experiential understanding of child development and theories of child development. We may ask them about the similarities and differences in the way they conceptualise child development and how theories have conceptualised it.

- Supervision can also include capacity building where supervisees can learn how to translate the theories of child development in their work with children.

Self-care Exercise

Sometimes working with children and seeing trauma responses may make us feel helpless and lose hope. We can develop a box of hope for ourselves. It can include:

- A special letter, card, or printed email from someone you care about
- Special pictures that bring up positive memories (family, friends, vacations, etc.)
- Success documents (report card, diploma, certificates, awards, etc.)
- Special quotations that are important to you
- Objects from your life that are associated with good memories
- Photos of loved ones

This chapter highlighted the process of child development and how it gets affected by traumatic events such as disasters. It also focused on how emotional distress gets experienced and expressed by children across different age groups. The next chapter will focus on the basic principles of providing mental health and psychosocial support for children during disasters.

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the strange situation. Hillsdale, NJ: Earlbaum

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). American Psychiatric Association.

American Psychiatric Association. (2016). Coping After Disaster, Trauma. Psychiatry.org. link

American Psychological Association. (2022). APA dictionary of psychology (2nd ed.). American Psychological Association

Betancourt, T. S., Meyers-Ohki, S. E., Charrow, A., & Tol, W. A. (2019). Interventions for children affected by war: An ecological perspective on psychosocial support and mental health care. Harvard Review of Psychiatry, 21(2), 70-91. https://doi.org/10.1097/HRP.0b013e318283bf8f

Bourgeois, J.P. (1997). Synaptogenesis, heterochrony and epigenesis in the mammalian neocortex. Acta Paediatrica, Supplement 422, 27-33.

Bush, G., Luu, P., & Posner, M.I. (2000). Cognitive and emotional influences in anterior cingulate cortex. Trends in Cognitive Sciences, 4(6), 215-222.

Center on the Developing Child at Harvard University (2016). From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families. http://www.developingchild.harvard.edu

Center on the Developing Child at Harvard University. (2016). Building core capabilities for life: The science behind the skills adults need to succeed in parenting and in the workplace. Retrieved from http://www.developingchild.harvard.edu.

Condly, S.J. (2006). Resiliene in children: A review of literature with implications for education. Urban Education, 41, 211-236.

Danese, A., & Widom, C. S. (2020). The long-term effects of disaster exposure on health: A systematic review of studies on older adults. American Journal of Public Health, 110(8), e17-e21. https://doi.org/10.2105/AJPH.2020.305752

Davidson, R.J., Lewis, M., Alloy, L.B., Amaral, D.G., Bush, G., Cohen, J., … Peterson, B.S. (2002). Neural and behavioral substrates of mood and mood regulation. Biological Psychiatry, 52(6), 478-502.

DiGangi, J. A., Gomez, D., Mendoza, L., Jason, L. A., & Keys, C. B. (2018). Posttraumatic stress disorder, substance use, and associated risk factors among hurricane survivors: A systematic review. Traumatology, 24(4), 278-288. https://doi.org/10.1037/trm0000158

Eckes, A., & Radunovich, H. L. (2007). Trauma and Adolescents. EDIS, 2007(20). link

Federal Emergency Management Agency (FEMA), & American Red Cross. (n.d.). Helping Children Cope with Disaster. Link

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998).

Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood cxperiences (ACE) study. American Journal of Preventive Medicine, 14(4), 245–258

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. American Journal of Preventive Medicine, 14(4), 245-258.

Finkelhor, D., Turner, H., Ormrod, R., Hamby, S., & Kracke, K. (2009). Children's exposure to violence: A comprehensive national survey. Juvenile Justice Bulletin OJJDP,

Hamblen, J., & Barnett, E. (2022). PTSD in Children and Adolescents - PTSD: National Center for PTSD. Va.gov.

https://www.nicabm.com/trauma-how-to-help-your-clients-understand-their-window-of-tolerance/

Huttenlocher, P.R., & Dabholkar, A.S. (1997). Regional differences in synaptogenesis in human cerebral cortex. The Journal of Comparative Neurology, 387, 167-178.

Jones, E.G. (2000). Cortical and subcortical contributions to activity-dependent plasticity in primate somatosensory cortex. Annual Review of Neuroscience, 23, 1-37.

Jones, R. T., Ollendick, T. H., & Shahar, G. (2020). Substance use following disasters. Journal of Child and Adolescent Psychopharmacology, 30(1), 18-25. https://doi.org/10.1089/cap.2019.0121

Kousky, C. (2016). Impacts of natural disasters on children. The Future of children, 73-92.

Lai, B. S., Auslander, B. A., Fitzpatrick, S. L., & Podkowirow, V. (2020). The role of digital communication in adolescent social relationships post-disaster. Cyberpsychology, Behavior, and Social Networking, 23(6), 377-384. https://doi.org/10.1089/cyber.2019.0598

Lilienfeld, S. O. (2003). Comorbidity between and within childhood externalizing and internalizing disorders: Reflections and directions. Journal of abnormal child psychology, 31, 285-291.

Masten, A.S. (2012). Risk and resilience in development. In P.D. Zelazo (Ed.), The Oxford Handbook of Developmental Psychology, Vol. 2. New York, NY: Oxford University Press

National Child Traumatic Stress Network (NCTSN). (2018). Age-Related Reactions to a Traumatic Event. The National Child Traumatic Stress Network. Link

National Child Traumatic Stress Network (NCTSN). (2018). Age-Related Reactions to a Traumatic Event. The National Child Traumatic Stress Network. Link

National Child Traumatic Stress Network. (NCTSN) (2003) What is child traumatic stress? [Fact Sheet]. Retrieved from http://www.nctsnet.org/sites/default/files/assets/pdfs/what_is_child_traumatic_stress_0.pdf

National Child Traumatic Stress Network. (NCTSN) (2005). Understanding Child Traumatic Stress [Brochure]. Retrieved from http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/Understanding_Child_Traumatic_Stres s_Brochure_9-29-05.pdf\

National Institute for the Clinical Application of Behavioral Medicine. (2017). How to Help Your Clients Understand Their Window of Tolerance. NICABM.

National Institute of Mental Health (NIMH). (n.d.). Coping With Traumatic Events. link

National Scientific Council on the Developing Child. (2004). Young children develop in an environment of relationships. Working paper no. 1. Retrieved from http://www.developingchild.net.

National Scientific Council on the Developing Child. (2005/2014). Excessive stress disrupts the architecture of the developing brain: Working paper no. 3. Updated edition. Retrieved from http://www.developingchild. harvard.edu

National Scientific Council on the Developing Child. (2007). The timing and quality of early experiences combine to shape brain architecture: Working paper no. 5. Retrieved from http://www.developingchild.harvard.edu.

North, C. S., Mendoza, S., Simic, Z., & Pfefferbaum, B. (2018). Parent-reported behavioral and emotional responses of children to disaster and parental psychopathology. Journal of loss and trauma, 23(4), 303-316.

Nurius, P. S., Prince, D. M., & Rocha, A. (2019). Cumulative disadvantage and youth well-being: A multi-domain examination with life course implications. Child Indicators Research, 12(1), 169-190. https://doi.org/10.1007/s12187-018-9545-3

Osofsky, J. (Ed.) (1997). Children in a violent society. New York: Guilford.

Pascalis, O., de Haan, M., & Nelson, C.A. (2002). Is face processing species-specific during the first year of life? Science, 296, 1321-1323

Pfefferbaum, B., Jacobs, A. K., Griffin, N., & Houston, J. B. (2019). Children's cognitive functioning after disasters and community violence: A systematic review. Current Psychiatry Reports, 21(10), Article 98. https://doi.org/10.1007/s11920-019-1093-y

Pfefferbaum, B., Jacobs, A. K., Griffin, N., & Houston, J. B. (2019). Children's cognitive functioning after disasters and community violence: A systematic review. Current Psychiatry Reports, 21(10), Article 98. https://doi.org/10.1007/s11920-019-1093-y

Pine, D. S., & Cohen, J. A. (2002). Trauma in children and adolescents: risk and treatment of psychiatric sequelae. Biological Psychiatry, 51(7), 519–531. Link

Reis, H.T., Collins, W.A., & Berscheid, E. (2000). Relationships in human behavior and development. Psychological Bulletin, 126(6), 844-872.

Rose, T., Bassi, S., & Pevalin, D. (2019). Displacement and social cohesion: The social dynamics of youth in disaster-stricken areas. Youth & Society, 51(7), 887-904. https://doi.org/10.1177/0044118X17741028

Rothbard, M.K., & Posner, M.I. (2005). Genes and experience in the development of executive attention and effortful control. In L.A. Jensen & R.W Larson (Eds.), New horizons in developmental theory and research (pp. 101-108). San Francisco, CA: Jossey-Bass.

Rutter, M. (2012). Resilience as a dynamic concept. Development and Psychopathology, 24(2), 335–344.

Schnurr, P. P., & Green, B. L. (2018). Understanding relationships among trauma, post-traumatic stress disorder, and health outcomes. Advances in Psychosomatic Medicine, 40, 11-24. https://doi.org/10.1159/000489233

Shaw, J. A. (2000). Children, adolescents and trauma. Psychiatric Quarterly, 71, 227-243.

Shonkoff, J. P., & Bales, S. N. (2018). Adverse childhood experiences and toxic stress: Implications for health and well-being. JAMA Pediatrics, 172(12), 1135-1140. https://doi.org/10.1001/jamapediatrics.201

Shonkoff, J.P., & Phillips, D. (Eds.) (2000). From neurons to neighborhoods: The science of early childhood development. Committee on Integrating the Science of Early Childhood Development. Washington, DC: National Academy Press.

Substance Abuse and Mental Health Services Administration. (2011). Helping children and youth who have experienced traumatic events: National children's mental health awareness day – May 3, 2011 [Short Report]. Retrieved from http://www.samhsa.gov/children/samhsa_short_report_2011.pdf

Sweatt, J.D. (2009). Experience-dependent epigenetic modifications in the central nervous system. Biological Psychiatry, 65(3), 191-197

Szyf, M. (2009). Early life, the epigenome and human health. Acta Paediatrica, 98(7), 1082-1084.

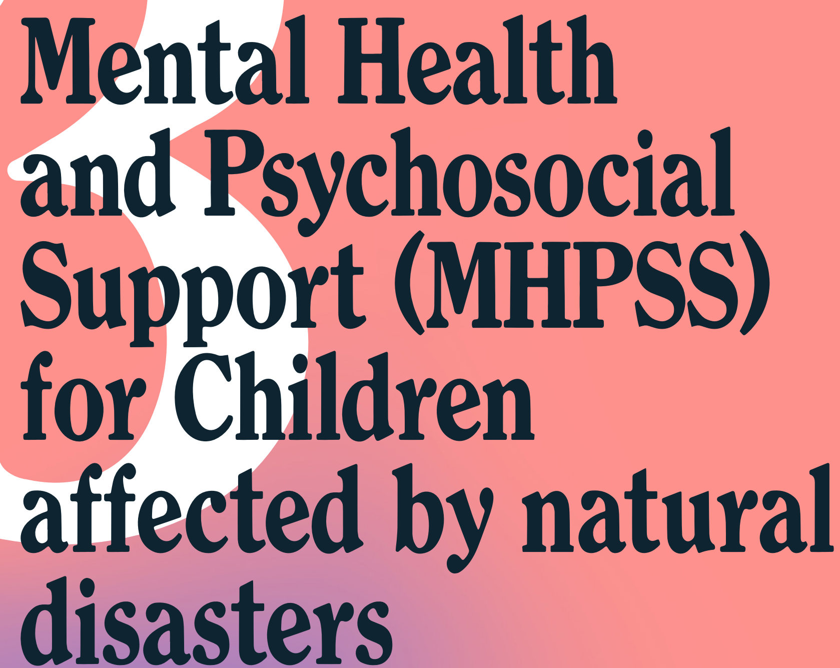
Thompson, R.A., & Lagattuta, K. (2006). Feeling and understanding: Early emotional development. In K. McCartney & D. Phillips (Eds.), The Blackwell Handbook of Early Childhood Development (pp. 317337). Oxford, UK: Blackwell.

