Psychosocial Assistance to Displaced Children and Families

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Displacement

Wars and mass conflict
Disasters (natural, antropogenic)
Urbanization, development

Relocation of population
Displacement
(involuntary!)

Displacement

- Displacement of population disrupts normal community structures: extended family systems, informal networks and support systems, social and health institutions
→ Increased risk for social and psychological problems or existing problems
→ Some displaced people may develop negative coping mechanisms while they struggle to meet basic needs
→ People with pre-existing health problems may experience exacerbation of their symptoms

Displacement and disasters

- Disaster: A situation or event that overwhelms local capacity and causes great damage, destruction, or human suffering
  - Acute: sudden onset of natural or human-induced events
  - Chronic: human-induced events (e.g. war, organized violence), climate change (e.g. drought)

Temporary or prolonged displacement

Disasters and risks for children

- Children and adolescents are more severely impacted by disaster than adults (Norris et al. 2002):
  - They are rapidly developing in mental, social and physical areas (Madrid et al. 2006)
  - Children at age of 5 are cognitively capable of understanding the effects of disaster (Pynoos et al. 1995)
  - Trauma during the early years can affect individuals for years to come

Peritraumatic experiences of children during disasters

- Exposure to traumatic events during incident, helplessness and horror
- Witnessing death of family members or friends (14% during Hurricane Katrina), family members or friends injured (21% during Katrina)
- Witnessing loss of home (up to 80%)
- Witnessing massive infrastructure destruction

Displacement as a mental health risk for children

- During post-disaster displacement children continue to cope with a series of extreme life stressors:
  - Change in family members' social role
  - Decrease of family social status
  - Loss of personal property: symbolic values and assets
  - Loss of natural social support system
  - Loss of friends and normative peer network
  - Dramatic loss of family and community resources

Life instability in displacement

- Multiple relocation of families (average of 3.5 times)
- Separation of children from primary caregiver (34% after Katrina)
- Many children change schools in a short period of time
- Multiple relocations prevent reestablishment of health, education, and employment relationships and undermine families' ability to maintain a regular routine

Life instability in displacement

- Disruption of daily routines that provide structure → increased distress (Pynoos et al. 1995)
- Confused beliefs regarding own vulnerability, parents' ability to protect, safety of the world in general → potential for interpersonal, behavioral and developmental problems
- Increased risk for academic problems, poor achievement and social functioning (Shannon et al. 1994)
- Increased risk for behavioral disruption (Armsworth and Holaday 1993)

Displacement and specific stressors for children

(Ajdukovic, Ajdukovic, 1998)

- Living with distressed parents:
  - child's distress symptoms correlated with mother's post traumatic stress (.27)
  - depression in children correlated with:
    - mother' s poor relationship with a child (.24)
    - mother' s general rejection index (.33)
    - deteriorating relations in family (.31)

Displacement and specific stressors for children

- Lack of emotional support from other important adults
- Families stigmatized as depending
- Children often not welcomed in a new school nor after returnning to the original community
- Uncertain future of return to and rebuilding of the original community
- Poor access to education, housing
- High unemployment, jobs below qualifications

Mental health of children in displacement

(Ajdukovic, Ajdukovic, 1998)

- Some children displayed high number of posttraumatic symptoms throughout 6, 12 and 40 months of follow-up in displacement (r=.49)

  → These children are at developmental risk, and probably less resilient to high levels of chronic displacement stress

  → Children with non-supportive family environment and pre-exisiting difficulties

Mental health of adolescents in displacement
(M. Ajdukovic, 1998)

- 45 adolescents (45% females), age 14-19, 96% in secondary school, displaced for 18 months
- Posttraumatic symptoms:
  - Intrusions 48.9%
  - Guilt feelings 42.2%
  - Loss of interest 40.9%
  - Nervousness 40.0%
  - Agitation 37.8%
  - Appetite disturbances 33.3%
  - Bitterness 31.8%

Mental health of adolescents in displacement
(M. Ajdukovic, 1998)

Posttraumatic stress correlated with:

- Depression .62
- Poor future orientation .42
- Feeling less competent .35
- External locus of control .31
- Rejecting mother parenting .30
- Female gender .42
- Prolonged displacement .28
- Anxiety of parents .28

Children's need for support and psychosocial assistance

- Psychosocial assistance should help overcome psychosocial problems by strengtening resilience factors in child's environment
- Parents remain a major source of support to children and they need to be helped to maintain this function

  → Can the parents meet these needs?

