
Abstract:

This article is part of a collaborative effort by experts in the field of emergency preparedness to complete an overview begun by the late Michael Shannon, MD, MPH, on the current challenges and future directions in pediatric disaster readiness. This particular article, "Mental Health Concerns," will address some of the unique developmental and psychological vulnerabilities of children as disaster victims (or as disaster witnesses) and strategies for timely identification and intervention for mental health concerns in children.

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Mental Health Concerns

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The need for psychological support of children and their families in the aftermath of a disaster is well documented in the literature. Research conducted after a range of major disasters demonstrates that children manifest a consistent pattern of adjustment difficulties and confirms the well-established risk factors. These risk factors are based on prior traumatic experiences or losses, premorbid mental health problems, and situational risk factors including the degree of direct involvement and exposure to the event, parental coping, and presence of other stressors such as separation from parents or loss of personal belongings.¹

The literature has tended to focus on the postdisaster prevalence of mental health disorders, especially posttraumatic stress disorder, anxiety, and depression. Although the prevalence of these conditions among children is quite high after a disaster, perhaps what is more disturbing, but less appreciated, is the nearly universal prevalence of adjustment reactions and their long-term persistence. In a study involving anonymous surveys of a representative sample of more than 8000 children attending grades 4 to 12 in New York City public schools, 87% of children reported having at least 1 adjustment difficulty persisting 6 months after the events of September 11, 2001; 76% reported often thinking about the attacks and 45% reported trying to avoid thinking, hearing, or talking about it; 25% found it harder to keep their mind on things; 24% were having problems sleeping; 17% had nightmares; and 18% stopped going to places or doing things that reminded them of the events.² Such a high prevalence of persistent adjustment difficulties highlights that, in addition to providing effective triage and referral for those with mental health conditions, it is critical that we find ways to provide psychological support for all children impacted by a disaster event. Pediatric health care providers, whether within the pediatric emergency medicine system or community sites, will likely be the first and probably only point of contact with the health care system where such services can be offered. Research has also consistently shown that most children with mental health problems, whether outside the context of a disaster or during the immediate

aftermath of a disaster, remain unidentified. Even when their needs are brought to the attention of health care providers and referrals to treatment are made, in large part because of stigma related to mental illness and numerous barriers related to access and payment for mental health services, most never access that mental health care. Therefore, even if mental health treatment services were 100% effective because the most children in need of such services never reach mental health providers, it is clear that alternative service delivery models are required.

Knowing how to identify and respond to adjustment difficulties of children and their families in an emergency setting is a core skill set for all emergency department (ED) health care providers, as it is a clinical skill that is invaluable for interactions with virtually every patient, every day. It is too easy for professionals working in EDs to become complacent with the setting and to forget that for patients and their families, medical emergencies are novel and often overwhelming experiences. When the health care provider is instead able to connect with the child and family and put them at ease, the evaluation is more likely to be accurate and the assessment and treatment more likely to be successful. It is a skill that can be used every day, but it is also one that becomes truly invaluable in the immediate aftermath of a disaster. The term Psychological First Aid (PFA) has been used to describe “the practice of recognizing and responding to people who need help because they are feeling stress, resulting from the disaster situations within which they find themselves.”³ Psychological First Aid involves practical strategies to provide information, education, emotional support, and advice on practicing positive coping strategies; identifying when more assistance is required; and offering help in accessing these additional services. Practical suggestions on how to provide such psychologic support can be found in another article in this issue.¹ Such psychologic first aid is core to effective clinical care—conveying that the health care provider cares about the needs of the patient and family allows clinical service to be called clinical “care.” Perhaps, for this reason, there has been limited research conducted to document its impact either in acute care medical settings or within the pediatric medical home. Research is required not only to document the benefit of PFA but also to identify the most effective and efficient strategies for the delivery of such services and approaches that should be used to train health care providers in mastering the clinical skills required.

Given the practical limitations of the capacity for the health care system to provide the range of supportive and mental health services that might be beneficial to children and their families in the aftermath of a disaster, models for delivery of services within community settings, especially schools, need to be developed and critically evaluated. Although there is solid data supporting the efficacy of cognitive behavioral therapy interventions provided in group settings in schools, there has been less opportunity for the study of PFA, psychoeducation, and brief supportive services delivered in schools and other community sites.

Many large-scale disasters will result in deaths of community members, including children and family members and friends of children. Pediatric emergency care providers require skills in providing sensitive death notification services after pediatric deaths; practical guidelines for conducting death notification in the specific context of a disaster are described elsewhere⁴ and can be modified for use in other contexts. In addition, many of children's adjustment difficulties after a disaster may be related to bereavement, an area that has received remarkably little research attention and relatively limited clinical attention. Pediatric health care providers therefore should become comfortable in talking to children about a death that has occurred⁵ and need to advocate for children to receive bereavement support. After a major community disaster resulting in many bereaved children, community sites such as schools may be best suited for providing bereavement support to children and families.⁶

Pediatric health care providers are trusted sources of medical and public health information and one of the professions most respected by the general public for the delivery of unbiased information during the immediate aftermath of a disaster. Pediatric emergency care providers should therefore become familiar with basic principles related to messaging in disaster settings.⁴ Overall, there are 2 possible major goals of such messages: either to provide reassurance when the risk is low or to inform the public of specific dangers and to provide specific recommendations on actions that can be taken to minimize or eliminate personal risk. Messages should avoid trying to provide false reassurance or alarming the public when little can be done to minimize risk. Health care providers, especially in the context of a disaster, should ensure that they have clear goals for their communication and craft messages toward achieving those goals, rather than simply trying to convey everything they know to “educate” the public. ☒

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