Tyrka, A. R., Price, L. H., Marsit, C., Walters, O. C., & Carpenter, L. L. (2019). Childhood adversity and epigenetic modulation of the leukocyte glucocorticoid receptor: Pathways to stress-related disease. Development and Psychopathology, 31(3), 917-925. https://doi.org/10.1017/S0954579419000349

USDVA.gov | Veterans Affairs. (n.d.). www.ptsd.va.gov. Link

ZERO TO THREE (1994). Diagnostic classification of mental health and developmental disorders in infancy and early childhood. Washington, DC: Author

ZERO TO THREE. (2005). INTRODUCING DC: 0–3R.



CHAPTER 3

Mental Health and Psychosocial Support (MHPSS) for Children affected by natural disasters

1

WHAT IS MHPSS?

It is clear that disasters are traumatic events which cause significant distress to children. It is important that the unique trajectories of child development are considered when planning responses to meet the needs of children during disasters. Mental health and psychosocial support during disasters can play an important role in this regard.

Mental health interventions are specialised interventions that are focused on preventing and treating distress, trauma and mental disorders directly. Psychosocial support includes those services and initiatives, that are offered before, during and after disaster, that aim to enhance wellbeing and reduce distress and trauma, by influencing the psychosocial context of individuals and communities. This involves meeting essential needs, supporting and promoting individual and community capacities; improving social ecology and understanding the influence of cultures, value systems, and social determinants of mental health.

Mental health and psychosocial support (MHPSS) aims to:

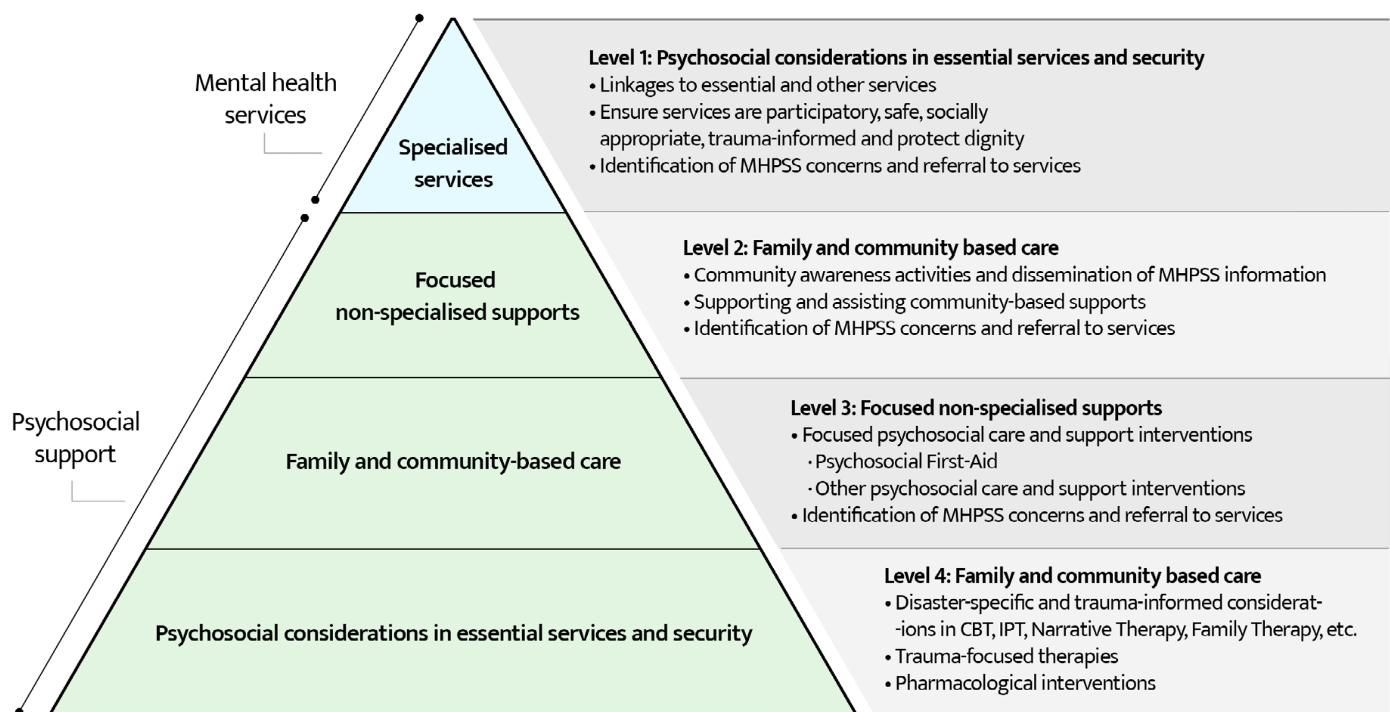
- Promote wellbeing
- Reduce emotional distress and trauma-related symptoms
- Prevent, reduce, or treat mental health concerns.

The psychosocial care component of the MHPSS is aimed at all people who have been directly or indirectly exposed to the disasters, particularly those who are socially vulnerable and/or experiencing reduced well-being. It also includes providing focused non-specialised support for people showing signs of distress and trauma responses. Trauma-focused mental health interventions are aimed at helping those who are experiencing long-term distress, showing trauma responses with significant difficulties in daily functioning and having diagnosable mental health concerns.

2

WHAT IS THE ROLE OF MENTAL HEALTH PROFESSIONALS WORKING WITH CHILDREN DURING DISASTERS?

Mental health professionals (MHPs) play a crucial role in managing trauma responses to disasters. We bring our unique competencies such as managing stress and developing coping strategies to the disaster situation (APA, 2021). The NDMA (2023) has prepared guidelines to help understand our role as MHPs in the disaster context. These guidelines highlight our role in every phase of disaster such as the preparedness phase, during early phases, response phase and restoration phase and across different levels of MHPSS mentioned above.



Prior to the occurrence of the disaster, that is in the preparedness phase, our role can be:

a. Carrying out assessment of vulnerabilities such as understanding the pre-existing psychosocial problems of the children in the communities in the disaster-prone area and the resources available to the community which may be helpful for children. This assessment which is carried out in a trauma-informed manner can guide the actions which need to be taken during the disaster phase for the children.

b. Building the capacities of stakeholders such as caregivers, school teachers, disaster responders, community level workers, local, state and central government personnels, health and allied health professionals, NGO personnels and media on identifying and working with the needs of children during disasters.

c. Building technological support such as a centralized portal to identify, consolidate, and provide access to disaster mental health and psychosocial support resources available containing IEC (Information, Education and Communication), self-help guides, information for help-seeking, to name a few. These resources can be made for children as well as for caregivers.

d. Providing support through research endeavors by participating in trauma-informed disaster mental health research on topics such as intervention, ethics, specific to children to name a few. These research endeavours can help map the resources available to the community which can be accessed during times of disasters.

The next phases are the early phases of disasters which last from one to eight weeks post disaster. MHPs are engaged in planning and preventive roles during these early phases of disasters such as:

a. Participating in a multi-disciplinary relief team. This may include collaborating with other medical and nutrition experts to create one stop centres for identifying and addressing the physical and psychological health concerns of children, partnering with school teachers and school counsellors to help children learn coping strategies during disasters, working with social workers and legal experts to help in reunifying children with parents who may have been separated during disasters, and working with community leaders, child protection agencies, and other stakeholders to educate the broader community about the mental health needs of children.

b. Carrying out rapid assessment which focuses on

- Nature of the hazard

- Social determinants of mental health for the children in the area such as the economic resources available to children, social networks that children can access, factors to maintain school continuity, access to safe households and neighborhoods, and healthcare.

- Mental health and psychosocial context of the children including prevalence of trauma responses and the common psychosocial responses of those children affected by the disaster

- Social and community based resources available for children such as community centres and safe spaces for children, school-based programs for continuity in education and stability, youth and peer support programs, NGOs supporting children, child protection services and recreational and play programs.

- Formal resources available for the children such as number of trained personnels, technological resources, healthcare institutions to name a few

- Socio-cultural beliefs and attitudes towards mental health of children such as the stigma around mental health of children, cultural beliefs about distress, community-based healing practices, and attitudes to mental health practitioners.

c. Providing capacity building services to understand disaster and children's responses through IEC material and self-help strategies which are particularly suited for their age and stage of development. It also includes carrying out community awareness programs promoting help-seeking behaviours for children. MHPs can be engaged in school sensitization programs as well as community awareness programs to reach out to important stakeholders in children's lives such as school authorities, teachers, community leaders and children themselves.

d. Providing psychosocial support such as psychological first-aid, and other specialised mental health services addressing trauma responses, emotions distress, and other responses for children. This may include creating safe space for children, ensuring that there are trusted adults to take care of children at

relief camps, establishing routines for children and promoting opportunities for cognitive, emotional and social development of children. These activities can be done in groups to facilitate peer learning and interactions. It also includes conducting training and supervision for those professionals who are working with children to ensure that these activities are carried out in a trauma-informed manner.

The next phase of disasters is the disillusionment phase starting after the end of the earlier phases (from two months) and can last for the next three years. MHPs are engaged in more curative roles including:

a. Interventions for those children with significant mental health concerns

b. Attending to the referrals for specialised care for those children who have been severely affected

c. Spreading the scope of capacity building activities for stakeholders involved in the care of children

d. Training and hand holding community members such as private physicians/doctors, primary health care staff, paramedical staffs, school teachers, anganwadi workers, alternative complementary medicine personnel, religious leaders, spiritual leaders and faith healers for better outreach of services for caregivers and children

e. Participating in community outreach camps where children are housed

f. Assessing the efficacy of interventions for children and developing a feedback mechanism

Lastly, the phase of restoration starts where MHPs are involved in the preparedness phase once again. This cycle shows the crucial role that MHPs have in every phase of disaster management. The scope of this work is covered more in detail in the NDMA guidelines (2023).

Reflective Exercise

- The above paragraphs discuss the roles that MHPs may play in the context of disasters. Which roles seem interesting to you as an MHP?
- Which roles may be challenging for us?
- What could be some ways in which we may enhance our skills to be able to play these diverse roles in the context of disasters?

3 WHAT APPROACHES MAY HELP GUIDE US WHILE WORKING WITH CHILDREN?

Within MHPSS practices, there are different approaches and theoretical standpoints that MHPs adopt and are influenced by. While working in the area of MHPSS for children during disasters, using Trauma-informed and Strengths-based frameworks, while incorporating creative arts could be promising and holistic. The trauma-informed framework has been discussed earlier. Some perspectives are discussed below.

3.1 STRENGTHS BASED APPROACH

Traditionally within the mental health practice, psychological concerns are widely understood from a medical or illness standpoint, i.e. symptoms represent underlying problems or 'deficits' that exist within the client. Strengths based approaches propose that 'solutions can be found irrespective of original issues' (Sharry, 2003; Xie, 2013). That is, the medical model looks at the problem experienced by the child and tries to fix that, whereas a solution-focused model looks at the solutions available to or strengths within the child and tries to build on that. Using a strengths-based perspective helps in recognising and promoting the idea that disasters are stressful situations and distress experienced during and after disaster is the expected response to this situation. Most children use their own capacities and resources to build their lives back and using a strength-based approach helps in acknowledging and celebrating these efforts by children.

