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CHAPTER FOUR: MENTAL HEALTH ISSUES

MENTAL HEALTH AND THE ROLE OF THE PEDIATRICIAN

Schools and pediatricians have generally become the de facto mental health providers for children. Children are most likely to receive treatment from primary care physicians for symptoms associated with mental disorders, and most psychotropic drug prescriptions for children and adolescents are prescribed by primary care physicians. In a disaster or terrorist event, the need for mental health services will be far greater and the resources even less adequate. Pediatricians and other health professionals that care for children will play many critical roles in identifying and addressing the mental health needs of children and families in a disaster or terrorist event.

For many, if not most, children affected by a critical event, pediatricians and other health care providers for children will be the first responders. Therefore, pediatricians need to be able to identify psychological symptoms, perform timely and effective triage of mental health complaints, initiate brief supportive interventions, and make appropriate referrals when necessary. Many children (and their parents) with emotional reactions to a disaster (manmade or otherwise) will not identify their problems as psychological in nature. Pediatricians will have to be vigilant for somatization and help children, and their families, recognize and address the underlying psychological cause of these physical complaints. Because children's adjustment depends to a great extent on their parents' own ability to cope with the situation, pediatricians should also attempt to identify parents who are having difficulties adjusting to the event and encourage them to seek support for themselves. Pediatricians can also help families identify and access appropriate supportive or counseling services, and they can help support families who are reluctant to seek mental health services because of misunderstandings related to the nature of the treatment or associated stigma.

PEDIATRIC TRAUMA-RELATED DISORDERS

Children are not immune to the emotional and behavioral consequences of disasters and terrorism. Their reactions depend on their own inherent characteristics and experiences, their developmental level, and family and social influences as well as the nature and magnitude of the event and their exposure to it.

Exposure to disasters and terrorism can be direct, interpersonal, or indirect. Children who are physically present during an incident are directly exposed. Interpersonal exposure occurs when relatives or close associates are directly affected. Indirect exposure occurs through secondary negative consequences of an event, such as chaos and disruption in daily activities. Children who are far away from an incident may be remotely affected with fear and generalized distress as they perceive the societal impact of these experiences.

Exposure to media coverage may play a role in the child's reaction to an event. Studies have documented an association between viewing television coverage of terrorist incidents and post-traumatic stress reactions, but these associations do not establish a causal relationship. Aroused children may be drawn to the information provided by the media, and it is possible

that other factors are responsible for the link between exposure to media coverage and these emotional states.

Reaction to Disasters and Terrorism

There are a wide range of adjustment reactions that may generally be seen in children after a disaster or act of terrorism, as outlined in **Table 4.1: Common Symptoms of Adjustment Reactions in Children after a Disaster or Act of Terrorism**. Children may develop psychiatric symptoms and disorders—including post-traumatic stress disorder (PTSD), anxiety, depression, and behavioral problems—after exposure to disasters or terrorist incidents. Grief in these situations can be compounded by the traumatic circumstances associated with the loss.

Table 4.1: Common Symptoms of Adjustment Reactions in Children after a Disaster or Act of Terrorism
Sleep problems: difficulty falling or staying asleep, frequent night awakenings or difficulty awakening in the morning, nightmares, or other sleep disruptions
Eating problems: loss of appetite or increased eating
Sadness or depression: may result in a reluctance to engage in previously enjoyed activities or a withdrawal from peers and adults
Anxiety, worries, or fears: children may be concerned about a repetition of the traumatic event (eg, become afraid during storms after surviving a tornado) or show an increase in unrelated fears (eg, become more fearful of the dark even if the disaster occurred during daylight); this may present as separation anxiety or school avoidance
Difficulties in concentration: the ability to learn and retain new information or to otherwise progress academically
Substance abuse: the new onset or exacerbation of alcohol, tobacco, or other substance use may be seen in children and adults after a disaster
Risk-taking behavior: increased sexual behavior or other reactive risk-taking can occur, especially among older children and adolescents
Somatization: children with adjustment difficulties may present instead with physical symptoms suggesting a physical condition
Developmental or social regression: children (and adults) may become less patient or tolerant of change or become irritable and disruptive
Post-traumatic reactions and disorders: see Table 2: Symptoms of Post-traumatic Stress Disorder)

Risk Factors for Adjustment Difficulties: The following factors are associated with an increased risk of post-traumatic symptoms and other adjustment difficulties:

- The children themselves, or others close to them, are direct victims, especially if injury is involved (or the death of significant others).
- Children directly witness the event, especially if there was exposure to horrific scenes (indirect exposure through the media to these scenes is also associated with increased risk).
- Children perceive during the event that their life is in jeopardy (even if the perception is inaccurate).
- Event results in separation from parents or other caregivers.

- Event results in loss of personal property or other disruption in regular environment.
- Children have a history of prior traumatic experiences.
- Children have a history of prior psychopathology.
- Parents have difficulty coping with the aftermath of the event.
- Family lacks a supportive communication style.
- Community lacks the resources to support children after the event.

Post-traumatic Stress Disorder: The essential feature of PTSD is the development of characteristic symptoms after exposure to a traumatic event that arouse intense fear, helplessness, or horror or that lead to disorganized or agitated behavior. Current diagnostic criteria are outlined in **Table 4.2: Symptoms of Post-Traumatic Stress Disorder.** Clinicians should note that children with other adjustment difficulties (eg, bereavement) may appear to meet these current diagnostic criteria.

Table 4.2: Symptoms of Post-Traumatic Stress Disorder

Exposure: The child is exposed to actual or threatened death, serious injury, or sexual violence. This exposure may be through the child's direct experience; by witnessing the traumatic event, especially when involving a caregiver; or by the child learning that the traumatic event occurred involving a close family member or friend without any direct experience or witnessing of the event by the child.

The following symptoms must occur for more than 1 month's time:

1. Intrusive symptoms:

- The child has repeated distressing memories and/or dreams (nightmares) about the traumatic event; it is not required for children to remember the content of these distressing dreams. For some children, repetitive play activities may involve themes or aspects of the traumatic event.
- The child may display a loss of awareness of present surroundings (dissociation) and act as if the traumatic event is reoccurring (flashbacks).
- The child may experience intense or prolonged psychological distress and/or physiological reactions at exposure to internal or external cues that symbolize or resemble the traumatic event.

2. Avoidance

- The child attempts to avoid distressing memories, thoughts, feelings, activities and/or places that remind him or her of the traumatic event.

