Psychosocial Assessment and Early Intervention

2

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Introduction

It is important to keep in mind that regardless of what type of crisis is occurring; manmade or natural, the immediate effects will be physical and psychological in nature. While the physical effects will be the same across nations, the psychological effects and the response to the stress will be different across cultures [1, 2]. Manmade events are associated with higher levels of stress as compared to climate-related disasters [3]. War, religious persecution or any conflict related event causes children to experience death, loss of possessions, home, and relocation. This also happens in climate-related events but the children are more likely to encounter a loving adult and immediate assistance after these than in conflict-related events.

Children experience and express symptoms based on their developmental age. Though many impacts seem to subside in the short to medium term, larger effects that occur at critical points in a child's development can persist for their lifetime and even be passed to the next generation.

The other thing to keep in mind is that the parents and immediate family are also experiencing stress, fear, grief, and loss. Children sense these feelings and feel even more vulnerable.

Describing symptoms and assessment by age group is a pragmatic way to approach mental health and trauma experience in children.

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Infancy: (0–1 Years)

Issues with the quality of attachment; be it secure or insecure; can occur in infants particularly 6 months and older. Parents play a central role in this developmental period. Any disruption can cause them to have changes in eating patterns and/or sleeping. They can appear cranky or irritable, hard to soothe or can appear listless and appear as a "good baby." Younger infants can exhibit an exaggerated startle response.

Toddlerhood (1–3 Years)

This is the time of autonomy and exploration. They are testing limits; physical and relational. Temperament affects behavior at an individual level. So, a slow to warm up child will exhibit clinginess and separation distress. A child with a difficult temperament might externalize, have tantrums and be difficult to console. At this age, they might regress, stop talking, refuse to do or have difficulty with previously learned self-help tasks. They might have regression in toileting/bowel bladder control. It is important to remember that overly good behavior or acting like "adults" is a sign of stress.

Young Children (Preschool Age 3–6 Years)

Around this age, children develop a vivid imagination and use magical thinking to solve problems or explain things. Many are not logical thinkers and are egocentric meaning that they are unable to distinguish between their point of view and the point of view of others. They have misunderstandings of death and believe it is reversible or just means that the person has gone somewhere. Children at this age may exhibit disrupted and or repetitive play, nightmares, acting out, being aggressive, or oppositional.

School Age (6–12 Years)

They now begin to see themselves as individuals capable of basic problem-solving. Peer acceptance and conformity start taking precedence and they start understanding peer hierarchy. Many still prefer structured activities over open-ended ones. Children may show symptoms of poor academic performance, withdrawal from normal activities, or decreased interest in peers. They may be anxious or depressed or may show externalizing behaviors like aggression or hyperactivity. The responses may vary based on gender. Boys show more antisocial and aggressive behaviors and girls display more emotions and or ask more questions.

Adolescence (12–18 Years)

During this age, children change in how they interact with family, friends, and peers. They are searching for their identity and this can be influenced by gender, peers, cultural background, media, and family expectations. They seek to be independent and responsible and look for new experiences and can engage in risk-taking behaviors. They start to develop a sexual identity and may start to explore or question it. In times of crisis, adolescents may go through an identity crisis, have feelings of despair, hopelessness, and loss of direction. They may experience disillusionment with their faith, become radicalized, or cling to a new idea. They might become parentified, engage in risk-taking behaviors, have difficulty concentrating, and have difficulty feeling pleasure.

How to Support Children and Teenagers

Those who are working with vulnerable children after a life-altering event or in a camp/detention center, first and foremost should remain calm. Children look to adults for support and care. Most children and adolescents will regain normal functioning provided that basic survival needs are met, safety and security are reestablished and developmental opportunities are restored as much as possible based on the resources available. Preexisting risk factors like preexisting mental health problems, reactive temperament, parental maladaptation, and social isolation can affect the response to emotional trauma and long-term well-being. On the other hand, intelligence, physical health, beliefs/religion, and supportive social frameworks, which include immediate and extended family, friends, and institutions, all promote resilience.

Meet Basic Requirements

A safe and loving home is a basic need for any child. Reunification and keeping families together is very important and should be encouraged and implemented as soon as possible. Make sure basic requirements that include food, clothing, shelter, and sanitation are being met. Children of different ages have specific dietary needs. For example, an infant requires breast milk and/or formula. Supply for breast milk is affected by whether the mother is present or not, maternal stress, and nutrition.

Make sure that children have appropriate clothing, including shoes. Clothing can be overlooked especially in poor countries. Shelters protect against the elements and also against exploitation. Efforts should be made to ensure safe water and good sanitation. Otherwise, children will likely become ill with infectious diseases and also infect their caretakers and other household members sick as well.