3.1.1 WHAT CONSTITUTES A STRENGTHS BASED APPROACH?

Using a strengths based approach can mean:

i. Assuming that each child has a unique set of skills, competencies, resources and expertise in finding the solutions to their problems

ii. Shifting our lens from finding problems and explanations for the same, to becoming curious about these innate capabilities and strengths

iii. Using practical approaches, lines of questioning and techniques that elicit strengths and build on solutions that children have expressed and identified themselves

iv. Helping children accept themselves and build an understanding that they are more than the concerns they are facing.

v. Encouraging and adopting methods that help renew hope through strengthening the child's relationship with themselves (Sharry, 2003; Yuen et al., 2020)

3.1.2 HOW TO IMPLEMENT A STRENGTHS BASED APPROACH?

To implement a strengths based approach, MHPs are required to start with changing their perspectives to a 'strengths based thinking' i.e. assume that all children possess strengths and as MHPs we need to find them. This involves being constantly curious and actively listening for the child's strengths, competencies and resources. In conversations with the child, the MHP consciously uses 'problem-free talk' and focuses on using their 'genuine and respectful curiosity' in developing a relationship with the child (Sharry, 2003, Xie, 2013). The MHP is also looking for strengths and resources in the child's environment and uses these as well to help children achieve their goals (Yuen, 2020). For example, when the MHP is asking about the experience of the child during a disaster, they ask about when things started getting better, what helped them, who was there to support them and so on.

3.1.3 WHY SHOULD WE USE A STRENGTHS-BASED APPROACH IN WORKING WITH CHILDREN DURING AND AFTER DISASTERS?

Having discussed the importance of focusing on individual strengths and characteristics, it is also essential to identify the strengths that communities possess in bouncing back from traumatic events such as disasters. We as individuals do not exist in a vacuum. As we have discussed earlier in this manual, social connection and community ties are protective factors in helping us cope with traumatic events such as disasters, particularly in the case of children who are heavily reliant on adults.

Various factors influence a community's recovery after disasters, some of these include the extent of the losses and damages suffered, economic resources or the extent of assistance from the state or external stakeholders. Even in severely impacted communities where some of the above mentioned factors are not favourable, it is found that if the community possesses greater social networks and strong relationships between members, the speed of recovery from disasters seems to be greater (Aldrich, 2012).

The extent to which communities combine their resources and efforts to rebuild their lives also has a positive impact on healing, recovery and resilience post disasters. These collective efforts can also increase the overall psychological well-being and further strengthen the cohesiveness within the community (Kaniasty & Norris, 2008). Lastly, communities affected by disasters have a shared identity of being survivors. This shared identity increases their ability to stick together and work towards bouncing back from the adverse effects of the disaster (Aldrich, 2012).

For all these reasons, it is important for us to help strengthen children's community ties, actively involve community members in their care and assess the hidden strengths that communities may possess in our MHPSS work with children post disasters.

3.2 USING CREATIVE ARTS

3.2.1 WHAT ARE THE KEY FUNCTIONS OF CREATIVE ARTS IN TRAUMA-INFORMED MHPSS WITH CHILDREN DURING DISASTERS? (Richarson, 2015; Malchiodi, 2020)

Creative arts serve key functions in trauma-informed MHPSS such as:

- **Self expression.** Creative arts allow children to express themselves to heal, play or to simply share their story. This need for self-expression may be especially important post disasters as children may feel unheard or confused about what has happened. They may make sense of the chaos that may accompany a disaster using art.

- **Externalisation.** Creative arts help children externalise their traumatic experience of disasters, i.e. separate themselves from their trauma by creating images or objects. This can also help children differentiate the present from the past which is important for children. For example, a child who creates the image of destruction during a flood may be able to consider this event as being in the past and separate from the now by drawing another image of the present.

- **Sensory processing.** Creative arts also activates the body and senses. Since traumatic experiences such as disasters significantly affect the body and its state of calmness or agitation, creative arts can become an important tool in teaching children how to identify agitation and return to their state of calmness. For example, a child who draws the image of the earthquake may be able to identify the state of agitation and its difference from their drawing of a safe space which may represent a feeling of calm. Art can be used by children to soothe and calm themselves.

- **Relational aspects.** Children who have experienced disasters often develop difficulties trusting others or the world at large. This is because their traumatic experiences such as disasters alter their perception of stability and safety. Playing with adults or drawing with them may help them regain the sense of trust and normalcy. Art is used in groups and school activities as well.

3.2.2 WHAT IS THE RATIONALE FOR USING CREATIVE ARTS IN MHPSS WITH CHILDREN AFFECTED BY DISASTERS?

There are various advantages of integrating creative art forms into MHPSS interventions for trauma experienced by children who have survived disasters. These are discussed below:

- **Developmentally appropriate.** Trauma interventions heavily rely on meaning making as an important pathway to recovery. This requires higher order linguistic, verbal and semantic abilities which are brain functions that young children typically develop much later in life. This makes the integration of creative art forms in our interventions helpful, as it is a developmentally appropriate modality which does not primarily rely on language functions for its execution. For example, a child who is experiencing feelings of fear around going to sleep alone, may make drawings of a child sleeping in between two adults to show her preference.

  Reduces impact of retraumatisation. When disaster related trauma memories are retrieved, it can cause significant distress in children due to retraumatisation. Using creative art forms can prove to be a safer and graded way to approach deeply distressing trauma related memories and emotions because it provides a relatively non-threatening way to contain or channelise overwhelming, trauma-related emotions.

- **Helps with skill building.** Creative arts help children have the opportunity to build affect-regulation skills by teaching them to contain their heightened emotions within specific objects, images, stories, music and so on. It can help a child develop a sense of agency over their body and mind, increasing their engagement with the outer world. For example, a child may keep all the feelings of fear and anxiety of surviving the fire in a sand castle and destroy it later. This may make them feel more in control of their experience of the event.

4

WHAT ARE THE ETHICS IN MHPSS WORK WITH CHILDREN IN DISASTER SETTINGS?

4.1 WHAT IS THE NEED FOR AN ETHICAL CODE OF CONDUCT FOR WORKING WITH CHILDREN DURING DISASTERS?

The responsibility in ensuring that ethical considerations are followed in MHPSS for children following disaster rests almost entirely with the MHPs. Children may or may not be able to understand nuances such as professional ethics or their rights as clients, making them a particularly vulnerable group as clients and making us inherently more powerful stakeholders. The need for an ethical code of conduct when working with children post-disasters is crucial due to the vulnerable nature of children and the complex, often chaotic, circumstances that disasters create. Children are among the most vulnerable populations during and after disasters due to their physical, emotional, and developmental needs. Presence of the ethical code of conduct ensures that these specific vulnerabilities are recognized and addressed appropriately (UNICEF, 2007).

An ethical code mandates that the best interests of the child are always the primary concern, that is, all actions and decisions made by MHPs need to be focused on the child's well being and dignity (Convention on the Rights of the Child, 1989). These codes are also used to ensure that the rights and dignity of children are protected. They will be involved in decisions that affect them, their voices are heard and their opinions are respected.

Ethical codes also help to navigate the complex ethical dilemmas which may arise during and in the aftermath of disasters. These may be unique to the disaster situation (APA, 2017). These codes also promote accountability and transparency in the work of MHPSS. This ensures that the heightened risk of children being exploited or harmed during disasters are mitigated (IFRC, 2013).

Discussed below are some ethical considerations that MHPs could consider while working with children:

4.2 BENEFICENCE AND NONMALEFICENCE

What do beneficence and nonmaleficence mean?

Beneficence and nonmaleficence are key ethical principles in the context of mental health and psychosocial support for children during disasters. These principles guide MHPs in ensuring that their actions promote the well-being of children while avoiding harm. Beneficence refers to the ethical principle which highlights the need to act in the best interest of the child, and promote their well-being. Nonmaleficence refers to the ethical obligation to avoid causing harm to the child. It is the principle of "do no harm," ensuring that the work we do does not worsen the child's situation or create additional difficulties for them. This is especially important in traumatic events like disasters where the risk of retraumatization is high.

How do we ascertain beneficence and nonmaleficence while working with children during disasters?

We can ascertain that these principles can be applied in the context of disasters by (APA, 2017, WHO, 2013):

1. **Focusing on promoting the child's well-being:** In the aftermath of a disaster, children may experience significant trauma, stress, and anxiety. MHPs must prioritize interventions that promote the child's psychological well-being, resilience, and recovery. This may include individual, group or community interventions.

2. **Providing necessary care:** The principle of beneficence can be applied by providing necessary care, such as counseling, therapy, or social support, that meets the child's immediate needs and plans for their long-term needs. This may involve creating safe spaces, offering emotional support, and helping children process their experiences in a healthy manner.

3. **Supporting overall development of the child:** The ethical principle of beneficence also extends to ensuring that working with children contributes to their overall development in the emotional, cognitive, and social domains. MHPSS can be helpful in this

regard by helping children regain a sense of normalcy and security.

4. **Avoiding re-traumatization:** The principle of nonmaleficence highlights the importance of avoiding actions or interventions that increase the risk of retraumatization of the child. This may include exposing a child to distressing reminders of the disaster or using inappropriate therapeutic techniques could cause further harm. This also includes knowing the limitations of our time and skill sets in selecting and delivering the work in the context of disasters.

5. **Providing culturally sensitive practices:** The ethical principle of nonmaleficence also emphasises the importance of being culturally sensitive and aware of the child's background. This will help in avoiding practices that might be harmful or inappropriate within the child's cultural context.

6. **Participating in ethical decision-making:** MHPs need to give careful consideration to the potential risks and benefits of any intervention that they are thinking of using with the child, choosing approaches that minimize harm in the context of disasters and prioritizing the child's safety and well-being. This may involve consulting with caregivers, respecting the child's autonomy, and ensuring that interventions are age-appropriate. It also includes knowing when to refer to a specialist to support the child's needs.

4.3 INFORMED CONSENT

What is the difference between Assent and Consent?
Consent refers to agreeing to voluntarily participate in a process as a result of making an informed decision about a matter, after considering relevant information regarding the same. To provide Consent one must: (i) be of legal age, (ii) volunteer to participate, (iii) have the mental ability to appraise the circumstances and information surrounding the matter. In our country, the law does not recognise children under the age of 18 years, as being capable of providing Consent in availing MHPSS, so it is mandated by law that it be obtained from a parent or a legal guardian prior to commencement of MHPSS with a child.

Assent refers to the willingness or agreement of a person in participating in a process or in taking an action, who may not possess the legal or mental capacity to provide Consent. Assent is not legally binding and therefore a MHP working with a child needs to procure the legal guardian's consent. However it is essential that the child's assent is sought in addition to procuring a guardian's consent before we commence working with them (APA, 2017; Bhaskaran & Seshadri, 2016). .

Why is seeking Assent from children for MHPSS important?

The law may not recognise children's abilities in providing Consent to avail MHPSS, but this does not mean that they do not possess the cognitive or emotional abilities to understand their circumstances and make decisions around them (Bhaskaran & Seshadri, 2016). It is extremely important that assent be sought from the child directly and that the child is given a choice to decide if they wish to engage with support. This may help the child feel like they have chosen to participate in the MHPSS process voluntarily, which may lead to a better experience for them overall. In case the child is too young, it is still recommended that an attempt be made to seek the child's consent in a developmentally relevant manner (Geldard et al., 2018; Koocher, 2008; Bhaskaran & Seshadri, 2016).

Ways to ascertain assent from children for MHPSS

With young children:

The MHP may begin by trying to establish a rapport with the child, by first introducing who we are and what our role is in the context of disaster. We can then ask the young child about what they might want to do. After the child appears at ease with the MHP, one may introduce the idea of working with the child regularly by making an invitation such as "Did you enjoy our time today?"

If the child says No, an effort must be made to ease the child into the process further. Involving a sibling, peer or parent in the activities may help the child feel comfortable or help build trust with the MHP.

If the child says Yes, then the MHP may ask the child "Would you like to come spend time with me more often, maybe once in a few days over the next few weeks? We can talk about how you feel or how your week went when we meet.

As a MHP, I care about the emotional well-being of children." We can also have a beginning and closing ritual in the sessions and give them a sense of time in the session. This promotes feelings of being in control and keeping things predictable.

With older children:

Middle aged children or adolescents may be better equipped to understand the context of MHPSS. The MHP may approach assent by saying "Hi, I am ____. I'm a MHP and my job is to help people affected by the recent disaster with MHPSS/ help people with their mental wellbeing. Do you know what MHPSS is?"

If the child says No, we can go on and explain that "MHPSS is a form of support offered to people affected by disasters. It includes different kinds of support including physical, social and emotional, or community level support to help people cope with the situation."

