Review Article

Children's mental health at times of disasters: a narrative review

Karen Olness

Department is Pediatrics, Case Western Reserve University, Cleveland, OH, USA

Correspondence to: Karen Olness, MD. 44500 66th Avenue Way, Kenyon, MN 55946, USA. Email: karen.olness@case.edu.

Background and Objective: About 40 million children were displaced by disasters in 2020. Displacements associated with natural disasters may be relatively short. Those associated with war and terrorism may continue for a lifetime. The objectives of this report were to provide information about types of disasters, international humanitarian law and children, the effects of disasters on child mental health, mental health assessment tools and acute interventions to reduce long term psychological trauma.

Methods: The author reviewed articles and internet information about the mental health effects of disasters on children. A search was carried out on PubMed and MEDLINE for relevant articles.

Key Content and Findings: Most children experience acute psychologic distress when there is a sudden, unexpected move, regardless of the cause. Depending on pre-existing personality factors, family support, length of displacement and prior trauma, children may develop long term mental health problems, including post traumatic stress disorder (PTSD). Early identification of psychologic distress and appropriate care of affected children can facilitate resilience and reduce long term problems. Persons who help children in the aftermath of disasters should be prepared to provide basic needs of children, help parents (including provision of respite time), screen for psychologic distress in children and parents, use a trauma informed approach in speaking with children, and provide safe play and recreation opportunities. They should also be aware of cultural differences and practices in their development of programs. Relief workers should recognize that they may also be a risk for psychologic distress related to the tragic situations they experience as well as to their own fatigue. There is a great need for more training of relief workers about the mental health issues of children who experience disasters and for training to prevent mental health distress in relief workers.

Conclusions: Recovery and resilience for children who experience disasters can be facilitated by provision of sufficient food, shelter, clothing and other daily needs, by support to parents or other caretakers, by early screening for psychological issues, and early psychotherapy when indicated. Adults who help children experiencing trauma should recognize their own psychologic distress and seek appropriate help. Relief workers need training about how to help children who have experienced disasters.

Keywords: Children and disasters; psychological trauma; relief workers

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Introduction

Disasters leading to displacement of children from their homes may include both natural and man-made disasters. At the end of 2019 there were 79.5 million people forcibly displaced due to persecution, conflict or violence. This number was a record high; half of these people were children. They included about 23 million children internally displaced, 13 million children who were refugees and about 2 million were seeking asylum. In 2019 an estimated 15,000 children were forcibly displaced each day (1). Some of the most affected areas include displaced children who currently include two million Nigerian children within Nigeria, 500,000 Rohingya children in Bangladesh, 2.5 million Venezuelan children who have left their country, 2 million South Sudanese children and 6.7 million children

from Syria. 3.3 million of the Syrian children were refugees in Lebanon, Jordan, Turkey and European countries (1). When one considers homeless children, sex trafficked children, and children displaced by natural disasters at any given moment in North America, the numbers there are also likely in the tens of thousands. The documentary, "Human Flow", demonstrates the constant movement of people leaving their countries and seeking stable homes in other places (2).

In general, children displaced by natural disasters such as hurricanes or tornadoes in North America are displaced for relatively short times, although all displacements from home are stressful for children especially if they will not be able to return to the home and life they knew. Risks for long-term psychological sequelae increase if the separation also includes separation from parents (3). After Hurricane Katrina in the United States some children did not return to a home with their nuclear families until six months had passed. Although children who actually experience a disaster suffer more, children who observe photos of disasters via television or movies or journals may also be traumatized (4). The objectives of this paper are to:

(I) Provide information about types of disasters.
(II) Provide information about international law related to children.
(III) Provide information about the mental health issues experienced by children who live through disasters.
(IV) Provide information about screening tools that are helpful to assess child mental health after a disaster.
(V) Provide general guidance about acute interventions for these children that may prevent long term mental health trauma.

Methods

The author reviewed articles and internet information about the mental health effects of disasters on children. A search was carried out on PubMed and MEDLINE for relevant articles.

Types of disasters

The term "disaster" may cover a range of events from a car crash causing the death of a child's parents to a war necessitating escape to a refugee camp in another country. Natural disasters may be caused by earthquakes, typhoons or hurricanes, tornadoes, forest fires, droughts, or floods. Chemical spills or radiation disasters also lead to displacement of families. Epidemics or pandemics are also disasters. Humanitarian Emergencies occur when either a manmade or natural disaster causes such devastation that assistance is required from international agencies or from other countries. Each week there is at least one disaster somewhere in the world requiring external assistance to its victims.

