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Mental Health and Psychosocial Care for Children Affected by Natural Disasters

This document offers guidelines to support humanitarian aid workers in their efforts to provide sensitive and appropriate care for children affected by natural disasters.

Part 1 is about effects of natural disasters on children
Part 2 is a WHO guidance on mental health in emergencies
Part 3 deals with specific interventions for children affected by disasters.

The manual is intended for humanitarian aid workers and health professionals, but is also addresses to teachers and parents.

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DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE

MENTAL HEALTH AND PSYCHOSOCIAL CARE FOR CHILDREN AFFECTED BY NATURAL DISASTERS

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(Contact: mnh@who.int)

MENTAL HEALTH AND PSYCHOSOCIAL CARE FOR CHILDREN AFFECTED BY NATURAL DISASTERS

This document contains information for humanitarian aid workers, health professionals, teachers, and parents to support them in their efforts to provide sensitive and appropriate care for children affected by natural disasters. An integrated, community-focused approach is adopted based on the principles and values of children's rights, child development, sensitivity to cultural differences, and effective practice based on scientific literature.

This document contains three parts:

Part 1: Effects of Natural Disasters on Children

- Impact of natural disasters on children
- Reactions by developmental age

Part 2: WHO Guidance on Mental Health in Emergencies

- Common problems in the provision of mental and psychosocial care to affected populations following disasters
- "Sphere" standard on mental health in emergencies

Part 3: Specific Interventions for Children Affected by Disasters

- Framework for helping children affected by disasters
- Interventions for pre-school aged children
- Interventions for school aged children
- Interventions for adolescents
- Potentially harmful interventions
- When to refer to a higher level of care

Part 1: Effects of Disasters on Children

The impact of natural disasters on individuals is substantial. Aside from the hardships of daily living, the survivors may experience injuries and be exposed to other distressing events including witnessing someone dying or being injured, seeing dismembered bodies or body pieces, being trapped under debris, or being separated from family (UNICEF; 2004). Survivors of disasters often experience a range of losses, including loved ones, their home, neighbourhood, and place of worship. Although distressing for all, children may be particularly affected by the loss of their familiar environment (home, school, peers), as children feel safe and secure when they have consistent and predictable routines in life. Disasters disrupt this sense of well-being by destroying normal life routines. Caregivers, during such times, are also often unable to give the care and comfort they provided before the disaster. This can cause anxiety, fear, and a great sense of

insecurity among children. Their worries and fears manifest themselves through a range of reactions which generally vary by age[1].

Pre-school children (0-5 years): Typical reactions can include crying, whimpering, and screaming. Non-verbal signs include trembling, and frightened facial expressions. Helplessness and passivity may be manifest by a fear of being separated from the parent, immobility and/or aimless motion, excessive clinging, and total withdrawal. Children may return to behaviors exhibited at earlier ages (these are called regressive behaviors), such as thumb-sucking, bedwetting, and fear of darkness. Children may not understand that the immediate danger is over, or may feel magically that what happened is a punishment for something they have done or thought. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event. Pre-school children have an incomplete understanding of death.

School aged children (6-12 years): School-aged children may show extreme withdrawal, disruptive behavior, and/or inability to sustain attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in children of this age. Also, the child may complain of stomach aches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depressed mood, anxiety, feelings of guilt and emotional numbing or "flatness" are often present as well. Children in this age group may feel a sense of responsibility for what has happened and express guilt and fear for the safety of others. Some may feel overwhelmed by all of the feelings they are experiencing.

Adolescents (13 and older): Adolescents may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and antisocial behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some youngsters are more vulnerable to the effects of extreme stressors than others. The impact of a traumatic event is likely to be greatest in the child or adolescent who had a pre-existing mental health problem, a history of prior trauma, greater exposure to the disaster and its aftermath, and those who lack family and peer support.

PART 2: WHO Guidance on Mental Health in Emergencies

Programs and services to children affected by disasters are often fragmented. Programs that provide a comprehensive and integrated model of care that cover a broad range of disaster induced problems are better suited to a natural disaster situation than those programs designed for a specific problem (e.g. Post-traumatic Stress Disorder [PTSD]). In response to challenges such as this, the WHO Department of Mental Health and Substance Abuse recently summarized its position with respect to principles and intervention strategies during and after emergencies (WHO, 2003).

[1] Adapted from NIMH (2001).

