Emerging Minds.

Supporting wellbeing and resilience in children before, during and after a natural disaster

Facilitator's Handbook
First Responders and Emergency Services Workers

National Workforce Centre for Child Mental Health

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Introduction to resources

First responders have specialised training and are among the first to arrive and provide aid at the scene of any emergency or traumatic event, including natural disasters. There is a high likelihood that interaction with children, however brief, will often form part of this response. This facilitator's handbook (and accompanying resources) has been designed to help deliver professional development training activities to professional and volunteer first responders.

The core outcome of the training is to equip first responders with the knowledge and skills required to promote resilience and coping and decrease long-term adverse reactions in children (aged 0-12 years) following a natural disaster event.

Training Focus

While it is acknowledged that first responders may also be parents, community members or (in the case of volunteer first responders) hold other professional positions that assist with disaster response (e.g. educator, GP, health and social services worker), it is also important to recognise that first responders may also hold none of these additional roles. For clarity of purpose and delivery, the current training will primarily focus on the role of first responders while directly performing their 'first response' role.

Extension module – First responders as parents/carers

In the midst of a disaster or emergency, first responders are focused on the needs of the community at large and transitions in and out of family life can be difficult. As such, an extension module targeting the very specific needs of first responders who are parents and carers has been included with this training. Facilitators are urged to encourage (but not require) all first responders to participate in this module, whether they are parents or not. Acknowledge that while the materials may not be directly relevant to all participants' circumstances, colleague support and understanding remains an invaluable resource for all first responders, and therefore the materials will have benefit for non-parents as well.

Acknowledgement:
This handbook was originally developed by the Centre of National Research on Disability and Rehabilitation Medicine, University of Queensland as part of the Queensland Government's response to the Queensland Natural Disasters. [Kenardy, De Young, Le Brocque & March. (2011) Brisbane: CONROD, University of Queensland].

The materials and content have been revised and extended for use as part of the Emerging Minds: National Workforce Centre for Child Mental Health Community Trauma Toolkit.

Resource outline

The resource training package is comprised of a facilitator's handbook and accompanying presentation slides, discussion/reflection activities, participant handouts and an 'additional resources' guide.

Part 1 of this handbook is provided as a psychoeducation module for facilitators to assist in gaining a broad understanding of trauma reactions in childhood prior to training delivery.

Part 2 discusses the important role that first responders can play in helping children during and after a natural disaster. The concept of Psychological First Aid (PFA) is discussed, as well as the importance of delivering PFA in the context of the needs of children.

Part 3 discusses the importance of first responder self-care in the context of a natural disaster event.

Part 4 is an extension module specifically targeting the needs of first responders as parents. The module addresses the impacts that might be felt by families of first responders during and after a natural disaster event and provides strategies for supporting first responders' own children in this time.

Part 5 is an appendix containing helpful information about more severe reactions that children may experience. Additional activities and handouts are also provided.

Flexible delivery

Facilitators are encouraged to tailor training to the needs of their participants. Content has been broken into five modules.

Modules are anticipated to run between 45-60 minutes each (depending on activities included). Optional activities and handouts provide choice as to how facilitators drive participant engagement, reflection and discussion within the training. Modules may be delivered in combination (i.e. full day/half-day workshop) or as a series. Modules may also be further split into shorter sessions (e.g. Module 1a/Module 1b) at the discretion of the facilitator.

The Resource Matrix may be used as an additional handout to guide individual study post-training and/or used by facilitators to access specific resources (e.g. recovery after a bushfire, recovery after a flood) for distribution in sessions.

Additional notes

While the content and strategies contained in this training package will have significant cross-over applicability to large-scale, man-made traumatic events (such as acts of terrorism or mass domestic violence) there are points of difference in how children may perceive and respond to these types of trauma that have not been addressed in these materials. While acknowledging this cross-over, facilitators should emphasise that the specific focus of the education is supporting children in regard to **natural disaster-related traumatic events**.

- Unless otherwise specified, the term 'child/children' will be used throughout the materials as a global term encompassing babies, toddlers, pre-schoolers and primary school-aged children aged 0-12 years.

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Contents

Part 1: Children and natural disaster events

Introduction

With its widely diverse landscape, Australia is susceptible to multiple natural hazards such as bushfires, floods, severe storms, earthquakes and cyclones. The threat of natural disasters can be frightening for anyone but can be particularly upsetting for children. Although children can be very resilient, they are vulnerable to trauma in highly stressful situations.

Natural disasters can impact on a child's sense of safety and security, cause the loss of their home, school or social networks, and produce significant trauma and grief. Research indicates that, with the challenge of rapid emotional and psychological development, fewer coping resources and high levels of dependence on caregivers for protection, younger children may find such events particularly distressing. Children may react to traumatic events immediately, days, or even weeks and months after the event.

528,154 Australians were affected by disaster between 2006 and 2015, with 947 reportedly killed.

Red Cross World Disasters Report, 2016

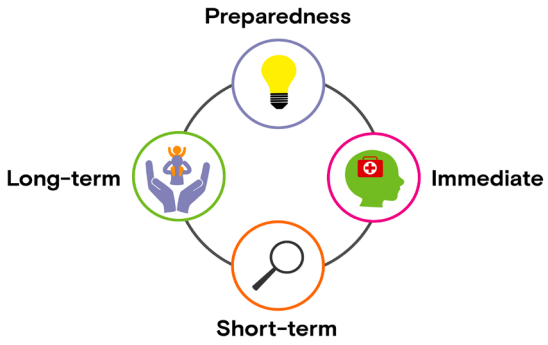
First responders are among the first to arrive and provide aid at the scene of any natural disaster event. There is a high likelihood that interaction with children, however brief, will frequently form part of this response. Evidence indicates that the process of helping children to recover from natural disasters can commence immediately at the scene of a traumatic event; therefore first responders can play an invaluable role in supporting resilience and enhancing outcomes for children who experience a natural disaster event.

Optional activity 1: Discussion and reflection: Children in natural disaster events (5–15 mins)

Timelines of a natural disaster

When thinking about the timelines of a disaster it is natural to think of a time immediately prior to the event; the period when the event occurs (and its immediate aftermath) and, finally, a shorter and longer-term post-disaster period.

In the course of their duties, first responders may interact with children before and after a natural disaster as part of community-engagement activities such as school visits, community presentations, local events and/or the course of their everyday duties.



While these contacts may provide opportunities to support and reinforce resilience in children, it is in the 'during' and 'immediate aftermath' stages of a natural disaster that first responders may play their most critical role in supporting children's recovery. Depending on the size and scale of the disaster, the 'during' and 'immediate aftermath' period may last for days or even weeks following the actual disaster event and reflect the time of immediate and urgent aid.

Trauma reactions in childhood

In times of disaster, children may be separated from loved ones, and first responders may step in (however briefly) to support their safety. First responder reactions and responses at this time can have a significant impact on a child and how they recover from the traumatic event. To best support children during this time, it is important for first responders to understand a little about how children of different ages perceive and respond to traumatic events.

What is a traumatic event?

A traumatic event is any situation that the child subjectively experiences as overwhelming (too frightening or painful). These events can be something experienced only by the individual (e.g. being in an accident, witnessing a terrible event) or events involving groups of people (e.g. floods, storms, bushfires). Up to one in four children will experience a traumatic event during childhood. Unfortunately, some children experience a number of traumas and the effect may be cumulative, which can make those children more vulnerable to stress reactions.

Some of the things that might be traumatic for children include:

- accidental injury that results in a visit to the hospital
- serious illness
- sexual or physical assault
- serious injury or sudden death of a parent or close family member, especially if witnessed first-hand
- man-made disasters such as terrorist attacks, incidents of mass violence; and
- natural disasters such as earthquakes, bushfires, floods, cyclones.

Natural disasters such as floods, bushfires and storms can be particularly traumatic for many children as they typically impact upon entire communities, involve significant damage and destruction and often result in loss of property and/or life. Further, the effects of such natural disasters are often long-term, creating adverse financial, social and emotional living circumstances for many families for extended periods of time.

Optional activity 2: Discussion and reflection: Potential longer-term impacts of natural disasters (5–15 mins)

How do children perceive a traumatic event?

When responding to a natural disaster event, first responders might sometimes witness what they consider to be very odd responses from children to a threat. For example, a child might not appear distressed at all in a situation where the first responder perceives significant threat, or might appear very distressed in a situation where there is little threat. Perception of threat can also have an impact on how a child reacts to trauma.