If the child says Yes, you can continue by saying "I am a MHP, meaning that I am a special helper who listens to feelings and thoughts and someone who can share some tools to help you feel sad, worried or angry. Do you think you would be willing to work with me/ speak to me about how you have been doing more recently after the disaster? I would be interested in helping you work through any emotional difficulties or distress you have been experiencing as a result of the disaster. If you agree to work with me, we would be meeting ...". You can go on to provide the child information about the sessions and what they would be like thereon.

What is Informed Consent in MHPSS and how do we ascertain it?

Informed consent includes the process of providing the child and the caregiver with all the relevant information about the MHPSS process before it starts. The information shared should ideally help them make an informed decision about whether they would like to avail support at that time or not from the current service. It should ideally include details about the sessions and the MHP working with the child. Details about the MHP could include their professional background, credentials, contact details or relevant work experience. Details about the sessions could be regarding the format (eg. individual/ group), the number of sessions, confidentiality and the limits of the same. It is important to clearly communicate about what information will be shared

with the parents.

In a disaster situation where people may not have a lot of choices, accessing such information and knowing the background of the MHP one is working with, may help the children and parents feel like they have some control over the situation. Typically, it is encouraged that this information be shared with the child and parent in a written format, so they may possess a record of the same. However, it is possible that during disasters, a verbal consent may have to suffice (ACA, 2024; APA, 2011, MHCA, 2017).

4.4 NAVIGATING CONFIDENTIALITY.

While working with children, it is crucial that both the child and the parents be informed about the extent and limits of confidentiality (ACA, 2024). Even though concerns related to confidentiality and its limits may influence their willingness to open up with a MHP, these need to be clearly communicated (Koocher, 2003). This is an important part of the trustworthiness and transparency part of working with a trauma-informed lens during MHPSS in disasters.

What should the child be informed about confidentiality?

Children have the right to know that their parents will be given updates about their progress, might be involved in some sessions if needed and that there are limits to confidentiality. The limits to confidentiality are situations where MHPs break confidentiality and engage another person in the conversations. This is done when there is a risk of harm. In situations, where the child may be thinking of harming themselves or others as well as those where the child is being harmed. These limits need to be clearly articulated to them right at the beginning of the sessions. Parental involvement is particularly relevant in our country wherein culturally, parents are significantly involved in their child's affairs and may frequently reach out to the MHPs particularly in times of disasters where MHPs may be an important point of contact for their parents (Bhaskaran & Seshadri, 2016).

How to navigate confidentiality with parents?

MHPs need to be kind but firm in setting boundaries

with parents and protecting the child's right to privacy, especially when parents insist on knowing details that the child may not want to share with them. Similarly, we should also know when to engage parents and share information tactfully on a need to know basis, without compromising confidential information (Bhaskaran & Seshadri, 2016; Geldard et al., 2018).

What are the limits to confidentiality?

If there are indications of harm to self or others, MHPs should inform the parents or legal guardians at the earliest to ensure the safety of the child or others involved all the while keeping the child informed that their parents are going to be involved (Bhaskaran & Seshadri, 2016; CAMH, 2010; MHCA, 2107). In case there is any indication that a child intends on harming themselves or someone else, as much as possible the MHP should try to inform the concerned person or relevant authorities to ensure the child's and other person's safety. MHPs could evaluate the level of self-harm related risk by evaluating one's intentions, potential plans of executing such intent or the consequences for the child if they were to execute such plans. In these situations, confidentiality is broken (a script to break confidentiality is provided later). Another area where confidentiality may be broken is when the child is using substances in harmful quantities. In the context of disasters, substance use and self-harm are often used as means of coping with the distressing emotions that a person may feel (SAMHSA, 2014). Thus, being on guard for these situations is important.

Is there such a thing as 'over-reporting'?

Another factor to consider within the area of mandatory reporting, is the tendency to engage in "Blanket reporting", wherein MHPs prematurely breach confidential information, even when the child is not in imminent harm or risk. So it is important to weigh in all factors before decisions around breaching confidentiality are reached, as it could negatively impact the child's participation in the process if confidentiality is unnecessarily breached (Jenkins, 2012).

Script to discuss confidentiality with children and adolescents

"Our sessions will be held with utmost privacy and you are free to discuss anything you'd like with me, including how you feel or think, things you have not shared with others or problems you would like for us to work on together. While our discussions are private, there are times when we may need to decide about getting another adult involved in our discussions. Let us discuss what that might look like and I would like to tell you why that is important. If there is a time where you might be likely to hurt or harm yourself, I would need to discuss this with your parents to ensure your and their safety. In these situations, I have to involve the concerned adults. Another situation where confidentiality is broken is when there is harm to others. If you share with me that you intend to harm someone else, in order to assure their safety, I will be contacting them. It is a rule or ethic that all MHPs follow to make sure that people's safety comes first. However I will inform you and try my best to help you understand why this must be done, before I do so. Barring these two situations, everything we speak about will be completely confidential.

There could be other situations, where I may have to speak to your parents about what is happening in our sessions, as they may have to be involved in some plans we are making as a part of your care, or may have general questions about how you are doing. In these situations, you and I can plan together on what we share with them and can even do so together. Please feel free to ask me any questions you have about any of this."

4.5 MAINTAINING BOUNDARIES.

Children need to be able to differentiate between personal relationships they share with parents, family or teachers, from the professional relationship they share with their MHP. In a disaster context this may be challenging as MHPs may be one of the adults who may be spending time with the child and hearing them. Nonetheless, maintaining boundaries becomes an essential part of our work with children (Schetky, 1995).

What are some ways in which boundary crossing or even violation may occur?

As MHPs we must be aware of our relationship with our own boundaries. This is an important first step to be aware of and understand when we feel that we have overextended ourselves beyond our boundaries. Some examples of MHPs' breaches in boundaries could include

things like buying the child toys or gifts, things to eat in session, especially in the disaster context where children may not have easy access to these things. These things might happen because of the power dynamics within the MHP-child relationship. In these circumstances, children may experience inequality and this could negatively impact the effectiveness of the care process (Geldard et al., 2018).

Transference and Countertransference dynamics between MHPs and clients can also cause boundary related concerns (Schetky, 1995; Bhaskaran & Seshadri, 2016). Simply put, Transference refers to when children unconsciously 'transfer' emotions originally meant for other individuals in their life onto the MHP. When this happens, it could bring up unconscious feelings within the MHP and could cause them to respond with a range of emotions towards the child. This is referred to as Countertransference (APA, 2015).

For example, sometimes as MHPs, we may get overly concerned about, feel disinterested towards or deeply angered by some children. When we have such strong emotional reactions towards a child, it is always better to look into it and see if there are any transference or countertransference dynamics at play and to ensure boundaries are not breached as a result.

It is possible that sometimes boundary crossing may occur from the child's side as well. Young children may sometimes initiate physical touch or may ask many questions about the MHP's personal life, may insist on giving gifts and so on (Schetky, 1995; Bhaskaran & Seshadri, 2016). While these may commonly be seen as breaches in boundaries, it is important for us to understand the child's world and perspectives, and to maintain our stance of respect and curiosity, while we navigate how to deal with these concerns.

It is imperative to understand the MHPSS happens during and in the aftermath of the disaster. The possibility of doing long-term work may or may not be present in this context. We might want to keep the context of disaster in mind when planning the scope of our work with children. Some children may need specialised care and long-term work and we may need to consider sharing referrals for them.

Reflective Exercise

Sima is a 30 year old counsellor, working in a local community center that works with school age children, in the outskirts of the town. After the flood, she got a lot of referrals for working with children at that time from the nearby school. She is a parent herself and her child goes to the same school that was sending her referrals. Recently she began working with Pushkar, a 6 year old boy after the floods. Pushkar was referred to Sima by his grade 2 class teacher for having difficulties getting along with his friends and looking sad and lonely after the floods destroyed his home and his father had to go to the nearby town to search for work.

Sima began working with him after connecting with his mother and trying to understand the child's background prior to the disaster. She learnt that Pushkar was due to have a new paint for his room that he and his father were going to select before the floods came and destroyed their home. He is sad that his father also does not spend a lot of time with them currently.

Sima's daughter Rakhi is in the same grade as Pushkar. Both Rakhi and Pushkar play in the same area of the school despite being in different schools. This is because repair work is going on in Rakhi's school after the flood water is still being drained. After seeing Sima pick up Rakhi at the school one day, Pushkar's mother began asking Sima if she could ask Rakhi to play with Pushkar. They also went on to request Sima to let the children play during the time allocated for the counselling sessions because they felt that would solve all Pushkar's problems.

1. How might Sima be feeling about Pushkar's mother's requests?
2. What are the challenges in maintaining professional boundaries?
3. What are things that Sima can do to address these concerns?
4. What are some alternatives that Sima can recommend to the parents?
5. What are some precautions that we can take to avoid being in Sima's situation?

Let's avoid...

Having a unidimensional understanding of our role as MHPs in the context of disaster. As MHPs, we bring our unique competence to contribute to all phases of disaster management as well as across different domains. We can contribute towards this endeavour in different roles.

Using unidimensional approaches. It may be beneficial to use integrative approaches while working with children, where we borrow from different, relevant and evidence-based therapeutic frameworks. Such a multidimensional approach might help if we are stuck in the process or are finding it hard to branch out and think of our work from different angles.

Ignoring the rights of children when planning for providing MHPSS to them during disasters. Children have certain rights that need to be respected especially in situations where they are vulnerable (such as the context of disasters) and it is imperative that we as MHPs recognise and respect those rights.

Not remembering power dynamics while working with children. While we may have the best intentions in ensuring we practice ethically, working with children, particularly young children, could pose challenges in maintaining the balance in power in the counselling relationship. There may be instances of boundary violations. If we're mindful of this and constantly check in on it, it could be helpful.

Keeping external stakeholders out of the loop. Much of our work with children is systemic in nature and involves working closely with parents, siblings, teachers or their school etc. They could be important resources in helping us understand the child's hidden strengths or resiliency. As a best practice, it might be advisable to have regular check-ins with these external stakeholders and maintain a good working relationship with them.

Tips for Supervisors

- We can help supervisees learn how to navigate ethical dilemmas by asking them to think of pros and cons of a particular decision, what their feelings about a particular decision are, and the values that may be in conflict. This way we can help them independently think through and navigate any dilemmas they face. We may also help them learn important frameworks for ethical decision-making.
- For supervisees who may be struggling with navigating boundaries with children or external stakeholders, we can give them things to say or do in those circumstances or help them practice them with us in roleplays in supervision, so they may feel more prepared for having tricky conversations and situations

Self-care Exercise

- **Attending to your emotions.** For MHPs experiencing conflicting values, ethical dilemmas or countertransference with children, it could be emotionally exhausting and overwhelming to handle. We could navigate these concerns by journaling after difficult sessions or doing self-soothing activities such as colouring or painting. We could also initiate discussions with trusted colleagues or supervisors to address countertransference issues, so that we do not feel stuck or alone.
- **Learning to say "No".** If there are any boundary concerns or conflicts arising with external stakeholders, such as parents or teachers, MHPs could face significant stress in navigating these issues. In such situations, it is important for us to have a workload we can handle and say no to work we may not be able to take on temporarily, to ensure we don't burnout or get overworked. We can ask for help if we are unable to manage certain situations and be okay to prioritize our bandwidth on one thing at a time as much as possible

This chapter focuses on the basic principles of MHPSS for children during disasters. Certain important frameworks that inform this process were also discussed. Lastly, this chapter also highlighted the ethics of working with children during disasters and some dilemmas that MHPs may face in this context. The next chapter will focus on key strategies for providing MHPSS for children during disasters.

References

Aldrich, D. P. (2012). Building resilience: Social capital in post-disaster recovery. University of Chicago Press.

American Psychological Association (APA) (2017). Ethical Principles of Psychologists and Code of Conduct. Washington, DC: American Psychological Association.

American Psychological Association. (2015). APA Dictionary of Psychology (2nd ed.). American Psychological Association.