The number of children throughout the world who were displaced by disasters in 2020 was estimated at 40 million (1).

International law related to care of children in disasters

Persons who help children affected by disasters should understand Human Rights and Humanitarian Law related to children. Several articles in the Universal Declaration of Human Rights relate specifically to children (5). Article 14 states that everyone has the right to seek and to enjoy asylum from persecution. Article 25 states that everyone has the right to a standard of living adequate for the health and well-being of themselves and their families. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock shall enjoy the same protections.

International Humanitarian Law, better known as the Geneva Conventions, provides a series of documents developed over decades for the protection of human rights in the context of armed conflict (6). These include laws that civilian persons, including children, are accorded respect and protection. They are to be provided special safe zones. The Convention on the Rights of the Child established by the UN in 1999, states that parties to an armed conflict should take all feasible measures to ensure protection and care of children in the conflict area (7). It has been signed by 196 countries, including the United States but it has not been ratified by the US. The Convention on the Rights of the Child also contains three optional protocols. The first two written in 2002 prohibit the involvement of children in armed conflict, the sale of children, child prostitution and child pornography. The third written in 2011 provides a communications procedure through which children can file individual complaints for violation of their rights. The United States has signed and ratified the first two optional protocols. In reality, there is poor compliance with international humanitarian law and human rights in most disasters. In many conflicts over the past 30 years military groups have targeted women and children. Unfortunately, this increases the likelihood of psychological trauma for

children.

Responsibility for reunification of family members separated by a disaster rests with the International Committee of the Red Cross (ICRC) and with National Red Cross and Red Crescent societies. These organizations can legally cross borders in order to find family members; however, emblems of the Red Cross or Red Crescent no longer assure protection of their workers.

Acute mental health issues experienced by children who live through disasters

These depend on the age, family support, personality, type and duration of the disaster event. Events that are most traumatic are those that lead to death of a parent or another family member, those that cause complete loss of a home and belongings, those that lead to physical abuse, mental abuse and/or to uncertainty about basic needs and the future. Intolerance of the uncertainty associated with a disaster leads to anxiety, fear and worry for both adults and children. Repetition of a displacement makes a child even more vulnerable to psychological trauma (8).

While the term post traumatic stress disorder (PTSD) is often used, the DSM-5 requires fulfillment of specific symptoms and duration of symptoms to make the diagnosis (9). The DSM-5 defines both Acute Stress Disorder and PTSD. Acute Stress Disorder includes specific fear behaviors that last from three days to a month after a traumatic event. Symptoms may include sleep disorders, negative affect, hypervigilance or complaints of physical symptoms such as headache or dizziness (9). With respect to children, the diagnosis of PTSD cannot be made in the first few weeks after a disaster. If the symptoms persist beyond a month, the clinician should consider the diagnosis of PTSD.

Children who had prior mental health diagnoses such as depression, anxiety or ADHD may demonstrate more symptoms after a disaster. The symptoms that children manifest in the immediate aftermath of a disaster will vary according to their ages and developmental stages (10). Listed here are some of the highlights of possible reactions of children.

Infancy (0–1 year)

The reactions of infants depend on presence of parents and regular provision of food. In a disaster situation a breast-feeding mother may not produce sufficient milk for an infant. Substitute nutrition may be unavailable. Disruptions in usual caretaking and feeding may result in irritability, or listlessness.

Toddlers (1–3 years)

Toddlers want to increase autonomy and to explore their surroundings. This is often not possible or safe after a disaster. Depending on the innate personality of a toddler, a child may exhibit increased separation anxiety.

Pre-schoolers (4–5 years)

Given their vivid imaginations and magical thinking these children may have strange understandings about the meaning of the disaster. If a close family member dies they believe the death is reversible or just means that the person has gone on a trip and will return. Their anxiety may be manifest by disrupted or repetitive play(acting out the disaster), nightmares, or being aggressive and oppositional.