Research has shown that perceptions of threat during a traumatic event may be very different for children and adults. What an adult perceives and experiences as threatening may not be the same for the child. For example, in the context of natural disasters, parents may feel that their life or the life of their child was threatened. The child, however, may be much more concerned about being separated from their parents and family during or immediately after the trauma. The fear of separation may continue for weeks or months following the trauma, depending on the age of the child and the severity of the threat. Similarly, losses that may be less important to adults (e.g. loss of a favourite possession) may be of profound significance to the child.

Differences in perceived priority of threat

Adults	Children
1. Threat to own or child's life	1. Separation from parents
2. Injury	2. Injury to self
3. Loss of property	3. Injury or loss of parent
4. Loss of business and livelihood	4. Loss of pet
5. Loss of pet	5. Loss of favourite things
6. Loss of community	6. Disruptions to routines

Some children may perceive threat or danger (e.g. potential separation or injury) even if they are not directly impacted by the disaster.

How do children react to traumatic events?

There is no way of predicting exactly how any individual child will react to a traumatic event. Experiences and perceptions of threat will vary depending on the child's developmental stage, age, personality, pre-trauma functioning and previous life events. The child's reactions will also depend on how their parents, carers and other adults around them express their reactions during and after a traumatic event.

Notably, children can and often do express trauma reactions in very different ways to adults. Some of these reactions might be adaptive and positive, whereas others may cause the child (and those around them) some difficulty and persist over time.

Trauma reactions are often dynamic and can present differently at any point in time. *For some children, witnessing the trauma or hearing about it will have as much of an impact as being directly involved in the event.*

Every child reacts differently to trauma

- The majority of children are resilient and experience only minimal, short-lived distress. Some even report feeling more confident or notice other positive changes following trauma. This is called Post-traumatic Growth.
- Some children may express a lot of different reactions, or one intense reaction immediately following the event, but gradually return to their previous functioning over time.
- Some children experience immediate traumatic stress reactions which can persist over time. Sometimes these reactions may intensify or develop into different emotional and behavioural problems.
- Some children appear resilient at first but display trauma reactions later on.

But they were only a baby when it happened…

A common (but incorrect) belief is that very young children are not affected by trauma and do not notice or remember traumatic events. In fact, anything that affects older children and adults can also affect very young children.

Babies and young children manage their feelings through their relationships with parents and other adult carers, depending on them to feel safe and secure and to buffer their stress. This means they can be very sensitive to the emotional states of their carers and can quickly become unsettled and feel unsafe in situations where their carers are distressed.

It is important to recognise that exposure to a traumatic event, such as a natural disaster, can impact upon the physical, behavioural, emotional and mental development of children of all ages, including babies and toddlers.

In the event of a natural disaster, you are a protective factor for the children in your care.

Types of reactions following traumatic events

Children are individuals and may express none, some or many reactions after a traumatic event. Common reactions to traumatic events like a natural disaster include:

- asking lots of questions about the event or the future.
- avoiding talking about what has happened.
- wanting to help others who have been affected.
- crying, feeling down.
- bad dreams or nightmares about different things.
- increased clinginess and having fears of separation (e.g. from loved ones, homes, pets).
- trouble getting to sleep, waking from sleep, occasionally sleepwalking.
- physical reactions (e.g. fast beating heart, upset stomach, headaches).
- feeling grumpy and losing their temper.
- trouble concentrating.
- difficulty with schoolwork.
- feeling agitated.
- difficulty interacting with peers and adults
- playing, drawing and re-enacting parts of the trauma.
- difficulties with everyday functioning (e.g. not completing homework, forgetting to pack bags or bring sports gear).
- feeling shocked.
- grief and sadness about loss of a loved one, pet or possessions.

Children's reactions to natural disasters may also differ depending on the nature of the traumatic event. For example, children who experienced flooding or destruction through gradual exposure (where they were able to safely remove themselves from the situation), may be more susceptible to reactions which focus on the loss of property and destruction of their homes. These children may be more likely to experience depressed mood, grief or simply withdraw following the disaster.

Other children who were victims of sudden inundation or destruction (where the child or family's safety was at risk) may be more susceptible to reactions such as post-traumatic stress, anxiety and enhanced threat perceptions regarding their safety.

Loss and grief

Unfortunately, some children experience many losses following a natural disaster (such as loved ones, pets, possessions, home). These losses can lead to grief reactions, which can further complicate a child's response to a traumatic event.

Childhood grief is a normal emotional experience following loss and typically presents as sadness, sleep problems, loss of appetite, decreased interest, physical complaints, irritability, regression in developmental skills and preoccupation with death. Children experiencing normal grief reactions, also known as uncomplicated bereavement, will gradually engage in activities that enable them to adapt and move on from the loss.

However, some children are at risk of childhood traumatic grief, which may occur when the death of a loved one is perceived by the child to be traumatic (e.g. parent swept away in the floods). In childhood traumatic grief, children experience trauma symptoms that interact with their grief reactions and impede the normal grieving process. Signs of childhood traumatic grief include intrusive memories about the death (e.g. nightmares), avoidance and numbing symptoms (e.g. avoiding reminders of that person) and increased physical and emotional arousal (e.g. anger outbursts, concentration difficulties).

For more information about loss and grief refer to **ACATLGN Children, adolescents and families: Grief and loss in disaster**.

How do children's reactions change over time?

Reactions to natural disasters may change over time. Often, families affected by a natural disaster will spend the first few weeks following the event surrounded by support and are busy managing the direct consequences (e.g. restoring their properties from destruction, helping neighbours or friends). Children and parents may be so busy during this time that their emotional reactions are somewhat contained. However, when routines start to return to normal, support diminishes, and families have time to stop and think. It is at this point that many people may begin to demonstrate problematic emotional reactions.

Although most children will recover over time, there are some who will experience significant ongoing difficulties. If trauma symptoms or emotional and behavioural difficulties are left untreated or do not resolve on their own, symptoms can follow a chronic and unremitting course and can have a significant adverse impact on children's social, emotional, behavioural and physical development. Symptoms may continue to be present 1-2 years later. Further, for some families, symptoms may only appear (or reappear) 6-12 months after the event, as economic and familial costs of the disaster begin to unfold.

For example, some businesses will experience economic distress; parents may begin to suffer emotionally (e.g. depression) from the losses associated with the disaster, and children may subsequently begin to demonstrate symptoms of distress.

For some children, these problems become so interfering that they are considered to cause 'clinical' levels of distress. For other children, having experienced the traumatic event may simply cause them to react differently to events over the following year. Some everyday events (e.g. homework, exams, arguments with friends) may trigger emotional or behavioural reactions (e.g. anxiety, depressed mood, fighting) that the person would not normally demonstrate.

In the months (and years) following trauma, children may experience a range of stress reactions. The most severe of these reactions and the most common include diagnoses of post-traumatic stress disorder (PTSD), other anxiety disorders such as separation anxiety disorder and panic attacks, and depression. Behaviour problems may be severe, such as oppositional defiant disorder (ODD) or conduct disorder, or may be expressed as increased aggression, interpersonal problems, substance use or risk-taking behaviours. Some children may have increased sensitivity to issues such as school yard or cyber bullying.

Although some of these issues may appear to be minor, over time the cumulative effect may impact on the child's development and ability to achieve and thrive emotionally, academically and socially.

For more information about more severe childhood stress reactions please refer to **Part 5 of this training manual**.

Symptoms over time				
Fear Agitation Nightmares Difficulty sleeping Clinginess Crying and distress Difficulty concentrating	>	Sleep problems Tiredness Loss of social skills Depression Poor school performance	>	Clinical level symptoms Poor academic outcomes Alcohol- and drug-related problems and increased risk-taking Problems with the law Interpersonal difficulties
IMMEDIATE		**INTERMEDIATE**		**LONG-TERM**

Risk Factors

There are a number of risk factors that may increase the likelihood that children will experience potentially debilitating trauma symptoms, with long-term consequences for their social, emotional, behavioural and academic development. These include:

Pre-trauma risk factors

- A history of emotional or behavioural difficulties (e.g. anxiety, ADHD) prior to the event.
- Pre-existing family stressors (e.g. parental conflict, divorce, financial strain, parental mental health concerns, lack of secure attachment with parent/carer).
- Prior exposure to traumatic or stressful life event/s.
- Academic difficulties.

Trauma-related risk factors

- Threat to life.
- Injury to self.
- Witnessing a family member or friend get injured or killed.
- Separation from parent/s.
- Loss of a family member or friend.
- Witnessing family members in a highly distressed state.
- Witnessing other property damaged by a disaster (e.g. neighbour's property).
- Loss of the child's own home, personal belongings, pets.
- Evacuation of the family.
- Abruptness/shock of the event.