Establish Routines

The most important thing is to establish routines. Resilience in children who experience a disaster is facilitated by establishing routines. Routines provide predictability and regularity which is comforting to kids. Therefore, it is important to encourage parents to be consistent in establishing routines for meals, naps, and bedtime and to set appropriate limits. Incorporate holidays and festivals that are important to the family into these routines. Set up a time to read together or to children daily [4]. Relief workers should speak with parents about their important role in helping children feel secure and should be encouraged to spend time with their children.

For toddlers, help parents to teach limit settings without excessive punishment. Expect temporary regression at all ages. Young children, especially toddlers, may test limits and caregivers should accept them as a learning opportunity and redirect them rather than taking it personally. Teach parents that the "bad" behavior is possibly a sign of distress or a cry for help as children do not know how to express themselves verbally like adults.

For older youth giving them chores and responsibilities will give them an opportunity to influence what is happening to them. Keeping them involved in the day-to-day management can decrease opportunities for risky behaviors. It also facilitates a connection with other peers who may be going through something similar. Fostering a sense of hope is important for their recovery. Explain to them that their feelings are normal, respect their emotions and do not minimize or dismiss their reactions.

Education/Learning

Reestablish schools when safe to do so. This helps in providing routines and a sense of normalcy to the day, provides safety, allows opportunities for children to meet with peers in a group environment where possible and, most importantly, gives hope for a future. Education is rarely a core focus after a disaster. But the impact it can have on children and young adolescents can be profound and long-lasting. Schools and school teachers can be integral in helping children and their families recover after a disaster has struck the community. It is important to also keep in mind that the teachers will also be struggling with stress-related symptoms and personal losses and it is important they also care for themselves. Please see Chap. 4 on schools for detailed information.

Reunification where Possible

It should be a priority to reunite children with parent/caregivers as soon as possible. Relief workers should assess parental/caregiver supports. It is important to remember that parental emotional and physical well-being will impact how they will interact and take care of their children. For infants that are being breastfed, monitoring maternal nutrition and hydration will be important. Make sure you focus on parental/

caregiver care along with the children. Be culturally sensitive to the needs of families. For unaccompanied minors, it is preferable to place them with kind and experienced foster mothers instead of having them in orphanage-type settings. Caring interactions between adults and children even if they are not related helps develop resiliency in children. It improves self-esteem in children and can also impact negative trajectories in teens and can prevent exposure to risky situations. These supports can be added at any developmental stage in a child's life and can compensate for missing familial support [5].

Allow Play

Make time for play. Play is critical for children and adolescent's development. It provides opportunities for them to learn critical social skills [6, 7].

Allocate safe areas where children can explore and play. Allow opportunities for imaginative and expressive play. Try to organize group sporting activities like soccer. Having a connection with others through play, particularly with peers, and the involvement of an older adult or older youth from the community can give a sense of belonging for the involved children and the teaching adult or youth. It helps them develop a sense of community.

Be aware of gender norms, in many cultures girls after a certain age cannot participate in sporting activities with boys or play sports in the presence of men. Try to find ways to get the girls involved in play or sports activities by either finding a time that does not take them away from chores or a place which can meet societal and cultural norms of segregation.

Disaster and Media

Avoid overexposure to disasters or events through media as they may contain graphic images or details that can be upsetting for children and adolescents. This can cause them to incessant worry about what is happening incessantly. For younger children, it can be more frightening than for older youth. Restricting media exposure for younger children is a good strategy. However, expect that children can hear frightening messages from neighbors or friends. In this day and age for older children, given the prevalence of media devices and social media access, the chances of them hearing or watching it are very likely. So, it is best to be prepared to answer questions and monitor for any changes in behavior. Parents should be encouraged to listen to their children and, taking their cues, to explain the context and provide reassurance [8].

Some parents might prefer that their children hear about an event from them. The recommendation is to provide information that is truthful and age appropriate. Keep it simple and brief and provide reassurance in a calm manner.

Tools Available for Health Professionals for Rapid Assessment after a Catastrophic Event (Disaster)

PsySTART

PsySTART is a rapid mental health triage system that can be used immediately after a disaster by health, mental health or first responders that are nonmental health workers. It can help ascertain how severe the disaster exposure is and how urgent are the mental health needs of an individual that has arrived at a hospital, healthcare facility, or any other setting after a disaster. It helps streamline and allows for targeted response by mental health providers based on the urgency of the mental health needs of individuals [9].

