Mental Health in the Disaster
Treatment Manual for Taiwanese Children

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For the parties concerned with medical treatment, health, and clinical psychology

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Introduction

After disaster, the victims can be left with many mental problems. These may include experiencing fear due to the disaster, dealing with the loss of close relatives, an intimate, or the family home (pets and toys can be very important for children), or dealing with a stressful new environment after living a sheltered life. Disasters also cause various thought disorders in children. There is large individual variation in these mental disorders, but there are some shared characteristics. This paper describes children's mental symptoms in the acute period (1-2 months after the disaster), makes suggestions as to how to conduct interviews and evaluations, and proposes methods of treatment. I hope that this will become a widely used general reference.

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Children, if not supported in an environment of basic mutual trust, are more prone to develop problems than adults because their mental function (ego function) is undeveloped. It is a myth that it is always easier for a child to adjust. Even a very 'normal' child can develop many of the following symptoms and problems. Many of these responses are general reactions, and they only become a problem when the child cannot adjust to reality because the reaction is too strong or prolonged. Differences also depend on the developmental stage of the child. If you have any doubts, please consult an expert in child psychiatry or developmental psychology. An initial problem described here is likely to become a long-term problem (a delayed type), even if the adjustment appears to be relatively good initially. The child's growth is promoted by helping the child get over the painful experiences of the disaster. It is important to have a positive outlook, and to be no more pessimistic than necessary.

A. Symptoms of PTSD (Post-Traumatic Stress Disorder) generally seen in children

PTSD (Post-Traumatic Stress Disorder) is a character disorder that occurs after terrifying experiences.

1. The experience of fear is recalled and re-experienced. The mental state returns to the past and is dissociated from the present, and fear is re-experienced in a flashback. A stimulus

(such as an aftershock, a fire, a siren, or the odor of gas) that recalls the fearful experience often becomes a trigger.

(1) The child (victim) gets excited suddenly, and becomes extremely uneasy (panics).
(2) The child changes suddenly.
(3) Some changes may not be sudden.
(4) The child has repeated nightmares.
(5) The child reenacts, plays at, or talks about the experience repeatedly. This in itself is not especially abnormal, but may be if the child is abnormally absorbed and becomes excited.

2. Decreased reaction to the external world. Paralysis of feelings or paralysis of mental activity in general.
   (1) The child becomes less expressive.
   (2) The child does not talk as much and becomes passive.
   (3) The child becomes much slower. This may be taken to extremes in basic daily activities such as eating meals, etc.
   (4) The child's memory and concentration decrease. It is difficult to concentrate on schoolwork.

3. Continuing tension.
   (1) Insomnia.
   (2) The child is always frightened more than normal.
   (3) A small stimulus causes a hypersensitive, violent reaction.
   (4) The child is nervous and becomes scatterbrained.

4. Others.
   (1) The child has excessive guilt or feelings of powerlessness or depression. Occasionally self-wounding, such as injuring the hand or beating the torso, occurs.
   (2) Remarkable regression is seen (baby talk, becoming overly dependent, acting like an infant).
   (3) Physical symptoms develop: Not moving the hands or feet, loss of consciousness, falling, body pains such as headaches and stomachaches, nausea, vertigo, nocturnal enuresis, hyperventilation, increased frequency of micturation, stammering, etc.

B. Symptoms resulting from a loss experienced by the child

The loss may be the death of family members or significant acquaintances, or the loss of the home. Many of these symptoms occur along with symptoms of PTSD.

1. Mental confusion occurs, and ideas are not settled. The child cannot distinguish between real and imagined events.

2. Denial of loss.
   (1) The child acts as if the dead relative is still alive, and refuses to adjust to reality (perhaps by violently refusing to take shelter, or by refusing a meal without the dead relative, etc.).
   (2) The child hears the voice of the dead person. In remarkable cases, the child obeys vocal instructions from the dead person.

3. Not showing feelings (This is seen most often).
   (1) The child becomes expressionless and seldom speaks.

(2) The child will not cry.
(3) The child tries to avoid recalling the loss experience.
(4) A vivid feeling of reality disappears and the child loses desire.