Post-trauma environmental factors

- Changes in the family (e.g. loss of parent, increased parental absence due to changes in work).
- Parental mental health problems.
- Parent-child relationship difficulties.
- Family dysfunction (e.g. chaos, fighting, poor communication).
- Changes in parenting (e.g. less consistent and predictable).
- Family stressors (e.g. relocation, change in routines, grief, change in roles and responsibilities).
- Loss of school and/or community.
- Loss of social supports.
- Vicarious or secondary traumatisation from listening to people speaking about the disaster or through the media.

Age-related responses to trauma

A commonly held belief is that children under the age of 5 are immune to the negative effects of trauma. This is not true. In fact, children in this age group may be the most vulnerable to experiencing adverse outcomes as they are undergoing a rapid period of emotional and physiological development, have limited coping skills, and are strongly dependent on their primary caregiver to protect them physically and emotionally.

Although babies, preschoolers and children may present with a similar pattern of trauma symptoms, the way children process and respond to a traumatic event very much depends on their age and developmental maturity. It is therefore very important for first responders to have an awareness of how unique developmental differences may impact on the manifestation of trauma symptoms across age groups, as these need to be taken into consideration when deciding how best to help a child cope with a traumatic experience, such as a natural disaster.

Children aged 0–4 years

Babies (0 to 24 months)

Developmental considerations

Babies are especially dependent on their caregivers to nurture them and meet their needs for physical contact, comfort, food, sleep and attention. Developing a secure attachment with a primary caregiver is a crucial task at this stage of development. However, after a trauma it can be challenging for a parent to meet all their child's needs. This can affect a child's sense of trust in their parent's ability to protect them. Additionally, babies also have minimal skills to communicate or cope with pain or strong emotions, making them highly dependent on their parents/caregivers to help them feel safe and secure and to regulate their emotions.

This period is also when separation anxiety and fears of 'strangers' or unfamiliar people develop. Babies may therefore be more aware of and frightened by separations from their caregivers and react fearfully around strangers. In the early stages after a trauma, it is therefore best to minimise separations from parents wherever possible.

Psychological reactions to trauma

- Heightened arousal (e.g. disturbed sleep, jumpy or easily startled, hard to settle or soothe).
- Changes in appetite (e.g. fussy eating, no appetite).
- Regression in previously acquired developmental skills (e.g. rolling over, sitting, crawling).
- Decrease in vocalisations (e.g. less babbling or cooing).
- Behavioural changes (e.g. increased irritability, extreme temper tantrums, fussiness, attention-seeking, aggressive behaviour).
- Excessive clinginess to primary caregiver (e.g. crying upon separation, insisting on being picked up).
- Clinginess to anyone – even complete strangers.
- Decrease in responsiveness (e.g. lack of emotional responses, numb appearance, lack of eye contact, little interest in environment/objects around them).
- Inconsolable crying.
- Alarmed by reminders of the event (e.g. sights, sounds, smells).

Optional handout: First responder fact sheet 1 – trauma responses in children aged 0–24 months

Toddlers and preschool children (2–4 years)

Developmental considerations

Toddlers and pre-schoolers are also highly dependent on their caregivers to help them feel safe and secure and to help them understand and cope following a disaster. Preschoolers become more aware of how others think and feel and are therefore likely to notice and be sensitive to how their family members are responding to the event. Due to their limited physical, cognitive and emotional skills, they lack the ability to protect themselves and can feel helpless and powerless. Toddlerhood also represents a time where children are struggling to gain a sense of autonomy and are learning new skills. Following trauma, toddlers may regress or show a delay in acquiring new developmental skills.

Young children will also often recreate parts of the event through their play or drawing. In addition, they may experience increased physical symptoms (e.g. tummy pains) and often remember negative images of the disaster during quiet times, rest times and bed times. They often seek to avoid the unsettling memories by 'misbehaving' at these times, protesting separations and/or seeking out additional closeness with their caregivers.

Preschoolers are particularly vulnerable following a traumatic event as they are more likely to develop false assumptions about its cause. For example, because they are egocentric (which means they find it hard to understand other people's point of view), preschool children are more likely to think, 'The flood happened because I was bad'.

Preschool children are also more likely to overgeneralise or catastrophise from the facts they have available. For example, they might think 'Our house blew away, so that means there must be no houses left at all'. They may not understand that conditions that led to the natural disaster are different to conditions today. This is also the stage of asking questions; there is a need to make sense of what is happening in their environment.

Children of this age may also have more difficulties understanding that loss is permanent. Due to their limited communication skills, they may not be able to explain what is upsetting them or understand why their parents are distressed. Therefore, younger children's responses to traumatic events tend to be more behavioural. Given that some of these behaviours are 'normal' during this stage and can be mistaken as the 'terrible twos', it is extra important to observe these behaviours closely to determine if they are within normal limits for the child's age or are new and indicating signs of distress.

Psychological reactions to trauma

- Heightened arousal (e.g. disturbed sleep, jumpy or easily startled by loud noises, difficulties concentrating, hard to settle or soothe).
- Changes in appetite (e.g. fussy eating, no appetite).
- Regression in previously acquired developmental skills (e.g. walking, crawling, toileting skills, talking like a baby, thumb-sucking).
- Loss of confidence.
- Appearing sad and withdrawn.
- Increased physical complaints (e.g. tummy aches, headaches).
- Behavioural changes (e.g. increased irritability, extreme temper tantrums, fussiness, attention-seeking, defiance, aggressive behaviour).
- Difficulty concentrating and paying attention.
- Aggression and/or angry behaviours toward themselves or others (e.g. head banging, hitting, biting).
- Reliving the trauma (e.g. traumatic play or drawing, nightmares, repeatedly talking about the event, asking questions repeatedly).
- Separation anxiety or excessive clinginess to primary caregiver or teachers (e.g. crying upon separation, insisting to be picked up, refusing to stay in room alone).
- Concern that something terrible will happen to primary carers.
- Clinginess to strangers.
- Development of new fears that are unrelated to the trauma (e.g. the dark, monsters, animals).
- Avoiding reminders and/or visibly distressed by reminders of the event (e.g. sights, sounds, smells, tastes, physical reminders).
- Decrease in responsiveness (e.g. lack of emotional responses; numb appearance; lack of eye contact; withdrawal from family, teachers and friends; less interest in play; restricted exploratory behaviour).
- Relationship difficulties with caregivers, siblings or peers.

Optional handout: First responder fact sheet 2 - trauma responses in children aged 2 – 4 years

Children aged 0–4 years

- Babies, toddlers and preschoolers are vulnerable to the negative effects of trauma.
- Trauma responses can vary greatly between individuals. First responders need to be aware of children who are exhibiting behaviour problems, as well as children who are quieter and more withdrawn.
- Behavioural expressions of trauma (e.g. tantrums, aggression, hyperactivity) may be misinterpreted as 'bad behaviour', ADHD or oppositional behaviour.
- Babies, toddlers and preschoolers are particularly at risk of adverse outcomes if they witnessed threat to their parent/s, were separated from their parent/s or if their parent/s reports significant psychological distress.
- **Early intervention is recommended to ensure that the behaviours do not become ingrained and the child continues to thrive and maximise their developmental trajectory.**

Children aged 5–12 years

Developmental considerations

After a trauma, children often feel out of control and overwhelmed. They are more likely to worry about the event and develop fears related to what happened. School-aged children have more coping skills available compared to preschoolers, but they will still observe adults to determine how serious the situation is and will often copy their responses. They may discount verbal explanations if what they observe, and notice does not match up with what adults are telling them. They will also use their imagination to 'fill in the blanks' when they do not have realistic information.

Psychological reactions to trauma

Middle childhood is a period of exploration and learning; however, children are still dependent on their parents to provide a safe and nurturing environment. Exposure to disaster can undermine the child's confidence, and post-trauma reactions may interfere with their cognitive abilities, such as memory and attention. As a result, deficits in knowledge may emerge in the months or years following trauma exposure.

Trauma responses that may commonly be exhibited by children in this age group include:

- Intrusions (e.g. distressing memories that pop into their head during the day; nightmares; emotional and physical distress around reminders; repeated discussion about the event; re-enactment of trauma in play).
- Avoidance (e.g. refusal to participate in school activities related to the disaster, refusal to talk about the event, memory blanks for important aspects of the event).
- Changes in arousal and reactivity (e.g. increased irritability and anger outbursts; difficulties concentrating; being overly alert and wound up; increased nervousness and jumpiness; sleep disturbance).
- Changes in mood and thinking (e.g. appearing flat, no emotion related to event, loss of interest in previously enjoyed activities).
- Emotional distress (e.g. self-blame and guilt, moodiness, crying and tearfulness).
- Behaviour changes (e.g. angry outbursts, aggression, non-compliance).