The Strength and Difficulties Questionnaire

The SDQ is another useful tool. It is an emotional and behavioral screening questionnaire that can be completed by children and youth as a self-report or by parents and teachers. It can take between 5 and 10 min to complete and comprises 25 questions divided between five subscales. These are

(i). emotional symptoms,
(ii). conduct problems,
(iii). hyperactivity/inattention,
(iv). peer relationship problems,
(v). prosocial problems.

An impact supplement and follow-up section are also available. The impact supplement asks questions about the chronicity of the problem, social impairment, and its impact on the child's life. The follow-up section asks two questions to detect change after an intervention. The SDQ is free and available in 20 languages. It can be printed or completed online [10].

Considerations for Health Relief Responders Working in Refugee Camps and Health Professionals in Resettlement Clinics

Refugee children have unique needs including catch-up immunizations, nutritional deficiencies, mental health, and trauma concerns. It is important to remember that these children may have experienced specific infections, specific nutrient deficiencies, and/or traumatic experiences during important developmental stages of their lives. These can impact their development and future learning significantly and being aware and assessing development can greatly impact their lives. It is also important to note that caregivers might not be aware of any delays in their child's

development. They might not have the word "development" in their language and have limited awareness of developmental milestones, poor health care knowledge, or have strong beliefs in traditional healing practices [11].

Therefore, it is important to obtain a detailed birth history and maternal gestational history focusing on toxic exposures, nutritional status, prematurity, anemia, lead exposure, specific infections like cerebral malaria, parasitic infestations/intestinal worms, etc.

Parental mental health/trauma can also greatly impact their relationship with their children. These can manifest as atypical bonding relationships in younger children or contentious relationships with teenaged children.

The following are some structured developmental tools that can help identify developmental issues.

- Ages and Stages Questionnaires (ASQ).
  The ASQ is a screening tool that looks at five developmental areas; communication, fine motor, gross motor, problem-solving, and personal social. It helps identify concerns in these domains in children from 2–60 months of age. Parents can complete this in 12–18 min independently or with assistance by professionals. It is available in English, Spanish, Somali, Hmong, French, Arabic, Dutch, Norwegian, Vietnamese, Turkish, Chinese, Hindi, and Persian [12].
- Survey of Well-being of Young Children (SWYC).
  The SWYC is a short free developmental screening tool for parents to complete for their children between 2 and 60 months. It screens for motor, cognitive, social emotional, language delays as well as autism and family risk factors like domestic violence, substance use, food insecurity, and parental mental health concerns. The SWYC has been translated into Spanish, Burmese, Nepali, Portuguese, Haitian-Creole, Vietnamese, Somali, and Arabic [13].
- Parents' Evaluation of Developmental Status (PEDS).
  PEDS is an evidence-based screening tool that can detect and also address developmental and behavioral problems in children from birth to 7 years 11 months of age. It is available in many languages and can be administered as an interview with the parents or can be completed at home or prior to the visit by the parents/caregivers.
- PEDS: Developmental Milestones (PEDS:DM).
  This is a tool that can be used with PEDS or on its own targeting the same age group. This measure includes 6–8 items for each age/encounter. The questions elicit responses that cover the following developmental domains. Gross motor, fine motor, expressive language, receptive language, self-help and for older children; math and reading. These responses can give information and help monitor development. There are additional supplemental measures that assess psychosocial risk, resilience, an autism-specific screening (M-CHAT-R), and the Vanderbilt ADHD scale (for older children). There is also an assessment level version for children at risk that are already in early intervention or in a NICU graduate.

PEDS is printed in English and Spanish. There are translations in Albanian, Amharic, Arabic, Armenian, Bengali, Bulgarian, Burmese, Cambodian, Chinese (Traditional and Simplified characters), Congolese Swahili, Danish, Dutch, Dzongkha, Farsi, Filipino Tagalog, French, Galician, German, Greek, Gujarati, Haitian-Creole, Hebrew, Hindi, Hmong, Icelandic, Indonesian, Karen, Korean, Laotian, Malay, Nepali, Polish, Portuguese and Cape Verdean, Punjabi, Quechua, Russian, Serbian (Cyrillic and Latin), Samoan, Somali, Sotho, Swahili, Swedish, Tagalog available as well [14].

Advocating for an integrated health care model with collaboration between health care professionals, social workers, and schools could help facilitate appropriate supports for refugee children in schools [15]. One needs to be aware of the differences in access to assistance in refugee camps versus organized settlements and self-settlements. Increased use of detention centers in developed countries is also impacting the development and mental well-being of children. Studies have shown that increased parental employment, improved language proficiency, and integration into the resettled host country are strong predictors of improved overall outcome in the long term [16].

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