3. Negative alterations in cognitions and mood

- The child has problems remembering important aspects of the traumatic event.
- The child maintains negative beliefs or expectations about oneself, others, or the world.
- The child has thoughts about the cause or consequences of the traumatic event that lead to blame of self/others.
- The child experiences negative emotional states, such as depression, and has trouble experiencing and expressing positive emotions.
- The child shows a markedly diminished interest or participation in significant activities including play.
- The child feels distant from others, which may lead the child to become socially withdrawn and avoid people, conversations, or interpersonal situations.

4. Increased arousal and reactivity associated with the traumatic event:

- Irritable and angry outbursts (extreme temper tantrums)
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

The symptoms must last for more than 1 month and must cause clinically significant distress or impaired functioning. Because of developmental influences, symptoms in young children may not correspond exactly to those in adults.

Other Conditions: Other conditions, especially anxiety and affective disorders, are common after crisis events and may occur independently or together with PTSD. These conditions may precede, follow, or develop at the same time as PTSD. Establishing the temporal relationship in onset of disorders may aid in treatment. For example, PTSD stems from the primary traumatic event, whereas depression may result secondarily from persistent severe PTSD symptoms or intervening stresses. Fear and avoidance of situations reminiscent of the trauma may persist for years.

Behavioral Reactions: Signs of trauma may be evident in children's behavior, mood, and interactions with others. Traumatized children may adopt behavior more appropriate of younger children. Although they may not share their concerns and they may be especially compliant in the aftermath of an incident, compliant behavior does not mean the child is unaffected. Withdrawal is a cause for concern as it may represent a symptom of PTSD, and it potentially distances the child from adults who could provide support and assistance. Girls are more likely to express anxiety and sadness; boys tend to exhibit more behavior problems.

The child's reaction will reflect his or her developmental level. Infants may experience sleep and feeding problems, irritability, and failure to achieve developmental milestones. Problems in preschool children include separation anxiety, dependence, clinginess, irritability, misbehavior, sleep disturbance, and withdrawal. Problems in school-aged children and adolescents includes those seen in younger children as well as somatic complaints, anxiety, change in academic performance, guilt, anger and hate, and preoccupation with death.

Grief and Traumatic Grief: Although grief is not a mental disorder, it may require professional attention, especially if it is complicated by depression or PTSD. Traumatic deaths are of particular concern in disasters because of the implications for assessment, which should include an evaluation of the circumstances of the death and the child's exposure, and for treatment, which should address trauma symptoms as well as grief. In some ways, any death may be perceived by survivors as subjectively traumatic; however, 5 factors have been described that are likely to be present in death circumstances that are considered "traumatic deaths":

- Sudden, unanticipated deaths
- Deaths involving violence, mutilation, and destruction
- Deaths that are perceived as random and/or preventable
- Multiple deaths
- Deaths witnessed by the survivor that are associated with a significant threat to personal survival or a massive or shocking confrontation with the death and mutilation

Deaths that occur in the context of a disaster or terrorist situation often meet these criteria and pose an increased risk of traumatic grief. Referral to a pediatric mental health professional is often indicated in these situations, but this approach may also be of benefit when grief reactions are extreme, atypical, prolonged, or disrupting daily functioning.

ASSESSMENT AND TREATMENT OF TRAUMA-RELATED DISORDERS

Assessment and treatment of trauma-related disorders in children after a disaster will vary, depending on the characteristics of the disaster and the child's exposure, the setting, and the length of time since the event.

Early Interventions

In the acute-impact and early postimpact phases, supportive interventions should ensure the child's safety and protection from additional harm, address immediate physical needs, provide reassurance, minimize exposure to traumatic aspects of the event, validate experiences and feelings, and restore routine. Children benefit from accurate information, but it should be age-appropriate and measured, avoiding unnecessary or graphic details. If possible, pediatric mental health professionals can help other health professionals and family members with the process of death notification. Reuniting family members is a priority.

Assessment and Screening

Assessment should include a history of the child's exposure and reactions. When children or their close family members have been directly exposed, the children may require more comprehensive assessment. Children with less direct exposure may also need attention. Children and their parents should be educated about trauma reactions and coping and may welcome opportunities to ask questions and correct misperceptions. Children may not spontaneously describe their feelings, and adults may underestimate trauma in children. Therefore, it is essential to ask children directly about their experiences. Observation and the use of projective techniques, such as play and the use of art, aid in assessment and are useful in treatment as well.

Screening to identify children at risk and those needing referral can be conducted with symptom rating scales, which typically measure the type and degree of exposure, subjective reactions, personal consequences, and PTSD symptoms, and inquire about other related symptoms such as fear and depression, grief, and functioning.

Treatment

Treatment should be guided by the child's exposure and reactions. Cognitive behavioral therapy and psychoeducation provide structure and support and may be used in individual or group sessions after disasters.

Group sessions can be used to provide age-appropriate explanations of acute and longer-term reactions, reactions to traumatic reminders, secondary effects, anniversary reactions, and coping. Parallel parent groups provide a means to address parental reactions and concerns and to discuss effective management. These groups also provide an opportunity to teach parents how to parent their children who have been traumatized.

The family has a major role in the child's adjustment to trauma, and parents should be included in treatment. Often, more than one family member will be traumatized, although specific aspects of exposure may differ among family members. Helping parents resolve their own emotional distress can increase their perceptiveness and responsiveness to their children. Parents may also

benefit from psychoeducation about symptoms, how to manage symptoms effectively, and ways to decrease traumatic reminders and secondary stresses.

Medication is rarely indicated in children after disasters but might be used for those with severe reactions. Consultation with a child psychiatrist is recommended when medication is being considered. When used, medication should be coupled with psychotherapeutic interventions such as play therapy or cognitive behavioral approaches. Specific symptoms determine whether to use a drug, which drug to use, and how long to use it. Comorbid conditions should be considered in selecting an agent. Selective serotonin reuptake inhibitors may be effective in treating childhood PTSD and comorbid anxiety and depression.

School-Based Interventions

Schools are an excellent setting to deliver mental health services to children and families after a disaster. They provide access to children, encourage normalcy, and minimize stigma. PTSD and associated symptoms are likely to emerge in the school setting. For example, intrusive thoughts and difficulty concentrating may interfere with academic performance and social adaptation. Therefore, school consultation about the consequences of trauma and the recovery process may be indicated. School-based interventions, which can include curricular materials and activities, should be appropriate for the setting and should not supplant efforts to identify and refer children in need of more intensive individual evaluation and treatment. Manualized group interventions based on cognitive behavioral approaches, such as CBITS (Cognitive Behavioral Intervention for Trauma in Schools), can be delivered in schools by mental health professionals and have been shown to be effective in treating symptoms of PTSD.