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct

APA Practice Organization. (2011). Working with Children and Adolescents: Answers to questions about privacy, consent to treatment and access to records. Apaservices.org. https://www.apaservices.org/practice/good-practice/winter11-working.pdf

Australian Counselling Association (ACA). (2024). Code Of Ethics and Practice. link

Bennett, L. (2008). Narrative methods and children: Theoretical explanations and practice issues. Journal of Child and Adolescent Psychiatric Nursing, 21(1), 13-23.

Bhaskaran TS, S., & Seshadri, S. P. (2016). Ethics in Child Psychotherapy: A Practitioner's Perspective. Ethical Issues in Counselling and Psychotherapy Practice: Walking the Line, 37-55.

Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011).Trauma-informed care and mental health. Directions in Psychiatry, 31, 197-210.

Center for Addiction and Mental Health (CAMH). (2010). Suicide prevention and assessment handbook. link

Denborough, D. (2014). Retelling the stories of our lives: Everyday narrative therapy to draw inspiration and transform experience. New York: Norton.

Doan, R. E. (1997). Narrative therapy, postmodernism, social constructionism, and constructivism: Discussion and distinctions. Transactional Analysis Journal, 27(2), 128-133.

Epston, D., & Roth, S. (n.d.). Engaging Young Persons in Externalizing Conversations: Developing Abilities and Knowledge. narrativeapproaches.com. link

Freedman, J., Epston, D., & Lobovits, D. (n.d.). About Narrative Therapy With Children. narrativeapproaches.com. link

Geldard, K., Geldard, D., & Rebecca Yin Foo. (2018). Counselling children: A practical introduction (5th ed., pp. 16–22). Los Angeles, Calif. Sage.

Hunter, S. V. (2012). In the Best Interests of the Child: Ethical Challenges for Counsellors and Psychotherapists. Psychotherapy and Counselling Journal of Australia, 1(1).

International Federation of Red Cross and Red Crescent Societies (IFRC). (2016). Nepal earthquake: Six months on – Moving from emergency response to recovery. Retrieved from https://www.ifrc.org/document/nepal-earthquake-six-months-moving-emergency-response-recovery

Jenkins, P. (2020). The rights of the child. www.bacp.co.uk. Link

Kaniasty, K., & Norris, F. H. (2008). Longitudinal trajectories of distress and social resources following natural disasters. Journal of Applied Social Psychology, 38(4), 1108-1133.

Koocher, G. P. (2003). Ethical issues in psychotherapy with adolescents. Journal of clinical psychology, 59(11), 1247-1256.

Koocher, G. P. (2008). Ethical challenges in mental health services to children and families. Journal of Clinical Psychology, 64(5), 601-612.

Malchiodi, C. A. (2020). Creative interventions with traumatized children (2nd ed.). The Guilford Press.

Malikiosi-Loizos, M. (2013). Personal therapy for future therapists: Reflections on a still debated issue. The European Journal of Counselling Psychology, 2(1), 33-50.

Masten, A. S., & Narayan, A. J. (2012). Child development in the context of disaster, war, and terrorism: Pathways of risk and resilience. *Annual Review of Psychology, 63*, 227-257. https://doi.org/10.1146/annurev-psych-120710-100356

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Center for Health Care Strategies. link

Mental Healthcare Act (MHCA). (2017) Ministry of Health and Family Welfare. Link

Morgan, A. (2000). What is Narrative Therapy? An easy-to-read introduction. Australia: Dulwich Centre Publications.

Morgan, A. (2002). Beginning to use a narrative approach in therapy. International Journal of Narrative Therapy & Community Work, 2002(1), 85-90.

Prilleltensky, I., Walsh-Bowers, R., & Rossiter, A. (1999). Clinicians' lived experience of ethics: Values and challenges in helping children. Journal of Educational and Psychological Consultation, 10(4), 315-342.

Ramey, H. L., & Grubb, S. (2009). Modern understanding of narrative therapy: Distinguishing foundational and contemporary influences. Contemporary Family Therapy, 31(3), 197-209. https://doi.org/10.1007/s10591-009-9092-4

Richardson, C. (2015). Expressive arts therapy for traumatized children and adolescents: A four-phase model. Routledge.

Schetky, D. H. (1995). Boundaries in child and adolescent psychiatry. Child and Adolescent Psychiatric Clinics, 4(4), 769-778.

Sharry, J. (2003). Counselling children, adolescents and families: A strengths-based approach.

Sondheimer, A., & Rey, J. M. (2012). Ethics and international child and adolescent psychiatry. IACAPAP e-textbook of child and adolescent mental health, 1-27.

Spring, B. (2007). Evidence-based practice in clinical psychology: What it is, why it matters; what you need to know. Journal of clinical psychology, 63(7), 611-631.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach Prepared by SAMHSA's Trauma and Justice Strategic Initiative. link

UNICEF (2007). The State of the World's Children 2007: Women and Children - The Double Dividend of Gender Equality. New York, NY: United Nations Children's Fund

United Nations. (1989). United Nations Convention on the Rights of the Child (UNCRC). link

World Health Organization (WHO) (2013). Guidelines for the Management of Conditions Specifically Related to Stress. Geneva, Switzerland: WHO.

Ye, H. (2013). Strengths-based approach for mental health recovery. Iranian journal of psychiatry and behavioral sciences, 7(2), 5.

Yuen, E., Sadhu, J., Pfeffer, C., Sarvet, B., Daily, R. S., Dowben, J., Jackson, K., Schowalter, J., Shapiro, T., Stubbe, D., & Group for the Advancement of Psychiatry (GAP) Child Committee (2020). Accentuate the Positive: Strengths-Based Therapy for Adolescents. Adolescent psychiatry (Hilversum, Netherlands), 10(3), 166–171. https://doi.org/10.2174/221067 6610666200225105529

CHAPTER 4

Trauma-informed MHPSS Interventions for children during disasters

Responding to children during traumatic events to promote healing and recovery involves engaging important stakeholders such as children themselves, parents and other adults who are a part of their lives. It is imperative for us to understand that a child's recovery from trauma will not be a linear process, and there might be setbacks, challenges, and fluctuations in progress. This may be especially important for the child and the family to understand. Children will be impacted by disasters, and the experiences of disaster are not to be simply forgotten or moved on from. Healing may not mean returning to the way things were before the disaster, but rather about finding new ways of living and thriving in spite of this experience.

Working with children in distress may evoke some feelings for us as mental health professionals too. It is possible that we may also feel upset or overwhelmed in this process. It is important for us to use the strategies discussed in manual called 'Trauma-Informed Approach to Mental and Psychosocial Support during Disasters' for regulating ourselves.

This chapter discusses the strategies that we may use to identify, understand and respond to children's mental health concerns post disaster. It will cover important strategies for establishing safety which can be used with children, the adults around them and with communities. Even if these strategies have been discussed in the context of one-on-one therapy, they can also be adapted to the group format..

1

STRATEGIES FOR PROMOTING STRUCTURE AND CONSISTENCY

After a disaster, maintaining consistent routines is crucial for children because it provides them with a sense of security and normalcy during a time of uncertainty. Routines help children feel safe by giving them a structure they can rely on. After a disaster, the environment can feel chaotic. Routines and rituals provide a predictable pattern, which can reduce anxiety and fear as children know what to expect next. This makes the world feel less frightening and more in their control.

Post-disaster, maintaining routines such as bedtime stories, meals, and playtime helps ensure that children continue to engage in activities crucial for their development, even when their external world has changed. Caregivers can be given this information before helping them with setting up these routines. At the same time, it is crucial that we also psychoeducate children about the importance of routines. We may say,

> *"After something big and scary happens, everything*

can feel a bit mixed up. Having a routine, which is doing the same things in the same order every day, helps us feel safe and know what to expect. Imagine if every morning we knew we would have breakfast, brush our teeth, and play with our favourite toy. Even if something scary has happened, doing those same things every day can make us feel calmer and more like ourselves. It's like when we know our bedtime story is coming, and it makes us feel cozy and ready to sleep. So, routines are like a special way to help us feel better when things around us might seem a little different or scary."

1.1 PROMOTING CONSISTENCY FOR INFANTS AND TODDLERS.

We can ensure that infants and toddlers receive consistent and responsive caregiving from caregivers by asking them to maintain similar routines as much as possible. This may be difficult for them to achieve with consistency particularly after a disaster, when they may be dealing with multiple stressors simultaneously. So we can suggest simple and basic ways of achieving routine related consistency, so that parents do not feel overwhelmed or further burdened by this, during an understandably stressful time for them.

Creating fixed time for regular feeding, sleeping, and play schedules can help. It could also help to ensure that living and play areas are free from hazards or overwhelming stimuli such as bright lights or sudden loud noises. A young child might feel a higher sense of comfort and safety if their physical spaces included soft lighting, soothing colours, gentle music, calming scents and comforting objects like blankets or stuffed animals. For situations where this may not be feasible because families have been dislocated from their homes and are having to stay at temporary living arrangements such as shelters, parents may choose to find a safe spot within the accommodation where the child feels comfortable playing or being at. They can try to build a daily routine that involves either feeding, playing or spending quality time together there. Toddlers prefer autonomy and choice and can be given options to make choices wherever possible. When toddlers make these choices, they must be appreciated for their suggestions and efforts in engaging in this process.

Parents can also be encouraged to be physically present with children and mindfully take interest in their activities and respond promptly to the child's needs. This can be another simple but effective way to build consistency around quality time with the child during otherwise chaotic situations such as disasters wherein access to resources may be scarce. We can ask the parents about how they have been trying these routines on their own and appreciate their efforts in meeting their children's needs in the midst of a stressful situation for them as well.

1.2 CREATING A SAFE AND SUPPORTIVE ENVIRONMENT FOR SCHOOL-GOING CHILDREN.

With school-going children, we can establish predictable routines by reinforcing regular schedules for school, meals, and bedtime. We can even use visual schedules and charts to help children understand and anticipate daily activities (Masten & Narayan, 2012). This also includes providing a safe physical space where children feel secure (APA, 2021). We may suggest schools and community centers to have quiet spaces where children can retreat and feel safe. Some group activities to make them feel safe and have some routines may also be encouraged. These are different ways to help children consistently look forward to something on a day to day basis following a disaster. The previously mentioned interactions with caregivers may also be carried out with this age group as well.

1.3 FOR ADOLESCENTS

In addition to collaboratively setting up daily routines with adolescents, we can also focus on goal setting and future planning for adolescents in the aftermath of disasters. We can ask them about what they think are their strengths and how they can be used in the context of the disaster. We can assist adolescents in setting immediate or short-term goals related to their interests and priorities. We can also develop action plans and provide guidance and encouragement as they work towards these. This enables them to feel more in control of their circumstances as well identify their own

strengths and resilience. We can promote opportunities for them to take on responsibilities and leadership roles. For example, we can ask adolescents about their skill sets and interests and involve them in these areas during the recovery phase. Adolescents who are interested in caregiving can help in community care programs, those with good language skills can help in communicating the needs of the communities to authorities, those who are good at physical activities can be asked to take charge of keeping younger children engaged and so on. These activities can also be done in peer groups where adolescents may develop a support network.

2

ESTABLISHING PHYSICAL SAFETY

Disasters can have a profound effect on the sense of safety in children. It compromises the feeling of being safe physically as well as psychologically. Physical safety includes having access to physical space where the child's basic needs are met, there is no risk of harm to them and their privacy and right to play is protected. It is important that we as MHPs advocate for physical safety of children. We can psychoeducate communities and caregivers about the need for establishing privacy and safe play areas for children as a part of child rights. We can also collaborate with the relevant authorities to identify areas where children can have safe spaces for play even during their stay at refugee camps. When working with children, we can ask them about the play activities that they may be engaging in to gauge the play conditions and collaborate with relevant authorities to suggest improvements.