4. Excessive feeling of powerlessness.
    (1) Movements become remarkably slower. When severe, actions necessary to maintain life, such as eating, are not performed by babies or infants more than six months old.
    (2) There is a total lack of confidence.

5. Strong guilt.
    (1) The child is convinced that he/she is responsible for the loss. For instance, a boy is convinced that his older brother died because they fought the day before or a girl thinks that her mother died because she ignored her.
    (2) Acts of wounding are seen, and they can be very cruel.

6. Violent anger.
    (1) Violent irritation occurs.
    (2) Violence. It is important to note that children often have a high degree of self-control, and a child is quite likely to appear calm superficially. Symptoms might recur on the anniversary of the death or during the days approaching it.

C. Symptoms that result from the prolonged stress of living in an abnormal environment

1. Continuing tension
    (1) Attention is always paid to the surroundings.
    (2) Insomnia.
    (3) Fidgeting.
    (4) Trifles can cause violent surprise or upset.
    (5) Violent irritation.
    (6) No concentration.

2. Staying indoors to avoid the surrounding environment.

3. Panic. This is different from the panic of flashbacks. It does not happen because the child recalls the fearful experience, but because tension is easing. However, the child cannot comprehend this difference.

4. Physical symptoms. These symptoms are the same as the physical symptoms of PTSD. However, they are not tied to reliving the fearful experience, and they reduce the desire to adjust to the stress. It is difficult to make this distinction in children.

D. Suggestions for interviews and for helping a child to deal with a disaster

1. Do not cause more uneasiness than necessary. For instance, consider the location and setting of the interview; interview the child with the parent(s) if the child is very uneasy; avoid wearing a white coat or other clothing that might cause discomfort.

2. Make sure to listen to the whole story of the disaster from both the parents and the child. For infants and school children in lower grades, drawing pictures and simple play can be methods of expression.

3. Ensure that you understand the child's support system and living environment at the same time as you look into the child's mental problem, and look for the best overall way to provide help.
4. Adequate consideration must be paid to the parent's mental status.
5. Do not blame the parent, especially, in front of the child. The parent is the only person that can provide a sense of security to an uneasy child.
6. It is important to explain the child's mental status and needs to the parent fully.
7. It is important to plan possible solutions with parents. If the child works together with adults, the child develops confidence, solidarity, oneness, and a sense of achievement.
8. Try to obtain help from as many sources as possible (medical, health, welfare, and education resources) to reinforce the effects of treatment.
9. Since a longer-term problem may develop, the system should be consulted again if the situation improves only temporarily.

E. Evaluating the child

Evaluating the child's mental problem

1. The professional must not only understand the chief complaint and symptoms, but also look for the presence of the symptoms mentioned above and assess their degree.
2. The ability to separate reality and non-reality, and mental function, should be examined. The ability to adjust to reality is evaluated while considering the extent of the feeling disorder (paralysis of feelings), to determine whether it is possible for the child to endure the present state easily.
3. Evaluate the child's basal mental function. A disaster or loss can readily precipitate a disorder in a child who had problems in mental function originally.
4. It must be decided whether symptoms of unease or depression caused by the frightening experience are more significant than those caused by living in an existing stressful environment.

Evaluating the environment and support system

1. Family function: Do the parents or any guardian who replaced them have a firm grasp of the situation?
2. Does the parent pay attention to the child, or is their family violence?
3. How are family members functioning mentally?
4. How does the child grasp the loss experience? Is a family member or acquaintance either dead or missing? Has the familiar family home been destroyed? Are there dead or missing pets or important items?
5. How well does the family grasp the loss experience? Even if the child does not know directly, situations that may influence the family should be examined: family life, group life, friends, sounds, fighting, etc.
6. How is the family coping with the changes in their environment? Is there a special support system for the situation, a refuge, or a regional support group? What help is necessary, and is help available from the health and welfare department at the school.

F. Help available for children

Basic target of treatment and advice

1. First, an interpersonal relationship that the child trusts must be developed.
2. Any description of the mental injury, the loss experience, and the resulting feelings should be expressed at a level that the child can comprehend. Furthermore, the disaster is a past memory, and the adjustment to reality should focus on the present and future.