Long-term and Staged Interventions

Long-term interventions may be necessary, especially for children with direct or interpersonal exposure and for those with enduring symptoms, pre-existing or comorbid conditions, prior or subsequent trauma, or family problems. New issues related to trauma may emerge as children mature. Thus, developmentally-appropriate staged interventions, which anticipate and address the course of recovery, should be considered during developmental transitions and at marker events such as anniversaries.

DEATH NOTIFICATION AND PEDIATRIC BEREAVEMENT

Considerations in Notifying Individuals About an Unexpected Death

At the time of a large-scale disaster or terrorist attack, it is very unlikely that pediatric health care providers will have the time and resources to deliver death notification in an optimal manner. Nonetheless, sensitivity to the issues discussed here can help minimize the short- and long-term impact on survivors.

Before Notification: Consider these issues before initiating the notification process:

- Verify the identity of the deceased and identify the next of kin.
- Establish contact as soon as possible. Do not delay contact waiting for a time thought to be more convenient for the survivors (eg, if the death occurs in the middle of the night, do not wait until the following morning).

- Contact the next of kin. Phone calls can be used to contact next of kin, but death notification is preferably done in person. Alternatively, someone (eg, police) can be sent to the home of the next of kin to ask them to come to the hospital for notification purposes.
- Minimize the likelihood that you will be compelled to notify the family members of the death over the phone. If you contact the survivor(s) by phone to request they come to the hospital, try to contact the family before the death has been declared (ie, during resuscitation) or have someone else who has not been directly involved in the care call on your behalf. Someone not directly involved in the care could make a statement such as: “I know that your husband was seriously hurt in the bombing, but I don’t have any further information. If you come to the hospital now, someone who has been taking care of your husband will be available to talk with you when you arrive.” If family members demand information on the phone, the caller can state: “I would prefer to talk with you about this in person when you arrive at the hospital.”
- Consider inviting additional family members or friends to accompany the next of kin to the hospital for notification. If a child has died, it is best to notify both parents at the same time. When any family member has died, survivors may benefit from being told with at least one other family member or friend present. Family members and friends can provide support to the next of kin and help notify other relatives and friends (instead of the entire burden being placed on one survivor).
- Before notifying the family, briefly review the basic facts, including the name of the deceased, the relationship to individual(s) that will be notified, the basic circumstances of injury and death, and the nature of medical care provided. For example, the individual was in a building when a bomb detonated and was found under rubble; CPR was performed until arrival in the emergency department, where after an attempt at resuscitation, he was pronounced dead. Identify who else will participate in the notification, and consider planning in advance for how to initiate the conversation.

At the Hospital: Once the family arrives at the hospital, consider the following:

- When the family arrives at the hospital (or site where death notification will be occurring), have them escorted to a private location, if possible. Try to inform them in as private a site as possible; if there is no opportunity for a private room, make every reasonable effort to maximize privacy (eg, use a curtain or notify the family while standing behind the building instead of in front). Do not inform family members in view of the media; anticipate the presence of media or members of the public who might otherwise photograph or videotape family members and try to offer survivors the opportunity to maintain their privacy as much as possible immediately after notification.
- If possible, have the notification conducted by a physician who was involved in the care, especially if he or she knows the family or had some direct involvement. Comments such as “I was with your husband when he first arrived at the hospital. He was not conscious at the time and therefore was not feeling any pain” can be very helpful to families. Inform the patient’s primary care provider whenever possible.
- Consider involving at least one other professional on the health care team, such as a social worker, chaplain, nurse, etc. If more than one family member is receiving the notification, conducting the notification with another professional is especially helpful; however, one staff person should be in charge of the discussion. Try to include at least 2 staff people for notification, even when notification is conducted in the field, but limit the number of staff to

those directly involved. It can be overwhelming for a family member to be notified by a large team.

- Just before and during the notification process, try to assess whether the survivors have any physical (eg, severe heart disease) or psychological (eg, major depression) risk factors, and assess their status after notification has been completed.

During Notification: When it is time to notify the family in person, remember to:

- Introduce yourself and any other member(s) of the health care team who are participating by name and title and offer to shake hands.
- Offer seating to the survivors. Sit close to them and face them so that eye-to-eye contact can be easily maintained.
- Refer to the deceased by name and/or relationship to the survivor (eg, “Mr. Smith” or “your husband”). Avoid referring to the person as “the deceased” or “the victim.” If children are included, involve professionals with training and experience in working with children in the notification process. Notification of the death of a family member is preferably provided to children by family members (such as the surviving parent) soon after the parent is informed, rather than having notification be provided by professionals unknown to the child. However, parents may wish for professionals to be present when children are told to provide support and to help answer questions.
- Remember that informing survivors of a death is a process, not an act. Pacing of the discussion is important. Do not start by stating that the individual is dead, because survivors are unlikely to hear any further information.
- Start by asking the family what they have already been told or know. Then provide a brief description of the circumstances of the injury and the relief efforts. This information helps the survivors understand the context of the death; not knowing what happened introduces a discontinuity in the history that impairs adjustment. After giving brief background information, it is useful to give a “warning notice” and then proceed fairly quickly to stating that the individual died. Ideally, the family will be present during the resuscitation efforts, and medical staff can provide the background information when the resuscitation begins and return to deliver updates that may serve as a “warning notice.” For example, “The team has given several medications to try to get your husband’s heart starting again, but so far there has not been any response.”
- An example of a notification initiated after a death might be: “There was an explosion 2 hours ago that we believe was caused by a bomb in the building where your husband works. The explosion started a fire that spread rapidly. Firefighters arrived on the scene within several minutes, but the exits were blocked and flames spread quickly. Many individuals were unable to get out of the building before they were overwhelmed by smoke. I am sorry to say that your husband did not get out of the building in time. We believe he died as a result of the smoke from the fire. His body was recovered by a firefighter, and we identified him by the wallet that we found in his pocket. We found your phone number in the wallet. I am very sorry to have to be telling you this news.”
- After notifying the survivor(s) of the death, pause to allow both the information to be processed and emotions to be expressed. Do not try to fill the silence, even though it may seem awkward. Listen more than you speak. Silence is often better than anything you can say. Stay with the family members as they are reacting to the news, even if they are not talking.