  → Maintaining quality of parent-child relations should be a part of psychosocial assistance for displaced children

Psychosocial assistance and support

A community-based approach that recognizes the resilience, capacities, skills and resources of the displaced population, and focuses on building capacities for successful coping with distress through promoting self-care, self-respect, mutual support and community recovery.

Psychosocial assistance and support

- All processes that promote the wellbeing of people:
  - support provided by family, friends and the community
  - what people do for their psychosocial wellbeing
  - interventions that meet psychological, social, emotional and practical needs
- Goal: change a situation which threathens the social and psychological well-being of affected populations
- Domains of interventions: skills, emotional well-being, social well-being (UNICEF, 2011)

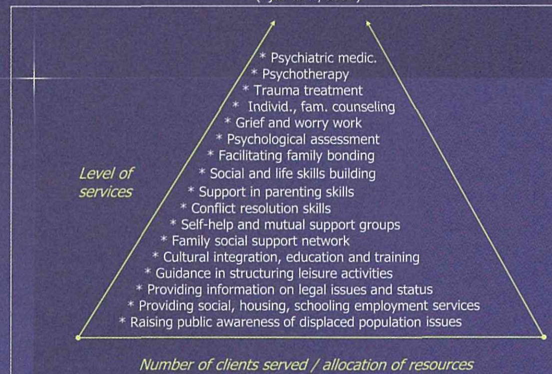
Mental health and psychosocial support (MHSS)
(IASC, 2007)

Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.

Resilience factors
(after Masten, 2009)

- Positive attachment with caregivers and other competent adults
- Self-regulation skills (self-control and executive functions)
- Positive self-perceptions and self-efficacy
- Hope, sense of meaning in life
- Friends who are supportive and prosocial
- Bonds to schools and other prosocial organizations
- Communities with services and supports for families and children
- Cultures that provide positive standards, rituals, relationships

Pyramid of community-based psychosocial assistance
(Ajdukovic, 1997)



Intervention pyramid for mental health and psychosocial support in emergencies
(IASC, 2007)

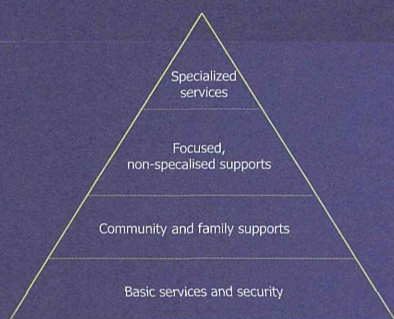


Illustration of psychosocial interventions in a community of displaced families in Croatia

- Assessment of children as requested by school staff
- Individual treatment of highly traumatized children using CBT, narratives, supportive therapy
- Group work for children:
  - Increasing self-esteem and positive self-concept
  - Building social skills
  - Building non-violent conflict resolution skills
  - Promoting peer support, bonding and cooperation
  - Building problem solving skills
  - Help with academic problems
- Therapy for parents (trauma focused, marital therapy)
- Group support for parents (employment, parenting)
- Building capacity of local service providers (school staff, volunteers)

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Fukushima

Suicidal Behavior in the Aftermath of Natural Disaster

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Sendai

Introduction

- Increase in natural disasters 1975-2010
- Number of affected people rising
- Numbers of people killed falling
- General factors
- Suicidal behavior

Suicidal Behavior in the Aftermath of Natural Disaster

- Earthquakes (20 studies)
- Hurricanes (11 studies)
- Tsunamis (4 studies)
- Floods (3 studies)
- Droughts and Heatwaves (1 study)