School age (6–12 years)

Children begin to understand death as permanent around age 7 years. After experiencing a disaster school age children may show symptoms of poor academic performance, withdrawal from normal activities, or decreased interest in peers. They may be anxious or depressed or may show externalizing behaviors such as aggression or hyperactivity. Some may develop a sense of guilt about what happened. "It happened because I didn't obey my parents" or "I should have been more helpful". The responses may vary based on gender. In general, boys show more antisocial and aggressive behaviors and girls display more emotional lability and/or ask more questions. School age children are likely to experience developmental interference due to gaps in education, loss of peer connections, anxiety and fear.

Adolescence (12–18 years)

As adolescents search for identity, the experience of a disaster may trigger a personal crisis. As they perceive the sudden changes, their inability to continue school or usual activities, loss of usual peer relationships and the suffering of their families, many manifest despair, hopelessness, anhedonia, and a loss of direction. Some may suddenly find themselves in adult roles as they assume care for younger siblings. They may also develop a sense of guilt about some aspect of their behavior related to the disaster. Some

adolescents increase risk taking behaviors. Adolescents who have developed the capacity for abstract reasoning may cope better than those who have not. Adolescents vary in their abilities to tolerate uncertainty; some manifest generalized anxiety after a disaster (11).

Children and adolescents look to adults for support and care. Most children and adolescents will regain normal functioning provided that basic survival needs are met, safety and security is re-established, and developmental opportunities are restored. Preexisting risk factors including mental health problems, reactive temperament, intellectual disabilities, parental maladaptation and social isolation increase the likelihood of long-term mental health problems. On the other hand, pre-existing mental and physical health, the capacity for executive function, and supportive religious or social frameworks, including immediate and extended family, friends and institutions, all promote resilience.

Long-term mental health effects of disasters

Long-term mental health effects of disasters include PTSD, depression, anxiety, intellectual disabilities, weather phobia, sleep disorders and anti-social disorders. Studies vary in the frequency reported (12,13). There are actually relatively few well done long term follow-up studies of children who have experienced disasters. It is often difficult to identify comparable control groups and to do follow-up of children who have experienced disasters. The first reported follow up of children after a natural disaster was after hurricane Andrew in 1994 (12). There were also careful follow-ups of children after Hurricane Katrina in 2006. Fifteen percent had emotional disturbances up to 27 months after the disaster. These included anxiety, fearfulness, aggressive behavior, learning difficulties and PTSD. Thirty-six months after Hurricane Katrina the number of children with mental health disturbances was 11 percent, higher than the estimated pre-hurricane baseline of four percent (13).

Prevalence of PTSD reported varies depending on levels of exposure and types of disaster ranging from 10% to 90% (14-17). Although children and adolescents can experience PTSD from hearing about a trauma to someone in their social network, PTSD is higher among those who have had a direct personal trauma. The prevalence of PTSD is reported as higher in children who have experienced war or terrorism. When children have lived in areas of sustained conflict they are likely to have higher rates of PTSD (14,18). Children and adolescents separated from parents have been described as more likely to experience PTSD (3). A follow-up study of 68 Rwandan orphans living either in a child headed household or in an orphanage found that 44% had PTSD; 41% had witnessed the murder of their own father or mother. PTSD was more frequent in those who were 8–13 years old during the genocide than in those who were 3–7 years old (19).

Much of the trauma experienced by children and adolescents related to disasters may be due to experiences that can be defined as torture. However, reviews found no reliable statistics, and no comprehensive guidelines and tools for diagnosis or documentation of child torture (20,21). The reviews stated that children at high risk for torture were those detained during political violence, those internally displaced in refugee camps, and child soldiers. Perpetrators of torture included peacekeeping forces, military forces, prison guards, and police (21).

The "*Ghosts of the Tsunami*" by Parry describes the long term trauma in an entire Japanese community after many children were left in a school and drowned. Not only did both children and adults experience anxiety, depression and PTSD but community members reported an epidemic of ghosts that increased general fear and anxiety (22).

Weather Phobia occurs frequently in children who have experienced a weather-related disaster. Children with this problem have an overwhelming fear or dread when a few clouds are in the sky and even when there is only a slight chance of rain in the forecast. They are often reluctant to leave their homes (23). Many children who lived through Hurricane Andrew developed Weather Phobia (12).

