Supporting Children and Adolescents in Disaster

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Target Audience: All health care providers

Learning Outcome: Nurses to provide appropriate supportive care based on best practices which can be individualized to the needs of children and adolescents in times of a disaster.

Contact Hours: ANCC /1.0 ABN/1.2

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Fees: ASNA Members free Non-members $10

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Instruction for credit: Participants should read the Learning Outcome online or printed out. After reading complete the posttest and compare answers to ones provided and review any incorrect responses by reviewing content in the monograph. Participant must complete the evaluation online and submit the appropriate fee to receive continuing nursing education credit. The Certificate of Completion will be generated after the evaluation has been completed. ASNA will report the hours to the Alabama Board of Nursing within 2 weeks of completion.

Online link: http://bit.ly/2tUxAup

Supporting Children and Adolescents in Disasters

In Alabama when the word disaster comes to mind we tend to think about just hurricanes and tornados; however, there are many other types of disasters impacting children and adolescents. Some are caused by human intervention related to political issues or hate related interventions. Examples include bombings, mass shootings, and/or riots. Other potential disaster sources are biohazards following a train derailment or interstate accidents. Depending on rain fall, areas of a state may be involved in wildfires or in some cases house fires. Following a disaster of such magnitude that the President declares the area eligible for Federal Assistance, the community is usually in chaos with individuals

having feelings of shock and disbelief. Although most individuals are resilient and well-functioning they will be caught by surprise with the magnitude of any disaster. They will have the capacity to cope as their communities, families, and social support systems pull together to comfort the most affected. Nurses living in the affected area are often overwhelmed with the immediate tasks of crisis response and a feeling of responsibility to help. But before helping others these nurses (and other responders) need to take time to meet the emotional and physical needs for themselves and their family and then respond to the community's needs.

What are some of the Basic Principles for Mental Health Intervention as provided by volunteer Nurses?

Nurses are usually among the first volunteers in stricken areas. Special mental health disaster training is valuable but not essential. Concepts for nurses to keep in mind include the following: assistance needs to be tailored to the community involved using cultural competence as a guide. Remember that all will experience some type of a trauma reaction. This normal trauma reaction will abate in time; however, a minority of survivors will experience long-term psychological issues such PTSD. Be prepared that some survivors and their families will reject services provided. It is essential to collaborate and consult with trusted organizations and community leaders to make sure all members of the community are served. This monograph is tailored specific to the needs children and adolescents. The term parents will only be used and it is inclusive of parents and other adult significant figures throughout this monograph.

At the heart of the issue following the disaster, is the fact that children may be left in the care of unfamiliar people and be provided with very limited explanations of just what is occurring. Care givers must be responsive to the emotional vulnerability of children. The child's current stage of emotional development influences how they behave as well as their level of understand of the world as they see it now. Essential to working with children, is being a supportive listener and sensitive to their cultural, racial, and ethnic experiences. The worker's response needs to be appropriate to the child's level of development, keeping in mind that the child may exhibit symptoms of regression. This involves knowing the emotional status of the child, such as are they afraid or

withdrawn. A determination needs to be made regarding the comfort and security level that the children have for themselves, their families, those they care about, and their pets.

Children perceive the world differently at various chronological ages. The theorist, Jean Piaget, classic research best describes this. For example, a 7-year-old is shown two containers, one is filled with water and short and wide while the other is empty and tall and thin in shape. The child believes if the volume of water is transferred to the tall container the volume changes also. Another example is a child of ten or eleven cannot comprehend the abstract concept that a>b and b>c, therefore, a<c. But if this same problem is given to the child with solid objects it is easily solved because concrete objects are visible. The adolescent can solve the abstract by creating mental images of a, b, and c and solving the problem in their head. Piaget postulated that organisms seek homeostasis or a steady state of equilibrium and when faced with disequilibrium humans constantly try to return to a state of equilibrium. Briefly stated, as we grow we change internally, thus our capacity to engage with the environment evolves. The terms he used were assimilation and accommodation. Assimilation is a process of interpreting new/additional information within the context of our existing cognitive structure and at the same time we accommodate the new/additional information or the demands of our environment such as in the case if a disaster. Humans develop from an infant responding primarily to sensations such as hunger to adult capable of complex abstract thinking. Operationalizing this concept is that parents can identify with a child refusing to complete assigned chores. The question becomes is the child disobedient or is the parent providing commands in an abstract manor. The command may be clear to the parent, but not to the child trying to translate it into a concrete action with their cognitive skill set. Volunteers working is disaster situations must be cognizant that children think and develop their responses to the situation differently depending on their current stage of cognitive development.