- Use clear and simple language. Avoid euphemisms such as terminated, expired, or passed away. State that the individual died or is dead.
- Do not provide unnecessary graphic details. Begin by providing basic information and allow the individual to ask questions for more details.
- Do not lie or speculate. If you do not know the answer to a question, say so. Try to get the answer if possible.
- Be conscious of nonverbal communication and cues, both those of the family as well as your own.
- Be aware of and sensitive to cultural differences. If you do not know how a particular culture deals with a death, it is fine to ask the family. Be particularly attentive to difficulty speaking or understanding English. If there is any doubt whether the family members are fluent in English, make sure to have a professional translator present unless you are fluent in the family's preferred language. Using family and friends as unofficial translators often leads to inadequate translation in the general medical setting. Such reliance on family and friends as translators for death notification is particularly burdensome to them and should be avoided.
- Consider the use of limited physical contact (eg, placing a hand on the family member's shoulder or providing a shoulder to cry on). Monitor the individual's body language and if at all in doubt whether such contact would be well received, ask first.

Additional Considerations: Below are a few additional issues to keep in mind:

- Realize that the individual may initially appear to be in shock or denial. Expect additional reactions, such as sadness, anger, guilt, or blame. Acknowledge emotions and allow them to be expressed without judgment.
- Do not ignore or dismiss suicidal or homicidal statements or threats. Investigate any such statements (often this will be facilitated by the involvement of mental health professionals), and if concerns persist, take appropriate action.
- If possible, write down your name and contact information in case the family wants further information at a later time. If the situation is not appropriate for providing your name and contact information, then consider how the family may be able to obtain additional information in the future (even months later). For example: "I work as a volunteer for the Red Cross. Here is my name and the contact information for the Red Cross Chapter. If later you wish more information about what happened to your husband, you can call them at this number and they should be able to look at the records." Survivors may not be ready to think of or ask questions and may later regret not asking for critical information.
- Do not try to "cheer-up" survivors by making statements such as "I know it hurts very much right now, but I know you will feel better within a short period of time." Instead, allow them their grief. Do not encourage them to be strong or to cover up their emotions by saying "You need to be strong for your children; you don't want them to see you crying, do you?"
- Feel free to express your own feelings and to demonstrate empathy, but do not state you know exactly how family members feel. Comments such as "I realize this must be extremely difficult for you" or "I can only begin to imagine how painful this must be to hear" can demonstrate empathy. Avoid statements such as "I know exactly what you are going through" (you can't know this) or "You must be angry" (let the individual express his or her own feelings; don't tell the person how to feel) or "Both my parents died when I was your age" (don't compete with the survivor for sympathy). Provide whatever reassuring information you may be able to, such as "It appears your husband died immediately after the

explosion. It is unlikely he was even aware of what happened and did not suffer before he died.” However, do not appear to use such information as an attempt to “cheer-up” family members (eg, “You should be happy, many people suffered painful burns or were trapped under rubble for an hour before they died. At least your husband didn’t experience that.”)

- Feel free to demonstrate that you are upset as well—it is fine to get choked-up or become tearful. If you feel, though, that you are likely to become overwhelmed (eg, sobbing or hysterical), then try to identify someone else to do the notification.

After Notification: Consider the following as discussions conclude:

- After you have provided the information to the family and allowed adequate time for them to process the information, you may wish to ask questions to verify comprehension.
- Offer the family the opportunity to view the body of the deceased and to spend some time with their loved one. Before allowing the family to view the body, the health care team should prepare it for viewing by others. A member of the health care team should escort the family to the viewing and remain present, at least initially. Tell them what needs to be done regarding the disposition of the body. For further information about preparation of the body for viewing, as well as additional recommendations about the death notification process, see *Death Notification: A Practical Guide to the Process* by R.M Leash (Hinesburg, VT: Upper Access, 1994).
- Help families figure out what to do next. Offer to help them notify additional family members or close friends. Check to see whether they have a means to get home safely (if they have driven to the notification, they may not feel able to drive back safely). Ask if they have someone they can be with when they return home.
- Help survivors identify potential sources of support within the community (eg, member of the clergy, their pediatrician, family members, or close friends).
- Take care of yourself. Death notification can be very stressful to health care providers. Health care providers need to explore and come to understand their own reactions to patient death and associated emotions, which may include sadness, anger, guilt, or a sense of responsibility. It is important to provide support to professionals who provide death notification, especially if related to tragic deaths or when multiple deaths are involved (as would be anticipated in a major disaster or terrorist event).

Explaining Death to Children

Children’s understanding of death may be very different from that of adults. Children have had far less personal experience of loss and have accumulated less information about death. They can also have difficulty understanding what they have seen and what they are told unless the basic concepts related to death are explained to them. Adults will need to provide especially young children with both the basic facts about what happens to people after they die, as well as the concepts that help them to explain those facts. For example, young children may be told that after people have died, their body is buried in a cemetery or turned to ashes that can then be buried or scattered. Children can be very distressed by these facts unless they are helped to understand the concept that at the time of death, all life functions end completely and permanently—the body can no longer move, and the person is no longer able to feel pain. That is why it is okay to bury or cremate the body.

Children need to understand 4 concepts about death to comprehend what death means and to adjust to a personal loss: irreversibility, finality, inevitability, and causality (**Table 4.3: Concepts of Death and Implications of Incomplete Understanding for Adjustment to Loss**). Most children will develop an understanding of these concepts between ages 5 and 7, but this varies widely among children of the same age or developmental level, based in part on their experience and what others have taught them. When faced with a personal loss, some children 2 years or younger may demonstrate at least some comprehension of these concepts. Adults should not underestimate the ability of young children to understand what death means if it is explained to them appropriately. Therefore, it is best to ask children what they understand about death, instead of assuming a level of comprehension based on their age. As children explain what they already understand, it will be possible to identify their misunderstandings and misinformation and to correct them accordingly.

Table 4.3: Concepts of Death and Implications of Incomplete Understanding for Adjustment to Loss		
Concept	Example of Incomplete Understanding	Implication
<i>Irreversibility</i>		
Death is seen as a permanent phenomenon from which there is no recovery or return.	Child expects the deceased to return, as if from a trip.	Failure to comprehend this concept prevents child from taking the first step in the mourning process, that of appreciating the permanence of the loss and the need to adjust ties to the deceased.
<i>Finality (Nonfunctionality)</i>		
Death is seen as a state in which all life functions cease completely.	Child worries about a buried relative being in pain or trying to dig himself or herself out of the grave; child wishes to bury food with the deceased.	Can lead to preoccupation with physical suffering of the deceased and may impair readjustment; serves as the basis for many horror stories and films directed at children and youth (eg, zombies, vampires, and other “living dead”).
<i>Inevitability (Universality)</i>		
Death is seen as a natural phenomenon that no living being can escape indefinitely.	Child views significant individuals (ie, self, parents) as immortal.	If child does not view death as inevitable, he or she is likely to view death as a punishment (either for actions or thoughts of the child or the deceased), leading to excessive guilt and shame.
<i>Causality</i>		
A realistic understanding of the causes of death is developed.	Child who relies on magical thinking is apt to assume responsibility for death of a loved one by assuming bad thoughts or unrelated actions were causative.	Tends to lead to excessive guilt that is difficult for child to resolve.