Children who have pre-existing intellectual disabilities and chronic diseases are likely to be more vulnerable to emotional distress than are unimpaired children in disasters (24). Unfortunately, displacement after a disaster may lead to an increase of infectious diseases and malnutrition in children. This is due to poor sanitation, crowding, depressed immune systems related to stress (25,26) and lack of food. Children may then develop cognitive impairment related directly to malnutrition or to the malnutrition associated with diseases such as measles and diarrhea. Children who experience a few months of malnutrition in the first two years of life while in a disaster setting may later be resettled and have sufficient nutrition. The effects of early malnutrition on higher order intellectual functions such as executive function may not manifest until the period of middle school or early adolescence (27,28). Teachers and therapists who evaluate these children years after the disaster are unlikely to have documentation of the early period of

brain injury. Studies of school children traumatized by the 911 disaster in the US found that those who had experienced prior trauma were more likely to experience anxiety or depressive disorders than children who had not experienced prior trauma (29).

Providing acute psychological care in the aftermath of a disaster

It is important that persons working in humanitarian emergencies have knowledge about responsibilities of various UN, government and non-governmental organizations (NGOs).

In 2005 after a major Pakistan earthquake the World Health Organization (WHO) created the cluster system to increase the effectiveness of humanitarian responses and to make clearer the division of labor among UN and NGOs (30). Until then, UNICEF had been mostly responsible for psychosocial recovery programs for children. In 2005 WHO became responsible for all physical and mental health evaluations and recovery programs. However, UNICEF remains responsible as the focal point agency for Child Protection and co-focal point agency with the United Nations Population Fund for the areas of Gender-Based Violence.

In the US disaster management remains under individual state control but governors and Indian Tribal Centers can request federal assistance through Federal Emergency Management Agency (FEMA) (31). Most declared disasters in the US are natural disasters.

In spite of planned systems to help disaster victims, it usually takes substantial time for assistance to arrive. Immediate management of disasters is almost always in local hands and depends heavily on the generosity of unaffected communities.

Provide basic needs as soon as possible

Children and their parents need provision of basic needs to reduce anxiety. Provision of food, safe water, shelter, clothing and medical care are high priorities in the immediate aftermath of a disaster. Children and adolescents benefit from routines. Efforts to reduce the sense of chaos will reduce anxiety.

Help parents

It is important to give parents strategies to calm themselves. These may vary depending on the culture. Simple regular breathing exercises are acceptable to most people and facilitate calming. Parents benefit from group discussions about the trauma to their children and how they can help children and one another. They are likely to describe new and worrisome behaviors in their children and may benefit from explanations about how stress is responsible. Parents, especially mothers, can benefit from a break. Provision of a supervised play tent for children may give them this break.

Consider the culture

Taking time to learn about a family's cultural beliefs and customs may help to explain activities and behaviors that might otherwise be interpreted as negative or nonadherent (32). Understanding a family's values and beliefs may take a long time even when there is a shared language. Mental health providers should assess how their personal social and cultural beliefs might influence their interpretation of a child's problems. Cultural norm differences have far-reaching impacts on perceptions around mental health diseases and appropriate treatment. Different cultures have different ideas about what causes emotional or behavioral difficulties and what should be treated.

Be aware that psychological problems are an inevitable part of any disaster

It is obviously important that the developmental and psychological needs of children be addressed as soon as possible when a disaster has happened. In most disasters there is a lack of mental health professionals. However, relief workers who are not child or mental health professionals can be trained to recognize and mitigate psychological distress in children and families. An effort should be to identify persons such as teachers, social workers, religious leaders in the affected community who are known to the children and who may be able to provide comfort and reassurance. Relief workers should consider the culture of displaced families and learn about preferred approaches for dealing with stress.

Efforts should also be made to recognize coping skills in children who have experienced a disaster. For example, older children may play with younger children, feed them, sing with them or read to them. These positive behaviors should be acknowledged and praised. This type of recognition enhances the sense of being in control among children of all ages. As soon as possible, in the wake of a

disaster, relief workers can organize group activities among children. If there is a safe space for sports activities, these should be arranged. Other group activities such as singing, dancing, storytelling can facilitate normalcy and stimulation for children. Parents also need stimulation and support and can benefit from social groups, craft activities (knitting, local crafts), and reactivation of cultural events such as holiday celebrations.

