

CHILDREN AND DISASTER

Children often show remarkable resilience in the aftermath of disaster. However, its psychological impact on children is neither uniform nor universal in nature (Hagan et al., 2005) - **children cannot be treated like little adults**. The nature of the disaster, the level of exposure to the disaster, and the extent to which people are personally affected by the disaster can all have an impact on the levels of distress experienced in its wake. In addition to these considerations, though, children's reactions are affected by their age and stage of development (e.g., Pine and Cohen, 2002). As well, they are influenced not just by the trauma of the event, but also their parents' level of fear and distress (Beauchesne et al., 2002), and by extension, the level of fear and distress perceived in those acting in *loco parentis*, such as teachers, caregivers, and PFA providers.

Like adults, a child's risk of developing mental health difficulties following a disaster is exacerbated by a prior history of abuse or trauma. Urban children and youth have higher rates of prior histories of exposure to/witnessing extreme violence, injury, and death. Those who have newly immigrated often arrive having been exposed to violence in their countries of origin, as well (Pynoos, 2002). An additional concern for children involves changes to their brains when exposed to extreme stress. Reduced cortical growth and a delayed ability to inhibit their startle reflex (necessary for being able to focus and learn) are two such changes that have been documented, and can have a direct impact on their education. As these traumatized children mature, they are at greater risk of developing depression, substance abuse, or risk-taking behaviour when they hit adolescence and adulthood (e.g., Goenjian et al., 1995).

Dolan and Krug (2006) documented some of the difficulties faced by children in the wake of Katrina. While many of concerns involved physical care, one of the noteworthy psychosocial challenges involved the reunification of unaccompanied children with their parents, particularly infants and pre-verbal toddlers. Such children are particularly vulnerable to exploitation by others, in the absence of a parent or caregiver, and the separation of infants and young toddlers from parents in and of itself can become traumatizing for parents and children alike.

So, children are not just little adults; they have special needs when exposed to trauma. We also know that there are strategies to use in order to mitigate the effects of disaster when dealing with children. First and foremost, with all children, look to limit exposure to traumatic stimuli, including media images. As well, remain with children until they can be reunited with parents/caregivers. Reunification with family members would constitute a basic need, and as such, must always be addressed prior to any psychological intervention.

Development and Reactions to Trauma

Early Childhood (0-2 years). Infants and toddlers react to changes in routine such as unfamiliar surroundings, unpredictable feeding times, and a lack of familiar caregivers – these can all become sources of distress. These children have limited or no verbal skills,

and communicate through their behaviour (e.g., regression, changes in sleep habits, increased irritability, changes in eating habits). Strategies to deal with this age group include the provision of basic needs, including some sense of routine, high levels of contact and reassurance, and obviously reunification with family as soon as possible.

Preschool and Kindergarten. Children at this age have begun to perceive when they're not safe, and can be overwhelmed with feelings of insecurity and fear. They do not understand the permanence of death, and in the event of the death of a parent, will continue to ask when mommy or daddy will be coming home. Strategies involve limiting exposure, using drawing and play activities (provide crayons and paper as a starting point), answering questions with appropriate detail, reassurance, and establishment or resumption of routine. Regression can also occur with this age group.

Ages 7 – 11. Children at this age understand the permanence of death. They can take an inordinate amount of interest in knowing the details of the disaster, and are very concrete in their thinking. Strategies include limiting exposure, give them an opportunity to talk, and answer questions factually with appropriate detail. Stories, drawing, and writing activities can be helpful, and “teachable moments” may help them in their understanding. Regression can also occur with this age group.

Pre-adolescence and Adolescence. Children and youth at this age feel pressure to appear knowledgeable and experienced, and do not want to feel different than their peers. When stressed, they may show increasing restlessness and may engage in risk-taking behaviours, perhaps believing in their own immortality. While all children can regress following trauma, it can be particularly disconcerting for parents of this age group (e.g., 16 year old son crawling into bed with them in the night). Increased fearfulness and withdrawal can also occur with this age group. Intellectually, this group is as capable of rational thought as many adults, but lack the context to understand what has occurred. They also require reassurance from those around them but often have difficulty asking for and accepting support. Strategies for dealing with this group include group-based activities, providing as much information as possible (again with appropriate detail), and having respected adults share their own experiences and reactions. Normalizing reactions, setting limits, and re-establishing routines are other useful strategies. Regression can also occur with this age group.

Some Final Thoughts

Schools can become valuable resources in dealing with children and youth following a disaster; ideally, there can be a pre-existing respectful and caring relationship between students and staff. Community agencies, religious leaders, family physicians, and help lines are additional resources that can be involved in recovery efforts. Children frequently do have a tremendous capacity for resilience, but along with this, have unique vulnerabilities. It is our responsibility as providers of PFA to be sensitive and informed in our dealings with children, as we offer psychosocial support in the wake of a disaster.