- Decline in school performance resulting from non-attendance, difficulties with concentration and memory, lack of motivation.
- Increase in physical complaints (e.g. headaches, stomach aches, rashes).
- Withdrawal from family and friends.
- Changes in appetite (e.g. fussy eating, no appetite).
- Anxiety and fear of their own and others' safety (e.g. increased clinginess)

Children aged 5–12 years

- Children aged 5–12 years are vulnerable to the negative effects of trauma.
- There can be tremendous individual variability in trauma responses.
- Post-trauma reactions may interfere with the child's cognitive abilities such as memory and attention. As a result, deficits in knowledge may emerge in the months or years following trauma exposure.
- **Early intervention is recommended to ensure that the behaviours do not become ingrained and the child continues to thrive and maximise their developmental trajectory.**

Optional Handout: First responder fact sheet 3 – trauma responses in children aged 5–12 years

Optional Activity 3: Reflection and discussion: Child trauma responses (5–12 years) (10 mins)

Parenting and environment post-trauma

A post-trauma or post-disaster environment may mean some parents and other caregivers are unable to provide basic needs such as food and shelter. A post-trauma environment may also be disorganised and unpredictable due to moving house, changing schools, lack of familiarity with surroundings at home/school, or living in conditions that require sharing and are possibly overcrowded.

Parents are also at increased risk of experiencing adverse psychological outcomes and may develop ineffective parenting behaviours following a disaster. Anxious parents may become more restrictive or overprotective in their parenting (e.g. not allowing the child out of their sight) or may incidentally model their fear responses and maladaptive coping responses to their child. Parents suffering from depression may become more emotionally withdrawn, unresponsive and/or unavailable and therefore may not be as able to help their child to process and cope with distressing trauma symptoms and experiences.

These changes in parenting style and environment may have a negative impact on the parent-child relationship; further exacerbate behavioural and emotional difficulties; or contribute to a child's belief that the world is a dangerous and unsafe place. It is therefore important to be aware of how parents are coping with the disaster and whether they would benefit from additional support.

Summary

Every young person reacts differently to traumatic events and most children will cope well following trauma. Some children will be distressed but recover fairly quickly. For others, symptoms continue and may even increase over time, resulting in academic, social, emotional and behavioural problems.

A child with symptoms that continue in the long-term, increase in intensity or interfere with the child's functioning may require intervention. Fortunately, there are now a range of evidence-based assessment tools, prevention and intervention programs available that can prevent or minimise the negative repercussions of trauma.

Part 2: The role of first responders in children's recovery

The aftermath of a natural disaster or community trauma can be overwhelming, confusing and difficult for all community members. Reactions will be at their most intense immediately afterwards and children (and adults) will have different ways of dealing with the 'big' feelings they experience. Children may be particularly affected as their belief that the world is a safe place, or that adults would always be able to protect them, may have been shaken or lost.

Community members will look to first responders for guidance, reassurance and advice about what to do and what is going to happen next. While trained to undertake vital post-disaster practical tasks, first responders are also key to supporting the social and emotional wellbeing of the members of their community, including children.

Research indicates that the chances of children having ongoing difficulties are significantly reduced if they receive support, comfort and reassurance from the adults around them at the earliest possible stage post-disaster. First responders may be one of the first adults that a child encounters after a natural disaster. Even if this contact is brief, simply by doing their job, remaining calm, acting in a controlled manner and displaying good coping skills, first responders will help minimise stress and anxiety in any children they encounter. In addition, the application of some simple strategies, known as 'Psychological First Aid', will greatly assist children to regain a sense of emotional and physical safety following a natural disaster.

Psychological First Aid

Psychological First Aid (PFA) is a set of strategies to assist and protect people in any emergency which has threatened their lives or wellbeing. Endorsed by the World Health Organisation, PFA is based on the principle of 'do no harm' and is a proven approach to helping people affected by an emergency, disaster or traumatic event. Although the principles can be used anytime, PFA is most widely used in the first hours, days and weeks following emergencies, when those affected by a disaster will be experiencing a range of early reactions that may interfere with their ability to cope.

Just like physical first aid, PFA includes basic, common sense principles of support to promote positive recovery, such as helping people to feel safe, connected to others, calm, and hopeful, while also encouraging people to regain control and self-efficacy. PFA supports natural recovery by helping people identify their immediate needs, and their personal strengths and abilities to meet these needs.

While many first responders have been trained in Psychological First Aid, it is important to remember that children and babies have unique needs. Psychological First Aid therefore needs to be applied in the context of these needs.

One of the most important research findings is that a person's belief in their ability to cope can predict their outcome. PFA supports recovery by helping people identify their immediate needs and their strengths and abilities to meet these needs.

Psychological First Aid for children

When confronted with an overwhelming or frightening event, children, babies and toddlers in distress may shake, babble, scream, cling, cry and/or be completely inconsolable.

They may be completely silent, non-responsive and seem zoned out or frozen. They may swing rapidly between different behaviours. They are likely to be deeply afraid and highly anxious and will have an overwhelming need to feel the protection, safety and comfort of the most important and familiar people in their lives, such as their parents, extended family and other caregivers. They will rely on the adults around them to help them manage and make sense of the world around them.

Regaining a sense of emotional and physical safety, comfort, calmness and security can limit the adverse impacts of trauma upon children and greatly assist with resilience, recovery and wellbeing.

The key words used to inform Psychological First Aid for children in a disaster or other emergency are:

- Listen/Look
- Protect
- Connect

Key PFA strategies to support children after a traumatic event or disaster include:

1	2	3	4	5
Ensure safety	**Keep calm**	**Connect with others**	**Encourage self-efficacy**	**Have hope**
Remove the child from, or reduce exposure to the threat of harm.	Provide a calm environment, away from stressful situations or exposure to sights, sounds and smells of the trauma event.	Keep families together and keep children with their parents or other close relatives whenever possible.	Help families to identify their own strengths and abilities to cope.	Reassure the child that their feelings are normal, but assure them that things will be ok.

Ensure safety – Make children as physically safe as possible and do not leave unattended. Look for a quiet place where there are other people who are calm. Protect them from the media or from people who want to talk to them who are not part of the emergency response.

Keep calm – Speak in a low, calm voice and try to manage your own responses - quiet conversation will help a child to settle and feel safe. Explain what has happened using clear facts and, if possible, what will happen next. Answer questions and concerns with honesty, but without details that may be graphic or frightening for younger children. Tell children they are safe (when this is the case). Tell them that they have you and other adults looking out for them and that they will be with their families soon. Where possible, protect children from being witness to any gruesome scenes (e.g. death, injury, mass destruction). Try to keep them away from other distressed adults and people who are talking about what happened.

Connect – As soon as possible, connect children with something familiar – a person, a place, an object. Familiarity and routine help children to establish and maintain recovery. Babies and children have an overwhelming need to feel safe in frightening situations, so it is important to reunite children with their families and loved ones as soon as possible after a disaster or traumatic event. If this is not possible, try to keep in regular touch by any means available (e.g. phone, text, private message, email).

Self-efficacy – Where practical, encourage children to meet their own needs. For example, if children are agitated consider redirecting their attention to any calming strategies you've used before. An effective approach may be to ask them to help you.

> *'Hey, I'm feeling a little bit anxious. What do you think could help me calm down?'* (Prompt children to help access a strategy and then ask them to practise it with you.) *'Slow breath – what an excellent idea! Will you guys help me? Let's try 'Snake breath'. Let's breathe in through our nosesssssssss and hissssssssssssssss.'*

Alternatively, consider giving them small tasks they can assist with (e.g. filling water bottles, carrying blankets) and acknowledge/praise their assistance. 'Thanks, that's great helping. I wouldn't have been able to carry all these water bottles without your help!'

Reassure – Be mindful of children's needs and reactions and be responsive to them. Reassure the child that their reactions are normal and will pass in time. Be gentle and accept all responses. Don't tell them to 'be good', 'stop being silly' or to 'be brave'. Remember that most children will need time for their natural resilience to emerge and develop, and will need additional support, care and sensitivity from adults to help this process along. If passing time with children, try to involve them in play activities (e.g. singing, drawing, slow breathing) or simple conversation about their interests, according to their age. Some children may require physical touch for reassurance such as hugs, holding hands or leaning on you. Quiet conversation and singing can also help to reassure them that they will be ok.

Don't forget to look after yourself

As a first responder supporting children during a disaster, the delivery of psychological first aid can be very rewarding – however it can also be very challenging and stressful. It is important to remember that to support children in times of crisis, you need to support yourself.

