Information for Caregivers: Children's responses to emergency situations, evacuation and intervention in the acute phase

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As a result of exposure to a traumatic event, children, during the first two days, have physical and emotional reactions that constitute a normal response to the event. Except in extremely rare cases, there is no reason to give a pathological diagnostic title to these immediate responses, because they are usually transient on their own. Lack of such response to the incident is a very worrying sign for a child.

There can be different types of reactions. There is often an initial stage of "shock", some reduction of consciousness and limitation of attention, inability to perceive and understand stimuli, which can lead to disorientation or stagnation. Alternatively, (or with the onset of the initial "shock") there may be over-excitement, over-activity, acute restlessness (running around, trembling, etc.) and / or over-attachment to the parents. Physical signs of stress (accelerated heart rate, sweating, nausea, muscle tension, rapid breathing) are extremely important, especially in infants and young children who can not yet express themselves verbally.

In infants the main manifestation of the reaction will be through a change in basic regulation: at one end of the sequence there will be apathy and decreased physical response to touch and at the other end of the sequence continuous crying with decreased ability to relax by normal actions of mother / caregiver and changes in normal sleep / sleep cycle eating.

Very dissociative signs are common in children during the trauma event and in the early stages after, and they too do not necessarily constitute a sign of pathology but are part of the expected response to the abnormal event. Typical examples of dissociative signs in children: partial or complete forgetfulness of the event, feeling that things are not really happening but "like it's a movie", feeling that the body seems to be changing (or sensory sensations different from what happens in reality) and feeling that time passes slowly / faster than really happens. The children will not tell on their own initiative about these feelings but it is important to ask them (in words appropriate to the developmental level) because it is very easy for them when they find out that they understand what they are going through and explain to them that it will pass. In infants, sudden anesthesia can be a substitute for dissociative detachment.

Usually all of the above reactions appear within minutes of exposure to the traumatic event and disappear within hours, but remnants of them can continue for up to two to three days.

One of the most important roles of the clinician is to assess the response trend: if the trend is in the direction of a decrease in the acute response signs, even if some of the functions are still impaired, an independent continuation of the improvement can be expected. But if there is no trend of improvement, one needs to find what is the factor that stops the natural recovery. The most common factors are:

1. There is a shortage at the level of basic needs: the child is hungry or cold or without a companion who is sufficiently familiar to him / who gives him enough confidence.

2. The child is still exposed to an ongoing stressor such as untreated physical pain or to the television broadcasting images of the event.

3. The parent or guardian of the child is overly anxious and / or reacts inconsistently.

4. The medical staff performs interventions on the child without preparing him, without explanations and the like.

If all of these symptoms have been treated and there is still no recovery trend in the response, a pediatric trauma specialist should be consulted.

In intervening with children, emphasis should be placed on:

• Presence of an adult known to the child in order for the intervention to be done in his presence and participation.

• Removal of the barriers to natural recovery listed above (such as filling out initial deficiencies, making sure the medical staff gives enough painkillers, etc.).

• Parental guidance in order to achieve a decrease in the level of arousal of the child. An explanation of the child's reactions, being normal as a result of the event and instruction on how to establish confidence and calmness as well as what signs to follow.

• In cases where both parents are absent, a relative, teacher or other adult familiar to the child should be invited. It is essential to assure the child that he is not alone and has no intention of leaving him alone but that an adult familiar to him will be responsible for him until his parents are found or absent: family / relatives / neighbors or welfare officials who will ensure his return to his family and appropriate shelter.

• Children respond well to playful play, for example breathing exercises can be taught with the help of soap balloons. With preschoolers you should use a transition object such as a fur doll. Encouraging feedback accompanied by a

sticker can also be used. When working with a child it is of course important to use stories and metaphors that are appropriate for his developmental level.

The use of a visual bar (VAS) or a painted "thermometer" is very effective in assessing the condition of children.

0- No distress
1- Some distress
2- Mild distress
3- High distress
4- Severe distress

Post-traumatic symptoms in children

After the first two days, if the signs of the acute reaction have not yet passed and post-traumatic symptoms begin to appear and there is still significant emotional distress and / or severe dysfunction, a sign that this is a child at risk of developing chronic disorder (PTSD) later on. Crisis intervention must be continued or referred to a pediatrician, although there is still a high chance that the symptoms will diminish on their own and the function will improve (in the process of natural recovery) but it is very important to know the symptoms to know what to follow, in order to properly guide parents and to locate endangered children.

We will mention here only the symptoms in which there is a difference in expression in children compared to adults:

• In children, if the trauma results in frightening dreams and / or nightmares, the content does not have to be related to the event.

• Instead of "intrusive images or thoughts," post-traumatic play will appear in young children.

• Instead of reenacting in dissociative disconnection ("flashback") in young children, reenactment in play will appear.

• The younger the child, the more likely it is that the "reaction to things reminiscent of the event" will be more physical than emotional.

• Instead of "reduction in areas of interest", there will be a reduction in children in the areas of play.

• A new type (did not exist before the event) of anxiety (such as parting anxiety or fear of the dark, even if there is no connection between darkness and the trauma event) is a significant post-traumatic sign in children.

• The appearance of new aggression (which did not exist before the event) such as involvement in fights is a clear post-traumatic sign in children.

• Trauma always stops the child's development and sometimes even developmental regression ("regression"). Examples: decreased level of language or speech, excessive attachment to parents, finger sucking, loss of control over the braces, request to be fed, back to the bottle, fear of sleeping alone, demand to sleep with parents and more.

It is important to remember that if we are still in the first few weeks after the event, any post-traumatic symptom (like the ones listed above) can be part of the natural response to the trauma.

One of the most important roles of the therapist is to assess the response trend:

If the trend is:

1. Decrease in the intensity and / or frequency of the symptoms (even if they have not completely disappeared yet)

2. Gradual improvement in function and a gradual return to routine (even if the function in some areas is still impaired)

If both of these conditions are met, further improvement in the natural recovery process can be expected.

But if one of the above conditions is not met, Or if four weeks after exposure to the traumatic event there is still significant emotional distress or there is still significant dysfunction,

So there is a concern that a chronic post-traumatic stress disorder is developing. In these cases, parents must be explained the importance of referring to trauma-focused therapy with a child-focused trauma therapist (not every therapist has knowledge and experience in this area). It is very important not only to give the above explanation to the parent but also to help him practically find a place for such treatment and make an appointment.

Summary: Key emphases in the approach to children and their parents during intervention in the acute phase

• Remove harmful agents, ensure basic safety

• Treatment of basic needs

• Assessment of the level of arousal

• Evaluation of parental functioning

• All acts of the caregiver constitute MODELLING to the parent

• Evaluation and intervention are done at the same time

• Basic psychological training ("psycho education")

• Dialogue, play - yes but do not lecture!

Relief of uncertainty and helplessness

• Treating anxiety

• Restoring control and regulation

• Narrative without flooding

• Guiding the parent in finding the right balance in the axis:

"Inclusion of symptoms" versus "encouragement to return to function"

• Identification of risk factors for the development of chronic post-traumatic stress disorder