Most children when surrounded by supportive adults and peers can adjust to the traumatic events of the disaster. They will assimilate the experience into the context of their own individual development with time. The children experiencing childhood in a negative environment (loss of home and family members, pets, etc.) and if they are adapting maladaptive survival strategies will recover from

traumatic events in a complex and time-consuming manor. Overall, it can impact how the children function in their world. Examples would be drop in academic performance or disruptive social interactions with family and peers. If this disruption in social and cognitive functioning is significant, children may be at risk for developing PTSD or another form of emotional disorder such as developing risk-taking behaviors.

What are the 'Normal' or Expected Reactions to Disaster Induced Stress

The American Academy of Child and Adolescent Psychiatry issued in a Fact Sheet in 1998 that the child's reaction to the disaster depends on how much destruction they experience during and after the event. This seems self-evident. What is important is how they are influenced by second hand means such the TV and other social media sources. In addition, the volunteer nurses need to be aware of the things that have the most profound negative impact. They are in order, death of a family member or friends; loss of family home, school, special pets; and the extent of the damage to the community. Most of these children will recover from the frightening experience without professional interventions. What is needed is for them to experience the world in a secure place with nurturing parents who appear to the children as being in charge of their lives.

Anticipated reactions of the children that volunteers often observe include the following: feeling irritable, alone, and having difficulty talking to their parents – some may talk more freely with volunteers than the parents and parents need to understand that this is normal behavior. Other feelings include guilt for not being injured and losing their home. Some of the children, in an attempt to reconcile feelings, will engage in disaster associated play and will produce repetitive drawings of disaster related themes. Girls tend to exhibit more stress related actions and brighter children tend to return to pre-disaster functioning more rapidly. Adolescents are more prone to bouts of anxiety and depression whereas younger children demonstrate regressive behavior associated with a younger developmental stage. All age groups return to pre-disaster functioning if families can share their experience with one another. The degree of exposure to frightening events has a direct correlation to return to pre-disaster functioning. An example would be losing a home to a hurricane after you have had time to evacuate as compared to leaving a burning home in the middle of the night.

Age specific anticipated behaviors These behaviors are normal and abate over time, usually no more than a month:

Preschool (Fears because their secure world has been disrupted)
Crying on a continuum from whimpering to screaming
confusion
excessive clinging
irritability
running toward adults or running aimlessly
trembling or becoming immobile
regressive behaviors (specific behaviors that had been overcome) – bed-wetting, loss of bowel/bladder control, thumb sucking, fears of dark or animals or being alone, inability to dress self or to feed self

6-12 years old (Fears related to dangers to self and loved ones as well as a fear of damage to the environment. They have difficulty with the loss of prized possessions and pets)
Regressive behaviors – bed-wetting, nightmares, sleep issues, irrational fears such as building safety
disobedience
excessive clinging
somatic complaints – headaches, nausea, visual or hearing issues
school issues – refusal to go to school, decline in grades, concentration difficulties,
fighting, withdrawal from peers

12 – 17 Year old (The teenager will react to the degree that the event disrupts their family and the community. It may stimulate thoughts of loss .of family, peers, school life and even intactness of their own bodies. They may regress to earlier stages of cognitive development.)
Withdrawal, isolation, depression, and/or sadness
antisocial behavior (stealing, acting out, aggressive behavior)
School problems (disruptive behaviors, acting out, decline in grades)
Risk taking behaviors – alcohol, drugs, driving too fast
Sleep disturbances

Avoidance of developmentally appropriate behaviors such as going to camp or college

Case Study:
A number of survivors following Katrina who experienced time in the Super Dome and/or had lived in the 9th Ward and were rescued from their roof tops were temporarily relocated on a cruise ship docked on the Alabama Gulf Coast. The Alabama Department of Mental Health sent a number of mental health professional volunteers to work with the individuals on the cruise ship. When they arrived Hurricane Rita was forming the Gulf of Mexico. The ship had multiple televisions on every deck. They described the adults and children, but most profoundly children, fixated on the Weather Channel. The children sat or stood motionless 30 minutes at a time watching the storm depicted as a big red ball on the screen. Their eyes were glazed over. They could not follow a conversation; could not make eye contact. After a quick assessment of the situation the first action by the volunteers was to turn off the televisions and organize age appropriate groups and play therapy. In time the survivor's behavior reflected improvement. The lesson is that television and social media dwelling on negative aspects of a disaster can impede the recovery process.

What are the Factors that Influence the Development of PTSD?

PTSD sometimes develops several years after the event. Many children normally exhibit stressors 1-2 years following the event but most adapt without developing this. The severity of the event in association with the strains of everyday life has an impact on the children normal adapting reactions. Strains of ongoing life include a parent's loss of employment or divorce; both of which may limit availability of a supportive environment. Other factors associated with the development of PTSD include loss of essential support in the community and especially the schools.