The WHO promotes a community-focused psychosocial approach to mental health care in disasters. The term 'social intervention' describes those activities that primarily aim to have social effects, and 'psychological intervention' for interventions that primarily aim to have a psychological effect. This distinction was made with the explicit acknowledgment that social interventions usually have secondary psychological effects and that psychological interventions may have secondary social effects. This approach addresses children's issues and needs in a holistic manner and places mental health interventions within a wider context such as education or health care. Table 1 provides an overview of the general guidelines outlined by the Sphere Standard (Sphere Project, 2004) for 'mental and social aspects on health,' which is supported by WHO. Although these interventions were designed for all populations, a recent literature review suggests that the interventions are relevant and important for children as well. Specific interventions for children based on their developmental level are provided in Part 3.

Table 1: Sphere Standard for Mental and Social Aspects of Health in Disasters: Key Social Intervention Indicators

Key Social Intervention Indicators[2]
1. People have access to ongoing, reliable flow of credible information on the disaster and associated relief efforts.
2. Normal cultural and religious events are maintained or re-established (including grieving rituals conducted by relevant spiritual and religious practitioners). People are able to conduct funeral ceremonies.
3. As soon as resources permit, children and adolescents have access to formal or informal schooling and to normal recreational activities.
4. Adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities.
5. Isolated persons, such as separated or orphaned children, child combatants, widows and widowers, older people or others without their families, have access to activities that facilitate inclusion in social networks.
6. When necessary, a tracing service is established to reunite people and families.
7. Where people are displaced, shelter is organized with the aim of keeping family members and communities together.
8. The community is consulted regarding decisions on where to locate religious places, schools, water points and sanitation facilities. The design of settlements for displaced people includes recreational and cultural space.

[2] Sphere Project, 2004, p.291

Table 2: Sphere Standard for Mental and Social Aspects of Health in Disasters: Psychological and Psychiatric Intervention Indicators

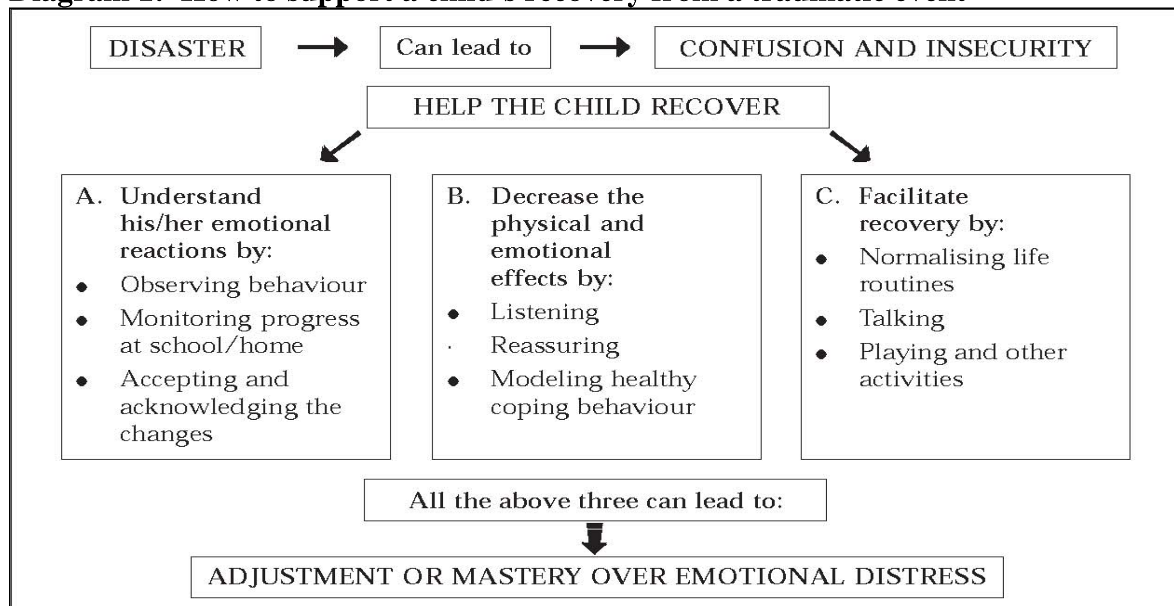
Key Psychological and Psychiatric Intervention Indicators
1. Individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health service facilities and in the community.
2. Care for urgent psychiatric complaints is available through the primary health care system. Essential psychiatric medications, consistent with the essential drug list, are available at primary care facilities.
3. Individuals with pre-existing psychiatric disorders continue to receive relevant treatment, and harmful, sudden discontinuation of medications is avoided. Basic needs of patients in custodial psychiatric hospitals are addressed.
4. If the disaster becomes protracted, plans are initiated to provide a more comprehensive range of community-based psychological interventions for the post-disaster phase.