If you need a moment away, ask for someone to help look after your responsibilities for a moment and take some time to breathe. If food and drink is available, take some time to eat, drink and talk with other calm adults. Use coping strategies that have previously worked for you (e.g. slow breathing, meditation, a hot cup of tea, physical movement/stretching) to assist in reducing your own sense of stress and anxiety. Remember, children can pick up if you are upset or stressed, which can sometimes frighten them more. Remaining calm and looking after yourself will ensure that the children in your care feel as safe and secure as they can in the circumstances.

During and immediately after a natural disaster, the application of PFA is widely endorsed as being best practice for assisting children (and adults) to respond to and recover from an emergency.

Additional reading:

For more resources about PFA refer to the **Resource Matrix**.

Optional activity 4: Calming strategies: Breathing exercises (5–10 mins)

Communicating with children during a disaster

Children look to adults to guide them in how to behave in unfamiliar situations, so a positive outlook, encouragement and reassurance are essential to supporting recovery after a natural disaster. Some other key tips include:

- **Get down to eye level with the child**. If the child does not make eye contact don't try and make them.
- **Communicate calmness and reassurance** through calm body language, vocal tone and gestures. Speak in a confident and lower-pitched voice.
- **Avoid saying things like** 'don't be sad/angry/worried/upset' to reassure a child or baby. Being told not to feel a certain way may invalidate the child's feelings and leave them feeling embarrassed or misunderstood.
- **Use words and concepts children can understand**. Tailor explanations to the child's age, language, and developmental level. If the child is old enough to speak, try and model your language off the language of the child. If the child is not speaking yet, still talk to them. They may not have the words, but they will be listening and responding to your voice and body language cues.
- **Don't force children to talk if they don't want to**. Even if they are not talking, they will be listening. Let them ask questions or make comments in their own time.
- **Children may want to go over the ideas more than once**. Acknowledge the child's thoughts, feelings and reactions and let them know that their questions are important and appropriate. Asking the same question over and over may also be a way for children to ask for reassurance.
- **Model positive coping skills** like using humour, positive statements, and problem-solving behaviours and encourage children to use these skills as well.
- If the opportunity presents **offer praise** and **acknowledge and reinforce children's strengths, good behaviours and coping strategies:**

  'Hey, thanks for helping me carry the blankets. You've very strong'.

  'Great job. Yes, you got it. Hold on tight'.

Optional handout: 'Psychological First Aid for children' available here

After the disaster – Short and long-term Recovery

It can take many months, and even years, for families and communities to find a 'new normal' after a disaster or traumatic event. Children, especially, need adults in their lives to help them when memories of the disaster, or big feelings like sadness or anger, come up for them - and they may display a variety of behaviours for a long time after the event. This is their way of coping.

First responders are often highly visible in the community due to their equipment, vehicles and uniforms. This attracts the attention of children and can provide additional opportunities for first responders to support children in their wellbeing and recovery in the weeks and months immediately following a disaster. Opportunities to connect with children include:

- a simple wave or smile.
- getting involved in preparedness activities and presentations in your community.
- providing the children you speak to with age-appropriate information about what you are doing, and how this will help their community.
- providing reassurance about how the adults are trained and experts at post-disaster recovery and are all working to keep the community safe.
- letting parents know that children can ask you questions, and you will do your best to answer them; and
- partnering with schools to provide opportunities for education and support around disaster preparedness and recovery and help children to connect and feel safe and supported within their wider community.

A note of caution (!)

In the weeks and months following a disaster, reminders of the event such as the sights and sounds of emergency vehicles and even uniforms can prompt distress or fear in children. If this occurs, give the child some space and help them name and give words to their feelings:

> *'Oh, I think the sounds of the sirens made you feel a little scared. Let's turn them off.'*
>
> *'I wonder if seeing all of us adults in uniforms reminds you of the scary times when the waters got really high?'*

Community events can provide an opportunity for first responders and the whole community to connect, giving children a chance to interact with first responders in a fun environment, rather than just linking them with the frightening event.

Summary

First responders do not have to spend long with a child to have a significant impact on their recovery. Simple strategies such as a reassuring word, modelling calmness and positive coping, and providing information about 'what happens next' can make a difference to a child during and after a natural disaster event.

Part 3: First responder self-care

Optional activity 5: Brainstorming: How do you normally take care of yourself? (5 mins)

First responders have many roles in the community and are often faced with confronting and distressing situations – including the trauma of others. It can be challenging to be continuously looking after the needs of others, leaving first responders feeling physically and emotionally 'worn out' and with little left to give in terms of understanding or support for personal relationships. This is often referred to as 'compassion fatigue'.

For those who reside within the community in which they are responding to a natural disaster, it is very likely that the first responder will be affected themselves in their 'everyday' life, potentially compounding their sense of exhaustion and distress. Such reactions are not a sign of weakness. Rather, they are the cost of caring for and helping others.

Exposure to trauma is an occupational hazard for first responders and emergency services workers. It is therefore critical that first responders practice self-care and know the signs that trauma is taking a toll.

Signs that may indicate distress/secondary traumatic stress:

- decreased concentration and attention.
- increased irritability or agitation with the people around you.
- problems planning and maintaining routines
- generalised fear.
- intense feelings, intrusive thoughts or dreams about trauma that you witnessed (that don't reduce over time).
- feeling a lack of control or hopelessness.
- feeling nervous or tense all the time, or feeling flat and detached.
- relationship conflict and/or intimacy issues.
- feeling numb.
- drinking more than usual.
- increased substance use (e.g. tobacco, drugs).
- making simple mistakes or forgetfulness.
- experiencing more workplace conflict. than usual.
- symptoms that don't improve after a couple of weeks.

At its most severe, first responders' feelings of physical, emotional and 'spiritual' exhaustion may combine with other traumatic symptoms creating 'secondary traumatic stress' – which can lead to adverse outcomes not only for the first responders, but for the victims they seek to help. If symptoms persist for more than a month, professional assistance should be sought.

Evidence indicates that first responders who look after themselves and manage their own stress levels are better equipped to work effectively in the community, while first responders who experience strong and lasting emotional reactions will find it harder to react in calm and constructive ways to children who are demonstrating difficult behaviours.

First responder self-care incorporates:

- identifying when you are stressed.
- managing stress levels and emotional reactions.
- using helpful coping strategies.
- linking into peer supports.
- maintaining a healthy lifestyle.
- seeking opportunities to reflect on your experiences with your professional colleagues; and
- making time for yourself, family and friends.

Tips for first responder self-care

- **Monitor your own reactions**, emotions and needs.
- **Avoid over-identifying with the person being assisted.** Be aware of unhelpful internal language like, *'What if that happened to my child (parent, sister, etc.).'*
- **Seek out support.** If signs persist for longer than two or three weeks, it might be a good idea to seek further assessment or assistance from a health professional (or via Employee Assistance Programmes if they are available).
- **Find and engage your emotional support system** (e.g. friends, family, colleagues). Talk to other first responders, ask for support from your line managers and trusted colleagues, work in teams, and establish or maintain your external support systems.
- **Seek help for your own trauma-related distress.** Just like children, first responders may also need to seek further assistance to help manage emotions and reactions following traumatic events. First responders who were also involved in the trauma or who have other unresolved traumatic experiences are at greater risk of developing 'compassion fatigue'.
- **Use positive coping strategies to manage emotions and distress.**
  - Try out calm breathing techniques, muscle relaxation, or relaxing imagery.
  - Challenge unhelpful thoughts that cause you distress. Try and generate more helpful thoughts and positive coping statements.
  - Look for resources to help you try new coping strategies. There are many good books, CDs, YouTube videos, websites and apps that can teach you calm breathing, relaxation techniques and how to challenge your unhelpful thoughts.
- **Maintain a structured life.**
  - Be prepared, plan ahead, create certainty
  - Schedule relaxation or quiet time each day.
- **Maintain a healthy lifestyle.** Practice good eating, exercise, relaxation and sleeping habits. First responders who maintain a healthy lifestyle are better able to manage their own stress reactions and respond effectively to children's reactions and difficult behaviour.
- **Make time for yourself, family and friends.** Actively schedule events rather than waiting for opportunities.
- **Challenge unhelpful thoughts that cause distress.** Substitute with helpful (and realistic!) thoughts and coping statements instead (e.g. Substitute *'I can't do anything right'* with an opposing statement like *'I know how to do this, I've just got to have a little patience'.*)
- **Use positive coping strategies** (e.g. breathing techniques, muscle relaxation, imagery.) There are lots of resources and apps available online.
- **Maintain a balance between professional and personal lives, with a focus on self-care** (e.g. relaxation, exercise, stress management, etc.) to prevent and lessen the effects of workplace stress.
- **Connect with others** by talking about your reactions with trusted colleagues or others who will listen.