It is normal for children to have fears and anxieties following a disaster. And at times they are unconnected to anything specific in their life. The child is best helped by accepting them as real and helping parents to also accept at face value. This may be difficult with a dysfunctional family and even more so if the family was dysfunctional prior to the disaster. The intensity and duration of the anxieties and fears will decrease more rapidly when families exhibit understanding. A normal reaction of children in families who are not supportive

is shame, rejection, and not being loved. Teach parents to expect regressive behavior in younger children and remind them that it is usually temporary. In words that parents understand, teach them that this is a cognitive mechanism to allow children to redevelop coping patterns that had been functioning prior to the disaster. One way to facilitate is offer praise for positive behaviors. Another coping mechanism parents may employ is to relax routine rules. Younger children express separation anxiety by clinging and refusing to let parents out of their sight – even if they have not expressed this behavior before. As the danger resolves the clinging behavior improves. Children exhibit the most fear when they do not understand what is occurring around them or if they are provided erroneous information. Remind parents that children can absorb factual information and will cope with the situation better if they are accurately informed. When families can remain together healing is enhanced. The adults modeling positive behavior can be growth enhancing for the children.

Sleep issues are problematic after a disaster. In fact, sleep issues are probably the number one problem following a disaster. It takes many forms – resistance to bedtime, inability to sleep, unwilling to sleep in own room, or refusal to sleep alone. The children often want to sleep in the parent's bed, insist that the parent remains in room until they fall asleep, or sleep with the lights on. Perhaps the most problematic is excessively early awakening. These are detrimental to the child's wellbeing as well as increasing stress for the parents. The before mentioned behaviors will resolve in time. Encourage parents to accept temporary changes such as child sleeping with you for a brief time but to aim for return of normal pre-disaster routines. Teenagers may need special consideration for bedtime privacy. If the parents do not already, encourage calming pre-bedtime activities to reduce chaos in the evening. However, some sleep behaviors may need professional intervention. Teach parents to be observant for continued sleep terrors, nightmares, and refusal to fall asleep. These behaviors point to deep-seated fears and anxieties.

How Can I Help?

There are some basic concepts that non psychiatric nurses (or other volunteers) may employ to help with the healing process. The first is to establish rapport. A few simple actions will enable this process. Show interest and respect, make sure

your communication is appropriate for the child's current cognitive level (in case of regression). Communicate trust and promise only what you can deliver. Let them know that you are an informed authority.

The second important action is to identify, define, and focus on problems. Once identified, focus on solving the issue and achieve a resolution. Inherent in this is to evaluate the capacity of the family to deal with the problems or the resolutions identified.

Another important action is to convey understanding. Display patience, listen to stories over and over, and reaffirm their feelings by providing a nurturing environment. Listen carefully and interpret the disaster from the child's point of view. Be aware that you will hear the same story over and over. Each time support the storyteller's feelings.

Communicate clearly in in words the children understand and if possible in their native tongue. Seek family members input to interpret code words if used by the children. An example would be a strange name for an object they treasure. It is often helpful to talk in groups of family members as the role of the family is to learn and work together through the crisis. Provide support and a nurturing environment to facilitate healing. One fact to keep in mind is the role of the child as an interpreter for the family members not fluent in English. Some of the information given to the families may be beyond to cognitive level of the child at the time. Be alert and use non-family interpreters as needed.

Determining when a volunteer needs rest

Nurses and other volunteers are at risk for burnout during the process. Look for potential symptoms in self or in others. Specifically, be alert to physical and emotional exhaustion, fatigue that will not go away despite adequate rest, and noticeable increased irritability in the volunteer situation and/or at home. And most of all a decrease in the ability to work effectively or a relentless nagging feeling of a desire not to work. If any of these or any combination occurs the volunteer should take a break from the situation and return when fully rested. Volunteering can be a rewarding experience but not when your body is mentally and physically drained.

Post Test – Score your test using the provided key. If any question is answered incorrect review monograph to determine the correct response. Select the one (1) best response)

1. Special Mental Health Training is necessary to volunteer in a disaster situation.
   A. True
   B. False
2. Teenagers should be encouraged not to ruminate over and over the same about the loss of a best friend.
   A. True
   B. False
3. The most frequently noted complaint in children following a disaster is
   A. Sleep issues
   B. Bed-wetting
4. In facilitating the healing process the first thing a volunteer nurse should do is to
   A. Establish rapport
   B. Define the problem to seek solutions
   C. Both are equal in importance
5. Parents need to understand that regressive behavior is
   A. To be expected
   B. Warning sign of potential development of PTSD

References:

Psychosocial Issues for Children and Adolescents in Disasters, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services. Pub. No. ADM86-1070R (Revised), 2005.

Mental Health Response to Mass Violence and Terrorism A Field Guide, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, 2005.

1. B	2. B	3. A	4. A	5. A