Trauma-informed approach to speaking with children

Although most relief workers who speak with a child initially are not psychotherapists, they can contribute a great deal to the child's comfort. It is better not to ask a child specifics about the disaster event, but to be a good listener or observer with respect to the child's spontaneous communication and behavior. It is important to be aware of how the child's developmental state contributes to what the child remembers, how he/she describes it and how it is manifested in play activities. It is helpful to make the environment as child friendly as possible. Some children reflect fear and anxiety in their play or in their drawings. For example, a five-year-old child who had lost his home and family members in the Thai tsunami played repetitively with a toy boat and kept tipping it. His father had been a fisherman lost during the tsunami. Relief workers should make efforts to provide paper, crayons, pencils and markers for children. They can also identify coaches and teachers who can guide adolescents to organize games and activities for younger children.

Screening tools useful to assess mental health after a disaster

Symptom-based screeners have been used to identify children with mental health problems in many disaster situations. However, these cannot differentiate children with transitory distress from those with more permanent distress. PsySTART is an evidence-based rapid mental health triage system that considers what happened to the child instead of the child's symptoms (33). It can be completed by non-mental health workers who check off risk factors such as deaths of family members, displacement from home or exposure to mutilated bodies. Children identified with high scores should be monitored closely and referred for mental health evaluation and treatment as soon as possible. Another PsySTART benefit in mental health triage is that it is independent of the cultural issues that impact symptoms, especially when relief workers are in an unfamiliar cultural environment.

A month or more after a disaster child health professionals can consider using a PTSD screening tool such as the University of California at Los Angeles (UCLA) PTSD Reaction Index for Children and Adolescents (PTSD-R). This widely used assessment tool can be administered to children and adolescents or to parents (34). It is available in many languages including Arabic, German, Spanish, Japanese, Simplified Chinese and Korean. Other screening tools such as the Penn State Worry Questionnaire may also be helpful if appropriate for the affected culture (35).

Reestablish Education programs

There are numerous examples of school openings being delayed after natural disasters. Unfortunately, only about half of refugee children are enrolled in school programs (36). Decisions to delay school openings have led to increased mental health issues among displaced children and their families (37). Even in the absence of physical schools, relief workers should make efforts to identify teachers among displaced people, and to organize regular classes for children. These need not all be academic classes but might involve music classes, handicraft, carpentry or gardening classes, depending on what expertise exists among adults who are available to help.

Reestablish recreation programs

Depending on the disaster and location it may be difficult to organize recreation programs. In many refugee camps UNICEF and other organizations have established "play tents" with books, toys and supervisors who may also be able to facilitate active games or sports competition. These contribute a great deal to a child's sense of normalcy. Most children, regardless of culture or ethnic group, will respond to opportunities to do free style drawing. In the aftermath of a disaster the drawing often tells more about what a child is feeling than efforts to engage the child in conversation. For example, television reports took photos of a smiling girl of about 8 years. The same girl had drawn a picture that day of herself and her family standing on a precipice with several guns pointed at them.

Because children reflect the mental health of their parents, it is a good idea to provide parents access to a respite center if possible. In some refugee camps volunteers

have organized "day care" for children in order to give parents a break for a few hours. This need may be even greater for families resettled into a new country who are less likely to have close neighbors of a familiar ethnic group. Resilience in both parents and children may be facilitated by parenting classes. The WHO website (38) contains resources for parenting programs available in multiple languages. UNICEF has developed a early childhood development kit for children, age infant–8 years who displaced by disasters (39). It contains games, puzzles, stacking boxes, board books, puppets, art supplies and soap and water containers for hand hygiene. It also provides an activity guide for parents and caretakers.

Books

There are books specifically tailored to calm the fears of children such as the "Freddy the Frogcaster" series related to hurricanes, tornadoes, and blizzards. There are also many books that explain weather to children. Distribution of culturally appropriate picture books to children after disasters has been helpful as demonstrated in Thailand after the tsunami and in the Philippines after Hurricane Yolanda (40).

Comfort items for children

It is important to provide simple comfort items to children who have experienced disasters as soon as possible. UNICEF programs in the aftermath of disasters have included "psychologic backpacks". These are backpacks or bags with items appealing to children such as toys, crayons, books. Culbert designed Comfort kits with items that have specific therapeutic benefit and instructions for parents and teachers. These have been translated into many languages and used extensively in disasters such as the tsunami of 2006, the Haiti earthquake of 2010 and the severe floods in Laos in 2018 (41). Comfort kits include finger puppets, crayons, stress squeeze balls, bubbles or pinwheels, biodots, small toys, and instructions for their use by parents and children. Relief workers can model the use of comfort kit items for children and their parents.

