

## Cultural Awareness: Children and Disasters

Ms. McGee: Hello. Welcome to our podcast, Cultural Awareness: Children and Disasters presented by the Substance Abuse and Mental Health Services Administration's Disaster Technical Assistance Center or SAMHSA DTAC. My name is Lori McGee and I will be your host for the podcast, which is the second in our series on cultural awareness. I currently serve as the Deputy Director for SAMHSA DTAC where I supervise the development and curriculum of training and lead the Crisis Counseling Program. Over the past 12 years, I have worked with a variety of special populations including at-risk and delinquent youth, women and families in crisis, and populations receiving mental health services. I would like to take a moment to thank SAMHSA for their supportive podcast, particularly Ms. Julie Liu for guidance and support through the development of this presentation has been most helpful and appreciated. Now it's my pleasure to introduce Ms. Julie Liu as our first presenter. Ms. Liu is a Public Health Advisor for the Crisis Counseling Assistance and Training Program with the Emergency Mental Health and Traumatic Stress Services Branch at SAMHSA. She brings 16 years of clinical experience as a mental health specialist and over 9 years of crisis counseling experience. Welcome Ms. Liu.

Ms. Liu: Thank you, Lori. As Lori has mentioned, I'm a Public Health Advisor with SAMHSA. Today I'm going to introduce our topic, the goals, and provide an overview of the presentation and introduce our speakers. This podcast is to assist disaster responders in providing culturally aware and appropriate disaster behavioral health services for children and families impacted by natural and human-caused disasters. By the end of this podcast, we hope that you will be able to define cultural awareness in reference to working with children in disaster services, understand the importance of cultural awareness in disaster services, identify common reactions of children to disaster and trauma, present helpful approaches to working with children impacted by a disaster. As an overview we'll discuss the culture, the major barriers, overcoming barriers, how to reach children, children's reactions both for young and older children or youth, how to interact with children and youth during a disaster response, and frequently asked questions. So now, I'm pleased to introduce our next presenter, Dr. Russell Jones. Dr. Jones is a Professor of Psychology at Virginia Tech University and a clinical psychologist who specializes in trauma psychology in the areas of natural and psychological disasters as well as interpersonal violence. He is the founder and director of REACT, Recovery Effort After Adult and Child Trauma, a program developed in conjunction with the Yale Child Study Center at Yale University designed to assist children and their families following a range of traumatic experiences. Please help me welcome Dr. Jones.

Dr. Jones: Okay. Hello. We are so pleased that you have sought out this presentation dealing with the topic of cultural awareness and its application to children during and following

disasters. In my 30-plus years of working with and studying children exposed to traumatic events the importance of “bringing everything to the table” to help those unable to help themselves can’t be overstated. I am so fortunate to work with so many wonderful colleagues, students, and members of the mental health profession as we continually and collectively seek to meet the needs of children. We are hopeful that this information will add to your arsenal of experience, wisdom, and knowledge, which will further help you when assisting traumatized children. As you know, many of the youngsters we have all worked with are from culturally diverse backgrounds. I think you would agree that targeting this group presents a number of very unique challenges in our attempt to bring about needed restoration following trauma. We know that people of color in the United States make up approximately 30 percent of the population. We also know that this number is increasing daily given that immigration is now worldwide. American Indians, Latinos, African Americans, and Chinese are among the groups that make up this quarter of the American population. We also know that approximately 57 percent of ethnic minorities are under the age of 18. Many of these individuals are likely to be exposed to trauma and experience difficulty coping with these consequences. For example in our work with child survivors of residential fires as well as wildfires children of color were often likely to experience symptoms of PTSD and depression more so than their Caucasian counterparts. This was due in part to living in substandard housing and having access or not having access rather to needed mental health services. There is no substitute for cultural awareness when working with children from varying backgrounds. The adage “knowledge is power” is quite apropos here. How many times have each of us labored to work with individuals of color in the field as well as our private practices only to fall short of our laudable goals and expectations. I have found more often than not my shortcomings have not been due to my passion, zeal, nor my desire to help others but more so to my lack of understanding of differences across races, cultures, and ethnicity. Next, this slide is quite valuable and a must-read and a must-study for my undergraduates and graduate students. It nicely provides an index to measure your level of cultural competence. That is your understanding and appreciation of differences across cultural groups; you can see that the range of levels begins with level one depicting little to no awareness of cultural differences to level four taking cultural differences into account when conceptualizing and implementing interventions. I encourage each of you if you have not already done so to measure your degree of cultural competence. You may be quite surprised at what you find. Next, as stated earlier there is a great need for cultural awareness of people of color given the frequency of traumatic exposures, greater risks for negative outcomes, and often lack of available culturally sensitive disaster services. I would like to briefly share with you an incident that occurred in Pearlington, Mississippi, shortly following Hurricanes Katrina and Rita that highlight this point. Following a 3½-hour drive from our base in Jackson, Mississippi, me and several members of our Disaster Recovery Team approached a large Red Cross shelter. Moments after being welcomed by a white female member of the Red Cross who spontaneously yelled out, “Thank God for an African-American male,” I was asked to go and see about a survivor of the storms. I learned that he was an African American and “refused to talk with white folks.” After receiving directions, I