When providing explanations to children, use simple and direct terms. Be sure to use the words “dead” or “died” instead of euphemisms that children may find confusing. If young children are told that the person who died is in “eternal sleep,” they may expect the deceased to later awaken and be afraid to go to sleep themselves. This description does little to help children understand death and may cause more confusion and distress. Religious explanations can be shared with

children of any age, but adults should appreciate that religious explanations are generally very abstract and therefore difficult for young children to comprehend. It is best to present both the facts about what happens to the physical body after death, as well as the religious beliefs that are held by the family.

Even when children are given appropriate explanations, they still may misinterpret what they have been told. For example, some children who have been told that the body is placed in a casket worry about where the head has been placed. After explanations have been given to children, it is helpful to ask them to review what they now understand about the death.

Common Reactions Among Children Who Have Experienced a Personal Loss

Like adults, children may be reluctant to talk about a death. They may at first be shocked by the news or fail to understand its implications. Young children have difficulty sustaining strong emotions, so they may appear upset for a brief period of time and then return to play. They may also use play or other creative activities, such as artwork or writing, to both express and work through their feelings associated with a loss. By observing play and the products of children's creative activities, we may find some clues as to what is bothering them, but it is important not to jump to conclusions about the meaning or relevance of what is observed.

Soon after notification, children often ask questions about the deceased and the meaning the death has for them personally. These questions may cause surviving family members' distress because they often are particularly poignant. Children pick up readily on the cues from others in their family that adults are made uncomfortable by these inquiries. They may conclude that such questions are unwelcome, inappropriate, or even represent misbehavior and stop asking. The silence that results is not an indication that children do not understand what has happened or have already coped. Rather, it may be a sign that they are trying to protect their parents who appear overwhelmed or that they do not feel comfortable asking questions or expressing their emotions, leaving them to deal with both alone. Therefore, it is important for adults to explicitly invite children to share their questions and feelings. Often it is helpful for an adult who is familiar with child development and who knows the child personally to provide an additional outlet for discussion. The child's pediatrician or a social worker from the child's school, for example, may be in a good position to start such a conversation.

Older children and adolescents may initially decline the assistance of adults because they are more accustomed to turning to peers for support and to address issues of concern. It is important to extend an open invitation to these young people to talk with you when they have questions or want to talk about the situation and to help them identify other adults in their lives they can turn to for support and assistance (eg, a chaplain, coach, or teacher).

Even in the setting of a natural disaster or terrorist event, children may still wonder if they were in some way responsible for the death. After a traumatic death, such guilt feelings may increase post-traumatic symptoms and complicate the grieving process. Young children, in particular, have a very limited understanding of why things occur and tend to be self-centered. As a result, they often use magical thinking to explain situations that they do not understand. This may result in extreme feelings of personal responsibility for a death that has occurred, even in situations when there is absolutely no logical reason why the child should feel responsible.

Often, such feelings of guilt are irrational. “If only I hadn’t gone to school that day, my dad would never have gone to the office and wouldn’t have been killed by the bomb,” “I was mean to my father yesterday and that’s probably why he died,” etc. Understandably, children are often reluctant to share their guilt feelings with adults; adults may not anticipate these feelings (or be burdened with their own guilt feelings). It may be helpful to reassure children of their complete lack of responsibility, even if they do not express feelings of guilt, and there is no logical reason why you might anticipate they would feel guilty.

At the time of a traumatic loss, children often think first about their own needs. Parents should be warned that this self-centeredness is not a sign that children are selfish; more likely, it is a sign that they are under considerable stress and in need of more support and assistance.

Children often regress in response to the stress of a personal loss. Children who had been successfully toilet-trained may now begin to wet their bed; children who had not had difficulty attending child care may now begin to show separation problems; children who had good social skills may now argue more or have difficulty getting along with peers. Children and adolescents may also develop somatic complaints, such as headaches, stomach aches, or generalized fatigue.

A disaster or terrorist event may uncover children’s concerns about another loss or personal crisis that has not been fully resolved. Children may react strongly to the death of someone that they did not know well or perhaps did not know at all. Or, children may be more preoccupied with their own personal crises than they are affected by the death of someone in their community.

A resource offering free multimedia training materials on how to support grieving children is available through the Coalition to Support Grieving Students at www.grievingstudents.org.

Indications of the Need for Referral

Not every child who has experienced the death of a family member or friend requires professional counseling, and in the setting of a major disaster or terrorist event, such resources are unlikely to be available for all those affected. It generally is helpful, however, for children who have experienced the death of a family member or friend to speak with someone outside of the immediate family who understands child development and can attend to the child’s needs (without being burdened with his or her own grief), such as their pediatrician or a school counselor or social worker. When a community disaster or crisis has occurred, it is important to help establish access to supportive services within community sites, such as schools, to provide services to larger numbers of children.

Significant stigma continues to be associated with receiving mental health services, and this stigma remains even in the setting of a major crisis event. Parents and other caregivers need to understand that even though bereavement is a normative experience, it still can be profoundly difficult. People, including children, can be helped through supportive services and, when indicated, group or individual counseling.

Children who have extreme reactions (eg, anxiety, post-traumatic symptoms, depression, or thoughts of suicide), atypical reactions (eg, appearing happy or disinterested), or prolonged reactions (eg, prolonged sleep problems or somatization) should be evaluated by their pediatrician and likely referred to a mental health professional experienced in the management of pediatric bereavement. Children who are having difficulty returning to their normal daily routines several weeks after the death or are demonstrating the new onset or worsening of problems interacting with peers should be referred. Children who are experiencing traumatic grief may require treatment of post-traumatic symptomatology before they are able to continue with normal grieving.

Soon after a death has occurred, many children may find comfort in returning to school, spending time with their friends, and taking part in the same activities that they did before the death. Allowances and adjustments should be made for a time (such as extra help with homework because of difficulty concentrating and learning) so that they can return to their day-to-day life as soon as possible. Some children may resist returning to school or resuming their regular daily activities. They may be fearful to leave other family members, worrying that they themselves—or their family members—may die in their absence or that grieving family members may need their support. These children require reassurance of the safety and well-being of surviving family members and encouragement to return to school. Other grieving family members, especially parents or guardians, should receive the support and assistance they need so children do not feel it is their responsibility.