General advice to parents and other adults

There are four main principles for helping a child:

1. Talk with the child, increase contact, and facilitate expression by the child.
2. Reassure the child: Emphasize the difference between the past experience and the present. Make the child feel safe, not abandoned. Understand that the child feels guilt, but make it clear to the child that he or she is not responsible for the events.
3. Ensure that the child's activities are as secure as possible, whether playing or helping with housework, etc. Complement the child.
4. Ensure that the child's environment is secure. Think from a child's perspective.

Concrete Examples of the four main principles.

1. Talk with the child:
   (1) Physical contact should be close and you should talk with the child often. Talk to babies more frequently than you normally might.
   (2) Make an effort to understand the child. Do not interrupt the child's story excessively.
   (3) Encourage the child to express their feelings. (It was scary, sad..., I feel angry, etc) Having the child write letters or keep a diary might be useful when age-appropriate.
   (4) Make explanations age-appropriate, so that the child does not feel left out.
   (5) Let the child use a method of expression (drawing, play, etc.) other than language.

2. Reassure the child:
   (1) As much as possible, ensure that the child is not lonely.
   (2) To eliminate irritation within the family, adopt a posture that defends the child, using cooperation.
   (3) Use speech and behavior to reassure the child. Tell the child you love him or her and show your feelings as much as possible.
   (4) Explain that these symptoms could happen to anyone and that they are not the child's responsibility. Let the child know not to feel ashamed if, for instance, their behavior regresses, or their ability to function independently decreases.
   (5) Help the child, while clearly distinguishing between the disaster and the present when she becomes uneasy.

3. Ensure that the child is secure
   (1) Limit the area that the child is allowed to play in.
   (2) Let the child work with an adult, so that the child builds a sense of achievement.
   (3) Admire the child.

4. Ensure that the child's environment is secure
   (1) Reduce background noises. Find a settled quiet, environment.
   (2) Children should be allowed to play outside only during the day.

Ways to alter the surroundings to deal with individual symptoms

1. When panic develops because of a flashback
   (1) Try to remain calm yourself.
   (2) If a particular temporary stimulus caused the attack, remove it. Try to identify sights or sounds that cause the child to feel afraid.
   (3) Do not scold the child.
   (4) If necessary, make the child feel safe by hugging him.
   (5) Point out progress to help the child distinguish between the past and the present, if there are signs of improvement.
   (6) Explain that panic is not abnormal; it is a normal response.
2. When there are physical symptoms
   (1) Do not deny the symptoms or force the child to ignore them; admit that the child feels pain or other symptoms.
   (2) Provide physical contact, such as rubbing the tummy.
   (3) Explain that it is not a serious illness and that it will get better. Reassure the child.
   (4) Devise ways of expressing feelings as much as possible.
   (5) Identify the continuing stress, and think of ways to counter it.
3. When a relative dies or a loss is experienced
   (1) When children experience a loss, you should not stop them from participating in actions or ceremonies that confirm the death. It is not necessary to force them to participate when they are very afraid or dislike the involvement, but the child should be encouraged to participate as much as possible. Seeing the dead person and participating in the funeral and cremation will help. As time passes, this is beneficial.
   (2) Adults must not intentionally avoid topics concerning death.
   (3) The death should be explained in an age-appropriate manner. Infants cannot fully comprehend death, so an alternate explanation should be devised.
   (4) Explain thoroughly that the child is not responsible for what happened.
   (5) The effort to help others in the surviving family, and being surrounded by adults, helps with the mental recovery.

Simple ways to help the child

1. Ensure that the child's feelings and concerns are listened to and understood.
2. Make the child feel relieved, not responsible. Explain that no shame or stigma should be attached; what is happening is natural. It is also important to receive help, and this is not shameful. Reassure the child that their condition does not mean that the body is developing a serious illness. There are no worries in the long term.
3. Express feelings as much as possible.
4. To help the child escape from a sense of being powerless, we must think of things that the child in question can do.