Part 3: Specific Interventions for Children Affected by Disasters

In addition to the general guidance outlined above, which apply to all populations affected by extreme stressors, a framework for working with children is provided along with interventions that recognize the specific needs of children at different life and age stages. These stages distinguish particular capacities and vulnerabilities that must be addressed to relieve suffering, to potentially prevent disorder, and to reinforce cultural and communal protective factors that enhance positive development, while at the same time minimize risk and avoid further harm.

The following diagram (Diagram 1) outlines how to support a child's recovery from a traumatic event such as a natural disaster. It involves: (a) understanding the child's emotional reactions through observation and monitoring, (b) decreasing emotional distress by listening, reassuring, and modelling healthy behaviour for the child, and (c) facilitating recovery by normalizing life routines, providing a space for the child to talk about his or her feelings, and providing opportunities for the child to engage in play and other recreational activities.

Diagram 1: How to support a child's recovery from a traumatic event [3]



A. Understand and monitor child emotional reactions

When children face any traumatic event, they have both emotional and physical reactions. These reactions and feelings are normal responses and occur in most children who face an event that overwhelms them. Encourage parents, teachers, and other caregivers to keep a watch on the child and observe any changes in him or her.

B. Help reduce effects by offering emotional support and security to the child.

Talking about the event and allowing the children to share their experiences and feelings may help to decrease emotional distress. Encourage caregivers to be available for the child and create a space where the child can talk openly. This will rebuild his/her trust in people and help the child feel cared for and secure. Stress that it is important to be there for the child if he or she wants to talk, but **do not push the child to talk**. The child may not talk at all but may find it comforting to know that there is somebody who cares. **Avoid flooding the child with advice** – give the child space but not impose ideas of how to behave or react. Listen to his/her views and feelings. Re-assure the child that it is common to feel the way they do after such an event. Being available and offering reassurance to the child can help to restore a greater sense of safety and security.

C. **Facilitate recovery by modelling healthy coping strategies.**

The child will often be confused about what can help him/her. The first task is to normalise their life routines. Help them get involved in routine tasks like returning to school or engaging in recreational activities. Children will look to caregivers to learn how to cope with these incidents/events. Try to model healthy coping by acting with calmness,

[3] Drawn from RIOTS Manual (2002).

following regular sleep times, eating well, taking an interest in outside activities, and exercising regularly. Your lifestyle will enable the child to also develop these healthy coping strategies. The child will realise that you have normalised your life and will be motivated to do the same.

Suggested Support and Interventions by Developmental Level

Children's reactions will vary by age. In the tables below, common reactions found in different age groups are provided along with suggested strategies for providing support. Some of the interventions are relevant to all providers of care for children, while others are more specifically targeted at parents. The interventions aim to enhance children's feelings of protection and security, sense of control, facilitate attachment to caregivers and peers, and increase a sense of belonging to a wider cultural community.

Pre-school (ages 0-5)

It should be noted that distress levels among pre-school children often depend on the response and level of distress of the parents. Providing support for parents will also help to reduce distress in pre-school aged children.

Table 3: Pre-School (ages 0-5) Reactions/Behaviours and Suggested Interventions

Reactions/behaviours	Suggested support/interventions[4]	Examples of how to implement interventions
Helplessness and passivity	Provide support, rest, comfort, food, opportunities to play and draw	Establish a "child friendly space" - a simple demarcation of an area with a rope or stones can preserve a place for children to play that can later be turned into a playground or school.
Generalized fear	Presence of calm, supportive adult caregivers. Identify adult caregivers if child is without specific adult caregivers.	"Safety hand exercise" Ask children to draw an outline of their hand and then think of at least five people they can talk to or approach for help. Have the children draw a picture of the identified people above each of the fingers of the drawing.

[4] Adapted from Pynoos (1988).