We can also introduce **circles of safety** (Hendricks et al, 2012). We may say,

> *"There are a lot of people who care about you and your safety. These are people you can go to if you need help or if you want someone to talk to. Please draw a picture of yourself in the middle of a page. Then create your circle of safety by drawing and/or writing the names of all the people who help keep you safe around you. You can include their phone numbers, too".*

We can encourage the child to reach out to any of the members of their circle of safety if and when they feel physically unsafe at any point in time. We can also highlight the strengths needed for children to

form relationships which they may fall back on during this time of distress. This could help children feel like they have both internal (ability to make friends and relationships) as well as external resources (people they can depend on) to fall back on in a moment of vulnerability. This activity can also be carried out in groups.

3

PROMOTING HELP-SEEKING IN CHILDREN DURING DISASTERS

An important part of working with children during disasters is to help them understand that help will be provided to them if they choose to access it. Of course prior to this, we will have to make sure that this promise can be fulfilled. We have to engage with the community to serve as advocates for promoting the mental health needs of children. We can help the caregivers and communities to understand the various trauma responses of children, use language which is non-stigmatising to discuss about them and the know-how of basic strategies which they can use to help children. We can do this through community sensitization programs for adults. We can also engage with caregivers by involving them in group activities and sessions with children. These steps can be taken in the pre-disaster, during disaster and post-disaster phase.

People to whom the child can reach out for help include someone at home, a teacher at school or another person they trust such as a relative, or even a counsellor. We can support children to make certain decisions like whom to speak with or checking in with themselves about how it would feel to talk to someone. They can also think about what to say. We can reassure them that it is okay if they do not know what to say before they meet the adult. They can wait to start talking and see where it goes. It is also important to emphasise that children can go at their own pace and share as much as they want to. They don't have to tell it all at once.

Reflective Exercise

- What can be the potential barriers to help-seeking for children and adolescents?
- How can we contribute to encouraging help-seeking within communities?

4

STRATEGIES FOR ESTABLISHING PSYCHOLOGICAL SAFETY

Psychological safety refers to the feeling that a child will not be rejected for being themselves; they feel confident and satisfied in themselves and in their relationship with others and are able to express themselves (Zhikhareva, 2018). For psychological safety, it is important to work with both the caregivers and the child themselves. For significant caregivers, we may have to explain to them the impact of the disaster on their mental health and well-being. We can then explain to them how their own hyperarousal (being irritable, anxious or angry) or their hypoarousal (feeling lost, not present, not being able to concentrate) will affect the psychological safety of the child. We may say,

> *"Children can often feel our emotions. They get their cue about the safety of the world around them with the help of our emotions. If they sense our distress or feeling numb, they may take this as a message that the world around them is not safe. Hence to promote the sense of safety for our children, we need to be aware of and manage our emotions. If you want, we can discuss some strategies for you."*

We can ask them how they have been managing these situations and appreciate their efforts. We can then proceed to teach strategies for stabilization such as grounding with them.

For establishing safety within the body we need to help clients understand what happens in the body during traumatic events, and then proceed to discuss specific tools for restoring safety. This process is called Stabilisation.

Reflective Exercise

- Can the same therapist work with both children and parents?
- How would the ethics discussed in the previous chapter be impacted in this context?

5

STRATEGIES FOR PROMOTING STABILIZATION

During disasters, children may get triggered by both internal and external stimuli and respond with intense fear, anxiety and emotional distress. Triggers can be understood as those external or internal stimuli that evoke memories or emotional responses related to traumatic events. Examples of internal stimuli could include distressing thoughts or intrusive memories or flashbacks of the disaster; these are considered internal as they occur within the child's mind. Examples of external stimuli could include conversations about the disaster or crossing physical locations that are reminders of the disaster and so on. This could cause the child to experience intense anxiety and distressing emotions abruptly. It is hard to predict when or how they may get triggered as they might come across these internal or external stimuli at any moment. This is the reason it is important for us to help children develop skills around Stabilisation. Stabilisation is the process of restoring safety and increasing a sense of control over trauma responses (Curtois & Ford, 2009)

Recovery unfolds in three stages (Herman, 1998).

The central task of the first stage is the **establishment of safety.**

The central task of the second stage is **remembrance and mourning.**

The central task of the third stage is **reconnection with ordinary life.**

For children, it is important that we use strategies which are appropriate as per their age. We can first ask them about what they do in these situations. We can suggest other strategies to them. A list of age-appropriate strategies for promoting stabilization are given below:

5.1 GROUNDING AND CENTERING TECHNIQUES

Grounding techniques involve a set of skills that can help children reestablish a sense of connection to the present moment and rebuild a sense of safety when they are feeling overwhelmed or emotionally distressed. These techniques are referred to as grounding because they help bring back or ground one's mind and body, after there has been an emotional trigger or disturbance. These activities can be taught individually as well as in groups.

Before we begin engaging the child with a potentially overwhelming conversation or activity we can prepare them by saying they may feel overwhelmed and that if they do they can apply these techniques to ground themselves. Some grounding techniques we can use with children include teaching them to focus on their breathing or help them connect to their physical environment using their bodily senses. To do this, we can ask the child to focus on the sense of their bare feet on the ground or to observe things they can see or hear around them (Fisher, 1999). By teaching children these techniques we can help them feel a sense of control and agency over their emotions and that they can handle themselves when they feel overwhelmed.

With infants and toddlers:

We can use sensory activities such as those activities that include touch, movement and other senses to help young children reduce their distress. This could include rocking them, swinging, or offering them textured objects such as beads, soft blankets, stuffed toys etc to soothe and stabilize young children. The **butterfly hug** (Artigas, et al, 2008) is a technique for self-soothing. We can do the butterfly hug and say,

> *"See how I am doing. Cross your arms over your chest so you are giving a big hug to yourself. Your hands will be on your arms, pointed towards your neck. Move your hands as if you are a butterfly flapping their wings."*

With very young children, we can ask the parent to do the following,

> *"Hold your child's body with their head against your chest or looking over your shoulder. Using your thumb and little finger of the hand resting on their shoulder, tap alternatively on the child's shoulder".*

For very young children, we can ask the parents to give them a hug like this. We can also use rhythm to help them in **grounding.** For example, we can ask the children to sit in a circle and clap their hands. We may say,

> *"All of us are going to do something now. On the count of 3, we will all clap our hands three times. Like this [show clapping motions]. Are you ready? Okay, I am counting now, 1, 2, 3 and clap. Very good!".*

We can repeat this activity a few times.

With school-going children and adolescents:

With school-age children and adolescents, we can begin by educating them about what grounding is and how it can help. Understanding why they are acquiring these skills and how it can help them might motivate them more to practice these and can help establish a sense of control in handling distressing emotions. We can help them to use their bodily senses (sight, touch, smell, hearing, taste and kinesthetic senses) to feel grounded or connected to the present moment. This could include asking them to sense their feet on the ground, list out objects that they see in their surroundings, name things they can hear around them and so on. We can also do the 54321 technique. This involves asking children to tell 5 things they can see, 4 things they are touching, 3 things they can hear, 2 things they can smell and one thing they can taste.

5.2 SAFE SPACE VISUALIZATION

We can do a safe space visualization with children. We can say,

> *"Take a few breaths and bring up a picture of a place you feel safe in. Imagine that you are standing or sitting there. In your imagination, take a look around and check what you see. Look at the details of what is nearby and see what it is made of, what are the*

colours that you see. Imagine reaching out and touching it. How does it feel? See the different colours, shapes, and shadows. This is your Safe Place and you can imagine whatever you want to be there. Once you are in your safe space, you feel calm and peaceful. Imagine your bare feet on the ground and walk around slowly. What does the ground feel like? What do you notice? What can you hear? What can you smell? In your Safe Place, you can see the things you want, and imagine touching and smelling them, and hearing pleasant sounds. You feel calm and happy. Now imagine that someone special is with you in your place, a superhero or a fantasy figure. This is someone who is there to be a good friend and to help you, someone strong and kind. They are there just to help you and they'll look after you. Imagine walking around and exploring your Safe Place slowly with them. You feel happy to be with them. Remember that this is your Safe Place. It will always be there. You can always imagine being here when you want to feel calm, secure, and happy. Your helper will always be there whenever you want them to be. Now get ready to open your eyes and leave your Safe Place for now. You can come back when you want. As you open your eyes, you feel more calm and happy. Well done!

Safe object technique may also help children feel a sense of safety and regulate their emotions. We can ask them to find a physical object that can anchor them. This object is something that has personal significance to them like a toy or a piece of cloth or jewellery or a photograph that can be carried around. We can ask them to imagine feeling safe with the comfort that this object may bring. We can also ask them to carry it around so that they can use it whenever they want.

5.3 BRINGING CHILDREN IN THEIR WINDOW OF TOLERANCE.

Window of tolerance (Seigel, 1999) is a concept that is used to understand level of arousal. It is said that in times of distress, we may feel hyperaroused, that is, our heart rate increases, breathing becomes more rapid and we may feel anxious, angry or upset. When we feel hypoaroused, that is, our arousal levels become less and our heart rate slows down, we feel fatigued and exhausted and may feel low, sad or even numb.

In between these two states exists a window where our arousal levels are optimal and we do not feel overwhelmed. When a child is hyperaroused, in order to get them back to their window of tolerance, we will be down-regulating them, that is decreasing the levels of arousal. When a child is hypoaroused, in order to get them back to their window of tolerance, we will be upregulating them, that is, increasing their levels of arousal.

We can help children understand their emotional distress. For young children, we can then help them understand how disasters affect their emotional states by using simple and jargon-free language. The umbrella technique may be used for this (D'Amico, 2016). We can show them a colorful, blunt-tip umbrella and discuss its use. We can then show how an umbrella protects us from storms, rain, wind, snow and sometimes even sunshine. We can show how when a person's umbrella blows back instead of protecting them, it makes it more difficult. We can then talk about times when the child has been in a metaphoric storm and has been protected by an umbrella: Who or what was the umbrella? What was the storm-like circumstance? Does it continue to exist? Were they ever the umbrella for themselves or another person? This question can be helpful for children in acknowledging their strengths in coping with their current situation.

We can continue to help them understand the various responses that children may have during disasters. These can be physical responses such as increased heartbeat, quickening of breath and sweating. It can also include feeling nothing. It can also be in thoughts where we may feel as if our thoughts are racing or sometimes it feels like there is a heaviness in our mind and we cannot think straight. Some older children may even be able to label their emotions such as anxiety, fear and so on. We can then show them the various techniques that may help. For helping children understand how certain emotional responses that were effective during the time of the disaster, may not continue to be helpful long after, we can consider using containers as a metaphor (D'Amico, 2016). We can discuss how containers help contain things by protecting, organising or keeping things in place. We also have to discuss how different containers can be used for different things. For example, food is protected in containers or boxes while silverware is

organized differently. We can even discuss how certain things have certain places. For example, a knife won't fit in the teaspoon area. Or we may have special containers for liquids and solids. We can use the metaphor of the containers to explain how we might bottle up or contain our emotions at times to protect ourselves, or even to help organize our emotions by meaning.

For adolescents, we may say,

> *"Many adolescents have scary memories or dreams about disasters. Some may also feel jumpy or nervous or angry. Many may start watching out for danger and worry about bad things happening to them or their loved ones. Some may even have trouble sleeping and paying attention in school. A lot of them feel like they DON'T want to talk about or think about the disaster but its memories pop into their minds anyway. When something reminds them of the event, they may feel upset and may have strong reactions in their bodies (heart beating fast, stomach ache). Some may also feel empty and numb, like they can't feel anything at all. They may use drugs or alcohol to try to deal with upsetting feelings."*

Psycho-educating children about the window of tolerance (Seigel, 1999), we may say,

> *"Imagine your feelings are like a river with two banks. When you're playing and having fun, you are swimming in the river—this is your "just right" zone where you feel okay. When you're in this window, you can handle things better, even if something a little scary or frustrating happens. But sometimes, things happen such as disasters that throw you towards one bank or the other. On one bank is where there are a lot of hills. When we go there, we go up too high (like when you get really excited, angry or upset). There is a lot of bouncing around, it is hard to stop here, even if we want to. On the other bank, there are a lot of valleys. When we go here, there are lows (like when you feel super tired or sad). It's like when you just want to lay down and not move because everything feels too hard."*

Psycho-educating children about hyperarousal and hypoarousal could be an important first step in helping them understand what is happening to their mind and

body when they experience a state of hypoarousal or hyperarousal. To do this we can use metaphors as it may be an easier way to introduce the concept to the child, particularly with younger or school-age children. The metaphor of an Emotional Thermostat (Fisher, 1999) may be used. The job of a Thermostat is to control and regulate the temperature in a room, ensuring it is not too hot or cold. When it malfunctions, the ability to regulate the temperature gets disrupted and it either gets too hot or too cold as a result. We can use this metaphor as a way to help children understand that similar to the Thermostat, when we experience traumatic events such as a disasters, our internal abilities to regulate our emotions may get disrupted temporarily and that we may experience feelings that are 'too hot' or very intense (state of hyperarousal) or become 'too cold', where we get fully numb or disconnected (state of hypoarousal). With older adolescents, it may be possible to converse more directly about the nervous system and its responses to traumatic events.