- K. Kolves et al. Journal of Affective Disorders 146 (2013) 1-14

Outcomes (Norris et al. 2002)

- Specific : PTSD, major depression
- Non-specific: stress related psychological and psychosomatic problems
- Health problems and concerns
- Chronic problems in living
- Loss of psychosocial support
- Problems specific to youth

Phases of Psychological Response to Disaster
(Pasnau and Fawzy, 1989)

- Impact phase (fear and confusion)
- Rescue phase (altruism, aid programs)
- Honeymoon phase (collaboration, community cohesion)
- Disillusionment (resource allocation envy)
- Reorganization (reconstruction and recovery)

Suicidal Behavior

Confounding Factors

- Man made usually less severe than natural
- More severe in developing countries
- Impact depends on cultural factors
- Preceding psychopathology
- Type and magnitude of event
- Threat to life and extent of loss
- Social support, coping skills, unemployment
- Children, elderly women, single parents

Kobe (Japan, 1995), (Nishio et al. 2009): Initial reduction for *middle aged males* and then return to former rates

Earthquakes

- **Northridge** (California, 1994) (Bourqe et al. 2002, Shoaf et al. 2004) : Overall downward trend in rates for 3 years: Upward trend for Hispanic males

Earthquakes 2

- **Nantou** (Taiwan,1999) (Chow et al. 2003) : Slight *increase in general* but **marked increase among victims** (1.71x or 42.3% increase in suicide rates) Male suicide rates affected by unemployment
- Female effect more immediate while male effect more delayed
- 7.2% showed suicidal tendencies after 3 years
- No association between degree of damage and suicide rates

Marmara (Turkey, 1999), (Akbiwik et al. 2004, Vehid et al. 2006) : no significant change in suicide but marked increase in suicidal thoughts in males

Cyclones

- **Hurricane Andrew** (Gulf Coast 1992), (Castellanos et al.2003) : Increase in homicide suicides for 6 months; pre-hurricane ideation and post hurricane depression predicted suicidal ideation

Earthquakes 3

- **Niguata-Chuetsa** (Japan, 2004), (Hyodo et al. 2010): 3 year drop in male suicide rates. Upward trend in females after 3 years
- **Sichuan** (China, 2008) , (Yu et al. 2010) : decrease in suicidal thinking (? Increased post traumatic growth)
- **L'Aaquilla** (Italy,2009), (Stratta et al. 2012) : more non-fatal suicide behaviors in females

Cyclones 2

- **Cyclone Orissa** (India, 1999), (Kar 2010) : remarkable increase in suicidal ideation (3.9 to 38% in 12m for suicidal ideation and 2.6% to 18.3% for suicide plans and 1.3% to 12.6% for suicide attempts)
- **Hurricane Mitch** (Nicaragua 1998), (Caldera et al 2001) : 10.5% with suicidal ideation -augmented by illiteracy, PTSD and major depression
- **Typhoon Morakot** (Taiwan 2009), (Tang et al, 2010) :high family support decreased suicidal ideation, death of a family member increased ideation

Cyclones

- **Hurricane Katrina** (gulf coast 2005), (Kessler et al. 2008): lower incidence of ideation and plans for 5-8mnths and increase one year later. Related to unemployment, displacement. Suicidal women were also more violent

Floods

- Buffalo Creek flood 1972, (Green et al. 1994): 17 year follow up showed a drop in psychiatric symptoms
- Red River Flood 2009, (Gordon et al. 2011) : volunteering increased feelings of belongingness and decreased feelings of burdensomeness
- Yangtze basin with periodic flooding, (He 1997): has 40% higher rates of suicide than rest of China

Tsunamis

- Indian Ocean Tsunami 2004, (Johnesson et al. 2011) : No change in suicide rates in Sri Lanka. Increase in suicidal ideation among Swedish tourists