Reactions/behaviours	Suggested support/interventions[4]	Examples of how to implement interventions
Cognitive confusion (e.g., do not understand that the immediate danger is over, may believe that death or illness is punishment for wrongdoing)	Give repeated, concrete clarifications.	Have parents, teachers, or trusted adults provide children with information about the disaster in simple, plain language.
Difficulty identifying what is bothering them	Provide emotional labels for common feelings following disasters (e.g., anger, sadness, etc.).	Provide art and play materials for children. Young children will often express their feelings through play and art rather than through words.
Lack of verbalization (selective mutism, repetitive nonverbal traumatic play)	Verbalize common feelings and complaints children may have after disasters (e.g., say something such as "children often feel sad that their home was destroyed").	As above. Do not force verbalization.
Attributing magical qualities to traumatic reminders	Separate what happened to them from physical reminders (e.g., seeing waves and thinking about the disaster will not cause it to happen again).	Shield children from the media and the constant coverage of the disaster which can be retriggering for the child and contribute to their confusion.
Sleep disturbances (night terrors, nightmares, fear of being alone at night)	Give the child extra time and reassurance at bedtime. Let him or her sleep with a light on or in their parents' room for a limited time if necessary. After a period of time, return to routine sleep patterns.	Plan calming activities before bedtime such as a bedtime storytelling. Choose a story that has a comforting theme.
Anxious attachment (clinging, not wanting to be away from attachment figures)	Provide consistent care and re-assurance (e.g., whereabouts of caretakers). Try to spend more time together as a family.	Establish a routine for the family or, at least, an anchor point when the family members are together during the day. For example, set aside daily family "play" or "talk" time.
Regressive symptoms (thumb-sucking, bed-wetting, baby-talk)	Tolerate symptoms in a time-limited manner. Do not criticize behaviour or shame the child with words like "babyish."	If children develop enuresis (bedwetting) be prepared to change clothes. Allow the child privacy, but not isolation.

Reactions/behaviours	Suggested support/interventions[4]	Examples of how to implement interventions
Anxieties related to incomplete understanding about death (expectations that the dead will return)	Provide culturally and developmentally appropriate explanations about the physical reality of death. Very young children may not have conceptualized the permanence of death and so consistent explanations must be given that do not lead to false hopes, but provide an explanation consistent with religious beliefs.	Encourage children to participate in cultural and religious grieving rituals. If they were not able to participate in community rituals, help them to find their own way to say goodbye to someone they have lost such as drawing a happy memory of them or lighting a candle and saying a prayer for them.

School age (ages 6-12)

Distress levels among school aged children will also often depend on the response and level of distress of the parents and other adults around them. To the extent possible caretakers should act with strength and calmness, which will provide children with a greater sense of security.

Table 4: School age (ages 6-12) Reactions/Behaviours and Interventions

Reactions/ behaviours	Suggested Support/Interventions[5]	Examples of how to implement interventions
Pre-occupation with their own actions during event (feeling responsible)	Provide a safe place for them to voice their fears and concerns. Offer re-assurance that it is not their fault.	Provide clear pictorial representations of what happened. For instance, tell about earthquakes and the tsunami drawing a wave, but do not show the actual wave or destruction with causalities.
Specific fears triggered by traumatic reminders	Help to identify and articulate traumatic reminders and anxieties; encourage them not to generalize.	Limit children's exposure to the media which can often trigger traumatic reminders.

[5] Adapted from Pynoos (1998).

Reactions/ behaviours	Suggested Support/Interventions[5]	Examples of how to implement interventions
Retelling and replaying of the event (traumatic play); cognitive distortions and obsessive detailing	Permit to talk and act out reactions. Address distortions, and acknowledge normality of feelings and reactions.	Provide art materials or paper for children to record their stories if they wish to do so.
Fear of being overwhelmed by their feelings	Provide safe space for them to express fear, anger, sadness, etc. in a supportive presence in order to not feel overwhelmed. Allow children to cry or be sad. Don't expect them to be brave or tough.	Provide art and play material for children. Also, encourage them to participate in structured activities (e.g., recreational activities) which will provide some structure to their days.
Impaired concentration and learning	Encourage children to let parents and teachers know when thoughts are interfering with learning.	Hold in-school sessions with entire classes, with smaller groups of students, or with individual students to provide factual and reliable information about the disaster and relief efforts. Also let students know that their fears and concerns are normal reactions.
Sleep disturbances (bad dreams, fear of sleeping alone)	Support them in reporting bad dreams; provide information about why they are having these dreams. Explain that this is natural under the circumstances.	Do not ask child to elaborate a bad dream but provide comfort. See sleep disturbances in previous table.
Concerns about their own and others safety	Help children to share their worries and reassure with realistic information.	Create a "worry box" where children can write out their worries and place them in the box. Set a time when the box will be emptied and the questions or concerns answered.
Altered and inconsistent behaviour (unusually aggressive and restless behaviour)	Help children to cope with the challenge to their own impulse control (e.g., "it must be hard to feel so angry").	Encourage children to engage in recreational activities and exercise to as an outlet for feelings and frustrations.