Attendance of Children at Funerals and Memorial Services

Children can be told in simple terms what to expect at a funeral or memorial service. If an open casket or gravesite ceremony is planned, children should be told and given explanations about what this involves. Children can be invited to participate to their level of comfort but should not be forced or coerced to attend. They should be encouraged to ask questions, which should be answered simply and honestly but without unnecessary details. At the ceremony, children should be accompanied by an adult they know and like (who is not personally grieving to the same extent as close family members) who can monitor the child's reactions, answer questions, and step out of the ceremony with the child if the child appears distressed or indicates a desire to leave. Even if children play quietly in the lobby of a funeral home, they may still have a sense of having participated in the ritual. Children who are not allowed to attend the funeral or memorial service often feel angry and hurt and lose out on the benefits of religious, family, and community support. They also may create fantasies about what occurs during funerals that are actually more frightening than the reality. It is also helpful if children can perform a small task at the funeral, such as handing out Mass cards at the entrance of the funeral home or selecting flowers to be placed near the coffin. Such tasks should be predominantly symbolic, of the child's choosing, and not overwhelming for the child.

THERAPIES FOR PSYCHIC TRAUMA

Crisis Response

Mass violence presents unique issues that differ from other episodes of interpersonal, community, and other forms of violence. Responding to individuals who are directly affected by the event is not enough—a multilevel strategy is required and should include victims and

witnesses, individuals with whom they are associated, and the broader community. Although crisis response providers do not have to perform all of these roles, they should work closely and collaborate with a number of individuals and agencies to ensure that the psychological impact of mass violence is addressed.

The first and foremost response to mass events is both directed and performed by the government and its agents, which are usually under the auspices of law enforcement, fire personnel, and/or emergency medical services and are typically managed by an Incident Command System (ICS). Mental health early responders should have pre-existing relationships with the ICS to perform their duties effectively. In most states and other jurisdictions, ICS staff members meet regularly to ensure efficient operation when needed. During episodes of mass violence, mental health providers need to be part of the ICS staff whenever possible. The pre-existing relationship with emergency response commanders permits more expeditious access to affected individuals and for the community's psychological needs to be considered consonant with emergency responses.

In addition, when mental health providers are members of the ICS, access to and allocation of resources for mental health crisis responders in situations of mass violence improves. Situating providers in the most useful locations, ensuring the flow of needed information and communications, and preventing well-intended but inexperienced and unlinked clinicians from arriving in masses in an attempt to provide services are essential to lessen the general confusion and chaos that accompany disasters.

A useful way of defining and understanding a response to a traumatic event is that the affected individual experiences the loss of both internal and external control. Therefore, maximizing organization and structure is a necessary prerequisite in providing mental health crisis response and early intervention. Mental health crisis models are best equipped to achieve this organization and structure when they are firmly rooted in the ICS.

Crisis Response for Children and Families

Unfortunately, there is limited empirical evidence for the effectiveness of any crisis response intervention. The frequently used and previously heralded Critical Incident Stress Debriefing or Management (CISD or CISM) strategies have not been demonstrated to be effective, and in some studies, they have been shown to be detrimental. Indeed, it has been recommended that compulsory debriefing of victims of trauma should cease. However, it is possible that an alternative method of early crisis intervention may be helpful for assisting people who may be recently traumatized. The following recommendations and guidelines for early intervention strategies are based on evidence from research on the risk factors for PTSD as well as some intervention research. Thus, they provide an empirical foundation for appropriate and useful approaches to assist potentially traumatized individuals.

Currently, there is no evidence that global intervention for all trauma survivors serves a function in preventing subsequent psychopathology. However, there is consensus that providing comfort, information, and support and meeting the immediate practical and emotional needs of affected individuals can help people cope with a highly stressful event. This intervention should be conceptualized as supportive and noninterventional and not as a

therapy or treatment. This suggestion recognizes that most people do not develop PTSD. Instead, they usually will experience transient stress reactions that will abate with time. The goal of early intervention is to create a supportive (but not intrusive) relationship that will result in the exposed individual being open to follow-up, further assessment, and referral to treatment when necessary. Inherent in this early intervention is the recognition that interpretation or directive interventions are not to be provided.

After ensuring that basic necessities are available and are not a pressing concern, the basic principles of intervention should be followed. These principles should ensure that no harm is being done in the intervention process and hopefully prevent or reduce symptomatology and impairment.

- Interventions should be grounded in the basic principles of child development, and providers should be experienced in working with children of different ages and levels of development.
- Mental health providers should have collaborative relationships with community providers to ensure access and community support for children and families.
- Children and families should be assessed for risk factors and symptoms, and interventions should be crafted to address the findings.
- An essential objective is to improve parental attention and family cohesion through assessment, psychoeducation, and treatment, when necessary, to parents and primary caregivers.
- Providers should make concerted efforts to prevent social disruption and displacement.
- Providers should identify, assess, and attempt to ameliorate or remove children and families from the continued threat of danger.
- Providers should have continued contact and monitor children for symptoms or impairment.

Handouts or flyers that describe trauma and if indicated bereavement, what to expect, and where to get help should be made available. Individuals should be given an array of intervention options that may best meet their needs. The goal is not to maximize emotional processing of horrific events, as in exposure therapy, but rather to respond to the acute need that arises in many to share their experience, while at the same time respecting those who do not wish to discuss what happened.

Medication

There is not yet clear evidence to support the use of pharmacotherapy in the treatment of post-traumatic symptoms in children. The first line of treatment for post-traumatic symptoms in children is trauma-focused cognitive behavioral treatments (CBTs), which include such interventions as graded desensitization and others. For children with severe reactions or comorbid conditions such as depression or anxiety (for whom selective serotonin reuptake inhibitors may be indicated), consultation with a child psychiatrist experienced in the treatment of PTSD would be helpful to determine whether medication should be considered an adjunct to psychotherapeutic interventions.

SCHOOL CRISIS RESPONSE

Most children benefit from receiving supportive services in the aftermath of a disaster or terrorist attack. Pediatricians can play a vital role in advocating for, consulting for, and actively participating in school crisis response teams to ensure that such supportive services can be provided to children within schools and other community sites.

School administrators, teachers, and other school staff will be affected by the same crisis event that is affecting their students. During such times, organizing and implementing an effective crisis response can be difficult or even impossible. Therefore, it is imperative that schools begin planning for potential crisis events before they occur, both to avert disasters whenever possible and to decrease the negative impact on students and staff when disasters cannot be prevented.