Discussion

- Overall analysis of natural disasters in the US failed to show any influence on suicide rates
- Various social, political economic and health related consequences of disasters can influence suicidal behaviors
- The results of different studies vary probably due to methodological problems
- Overall there seems to be no consistent direction (Kolves et al. 2013)

Drought and Heat waves

- Above 18C each 1 degree C was associated with a 5% increase in violent suicide (Basagna et al. 2011)

Discussion 3

- Drop in non-fatal suicidal behavior rates in the initial post-disaster (honeymoon) period (usually first 6 months)
- May also occur during the "pulling together" period
- A delayed increase in suicidal ideation may occur in the disillusionment phase
- Not applicable to suicide attempts

Discussion 2

- Suicide rates after the Northridge earthquake dropped for both genders and for males after Kobe and the Nigata-Chetsu earthquakes in Japan
- No change in rates for disasters in the US
- Marked increase in rates after Nantou earthquake in Taiwan may be due to SE Asia economic crisis

Discussion 5

- Results by Gender:
- High suicidal ideation in Italian girls
- High suicidal ideation in Turkish males
- Male suicide rates fell in Japan and US but rose in Taiwan
- Female downward trend became an upward trend after Nigata-Chuetsa

Discussion 4

- Vulnerability Factors:

1. Concurrent major depression
2. PTSD
3. Previous mental health problems
4. Exposure levels (severe destruction of property, injuries to relatives and danger to life)
5. Economic conditions, unemployment
6. Similar to other mental health problems

Conclusions

- Need for further studies using proper designs
- Create models of the pathway to suicidal behavior including interactions between vulnerability factors
- **Clear need to monitor mental health and suicidal behaviors for several years after the disaster**
- Special attention should be paid to the psychologically vulnerable (injured bereaved and displaced and those affected by the economic consequences of the disaster (e.g. unemployment)

Building Resilience after Mass Traumatic Events: An integrated Community Intervention

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What is Resilience?

- Resilience is an active process resulting in positive adaptation in the face of major adversity
- Positive Adaptation:
- Absence of psychopathology?
- Developing immunity?
- Post-traumatic growth?

What factors influence outcomes after wars and disasters in children and adolescents?

Social Factors: High SES, High Parental Education, economic support to rebuild community, engagement in religious activities

Family Factors: family violence, mothers with high punitive style

Personal Factors: coping styles such as self-blame, rationalization, fantasy and avoidance were associated with psychological symptoms among survivors of an earthquake in China

Effectiveness and specificity of a classroom-based group intervention in children and adolescents exposed to war in Lebanon

Elie G Karam, John A Fayyad, Aimee N Karam, Caroline C Tabet, Nadine Melhem, Zeina Mneimneh, Hani Dimassi

World Psychiatry, 2008, 7(2):103 -109.

GEE analyses : Baseline to 12 months in Specific Vs. Non-Specific Treatment Groups

Treatment / Time Effect	MDD		SAD		PTSD*	
	B (± SE)	P	B (± SE)	P	B (± SE)	P
Treatment groups (ST vs NST)	.14 (±.54)	.795	.34 (±.58)	.555	**	
Time	-4.64 (±1.47)	.001	-3.22 (±1.70)	.058	**	
Group x Time Interaction	2.00(±.88)	.022	1.48 (±.99)	.134	**	
Covariates**	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)
Disorders pre-war						
SAD			67.4	(6.29-720.76)	7.4	(2.69-20.24)
PTSD					8.2	(3.62-18.49)
Age: Children vs. Adolescents	2.8	(1.17-6.55)				
Family Violence						
Family quarrels	4.5	(2.03-10.18)	4.0	(2.30-9.26)	4.5	(2.07-9.80)
Fear of being beaten	7.4	(2.98-18.36)	6.7	(2.30-19.81)		
War Exposure						
Heard of the injury of a close person			2.7	(1.21-6.12)		

*The interaction Group x Time for PTSD could not be computed due to low numbers
** Only statistically significant relations reported
ST=Specific Treatment; NST=Non-Specific Treatment; GEE=Generalized Estimating Equation