Special help

1. Play therapy: This is necessary for children who cannot express themselves well verbally.

2. Group play therapy (4-6 children): This is effective for children attending a day nursery or the lower elementary grades.
3. Small group therapy (4-8 people): This can be set up easily through the school health unit.
4. Mid-sized group therapy (10-20 people): This can be done in a class at school.
5. Family therapy: This helps the entire family deal with the loss experience.
6. There should be sufficient cooperation with the education and welfare departments.

Purpose

1. First, develop an interpersonal relationship that gains the child's trust.
2. In this relationship, express feelings about the mental injury and the loss experience in a form that the child's mental function (ego) can comprehend. Deal with memories of the past, and promote the reality of making adjustments for the present and future.

Method

1. Develop an environment in which the children being helped can express themselves.
2. Allow the child to express feelings about the fearful experience and subsequent events through language and play.
3. Allow children to share feelings by speaking with other children who had the same experience. A child's feelings of isolation and self-reproach decrease in group therapy.
4. Build confidence by making the child accept the experience as it is.
5. When the child talks about the experience and associated feelings, and is heard, it helps them to recognize that the event is in the past.

Medical treatment

It is preferable that psychological treatment be made available. When symptoms are prominent or the victim's uneasiness is too marked for psychological treatment, administering appropriate medication during the acute period is also effective. However, medication should not be relied on alone. For instance, simply changing feelings chemically without changing the awareness of the event can lead to a feeling of powerlessness and to depression.

For professionals

-Psychotherapy in the treatment of Post-Traumatic Stress Disorder-

Youichi Inoue

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1. Introduction

The scene of a disaster needs time to recover, as do the minds of disaster victims. The first step in mental recovery begins with realizing that mental damage as well as physical damage has occurred. Initially, the victim is seldom fully aware of the seriousness of the mental damage that he or she has suffered. The mental damage is temporarily pushed to one side, while the victim is busy with immediate problems, and the effects only appear gradually as time passes. Anticipating the severity of possible damage causes anxiety, and victims may be reluctant to face their mental state. Just as the buildings after an earthquake can remain unstable if they are not leveled, the mind can also remain unstable indefinitely if the wound caused by a disaster does not heal, and the victim will suffer psychosomatic disorders for a long time.

Many people are needed to repair the physical damage in a disaster area; similarly, many people are needed to assist in mental recovery. A stable interpersonal relationship with family and friends provides support for recovery from mental damage. To assist in mental recovery, however, it is necessary to provide interpersonal relationships for victims who have lost family or friends, and for those who are weak at self-expression, especially infants, children, and elderly people who have difficulty speaking.

2. Help with the experience of psychic trauma and object loss

The counselor (listener) makes the victim feel secure, provides an ambience that allows the victim to express feelings freely, and is the person who accepts the victim's various feelings. The traumatic event is relived, and it can be sublimated if the victim feels that the listener will be supportive.

As analogies, frozen feelings might be said to gradually warm and then melt, or feelings that are too much to swallow whole initially are chewed up, digested, and ultimately absorbed.

3. How does psychic trauma develop?

The traumatic experience must be recalled to deal with the subject's feelings about it. The victims must draw the experience into their consciousness, be aware of the full meaning of the experience, and accept it. However, to accept the experience it is necessary for them to re-experience the pain and fear that are associated with it.

The disaster and associated losses are very serious experiences for individuals, and always occupy a large portion of their minds. The memories of the seriousness of the experience remain in the consciousness involuntarily, and yet victims are very hesitant to touch on the experience because of a lack of confidence about re-experiencing the feelings associated with the trauma, and a fear that it will be very painful. Repeatedly recalling a traumatic experience entails the risk of worsening the trauma, while mentally avoiding it is an instinctive self-defense mechanism.

The individual freezes their feelings, and by doing so, is less affected by them. This defense mechanism is temporarily effective, and protects the individual. However, the separation of the experience from the 'self' is maintained by mental tension, and causes various harmful effects when it continues for the long term.

Although the memories are painful, they cannot keep being ignored. Separating primary feelings in the mind means that a part of one's self is lost, and the ability to unite one's self is also lost. Languor and impassivity result. Moreover, separating the painful feelings can have adverse effects on the body and mind, such as sudden panic attacks, physical malfunction, etc. Therefore, it is necessary to deal with feelings that have been temporarily isolated quickly, and reintegrate them into the self.