immediately drove a few blocks and found an elderly African-American gentleman sitting on the hood of his automobile. He shared with me how he and his grandson had climbed a tree, waited for about 8 hours until the waters had subsided. He refused help from the Red Cross because he did not “trust white people.” It was clear, at least in this instance, that I possess the “complexion for the connection” to relate to this gentleman. I also had an appreciation of his reluctance to “talk with white folks.” Indeed, there are times when working with members of diverse groups the match across diversity and ethnicity with the client and mental health professional can be a big plus. Next, a number of factors that contribute to greater levels of risk or trauma prior to and after trauma include, number one, racism. We do know that race impacts diagnosis and treatment. For example, there are examples of documentation attesting to the fact that many African Americans and other ethnic groups are misdiagnosed and consequently given inappropriate treatments to target problem behavior. Two, discrimination. We do know that access to mental health and medical professionals is less available for people of color. Three, experience. Many mental health workers and clinicians have limited experience with people of color. I’ll discuss this a bit more later. And then number four, diathesis, we also know that diathesis plays an important role in the etiology as well as maintenance of mental disorders. The dose-response model has been particularly helpful in determining causes of psychopathology in children of color in highlighting the fundamental role of stress on one’s wellbeing. Next, in terms of barriers we do know that there are barriers to mental health assistance in times of dramatic crisis. One only needs to read the report of the Institute of Medicine of the National Academies 2002, which documents the following: one, racial ethnic minorities are less likely to receive even routine medical procedures; and two, when they do receive them they are of lower quality of health services. An additional read that I think is very relevant is the supplemental Surgeon General’s report on mental health of minorities in 2001 which documents: (1) a high degree of poor mental health services provided to racial and ethnic groups in the United States, (2) a significant illness burden on people of color, and (3) lack of access to mental health services. Additionally barriers to needed mental health and physical health services have stemmed from a number of historical injustices that place fear in the hearts and minds of people of color such as the Tuskegee experiment. Continued efforts are needed to remove fear, mindset, and stigma often associated with mental health assistance. Next, in terms of lack of familiarity with varied cultures, I’d like to know that the impact of lack of experience in working with individuals of color and in doing so I’m going to share my initial attempts to work with an individual of color during my internship year at Brown University. Due to my lack of experience working with African Americans in a clinical setting I had long looked forward to working with an African-American male. Though I highly valued my training at Penn State one of the shortcomings of our clinical program, as well as many other clinical programs, was the lack of access to people of color. I had worked with only a handful of diverse clients at that point. Nonetheless, I fearlessly charged into the experience with the goal “helping a brother out.” After being granted permission by my clinical supervisor to carry out an evaluation on this individual who was suffering from alcoholism I energetically walked into my office where the interview was to take place. Well,