Identifying feelings can help adolescents feel safe by helping them regain a sense of control with respect to their feelings (Hendricks, et al, 2012). This may help children to articulate and label their feelings, which could help them feel a sense of catharsis or release of emotions that leads to Stabilisation when in a state of hyperarousal or could help them realise they are feeling numb or disconnected, while in a state of hypoarousal. So identifying feelings can be a helpful first step to take in managing experiences of hypoarousal and hyperarousal.

For example, we can ask children to write down as many feelings as possible. We can ask them to link feelings with colours. We can then make an outline of the human body and ask them to identify where they feel their feelings. We may say,

> *"Remember the feelings and colors you listed? We're going to use those colors now to show where in your body you experience each feeling. You don't have to do all the feelings you listed; we can choose which feelings you want to include. For each feeling you choose, close your eyes and imagine having that feeling right now. Where do you experience that feeling in your body? Please color in the places on your body where you experience each feeling".*

For down-regulating to manage hyperarousal:

Scaling feelings can help children understand the intensity of their feelings. We may say,

> *"Sometimes we feel a feeling just a little bit, and other times we feel a feeling so strongly that we feel like we might BURST with that feeling. You can rate or measure your feelings, just like a thermometer measures temperature. The number tells how intense the feeling is."*

After the child is able to identify the intensity of their feelings, we can teach them to apply some of the techniques discussed below such as breathing exercises, relaxarion techniques, mindfulness and so on. Remember to be creative with the metaphors when working with children from diverse backgrounds. For example, if 'thermometer' and 'scale' may not be understandable for children from certain contexts, we can use other ideas like using hand gestures to communicate 'large' and 'small', or using pebbles to indicate quantity etc.

Breathing techniques are useful skills that could help children to calm and regulate the physical body. While experiencing intense anxiety, it is not uncommon for the body to react with signs of distress, such as shortness in or dysregulated breath, or feeling like one's muscles are tightening in the chest or stomach and so on. Regulating one's breathing can help children to navigate such trauma responses at the level of the body. We can use this technique to bring down the arousal levels of children. This is a helpful technique for groups as well. Doing these activities in groups may help children more in regulating their emotions.

With infants and toddlers

If young children feel restless, we can try an alternate activity that can be the bubble activity (D'Amico, 2016). We can ask caregivers to take a bubble solution and a wand and say to the child

> *“We are going to learn something fun today using bubbles”.*

We can then ask children to make great big bubbles. They can show them that in order to create great big bubbles children will need to have a lot of breath. They can then take the bubble solution and demonstrate quick puff breathing making small or no bubbles and say

> *“See when I use my little breath, my bubbles are small and hard to get out”.*

They can then demonstrate fast breathing and say

> *“See when I breathe fast the bubbles pop faster”.*

Finally, they can use deep slow breaths and blow a bubble and say

> *“See how I blew a big deep breath and my bubble got bigger and didn’t pop”.*

They can then show the children how slow, deep breaths are useful when blowing big bubbles.

With school-age children and adolescents:

We can teach them simple breathing exercises that they can learn and practice on their own when need be. We may say,

> *“Place your hands on your stomach, just below your ribs. Breathe in slowly through your nose all the way down to your stomach. Feel your stomach push out. And now blow out slowly through your mouth. Let all the air come out and feel your stomach go down. Now, I’ll count so we get a rhythm going. Breathe in…2..3…4 stomach up ..and out…2…3…4 stomach down…breathe in in…2…3…4…and out…2…3…4…breathe in…2…3…4. stomach up…and out…2…3…4 stomach down. Well done. Now we’ll do that again but this time, as you breathe out, say quietly to yourself “relax”. I’ll start you off by saying it then you can carry on without my help. Hands on tummies. Breathe in…2…3 …4 and out…2…3…4 Breathe in…2…3…4 Relax…2…3…4 and in…2…3 …4… Relax…2…3….4…Breathe in…2…3…4..Carry on …2…3 …4…*

Sometimes when children are too overwhelmed, they may need to be cued or guided through these breathing techniques by adults. So while we may help them to develop these skills and encourage them to practice them independently, sometimes we may have to guide them through the instructions when they are too overwhelmed to practice it themselves. In groups, children may be asked to help each other in reminding and carrying out these techniques.

Mindfulness techniques include a set of skills that can help children to calm their minds by bringing one's focus to the here and now. By bringing your mind to the present moment, we can help children to avoid engaging with distressing internal experiences. We can introduce mindfulness activities like mindful eating by asking them to pay attention to the food around them and describing through their senses this experience. These techniques may be particularly helpful with school-age children or adolescents and can be easily carried out in groups.

While mindfulness strategies attend to the mind, **relaxation techniques** can help regulate and calm the body. We can teach the basics of relaxation by asking children to clench their hands tightly, hold it for five seconds and slowly release them. This may help them in understanding the difference between stress and relaxation. We can also use mindfulness and relaxation techniques such as deep breathing, guided imagery, or body scans. We can use relaxation techniques like progressive muscle relaxation or yoga and incorporate these practices into daily routines (Thompson et al, 2011). These activities can be taught in groups.

Children may feel anxious or worried during and after disasters. Managing worry is then another way of down-regulating their emotions. A technique to manage worry can be to introduce caregivers to help children with a planned worry time. We can say,

> *"By learning to postpone worry, children may gain mastery over their troublesome thoughts. This involves setting aside a specific time period, e.g. 10 minutes a day, for these thoughts or worries. If the thoughts appear we ask them to just say to themselves that I am not going to worry or think about this now but later in the time set aside for this. We can ask them to*

> *acknowledge the thought and make a mental note of its content and let the thought fade at its own time. When the thoughts and worries appear, they can just notice them like clouds that pass over the sky without engaging in them. In the time they set aside to address their worries or thoughts they can write their thoughts down in detail and ask themselves questions about the reality of their worries (adapted from Wells & Sembi, 2004).”*

For upregulating in situations of hypoarousal:
While working with hypoarousal, we need to help children to feel more connected to their body, mind and experiences and to break away from the state of ‘shutdown’, feeling disconnected or numb. For this, we need to help them develop skills to ‘up-regulate’, increase the intensity of their feelings in the body and mind. The following techniques can help with this.

Using movement can be an extremely helpful strategy to reactivate the body. We can do this by employing a variety of movement exercises such as dancing to upbeat music, making children perform smaller bodily movements such as wiggling toes, changing body postures while seated or jumping exercises such as jumping jacks or using a skipping rope. These techniques may be particularly helpful if these are done in groups.

Using our senses can help children upregulate from the hypoarousal state. We can ask children to smell something they really like (a flower, a perfume or even a food smell), eat something crunchy or chewy, touch something which has texture like beads or a watch, roll a pencil in their hands, hold ice cubes in their hands or even massage their hands.

Reminding children of good memories that they can revisit can be helpful as a strategy to combat their negative emotions and mood. We can particularly focus on those memories which evoke feelings of pride and joy in their efforts to help themselves. We can also introduce a feel-good button (Smith et al, 2023). We can say,

> *“You could try a Good Feeling Button as well. All you need to do is think of some nice times and feelings. It could be a good meal, a happy moment, a funny game, anything to do with pleasure and fun. Each time you get this or another good feeling just press on*

a special bit on your body, like your hand or the tip of your finger to help you remember it. You have to keep on doing it to make it happen automatically. Then you'll find that this special spot will become your own Good Feeling Button. So, whenever you feel frightened or are reminded of something unpleasant, press on this spot to bring back the good feelings."

Reflective Exercise

- A number of strategies have been suggested here for stabilization. How can we decide which strategies to use at what time?
- How can we try to explain these strategies to caregivers?

6

BREAKING BAD NEWS IN THE POST DISASTER CONTEXT

Breaking bad news is the process of telling someone difficult or upsetting things such as the news of death or suffering. It is called "breaking" because the news can be sudden. This is an important part of work that we do as MHPs during disasters. This is especially important for children because they may need extra help in understanding and coping with the news of loss. During this time, our goal is to communicate the information clearly, honestly, and sensitively; keeping in mind the reaction of the child. It is imperative that we keep the following steps in mind for ourselves or help caregivers in breaking the news to children:

a. Finding a calm environment where the child is comfortable. This can be a safe and familiar space for the child where there are minimal interruptions.

b. Using a gentle tone of voice say something simple like,

> *"I have something very sad to tell you".*

Using words that are appropriate for the age of the child and their vocabulary is very important. For example, we may say,

> *"You know how the ... was a really big thing to happen? It hurt a lot of people. I'm so sorry, but [person's name] was hurt, too, and they are no more with us. That means their bodies have stopped working, and we won't be able to see them anymore."*

c. Allowing some time for processing. After saying this, the child must be given a moment to take in what is told to them. It is possible that they may not understand it completely. So we can offer them the opportunity to ask questions by waiting patiently for them. For example, the child might ask questions like, "Where did they go?" or "Are they coming back?" It is important that these questions are answered simply and truthfully. We may say, for example,

> *"They're not coming back, but we can remember them and keep them in our hearts."*

d. It is important at this time to listen to the feelings that may come up for the child. We can provide them with a space to express any feeling they may have, whether it's sadness, confusion, or even anger. In fact, these feelings can be normalized by saying,

> "It's okay to feel sad or scared. I'm here with you."

e. Offering comfort is also crucial at this stage. It can be done physically (offering a hug or folding their hand) or by being there for them emotionally and just sitting with them.

f. The explanations offered should be simple. For example, it is best not to use complicated concepts or words and be prepared for repeated explanations phrased differently till the child grasps the concept.

g. In the meantime, maintaining routines by helping them adhere to their normal is important.

h. We can also offer reassurances of safety. We can remind them that they are safe and there are people who will take care of them. However, care must be taken that these reassurances are not false.

i. Offer them opportunities for future conversations by checking in with them at later stages. We can verbally offer to them that we will be there to speak again or ask their questions.

j. Offer more people that they can speak to. This involves speaking to other trusted adults, teachers or even counselors.

Reflective Exercise

- Working with children requires certain unique competencies as discussed in the previous chapters. As we go through these exercises of working with children, which of these competencies do you think are most relevant?
- How can we maintain boundaries with caregivers while also involving them in our work with children?

7 HELPING CAREGIVERS UNDERSTAND THEIR CHILDREN'S RESPONSES

Helping caregivers make sense of their child's responses during and in the aftermath of the disaster will be helpful. Understanding their child's response may make the caregiver more attuned to them and reduce the risk of misunderstanding the child's responses. A detailed overview of how children respond to disasters across different age-groups is described in chapter 2. We can extend this by psychoeducating them about how disasters affect the children and adolescents. This can be done in groups so that caregivers can share their experiences and feel a sense of community with other adults in similar situations.