Self-care is particularly important in the context of the ongoing and often long-term stressors associated with rebuilding a community after a natural disaster.

Optional activity 6: Create a self-care plan (10–15 mins)

Self-care plan example

Self-Care Plan

This planner can help you to identify your own personal signs of stress and plan strategies that may help you to manage your own stress and emotions.

Emerging Minds.

What are your personal signs of stress? What are the signs that might tell you that you need to take some time to care for yourself? (E.g. irritability, decreased concentration, withdrawing from friends/activities)	My personal signs that might tell me I am becoming stressed or finding it difficult to manage are: • feeling edgy or restless • losing patience easily • difficulty planning things • I stop seeing friends/family as much • I stop doing exercise • I get irritated more easily • I have difficulties sleeping
What strategies can you use to manage stress? Be as specific as possible. (E.g. 'practice abdominal breathing for 10 minutes', 'talk to my partner', 'go for a run').	The strategies I would be able to use to manage stress include: • exercising each day for at least 20 mins • talking to my partner about how I am feeling • using my mindfulness app to help me 'calm and centre' • identifying unhelpful thoughts and replacing them with helpful thoughts.
Who can you call upon for support? Try and identify multiple people in different areas. (E.g. family, friends, colleagues)	If I need extra support, I can ask/talk to: • partner • friends • family • trusted work colleagues.
What enjoyable activities can you include in your routine over the next month? When? Try to make a list of various activities (big and small). Then schedule them into a Pleasant Events Schedule.	The activities that I will try to include in my routine (and stick to!) are: • going for a 30 min run, three times a week • seeing a movie with my partner • taking the kids to the beach for a swim on the weekend • taking 10 mins for myself to have a coffee and read a book.

Where can first responders find more information and help?

When first responders are concerned with their own emotional wellbeing or feel as though they might benefit from further assistance, there are numerous ways in which they can seek help. First responders will have access to a range of internal supports through their parent organisation. External to their organisation, first responders may choose to visit a general practitioner, psychologist, counsellor or mental health service (where available) and in some occasions may have access to such services as part of their employment (Employee Assistance Programmes).

However, there are now also many excellent online self-help resources that can be useful for adults who would like some help in managing their emotions, maintaining a healthy lifestyle or generally adjusting following traumatic or difficult situations.

Apps

Headspace

Guided meditation and mindfulness.

https://www.headspace.com/headspace-meditation-app

Stop, Breathe, Think

Check in with how you're feeling, and try short activities tuned to your emotions.

https://www.stopbreathethink.com/

Colorfy

Anxiety management tool using colouring therapy.

http://www.colorfy.net/

Online resources

e-couch – Offered by Australian National University:

e-couch is an interactive self-help program with modules for depression, generalised anxiety and worry, social anxiety, relationship breakdown, and loss and grief.

www.ecouch.anu.edu.au

MoodGYM – Offered by Australian National University:

MoodGYM is an interactive web program designed to prevent and decrease depressive symptoms. Although it was designed for young people, it is helpful for people of all ages.

www.moodgym.anu.edu.au

Black Dog Institute

The Black Dog Institute is a not-for-profit educational, research, clinical and community-oriented facility offering specialist expertise in depression and bipolar disorder.

www.blackdoginstitute.org.au

beyondblue – the national depression initiative

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders in Australia.

www.beyondblue.org.au

MindSpot

Online assessment and treatment for anxiety and depression. MindSpot offers free, therapist-guided digital mental health treatment.

www.mindspot.org.au

Part 4: The first responder as a parent

Activity 7

Case Study 1:

Meet Hudson, 6 months

Matthew is a 38-year-old firefighter who has been out assisting in the clean up after a fire destroyed several properties in their local area.

'When I got home my kids were jumping all over me and I just wanted some space. When I walked off the little one threw a wobbly and started yelling and crying at me. I couldn't believe it. Here she is, with everything she could want around her, being a brat. While I've spent my day with a family who have lost everything... I was so angry I just stormed out.

Later my wife and I chatted about it, she said something that made sense. She said that the kids don't know what I see every day, and that is a good thing. They don't know what horrible things happen to other kids, and they shouldn't have to yet.

She's right. I don't want them to know what I know. They're only tiny. So, I suppose I can't get cranky with then for not getting it and for being kids. I'm lucky the worst they have to deal with is arguments over toys or bedtimes. It's easy to lose perspective I suppose.'

While children are often full of pride for the role their loved ones play in the community as first responders, they are usually also very aware of the dangers involved. It is important to give children information and support so that they don't have to deal with their feelings on their own. During a disaster or emergency, first responders tend to focus on the community at large. However, it is important to give attention to the children within your own family/network at these times.

First responders are often faced with confronting and distressing situations. Returning to family life can be very difficult, where day-to-day challenges and issues may seem irrelevant or inconsequential compared to the trauma and destruction witnessed in the workplace. First responders can struggle with physical, mental and emotional exhaustion (i.e. 'compassion fatigue') and may keep themselves separate from their families and preoccupied with other priorities.

When parents are emotionally 'unavailable' to their children, children's behaviour can escalate and become increasingly demanding as they seek attention and try to get their needs met. This may manifest in more challenging behaviours, defiance or emotional outbursts. In turn, first responder parents may respond by feeling frustrated and seeing this as inappropriate, 'attention-seeking' behaviour. In reality, what may be happening is children are seeking parental support, comfort and help in managing their own 'big' feelings.

Supporting your family during a natural disaster response

On departure

Wherever possible, first responder parents who are called upon to respond to a natural disaster event should seek to provide their children with age-appropriate information about:

- who will take care of them
- where they will be taken care of; and
- when to expect your return (as much as you know).

Try and take some time to answer any questions they may have and provide reassurance that the adults involved (including yourself) are trained to respond to these situations.

Help children to cope with anxiety in your absence by reminding them of things that they can do if they are feeling worried or overwhelmed (e.g. calming activities, deep breathing, listening to music, colouring in, or whatever you know helps them keep calm).

On return

- Check in with your children and try to take some time to answer any questions they may have.
- Help them if they are feeling worried or overwhelmed, using age-appropriate 'calming' activities (e.g. deep breathing, listening to music, reading a story together, colouring in, playing with blocks).

It is also important for first responder parents to be mindful of the presence of their children when discussing the incident with a partner or other adults. Avoid discussing incidents of death, destruction or loss within children's hearing. Remember, **children can be traumatised by an event even if they have not witnessed it**. If children do overhear a conversation that might be distressing, parents should take the time to sit with them and clarify the context, answer any questions they may have and reassure them they are safe.

As the impact of natural disasters tend to require ongoing work in the aftermath, you may need to repeat the procedure with your children every time you depart and return, and regularly check in with them during longer periods at home together.

It is very important for first responder parents to be aware of their children when discussing the disaster with their partner or other adults. Children can be traumatised by an event even if they have not witnessed it. Avoid discussing incidents of death, destruction or loss within their hearing. If children do hear or see any information that may be distressing, take time to check in with them, clarify context and reassure them.

Ongoing support

Just like any other child who experiences a natural disaster event, the children of first responders may need ongoing support and reassurance in the months, even years, after a disaster or traumatic event. This reassurance may be needed regardless of whether children experienced the event directly or were involved vicariously through their parent first responder. While most children do recover in time from an experience with a natural disaster, ongoing difficulties can continue to challenge some children. It is important that children are given parent's time and support to assist with recovery.