Depending on access to cell phones or computers and apps, there are many electronic resources appealing to children who are experiencing the stress of disasters. Culbert's Comfort kit has been adapted to an app called Healing Buddies (42). Heart Math has stress reduction programs for children based on simple biofeedback systems in formats appealing to children (43). There are many free apps teaching various relaxation strategies, including belly breathing and mindfulness. The Meg Foundation for Pain website provides excellent free videos for young children about nonpharmacologic pain management. These videos have been translated into Spanish, Arabic, Chinese, Thai and Lao (44). It is important to select an app or video on the basis of those most likely to give children and adolescents a sense of being in control of themselves. A child who enjoys the ability to move a balloon or a horse or rainbow by control of his/her own autonomic responses may also increase the sense self-confidence and resilience.

Return to Happiness Programs (RTH)

RTH is a psychosocial intervention for the recovery of children affected by disasters (45). UNICEF created this initiative in the 90s and implemented in multiple countries and territories affected by conflict, war, natural disaster, or a combination of these. Professionals with vast experience working in disasters praise this program as a highly effective psychosocial intervention.

Community professionals (such as public health, general health, or social sciences professionals, teachers, and volunteers) help to conduct RTH programs. Efforts are coordinated by mental health professionals and community assistants who have been trained in the RTH program. The locations for RTHare in open parks, churches, schools, or sports centers, rather than individual offices. Methods used are required to be flexible, interactive, multigenerational, involving the community and families. It is essential to be sensitive and observant of local traditions and cultures. Local materials are critical to the success of the intervention, including the use of well-known games, songs, toys, stories, plays, dolls and puppets, pets, and known characters.

The Carousel in the RTH program consists of six separate stations arranged in a large circle. Children spend four to six hours moving from station to station and participating in the various activities. Circles include introduction, drawing and art activities, physical activities, music activities. Each activity lasts about 45 minutes. Mental health professionals observe children in the various stations to identify those who need further evaluation.

Resilience

Although the literature on children and disasters contains many examples of mental health challenges, there is also documentation of recovery and resilience (46-48). The

majority of humans, including children, are inherently resilient. When disasters occur children rarely comprehend the wider perspective. They see the world they once knew as coming to a standstill. Children who feel cared for and safe in challenging situations are more likely to bounce back. Resilience is facilitated by provision of basic needs, routines, and school, but the most effective facilitators are parents. The Nubader program (48) includes a variety of interventions to support children and parents and has been successful in a dozen countries. It provides youth judged to be most at risk with support groups on how to handle stress, team building programs and intensive outdoor activities.

The need for training of professionals who work with children in disasters

In an acute disaster there is an understandable focus on provision of food, water, shelter, housing, and medical care. Most relief workers are trained to focus on these needs. There is a great need for more training about mental health issues of displaced children and families as well as those of relief workers themselves (49). Furthermore, such training is needed by persons who make decisions about refugee status and by persons working to provide refugee services in resettlement countries. These include mental health professionals who, while trained to help traumatized children, may not be familiar with the varying expressions of mental health distress by children from different cultures. It is difficult to find training that focuses on the mental health needs specific to cultures.

Mental health of relief workers

The horrors of a disaster environment, the inherent uncertainty, the long hours of work, an unfamiliar culture and new work colleagues will challenge even the most experienced relief worker, including mental health therapists. There are many reports of mental health distress among disaster work professionals (50,51). It is important that all health care professionals prepare themselves for the inevitability of a request to help in a disaster at some time. Some of the same recommendations to help disaster victims are valid for relief workers. They are likely to be more productive and less anxious if they have regular meals, regular sleep, time for recreation (which may be reading a novel or listening to music from their phone) and a trusted confidante. After working in a disaster, it is essential to do a debriefing with someone who has had disaster work experience.

Conclusions

Recovery and resilience for children who experience disasters can be facilitated by provision of daily necessities on a predictable schedule, support to parents, provisions for recreation, programs to facilitate a sense of being in control, resumption of school, empathetic adults, attention to symptoms of emotional distress, and psychotherapy when indicated. Health care professionals who help children in disasters need to pay attention to their own mental health needs. There is a need for more training of relief workers about the mental health issues of children who experience disasters and ways to prevent or mitigate mental health distress in themselves.

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Footnote

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