4. Concrete interview method

(1) Expressing and speaking about feelings

By expressing and verbalizing feelings, an individual gradually deals with a painful experience and changes it into an experience that they can accept.

To express feelings naturally requires a listener. Feelings are expressed in interpersonal relationships. When an individual feels secure from criticism, regardless of what feelings are expressed, the free expression of feelings finally becomes possible.

The counselor should act as though the victim needs to be defended. The counselor must not compel the victim to express feelings, nor impose opinions upon the victim. Feelings that are drawn out in a stable setting and are revealed voluntarily have therapeutic meaning.

(2) The interview process

- First, start the interview with everyday, concrete topics. Choose important topics that are common to everyone, and far from the core of the problem, such as sleep or eating.
- After discussing topics of daily life, focus on a concrete story about the disaster experience. The counselor listens to the victim's story told in chronological sequence, while focusing on each place, time, and action. The listener does not compel the victim to tell the story, but follows the stream of the victim's feelings. When the victim falters in their story, ask a question that demands continuity like, "After that, what did you do?"
- Initially, sympathetic comments have a contrary effect. Since the individuality of the experience is disregarded, the victim does not feel that the counselor understands enough of his or her circumstances. Moreover, a sympathetic comment might cause the victim to stop telling their story. The counselor should maintain a neutral attitude until the victim finishes speaking. It is appropriate to nod, and to repeat phrases told by the victim.
- The counselor does not express sympathy, but lets the victim reproduce his or her own experience in the disaster. The counselor attends to what and how the victim felt, and concentrates on reproducing these feelings in the counselor's mind. If the story clarifies the images of the victim's experience, it is sure to generate a response from the listener.
- It is important that the counselor reflects back the images they develop to the victim, once the counselor understands the victim's experience. The experience is objectified through sharing the experience with others, and the victim can place the experience at a distance, where it can be controlled.
- When the listener feels that the victim is getting to the core of the story, then comments that invite the expression of feelings should be used. For example, "How did you think at that time?" "It might be serious..." or "What do you feel about that now?" If the listener encounters strong resistance, return to the concrete story again without trying to force the issues.
- The problem of a psychic trauma is not solved with one interview. The mind gradually becomes composed by repeatedly coming into contact with the traumatic experience. Allow the story to proceed and the victim's feelings will stream out proportionally. Never rush it.

3) Dealing with experiences of loss

Losing family members and other people of personal significance is a terrible, psychic trauma. It brings on a sense that part of one's self has been lost. The loss of people with whom the victim consulted, relied on, or shared experiences, brings about a terrible sense of loneliness. The survivor cannot acquire new interpersonal relationships in such a setting. That is, they lack the capacity for emotional interaction. It is necessary to deal with this problem, preferably with daily personal contact and encouragement. Counseling is necessary for people who get little or no help from their environment. In addition to the object loss experienced in the disaster, specific problems result because an intimate person was lost.

Since the loss experience awakens different feelings about the lost individual, the victim is faced with the problem of how to resolve these feelings. The relationship between the

survivor and the dead can cause problems. It is easier to accept the loss if there are positive images of the dead, such as mutual trust and happy memories; however, complex feelings such as sadness, guilt over material loss, or anger at being forsaken might arise. The fact that the opportunity to solve any previous conflict with those now dead was missed will become a load on the survivor. These conflicts must be solved.

Different feelings about the objective loss are gradually processed by being shared with the listener, and being objectified. The listener tries to develop a relationship that allows the victim to express their feelings, while maintaining a stable, accepting ambience. Since object loss is a delicate problem, the listener should look for and play close attention to changes in the victim's feelings. At times boldness is necessary, and this demands stepping into the core of the problem.

5. Conclusions

We must provide help by offering the necessary interpersonal relationships to victims. As to the problem of psychic trauma and object loss, the modality, level of damage, and recovery ability vary with the individual. Therefore, it is not good to set a fixed goal for the process, and rush to attain it. The important point is that the counselor does not lose composure, even when inadequate results are obtained. The counselor should assist the victim to make a natural recovery, which is within the capacity of every victim.