Tips for ongoing support

- **Listen and attend to your child carefully.** Speak to your children about how they are feeling after the event. Check in with them over time; shorter conversations that happen regularly are better than one-off chats. Allow them to ask questions about your role as a first responder and take their worries seriously. Tell them that it can take a long time to feel better after a frightening event and that they can talk to you about this. Set aside a particular time to catch up with your children, such as a weekly one-on-one walk or small activity.
- **Give children reassurance.** Let them know that it is normal to still feel upset after such a big event and that you are there to help them through this.
- **Continue to be on the lookout for changes in behaviour.** As the weeks go by, initial distress will begin to pass. However, if things aren't getting better, it is important to seek extra support for yourself and your child. As the months pass after the event most children will adapt to their 'new normal'. However, a significant minority of children will need extra assistance. *If you are worried about your child, please seek additional support. Your GP is a good place to start.*
- **Model the skills you want to see in your child.** Share with them about how you are coping. Be honest about how hard it has been for you and what has helped you. Let them know that with support and time, things will get easier.
- **Understand each child's unique needs.** Everyone experiences distressing events differently, including children within the same family. Talk about these differences together, focusing both on hard times and what is helping. Children can learn from this and see that it's OK to feel differently from others. Sometimes, children feel more comfortable talking to adults other than their parents, particularly if they think talking about the event is upsetting for their parents *(e.g. 'Every time we talk about the event Mum cries and Dad goes quiet')*.
- **Give your children extra time and attention.** This can be difficult when families are recovering and demands on adults are high. However, children need close personal attention to know they are safe. Time spent together doesn't have to be elaborate or lengthy, but the important thing is for children to feel connected to you and to know you can find time for them. If you are struggling to give your child the time and support you think they need, ask others for help. Children really benefit from close personal attention, particularly one-on-one. It could be a neighbour spending some time teaching your child about gardening, or a special weekly call from an uncle. **Don't expect perfection in yourself or your children.** If things have gone badly (i.e. you've lost your temper or broken down) that is OK. Speak with your children afterwards, apologise if necessary and reassure them that they are still safe and loved.
- **Help your children return to a normal routine.** It can be tempting to allow normal rules to slip but children do best when things are predictable, clear boundaries are set and followed, and they know what to expect.
- **Maintain (or establish) a connection with your child's day care or school.** This helps you to get a full picture of how your child is recovering. Sometimes, children can seem perfectly fine at home but display worrying behaviour at school (or vice versa).
- **Encourage children to maintain/re-establish their social connections.** Children may feel unsure about being away from you or worry about what to say if friends ask them questions about the event or they start to feel overwhelmed. Role play with your child(ren) ways to answer questions that help them feel secure and rehearse ways for them to seek help with their emotions. Begin with shorter play dates that grow longer over time and put a plan in place in case your children become distressed.

- **Have conversations about what has changed since the event**, including any unexpected positives. Acknowledging that there have been difficulties but focusing on new skills or strengths in the community, and in ourselves, can help us to feel more hopeful and in control.
- **Focus on strengths and hope.** It is really good for you and your children to do things that bring fun and a sense of achievement, and to plan things to look forward to.

Take care of yourself to take better care of your children

Children suffer if they are unable to connect and engage with their parents. Putting in place strategies for self-care is essential for all first responders.

Some essential tools for this include:

- linking into peer supports
- engaging in stress reduction activities; and
- seeking opportunities to reflect on your experiences with your professional colleagues.

For more information on first responder self-care, please refer to **Part 3 of this manual**.

Key points

- Parents often put themselves last, thinking this is best for their families; however, children are very sensitive to adults' wellbeing.
- Children can sense stress and suffer if parents are unable to 'connect' and engage with them.
- This often comes out in more challenging behaviours, which just makes things more difficult.
- Take care of yourself in order to take better care of your children.

Part 5: Appendix: Additional information and resources

Common severe stress reactions to a traumatic event

Note: The following information describes some of the possible difficulties children may demonstrate following exposure to various traumatic events. While every effort is made to ensure the accuracy of the material contained in this guide, the following information is not a substitute for independent professional advice or assessment and is not intended to be used to diagnose mental health difficulties.

Academic performance

Over time, some children may demonstrate a decline in academic performance. Although this could be due to a number of reasons, changes in academic performance can be linked to difficulties following exposure to a traumatic event.

Changes in academic performance following trauma may occur due to:

- difficulties completing homework tasks because of problems in the home environment (e.g. some children may not have returned to their home, may be staying with relatives, may not have been able to replace schoolbooks and resources, etc.).
- ongoing family difficulties (e.g. financial stressors, family conflict).
- ongoing medical issues resulting from the natural disaster which prevent the young person from completing schoolwork or attending school.
- difficulties sleeping (resulting from post-traumatic stress or anxiety) which interfere with the child's ability to concentrate at school.
- depressed mood or anxiety resulting from the trauma. Children who experience ongoing depressed mood or anxiety will find it difficult to concentrate and will find it hard to motivate themselves to complete schoolwork. Some children may require additional motivation and reinforcement.

Social or interpersonal difficulties

As previously discussed, following trauma, children may experience difficulty interacting socially and maintaining friendships. This may in part be due to other difficulties such as depression and anxiety, but can also be linked more directly to traumatic events. Children who have experienced traumatic events (particularly multiple events) may find it difficult to cope with interpersonal stress. For example, when faced with a difficult interpersonal situation (e.g. fighting with a friend, teasing, bullying), a child who has experienced something traumatic may respond differently to such situations (e.g. cry, withdraw) than they would have previously (e.g. using appropriate social skills to manage the situation). Thus, first responders and parents may find they need to intervene more often.

Over time, children may:

- start to withdraw from friends and classmates.
- get less enjoyment out of social activities
- fight more with friends.
- react negatively to minor interpersonal incidents.
- use inappropriate social skills or interaction patterns.

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress symptoms or Post-Traumatic Stress Disorder (PTSD) can develop after exposure to an extremely traumatic event in which the child experiences intense fear, horror or helplessness.

Children under 6 years

Children who are under the age of six and experience PTSD may experience some or all of the following symptoms:

Intrusive symptoms

- Recurrent, involuntary and intrusive distressing memories of the traumatic event.
- Recurring and upsetting dreams about the event.
- Flashbacks or other dissociative responses, where the child feels or acts as if the event were happening again.
- Strong and long-lasting psychological distress after being reminded of the event or after encountering trauma-related cues.
- Strong physical reactions (e.g. increased heart rate or sweating) to trauma-related reminders.

Avoidance symptoms

- Avoidance or attempted avoidance of activities, places, or physical reminders that arouse recollections of the traumatic event.
- Avoidance or attempted avoidance of people, conversations, or interpersonal situations that serve as reminders of the traumatic event.

Negative alterations in thoughts and moods

- More frequent negative emotional states, such as fear, guilt, shame or sadness.
- Increased lack of interest or participation in activities that used to be meaningful or pleasurable, including reduction of play.
- Social withdrawal.
- Decrease in the expression of positive emotions.

Changes in arousal or reactivity

- Increased irritable behaviour or angry outbursts. This may include extreme temper tantrums.
- Reckless or self-destructive behaviour.
- Hypervigilance, which consists of being on guard all the time and unable to relax.
- Exaggerated startle response.
- Difficulties concentrating.
- Problems with sleeping.

Children over 6 years

Intrusive symptoms

- Recurrent, involuntary and intrusive distressing memories of the traumatic event.
- Recurrent upsetting dreams about the event.
- Flashbacks or other dissociative responses where the child feels or acts as if the event were happening again.
- Strong and long-lasting psychological distress after being reminded of the event or after encountering trauma-related cues.
- Strong physical reactions (e.g. increased heart rate or sweating) to trauma-related reminders.

Avoidance symptoms

- Avoidance or attempted avoidance of distressing memories, thoughts or feelings about or associated with the traumatic event.
- Avoidance or attempted avoidance of people, places, conversations, activities, objects or situations that arouse distressing memories, thoughts or feelings about or associated with the traumatic event.

Negative alterations in thoughts and moods

- Inability to remember an important aspect of the traumatic event.
- Persistent and exaggerated negative beliefs about injury or death to self or others.
- Persistent distorted thoughts about the cause or consequences of the traumatic event that result in self-blame or blame of others.
- Persistent negative emotional states, such as fear, shame or sadness.
- Increased lack of interest in activities that used to be meaningful or pleasurable.
- Social withdrawal.
- Long-standing reduction in the expression of positive emotions.

Changes in arousal or reactivity

- Increased irritable behaviour or angry outbursts. This may include extreme temper tantrums.
- Reckless or self-destructive behaviour.
- Hypervigilance, which consists of being on guard all the time and unable to relax.
- Exaggerated startle response.
- Difficulties concentrating.
- Problems with sleeping.

It is important to understand that some of these signs are common for many children immediately following exposure to a traumatic event. However, if they persist or worsen over time they could indicate something more serious. If the signs remain evident after a month, it is possible that the child may require additional assistance to manage their difficulties.

Anxiety disorders

All children and adults experience anxiety. Anxiety is a normal and helpful response to threatening situations and helps prepare us for action. However, for some children, ongoing anxiety may interfere with social and/or academic functioning. Below are descriptions of some common anxiety reactions that children may demonstrate.

Separation anxiety

It is normal for children to want to be close to their family and friends. However, after a traumatic event some children may experience significant distress and fear when they are separated from loved ones, which can impact on their social and academic functioning. Children may also worry about the safety of loved ones or fear that something bad might force them to be separated. These worries can develop immediately following the traumatic event, or appear at a later date. At times, these children may be distressed on arrival to school, refuse to attend school camps or excursions, or complain of physical symptoms (e.g. nausea, headache) when separated from loved ones. These symptoms can persist over time and can develop into Separation Anxiety Disorder.