Reactions/ behaviours	Suggested Support/Interventions[5]	Examples of how to implement interventions
Somatic complaints - headaches, stomach-aches	Confirm whether there is a medical reason for the complaints. If not, provide support and comfort to the child and assure him/her that often children experience such symptoms. Do not reinforce the physical symptoms if satisfied that there is no reasonable reason for the complaint. Do not provide too much gratification in support of the complaint.	Exercise or breathing techniques can help relieve stress in the body. Example of a simple breathing exercise - take a deep breath and exhale to the count of five. Also, ensure that the child is getting enough sleep, water, and nutritious food.
Close monitoring of parents responses and recovery; hesitation to disturb parent with own anxieties	Be available to the child and provide them with the opportunities to talk about their feelings and worries.	Recognize when parents are having emotional difficulties and provide a referral for them to a mental health professional if necessary. Research shows children's responses often are a mirror of parents' difficulties.
Concern for other victims and their families	Encourage children to engage in constructive activities on behalf of the injured or deceased, but do not burden the child with undo responsibility in this regard.	Help children to form a "Children's Development Club" to help with the reconstructive efforts (Hart, 2002). Identify projects that are developmentally appropriate and meaningful (e.g., clearing rubble away from schools, etc.).

Adolescents (ages 13 and up)

Given the importance of the peer group to adolescents their reaction may be largely influenced by the response of their peers.

Table 5: Adolescents (ages 13 and up): Reactions/Behaviours and Interventions

Reactions/ behaviours	Suggested Support/Interventions[6]	Examples of how to implement interventions
Detachment, shame and guilt	Provide a safe space to discuss the events, their feelings, and realistic expectations of what can be done.	Establish a private space in a tent village where one can go to an "office" for discussion. Provide realistic information.
Self-consciousness about their fears, sense of vulnerability, and other emotional responses, fear of being labelled abnormal	Help them understand the adult nature of these feelings, encourage peer understanding and support.	Encourage participation in group based activities (e.g., sports teams, social groups) in order to facilitate peer social networks and support.
Acting out behaviour (e.g., using alcohol, drugs, sexual acting out).	Help them to understand acting out behaviour as an effort to numb their responses or to voice their anger over the event.	Limit access to alcohol and drugs. Use visual materials in camps to warn of dangers associated with alcohol, drugs and sex in young people. Explain clearly how alcohol and drugs can distort perceptions. If possible, use readily available AV products.
Life threatening re-enactment, self destructive or accident prone behaviour	Address the impulse towards reckless behaviour in the acute aftermath.	Try to identify through the development of a "calendar" or schedule a future orientation and goals.
Abrupt shifts in interpersonal relationships	Discuss the expectable strain on relationships with family and peers.	Engage parents in a discussion about parental roles in a crisis situation. Provide cognitive material for adolescents explaining possible parental reactions (e.g., "your parent is upset, do not take it personally." .
Radical changes in life attitudes which influence identity formation	Link attitude changes to the event's impact. When part of the acute response support idea that this is a natural feeling.	Provide adolescents with writing materials and paper and suggest that they may want to write about their experience and the impact it has had on them

[6] Adapted from Pynoos (1988)

Reactions/ behaviours	Suggested Support/Interventions[6]	Examples of how to implement interventions
Pre-mature entrance into adulthood (e.g., leaving school or getting married).	Encourage postponing radical decisions. Also, explore other ways that the adolescent can feel more control over his or her life.	Use posters and talks by respected individuals to suggest by example ways to be mature without taking actions that may be negative.

Potentially harmful interventions

1. **Ventilation techniques**: There is some evidence that ventilation interventions that stress emotional expression and the working through of traumatic memories in the absence of a trained mental health professional can increase distress and behaviour problems in children as it tends to raise anxieties (Paardekooper, 2002).

There is a difference between providing space for a child to express his or her feelings versus coercing the child to express his or her feelings. Being available for children to talk about their feelings provides them with a sense of safety and security. Coercing them to express or ventilate their feelings can be overwhelming to the child and increase their feelings of unsafety and insecurity.