The school crisis response plan should include generic protocols for the following:

- Notification of team members, school staff, students, and parents of a crisis event
- Delivery of psychoeducational services and brief crisis-oriented counseling, such as through support rooms or short-term support groups
- Memorialization and commemoration
- Follow-up

The structure provided by a pre-existing plan can be very comforting in times of crisis and helps to ensure that key issues are considered, appropriate steps are taken, and necessary resources are in place.

In addition, the crisis response plan should include guidelines on the following:

- Crisis team membership
- Roles of crisis team members
- Protocols for delivery of crisis intervention services
- Specific guidelines for responding to unique situations, such as large-scale natural disasters or a terrorist attack
- Physical safety and security
- Rapid dissemination of accurate and appropriate information
- Attention to the emotional impact of the events and the crisis response; all areas should be addressed concurrently and in a coordinated fashion

Delivery of supportive services to children during a crisis can be demanding work for school staff and community mental health providers working within the schools. Plans should also include mechanisms to ensure that supportive services for staff are included as a key component of a crisis response.

Free resources for training and guidance for schools responding to crisis can be found at the Web site for the National Center for School Crisis and Bereavement (www.schoolcrisiscenter.org).

ANNIVERSARY REACTIONS AND COMMEMORATIVE ACTIVITIES

As the anniversaries of stressful, critical, or traumatic events approach, many children and adults will have significant reactions. Throughout the year, reminders of the original crisis may

add to children's sense of further danger and emotional distress. Those reminders of the events may also increase the reactions of peers, parents, teachers, and other adults.

Remember:

- Memorial activities can further the process of healing and learning.
- The planning process is as important as the memorial activities themselves and should actively include children.
- Health and mental health care professionals, teachers, parents, and children all benefit from the planning process.
- Symptoms and reactions vary from child to child.
- There is no one "best way" to acknowledge an anniversary.
- Helping children deal with a difficult event is hard work; adults need to take care of themselves as well.

Anniversaries

At the time of the anniversary, children frequently experience a recurrence of some of the feelings associated with a loss or tragedy. These reactions vary widely, and they can be seen in both children and adults. Some children may not be interested in revisiting the events. For these children, it may be more appropriate that they are occupied with the typical concerns of childhood.

It is important to find ways within the school to recognize the anniversary of such an important event without imposing personal emotions or expectations on either students or staff.

Some children directly affected by the traumatic event may appear to be "back to normal" but may still be feeling sad, scared, anxious, or angry. Children do not always demonstrate their feelings directly, and we should pay special attention to signs of concern or distress. Children who are known to have histories or ongoing exposure to trauma or loss, even if they are not directly related to the traumatic event, may be especially vulnerable in the days and weeks surrounding the anniversary.

Heightened media coverage and publicity of memorial events may increase reactions in children. Parents should monitor and supervise their watching of television and, especially for younger children, consider limiting the amount of television exposure.

Some signs of distress to look for include the sudden appearance of or noticeable change in the following:

- Depressed or irritable mood
- Oppositional and defiant attitude
- Attention-getting or other behavioral problems
- Difficulties getting along with classmates and peer group
- Social isolation or withdrawal
- Deterioration in academic performance
- Physical complaints
- Changes in appetite
- Sleep disturbances

The extent and nature of potential difficulties may be related to many factors, including the following:

- Age and developmental level
- Personal history (eg, prior trauma, loss, or emotional difficulties)
- Support from peers, parents, and school staff

Memorialization

Memorialization is any activity designed to formally mark the anniversary or memory of a significant event. Memorial events can help children express and cope with their feelings that might otherwise seem overwhelming to deal with alone. By actively planning and participating in a memorial event, children can exercise some control over how they will remember the disturbing event.

Children may have needs similar to those of adults in times of crisis, but they often meet those needs in very different ways. It is important to find out from the children what they would like to remember and what they think would be the best way to acknowledge the anniversary. Children need to be part of the planning process for memorial events. A memorial planned by adults for children is likely to be more helpful to the adults and not necessarily meet the children's needs. The planning of a memorial activity can be more therapeutic than participating in the activity itself.

Remember also that different groups of children and adults will have different needs and wishes at the time of the anniversary. Memorial activities do not need to be formal or elaborate. It is best to take cues from children, considering their age and developmental level, when planning memorial activities. Discussion allows children to explore how they are feeling and to think about what might help them feel better.

Some children may wish to acknowledge the anniversary in a personally meaningful way (eg, drawing a picture, writing a poem or essay) but resist a group activity centered around the anniversary. Some children may prefer not to mark the anniversary with any formal or even informal activity. It is important to remember that those children who are grieving their own personal losses may resent or feel frustrated if the memorial event focuses only on the heroic efforts of rescue workers.

Planning a Memorial Activity

Memorial activities can be planned at various levels, including individual consultation with the pediatrician, with family members, in small student groups, or in larger community or school-wide committees. Children should be involved in the planning process, but it is equally important for adults to provide guidance, structure, and support.

- Consider the children's ages and developmental levels when planning activities.
- Some children may wish to involve other friends or family members in the planning process.
- Coordinate the planned events with the family and the school.
- Not all children will want to be involved in the planning process, and participation should be voluntary.

- Do not feel pressured to plan the “perfect event.” Any memorial event or activity, big or small, may be a helpful means for children to understand and mark an anniversary.
- Activities within a school or individual classroom may affect other students and staff within the school as well as children’s families at home. Therefore, other families should be informed about plans for memorial events within a school.
- Other adults will benefit from additional support and guidance on how to mark an anniversary in a sensitive manner.
- Awareness of school activities and plans often can help to initiate discussions at home, where children may be most comfortable talking about critical events and anniversaries.
- Parents should be invited to share any concerns related to the anniversary or relevant family experiences with the pediatrician, teachers, and school staff. Pediatricians, teachers, and school personnel should keep the lines of communication open with parents throughout the planning process. Parents should be encouraged to continue to discuss the planned activities with their children at home.
- Open discussion communicates to children that adults are available for further discussion and support.
- Look for signs of distress in students, such as agitation, acting out, or other unexpected behaviors, and help teachers, parents, and school personnel to be aware of them.

SUPPORTING SCHOOL STAFF

Some adults may find it difficult to discuss traumatic events, especially if dealing with their own losses. Adults should seek out support from other adults and colleagues when needed. This is difficult work for everyone, and it is important for staff to think about what their own feelings are in relation to the events. Providing an opportunity for staff to talk about their own reactions may be useful to them personally and may better prepare them to meet the children’s needs.

Remember that children look to adults for guidance and support during difficult times. We need to think about how our own reactions may impact children. Children’s questions may sometimes take us off guard and make us confront issues we would rather not think about.