Although concerns over separation from loved ones and home is often expected immediately following traumatic events, these behaviours may begin to interfere with the child's and family's functioning if they continue over time. Such separation concerns can be developmentally appropriate (e.g. for younger children); however, one sign that the young person might need further assistance is if their distress over separation becomes inappropriate for their developmental level or age, or if it prevents them from engaging in age-related activities. For example, a 13-year-old boy who would not leave his mother to go to a friend's house for two hours may be missing out on having fun, building friendships, and seeing that he can safely be separated from his parents.

Sometimes it can be difficult to determine if the child's emotional responses are developmentally appropriate and consistent with the type of separation the child is experiencing (e.g. first school camp), or an emotional response to trauma. Professional assessment and intervention can be successful in distinguishing between trauma-related and normal emotional responses, and in managing anxiety.

Generalised anxiety

Other children may develop or demonstrate more generalised forms of anxiety following exposure to traumatic events. Generalised Anxiety Disorder (GAD) is characterised by excessive and uncontrollable worry or anxiety in which the young person overestimates the likelihood of negative consequences. For example, after hearing a weather forecast predicting rain showers, a young person may worry that there will be so much rain that the town will be flooded.

To some degree, all children who have experienced natural disasters will be on alert and occasionally may expect the worst when presented with similar circumstances. While this may be a natural reaction, children who develop GAD will experience such worry on a daily basis, often in the absence of direct evidence of a threat. Further, such children often tend to worry about a number of issues, and the worry persists over time (often over six months). Notably, these worries are not always related to the traumatic event the child has experienced.

Topics that children with GAD may worry about include:

- schoolwork
- being good enough in sports or other activities
- friends and social situations
- their own health or a family member's health
- finances, housing issues and family relationships
- new situations
- world events (including natural disasters, terrorism, news stories, etc.).

Children with GAD may also experience some somatic or physical complaints including muscle aches, tension, concentration difficulties, irritability, fatigue and difficulty sleeping. A lot of these symptoms overlap with signs of other psychological difficulties (e.g. ADHD, PTSD). One way of distinguishing between these difficulties is to find out what is causing the symptoms. For example, in the case of GAD, children may have trouble concentrating or sleeping because they are distracted by their worries, not because they are unable to concentrate or sit still (such as in ADHD).

A distinctive feature of GAD is that children have difficulty controlling their worry and/or they excessively seek reassurance from others. Children with GAD might ask first responders (and parents) many questions over the course of a day. For example, they may ask questions like 'What if I am late to class?', 'What happens if it rains at lunch time?', 'What if my mum is late picking me up?' etc. Children with GAD might also be worried about others in their class and how they might be affected by others' behaviours. Children with GAD often ask a lot of 'What if...' questions.

Panic attacks and agoraphobia

Panic attacks and agoraphobia are generally less common in childhood than adulthood. However, some children may develop panic attacks following exposure to a traumatic event, which can then cause the child and their family significant distress.

Panic attacks are characterised by a sudden onset of intense fear or discomfort, which is often accompanied by a sense that something bad is about to happen. Typically, such panic attacks occur without a specific trigger (i.e. outside of anxiety-provoking situations) and can occur anywhere, any time. Children may report such feelings as non-specific anxiety about suddenly becoming ill, or fears of suddenly vomiting that are difficult to control.

Panic attacks are also typically accompanied by sudden physical sensations that the child misinterprets as a sign that something is wrong, which in turn increases their anxiety. Physical signs include increased heart rate, chest pain, sweating, trembling, dizziness, breathlessness, nausea and choking. Although physical symptoms are common across the various anxiety disorders, in panic disorder the symptoms come on quite suddenly and are typically time limited (e.g. 15-30 minutes). Children with panic disorder may also experience agoraphobia, which occurs when the young person begins to avoid going to places where they believe a panic attack might occur (e.g. a shopping centre).

The difference between avoidance in agoraphobia as opposed to avoidance within PTSD for example, is that in panic and agoraphobia, the young person is not afraid of the situation itself or the memories associated with it. Rather, they are worried that they will have a panic attack in that situation.

Depression

Depression is one of the most common mental health problems experienced by children and can develop following exposure to a traumatic event. While many children who are involved in natural disasters may feel sad, moody and low at times following the event, some of these children might experience these feelings for long periods of time, experience quite intense depressed mood and/or frequently feel this way without reason. Some children may continue to experience depressed moods long after the traumatic event (e.g. a year later).

Children with depression might find it hard to function, have difficulty with their schoolwork, and may stop participating in activities which they previously enjoyed. Depressed mood may be a direct reaction to the child's experience of the disaster or it may be a result of accumulating stressors and events.

Behaviours that might be evident in children with depression:

- changes in mood or moodiness that is out of character.
- increased irritability, especially for teenagers.
- withdrawal from or difficulty in social interactions.
- withdrawal from previously enjoyed activities (e.g. participation in sports, drama, etc.).
- alcohol and drug use.
- staying home from school.
- failure to complete homework and class activities or a reduction in academic performance.
- changes in concentration levels.
- changes in sleeping routines; always seems tired or exhausted.
- presence of negative thoughts, inability to take minor personal criticisms.
- general slowing in thoughts and performance.

Down or depressed moods that have persisted for an extended amount of time and are concerning first responders and educators may indicate that the young person requires further assessment and assistance.

Behaviour problems

All children experience times when they are disruptive, have difficulty getting along with peers, or have difficulty following rules. After a traumatic event, children may be more argumentative, aggressive, easily annoyed and/or have difficulty following rules, managing their emotions (e.g. anger) and engaging in appropriate peer relationships (i.e. they may bully/annoy others). Sometimes the young person's behavioural difficulties may be more serious and include activities such as stealing, lying and/or running away.

For most children, these behaviours are transient and disappear over time. However, for some children these behavioural difficulties will persist over time, impact on others (e.g. first responders, classmates) and interfere with the child's social, academic and home life. For some, these problems can become more serious or even present as Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) or Conduct Disorder – which are often referred to as 'externalising disorders' or 'behaviour disorders'.

- **Attention Deficit Hyperactivity Disorder (ADHD)** is a disorder characterised by difficulty with attention and concentration. Children with ADHD may also have difficulties with impulsivity and regulating their behaviour.
- **Oppositional Defiant Disorder (ODD)** is characterised by oppositional, defiant or hostile behaviours towards peers and adults, particularly authority figures.
- **Conduct Disorder (CD)** is a more serious form of externalising disorder and may include overt aggression, difficulties with the law and a disregard for the rights of others.

Although some children may be demonstrating these behavioural disorders, for others, such behaviours may in fact be an expression of trauma-related difficulties.

Sometimes it is unclear whether or not the child's behaviours are reactions to trauma or if the child is experiencing independent behavioural difficulties (e.g. ADHD).

Unfortunately, some of the more common treatments for ADHD (e.g. medication) are unlikely to assist in managing behaviours that are trauma reactions. New difficulties and behaviour problems that arise after exposure to a potentially traumatic event should be investigated. Distinctions between trauma reactions and independent behavioural difficulties can be made through professional assessments and interventions.

Other problem behaviours

A range of other behaviours may also be expressed by children following traumatic events. These include tension-reducing habits such as:

- thumb sucking
- nail biting
- body rocking
- breath holding
- hair pulling
- stuttering
- nervous tics.

These may be of concern for parents, caregivers and first responders if they are excessive, if other children notice the behaviours, and/or if the behaviours interfere with the child's ability to function in day-to-day life. Behaviours which seem typical of children younger than the child (e.g. thumb sucking) may also be of concern.

Often these habits will resolve with time as the child recovers post-trauma. If these behaviours persist or cause distress or impairment to the child, family or their peers, seeking professional help may be advised. Behaviours that are still evident some months after the trauma are likely to require assistance.

Optional handout: First responder fact sheet 4 – common severe stress reactions to a traumatic event

Training module breakdown

Four modules of 45-60 mins each (depending on activities utilised by trainer and individual delivery pace). Flexibility to deliver as one full-day workshop, two half-day workshops or four sessions.

The delivery times (below) have been calculated as incorporating 15 mins of activities (i.e. 1–2 activities per session).

Module 1

Intro + Children and trauma

8 slides + 3 optional activities

Module 2

The role of first responders in children's recovery

21 slides + 3 optional activities

Module 3

First responder self-care

14 slides + 2 optional activities

Module 4

The first responder as a parent

11 slides

Additional information and resources for Appendix/ Facilitators Kit

- Presentation slides
- Fact sheets x 4
- Handout – PFA for children: http://tgn.Anu.Edu.Au/wp-content/uploads/2014/10/psychological-first-aid-for-children-and-adolescents_0.Pdf
- Activities list
- Blank self-care plan
- Resource matrix