Forcing children to draw, play, or act out their feelings related to the trauma can also be distressing to them. Children will often spontaneously act out or draw traumatic material. This is different than merely providing materials for them to draw or act out their feelings if **they choose** to do so. When children engage in spontaneous play it gives them the power to create, protect and destroy without harming anyone and this gives them a sense of control, which in their lives they may not have. By directing children to play or how to play, one may rob them of their sense of control, which is critical to the healing nature of play for children.

2. **Critical incident debriefing programs:** This is an intervention that involves reviewing trauma-related material in depth in the immediate aftermath of an incident. A growing body of research has suggested that debriefing methods are ineffective and potentially harmful (Mayou, Ehlers, & Hobbs, 2000; Rose, Bisson, & Wessely, 2002). Debriefing may be especially harmful in cultures where talking about psychological problems is not the expectation.

What to expect

Most children and adolescents, if given support such as that described above, will recover almost completely from the fear and anxiety caused by a traumatic experience within a short time period. When routines are established, caregivers identified and schools or educational programs initiated then one should see a positive response and a gradual return to a normal pattern of behaviour. A child may exhibit different behaviours in different surroundings. For example, more fear may be expressed at school if this was

where the child experienced the tsunami, but be more like him or herself in other settings. It is important to recognize when parents or caregivers are having difficulties so an intervention can take place with them, which in turn will help children. Children and adolescents by nature differ, and one cannot set out a specific expectation in terms of days or weeks. However, there should be evidence of a gradual reduction in anxieties, a lessening of sadness and other symptoms of depression over a period of days and weeks. This does not mean that all problems are ended, but that there is evidence of an emotional capacity to heal. In fact, grief over the loss of a loved one, teacher, or friend may take months to resolve, and may be reawakened by reminders such as media reports or the anniversary of the death. Failure to see positive changes increases the likelihood that a more formal intervention may be needed.

Indications for more intensive and specific psychological interventions

In the immediate aftermath of a traumatic event, and in the weeks following, it is important to identify the children who are in need of more intensive support and therapy because of profound grief or other extreme emotions. While sometimes screening tools are utilized in situations to identify those who are most symptomatic or "at risk" this is not essential and may be contraindicated when the screening tools are suggestive of negative reactions that may not be present. Use of individuals to recognize symptomatic children as indicated above is a practical and sensitive manner to proceed in virtually all circumstances.

Children and adolescents may require the help of a mental health professional if there is:

- **No sign of any reduction in the reactions:** In the days and weeks following a natural disaster as the community comes together and the family or caregivers are reconstituted children will gradually return to their normal behaviour. If after a period of approximately four weeks, the intensity of the reaction has not diminished, the child should be identified for further evaluation. The evaluation should first identify unresolved issues in the family context, for example, significant unresolved parental grief or increase in family discord. In the absence of these factors, the child should be seen one on one by a person trained to ask sensitively about the child's perception of their ongoing problems or worries. Once identified an intervention can be developed that most likely will involve some form of talking with a supportive individual. There are very few, if any, indications for the use of psychotropic medications in these situations at any age.

- **Increase in severity of the symptoms**: Increasing severity of symptoms should alert caregivers or providers that the child or adolescent may be experiencing depression, PTSD or even a psychosis. Some children are more vulnerable than others to these reactions usually based on the support network available to them or based on their past history of mental stability. Worsening symptoms requires a formal evaluation and in this instance every effort should be made to have the individual seen by a trained mental health professional at least for evaluation.

- **The symptoms are highly distressing to the family/the child:** In this case, it is important to meet with the family to ascertain the acuteness of the problem, the family history of problems, the family's relationship with the identified individual experiencing problems. If the family acknowledges family related problems then instituting some form of counselling based on a cognitive model can be of use. The cognitive model basically seeks to give explanations for feelings and actions that would otherwise seem unexplainable. This must be done with knowledge of family history.

- **Symptoms interfere with the daily routine of the child or interrupt work or school:** When the child or adolescent is unable to re-engage school or work then there needs to be a one on one interview with the child to help the child express their concerns, worries or fantasies. Care must be taken in this process to not force on the child a set of preconceived ideas as to what might be bothering the child. For school age children, return to school can be helped by engaging parents to be more supportive than in the past by accompanying the child to school. The latter should be for a finite period of time so as to not reinforce a dependency. Finally, it should be noted that after disasters children live in a highly unusual environment (e.g., temporary shelters) so the "daily routine" the child will be what is available and expected within these circumstances.

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