7.1 UNDERSTANDING ABOUT IMPACT OF DISASTERS ON THE CHILD'S MENTAL HEALTH

We can explain in a clear and compassionate way about the impact of disasters on the child's mental health. We may say,

> *"Disasters can look scary and chaotic to the child. The suddenness of the event may be distressing for them as it disturbs their routine. They may feel a range of emotions such as fear, anxiety, sadness, anger and confusion. They may have nightmares and show changes in behaviours such as trouble sleeping or*

> *losing interest in the things they liked to do earlier. They may also be more clingy to you or may become withdrawn. Certain behaviours that they used to display earlier like bedwetting or thumb-sucking may also come back. They may be distracted, have trouble focusing on their tasks or struggle with their homework. It is important to understand that these are normal reactions to an abnormal situation. We can keep an eye on these reactions and discuss our concerns with mental health professionals."*

7.2 UNDERSTANDING ABOUT 'WINDOW OF TOLERANCE'.

For parents, we may help them understand the concept of window of tolerance by saying,

> *"The window of tolerance refers to the zone where a person can function effectively, manage their emotions and reactions without becoming overwhelmed. For children, staying within this window means they can process their experiences, regulate emotions, and respond to stress in a manageable way. Outside this window, children may either become hyper-aroused (overwhelmed, irritable, anxious, or angry) or hypo-aroused (numb, withdrawn, or shutting down). Post-disaster, children's windows of tolerance can become smaller, making it harder for them to manage stress. By creating routines, offering comfort, and being responsive to their needs, you can help your child stay within their window of tolerance, allowing them to feel safe and supported as they navigate their emotions and the changes around them."*

The techniques for upregulation and downregulation mentioned above can be taught to the parents. Care must be taken that the context of these techniques such as when to use them are explained to the caregivers. These techniques can be used indirectly. For example, for helping children learn strategies for managing their emotions, we can show the children how to soothe their toys which they will then use for themselves (Hendry & Buck, 2017).

8

STRATEGIES FOR PROMOTING HEALING IN GROUPS, FAMILIES AND COMMUNITIES

Communities have their own process of healing and rebuilding life. As mental health professionals we must acknowledge that all people have their own strengths, knowledge and wisdom which helps them cope as a collective. It is very important for us to remain curious, respectful and make the effort to collaborate with the community to understand how psychosocial support can be tailored for their needs, rather than imposing a readymade template for all groups. Collaborative dialogue can focus on discussing with communities how they can identify mental health concerns in children, what can help them communicate about disaster-related questions and responses with children, problem-solving for some common issues of safety and stabilization, and emotional support for children. We can also focus on community-based healing activities such as organizing community events like memorial services, cultural ceremonies, or community art projects. These activities can foster a sense of unity and shared healing and help children feel connected and supported by their larger community (Hobfoll, et al, 2007). It is also important that all these activities need to be culturally sensitive and inclusive. We can respect and integrate children's cultural backgrounds into the therapeutic process by using culturally appropriate methods and materials in therapy.

Building hope in groups:

We can do a group activity for toddlers to promote hope-building. An example of such an activity is called 'Growing garden' (Malchiodi, 2020). In this activity we can tell toddlers and young children, *"pretend to be a tiny flower seed under the soil"*. They can curl up in a little ball with their legs tucked under them. We can then say, *"when the sun warms the soil and the rain falls down on the seeds* (we can be the sun and rain and tap our fingers on their heads and shoulders), *they soak up the rainwater and begin to get bigger and bigger* (here we can ask the children to uncurl). *A stem begins to sprout* (we ask the children to raise one hand over their head and continue to uncurl). *The stem grows and grows and leaves appear on it* (ask the children to slowly stand up and spread their arms for leaves). *Then a lovely blossom begins to bloom* (children can smile brightly here). A *big storm comes, and the rain and wind come to the*

garden (ask them to sway and bend). The storm ends, the sun appears, and all is well." This may help toddlers understand that there is hope for normalcy.

For young children, we can promote hope-building by asking them to do "a wish upon a star" technique (D'Amico, 2016) to help understand what they want from the future. We can provide the child with large cardboard where either we can draw the stars or ask the child to draw them. Stars can be multicolored and include faces. Then we can ask the child to write a wish on the star. We can do balloon technique as well. We can provide the child with a drawing of a balloon bouquet, or a person holding balloons and ask them to fill these balloons with words or drawings with the attributes that they like about themselves.

For families: We can help create opportunities for supportive conversations where parents can share experiences and strategies for coping and relying on each other. For example, we can do an exercise in a group with children and parents, where everyone who is present is given a pencil and a paper. We can pre-draw a hand on the paper and ask the parents and children to write or draw the names of people and organisations who helped them. They can call these helping hands. We can also connect families with community resources and activities that promote resilience by providing information on local services, such as for those with basic needs, medical care, and mental health support. Encouraging participation in community events and activities that foster a sense of belonging and recovery may also be helpful in this context (Masten & Narayanan, 2012).

For communities: We can help communities heal together, by engaging in practices such as Disaster Storytelling. Disaster Storytelling is a practice that helps build disaster resilience through disaster education and disaster recovery related communications.
Here, we can bring groups of people together and facilitate discussions where disaster related stories and experiences are shared, with group members listening and partaking in each other's pain and resilience. This can be done at various stages after the disaster, either immediately, at an intermediary stage or long after disasters too (Kargillis et al., 2014). It can be used either before or after a disaster, to help communities either

prepare for disasters or make meaning of them after they have occurred. It is a tool that functions on indigenous knowledge and expertise of communities. We can facilitate such knowledge sharing by encouraging senior members of a community to take charge of sharing their experiences with the rest of the members of the community. This can be an important way in inculcating a sense of solidarity, belongingness and protection within the community. It can be a great tool to bring communities together, foster collective emotional healing, create a sense of unity and help build a shared sense of identity (Nagamatsu et al., 2021).

We can also do such hope building strategies for communities by helping them spontaneously give expression to their collective resolve. These expressions may include tying ribbons to trees, wearing bracelets, flying the flag, and building spontaneous shrines at the scene of the disaster (Malchiodi, 2020). Other examples include family activities, street performances, displaying people's drawings, painting murals, making posters, collecting their stories, and participating in commemorations. Such public expressions can create a powerful synergy because their performance requires an audience.

Another activity can be "Out of Ashes" (Malchiodi, 2020) where all community members are given a small piece of paper and a pencil. They are then invited to name or draw the disaster that they experienced. Then, in a safe container, we can burn the paper and mix the ashes into a piece of modeling clay. Further, we can invite the participants to think of one of the hopes they have for the future and using the clay, make a clay figurine representing the hopes.

Let's avoid...

Being outside our window of tolerance when working with triggered children. If we are not in our window of tolerance, we will not be able to identify and respond to what the child needs from us. This may lead to incongruent interventions which will prove to be unhelpful for the child.

Not taking into account the developmental stage of the child when responding to their experiences. Trauma responses are varied and depend on the developmental stage of the child. A response which may be age-appropriate for a young child; may be considered a trauma response in an older child. Thus, using a developmental lens may help us in deciding the intervention to be used.

Not acknowledging the strengths of children. Even in the face of disasters children may show many resilient responses. We can use strengths-based strategies to look for stories of resilience and nurture these narratives to build trust and efficacy. This is an important intervention in itself and must therefore be implemented wherever appropriate.

Negating the significance of caregivers as important stakeholders for interventions for children. We as MHPs are a part of a group of adults responsible for the well-being of children. It is imperative that we include parents, teachers and other significant caregivers in the lives of children in our plan for interventions and ensure that some techniques and strategies are shared with them.

Planning only one-to-one interventions for children. Interventions can be planned for groups, families and communities along with one-to-one interventions to promote a holistic atmosphere for children to move beyond the experience of disasters.

Tips for Supervisors

- It is possible that in the face of distress, MHPs may get overwhelmed themselves and may move out of their window of tolerance. It might be helpful for us as supervisors to help them recognise their window of tolerance. It is also important for us to help them identify their triggered states and the triggers which move them out of the window of tolerance.

- Similarly, it is important for supervisees to identify when to use a particular technique with the child. It is imperative that a trauma-informed lens is used in both supervision space as well as field to prevent re-traumatization. We can use role-plays to understand how supervisees are implementing strategies and offer suggestions.

- Holding space in supervision for times when MHPs have to break bad news to children may be helpful. It might be useful to provide a space to

supervisees to understand their views on death, what emotions are evoked for them and these might reflect in the MHPSS space with children.

Self-care Exercise

Working with children who have experienced disasters and other traumatic events may be overwhelming for us as MHPs as well. It might be helpful for us to consider the following activities:

- Having an outlet for our overwhelming emotions such as by exercising, writing, gardening, or engaging in activities that promote social action. These activities will be most helpful if they have concrete outcomes that foster a sense of accomplishment.

- Listening for stories or narratives that we tell about ourselves. Are we having high standards for ourselves? Are we feeling overwhelmed? Are we feeling helpless? Are we able to distinguish between what we are feeling and how we view ourselves?

- It is possible that our work with children in the context of disasters may be short-term. It might be helpful for us to remind ourselves of the limitations of the work we are doing. It may be imperative at this stage for us to remember that we cannot do this work alone.

- We can also draw a map of our social support network. We can identify who can provide us with emotional, knowledge and learning-based and logistical support. It is possible that the same people may not be available for all support. Acknowledging this may help us in empathising with ourselves about the nature and difficulties of the work that we do.

References

Artigas, L., & Jarero, I. (2010). The butterfly hug. In M. Luber (Ed.), Eye movement desensitization and reprocessing (EMDR) scripted protocols: Special populations (pp. 5–7). Springer Publishing Company.

Courtois, C. A., & Ford, J. D. (2009). Treating complex traumatic stress disorders: An evidence-based guide. New York, NY: The Guilford Press.

D'Amico, D. (2016). 101 Mindful Arts-based Activities to Get Children and Adolescents Talking: Working with Severe Trauma, Abuse and Neglect Using Found and Everyday Objects. Jessica Kingsley Publishers.

Fisher, J. (1999). The work of stabilization in trauma treatment. link

Hendricks, A., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). Dealing with trauma: A TF-CBT workbook for teens. Trauma-Focused Cognitive Behavioral Therapy-National Therapist Certification Program. https://tfcbt. org/dealing-trauma-workbook-teens.

Hendry, A., & Buck, E. T. (2017). Dyadic parent-child art psychotherapy with children who have been exposed to complex trauma. In A. Hendry, & J. Hasler, Creative therapies for complex trauma: Helping children and families in foster care, kinship care or adoption (pp. 116-134). London: Jessica Kingsley Publishers.

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., ... & Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. Psychiatry: Interpersonal and Biological Processes, 70(4), 283-315

Kargillis, C., Gillham, D., & Kako, M. (2014). Disaster survivors: A narrative approach towards emotional recovery. Australian Journal of Emergency Management, The, 29(2), 25-30.

Malchiodi, C. A. (2020). Trauma and expressive arts therapy: Brain, body, and imagination in the healing process. Guilford Publications.

Masten, A. S., & Narayan, A. J. (2012). Child development in the context of disaster, war, and terrorism: Pathways of risk and resilience. Annual Review of Psychology, 63, 227-257. doi:10.1146/annurev-psych-120710-100356

Nagamatsu, S., Fukasawa, Y., & Kobayashi, I. (2021). Why does disaster storytelling matter for a resilient society?. Journal of Disaster Research, 16(2), 127-134.

Siegel, D. J. (1999). The developing mind: How relationships and the brain interact to shape who we are. New York, NY: Guilford.

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. Psychological Inquiry, 13(4), 249-275

Thompson, R. W., Arnkoff, D. B., & Glass, C. R. (2011). Conceptualizing mindfulness and acceptance as components of psychological resilience to trauma. Trauma, Violence, & Abuse, 12(4), 220-235

Wells, A., & Sembi, S. (2004). Metacognitive therapy for PTSD: a preliminary investigation of a new brief treatment. Journal of Behavior Therapy and Experimental Psychiatry, 35, 307–318.

Zhikhareva, L. V. (2018). Socio-psychological characteristics of suicidal infection of the individual in the Internet space. In Scientific opinion (pp. 79–85). St. Petersburg American Psychological Association. (2021). Disaster recovery: A psychosocial priority. Retrieved from https://www.apa.org/topics/disasters-response/recovery-psychosocial

Thank you!