Having a plan to address these concerns in advance will help make the task easier. If the task seems too difficult, staff should share the responsibility with a colleague or invite someone else to help with the planning and process of memorialization.

PROFESSIONAL SELF-CARE

Pediatricians and other pediatric health care providers often live in the same community as their patients and, as such, may be affected, directly or indirectly, by the crisis event themselves—their homes may have been damaged or destroyed by a natural disaster, or family members or friends may have died or been injured by a mass casualty event. In addition, family and friends they care about, as well as colleagues with whom they work, may be affected. Despite these challenges, they may be expected to function in austere conditions and/or to address increased medical and mental health needs of their patients and their families at a time when colleagues and/or staff are unavailable or overwhelmed and the infrastructure and resources for the delivery of medical care may be compromised or over capacity. Pediatricians may need to devote significant—and generally uncompensated—time helping families navigate complex systems to

obtain needed financial or psychosocial support and encouraging families to seek often stigmatized mental health services that may be limited or virtually unavailable. Pediatricians may, by default, assume the primary or sole responsibility for the delivery of mental health services to patients and families in this setting, even though many pediatricians feel that they lack adequate training and confidence in their clinical skills in this area.

Listening to the stories of family, friends, colleagues, and patients who have experienced trauma or loss can be emotionally draining and may trigger memories of the pediatrician's own prior trauma or loss and increase a sense of personal vulnerability. Vivid narratives by patients and their families may contribute to the development of vicarious traumatization of the pediatrician. Pediatricians should help initiate discussion with their patients and families but refer to mental health professionals with trauma expertise for further processing and should limit what is shared with the pediatrician accordingly. Joining with families to experience their distress can also contribute to compassion fatigue, especially when the disaster is already jointly experienced by the patient and pediatrician. This does not mean that pediatricians have a finite reserve of compassion or that compassionate care will ultimately lead to burnout; indeed, the provision of compassionate care can bring a sense of meaning to clinical work and buffer against the development of provider burnout. But pediatricians should monitor the impact on themselves of providing such psychosocial support and allow themselves to limit such support to a level that feels comfortable and manageable at the time. Pediatricians should help ensure that patients and families get the support that is needed, but they should not feel compelled or obligated to provide all such support themselves.

If patients or their families are upset or overwhelmed, it can be hard to recognize that you are helping them, even when you are. In such a context, pediatricians may question their ability to meet the needs of patients and families and fail to see the important positive impact of their actions. Taking active steps to collaborate as a health care delivery team with shared responsibility and decision making and consciously working to share stories of positive contributions within the practice can be particularly important during the recovery period.

Pediatricians should establish realistic expectations for professional workload and outcomes during the recovery period, incorporate accommodations and flexibility in hours and work conditions as necessary and to the extent possible, and work to foster increased communication and social cohesion among members of the health care team. Adults who are under stress may experience the same adjustment reactions described above for children and youth. They may experience anxiety, confusion, anger, irritability, and distrust or suspiciousness. They may feel exhausted and become less tolerant of change, unpredictability, and increases in work load—all of which may be required by the changing work conditions and community need. Individual pediatricians should monitor themselves for negative thoughts, practice ongoing stress management and self-care, and seek to establish realistic boundaries between personal and professional time, recognizing that although the need may seem (and to an extent actually be) limitless, the pediatrician's capacity to provide service to patients and families is not.

There are many challenges to professional self-care in the context of a disaster. It is difficult for pediatricians to find the time to attend to their own needs when the needs of their patients and the community are so extensive. The reality is that pediatricians will need to “make” time rather than

wait to “find” it. Professionals often assume that others are having less difficulty adjusting and may feel shame or guilt for attending to their own needs ahead of those of their patients. Pediatricians should model a willingness to accept personal and professional assistance and support and seek resources to meet such needs for themselves and others within the practice.

RISK COMMUNICATION AND MEDIA ISSUES

Information should be communicated to the public in timely, accurate ways that do not heighten concern and fear. Communicating effectively during a crisis requires the following:

- Planning
- Preparation
- An understanding of communications protocols, messaging, and the media
- The ability to manage the flow of information

Each element is a challenge that can be met effectively, to the benefit of those receiving messages in times of crisis.

Developing Goals and Key Messages

People often fail to communicate effectively because of a lack of clear communications goals and key messages to support them. Setting such goals and identifying support messages are tasks that should be accomplished before issuing any public comment and are especially important in a crisis.

A communications goal of “educating the public on the complexities of bioterrorism and preparing them for any eventuality” is not realistic. Informing the public of the problem and specific dangers, providing guidance on appropriate responses, and easing concerns are achievable goals. Messages in support of these goals should also be direct and speak effectively to the audience.

A risk message is a written, verbal, or visual statement containing information about risk that may or may not include advice about behaviors to reduce risk. A formal risk message is a structured written, audio, or visual package developed with the express purpose of presenting information about risk. Risk messages may aim to ease public concern or provide guidance on how to respond.

Messages to Ease Public Concern: Examples of messages to ease public concern are:

- The risk is low.
- The illness is treatable.
- It is not easily contracted.
- Symptoms are easily recognized.

Messages on How to Respond: Examples of messages that give guidance on how to respond include:

- Take these precautions.
- If possibly exposed, contact a physician.
- If symptomatic, contact a physician.
- Note possible symptoms in others.

If the goal is to ease concern and the message in support of that goal is “the risk to the public is low,” that message should be clearly stated at the outset and returned to as often as possible.

- Raise points often enough that the audience leaves with a clear understanding of the message you wanted them to hear.
- Take opportunities to begin or end statements with a reiteration of your message.
- Do not be so repetitious with a single message that you appear to be trying to convince people of something that is not true.
- Do not repeat messages word-for-word every time you answer a question.

Exercise some control over the conversation you are having, be it an interview, press conference, or questions from an audience. Do not allow the conversation to be led down paths that are not pertinent to the goals or message—no matter how persistent the questioner might be in pursuing a line of inquiry.

Delivering Accurate and Timely Information: In a risk-communication situation, there is constant tension between providing accurate information and providing information quickly. Both demands pose challenges. To wait for all information to be complete and verified before releasing it to the public can create an information vacuum that will almost certainly be filled with rumor and speculation. To release information that has not been confirmed and turns out to be inaccurate, however, runs the risk of misleading the public and undermining your credibility as a spokesperson.

- Goals and messages should be simple, straightforward, and realistic.
- Information should be delivered with brevity, clarity, and effectiveness.

Provide statistics and key information to the media in written form. In presenting information, always know how the information was gathered and how any conclusions were reached.

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