midway through the interview he began to stare at me and abruptly stated, “You weren’t there when the cops were picking me up.” He went on to say, “Yeah, he also bumped my head when the cop was forcing me in the car.” At this point he began walking towards me with anger and vengeance in his eyes. I knew I was in trouble as he came closer and closer. Having learned the benefit of using humor as a defense mechanism by one of our psychodynamic faculty members at Penn State I quickly grabbed my glasses from my desk, put them on, and nervously said, “You wouldn’t hit a man with glasses would you.” It was obvious that he had not studied Freud and failed to see the humor or the value of this gesture. The next thing I knew he had drawn back and hit me in the jaw. I quickly and awkwardly exited the office. This somewhat humorous and most embarrassing situation has served me well as a “teachable moment” which I have drawn from many, many times. That is because of my lack of experiences working with this target population in a clinical setting, coupled with my naïve assumption that “since we were both African Americans I could fully relate to him.” I could not have been more wrong. No doubt this young man was totally turned off to the mental health profession that day due to my naiveté. As for me, I walked around for the next few hours with an ice pack on my jaw. Next, there is a great need to be able to speak the language of individuals of various races and ethnicities. For example, we know that 40 percent of Californians speak a language other than English, which points out the great need for mental health workers to become fluent in various languages or call upon the services of interpreters. Without such skills the probability of misdiagnosis and inappropriate treatment are likely to be greatly increased. A related skill set needed by mental health professionals is awareness of idioms of distress. That is being aware of the unique expression of symptoms of trauma within various cultures, ethnicity, and races. Some researchers have recently begun to identify idioms of distress among a number of ethnic groups in recent years. For example, among African Americans, idioms of distress have included more emotion such as sympathy and sadness when compared with Caucasians as well as greater levels of anger. Complication, chest pains, and gas are among forms of somatization in Puerto Ricans, Mexicans, and whites, whereas with Asians may exhibit cardiopulmonary and vestibular symptoms including vertigo, dizziness, and blurred vision. But even greater understanding and appreciation of these differences and symptom expression is of paramount importance if we are to better conceptualize, assess, and treat these populations. Next, in terms of family reorganization I think it’s always important to take into account the family dynamics when working with trauma survivors. Cultural and ethnic practices, religious beliefs, role of gender of parents and children in the family unit are also important factors that need to be considered. For example, it’s often the case that older children, particularly adolescents, will take on the role of parents following disaster. This is frequently the case when the parent is not doing well, maybe suffering from extreme levels of stress, posttraumatic stress disorder, or even depression. This can place an undue burden on adolescents who are unlikely to voice their symptoms nor seek out treatment. This can have a lasting residual affect on their later development. Next, one point I would like to drive home to my graduate students in my trauma-focused practicum and my undergraduates in my senior seminar entitled The Psychology of Trauma is the importance of knowing how to

relate to those that you interact with prior to, during, and following the trauma. I think that overcoming barriers is all about relationships. If you are deciding to buy or build a home for example the real estate industry has a saying, “Neighborhood, neighborhood, neighborhood.” When dealing with people of color I think a key to success is “Relationship, relationship, relationship.” You’ve got to develop relationships to overcome and deal with barriers often confronting people of color if meaningful and sustained interactions are to be obtained. Next, in terms of language issues, as I stated earlier it’s important to speak the lingo or know someone who does to foster interaction among traumatized children and their families and mental health change agents. As stated earlier, it may also be helpful to have a cultural liaison to assist you in understanding behavioral health issues related to trauma. Next, in terms of how to reach children, as pointed out earlier the topic of children and disaster will be discussed in great detail by April momentarily. Just before she does however, I would like to say a bit about the topic of how to reach children. Given the level of vulnerability and at-risk status of youngsters before, during, and following disasters, it is of paramount importance to give attention to this topic. As pointed out by my good friend and colleague [inaudible] three factors make the topic of reaching children even more significant. They are (1) children are understudied in disaster research. We know much more about adults and trauma than children. I think this is due in part to the lack of access to children as well of the overprotective nature of many parents regarding their children. What I have often heard many parents say in response to our request to talk with their children to determine how they are doing is “The storm is over, we’re moving on with our lives; furthermore by bringing it up again it is very likely to upset them and to start the nightmares again.” (2) Adults often underestimate the impact of disaster on children. I think this is due in part to parents feeling somewhat guilty or at least partially responsible for their children’s exposure to and negative reactions following trauma. They feel that they have in some way “let their child down.” If I had only been there for them this would not have taken place. Parents need to be educated that in most instances this is not at all the case and the responsible thing for them to do at this point is to allow their child to discuss their thoughts, feelings, and reactions, with them and/or a trained professional or paraprofessional. I would like to finish up with a brief story of an encounter that resulted in a metaphor to characterize post-disaster actions. Immediately following my second deployment to the Gulf Coast following Hurricane Katrina, I found myself in a plane discussing my experiences as a trauma psychologist with an individual in the seat next to me. During the course of our conversation, I learned that he was of all things a rocket scientist. An interesting discourse ensued. Being fully exhausted and somewhat frustrated with the fact that the pilot had announced that our plane was grounded and we were having engine problems I then curiously asked this rocket scientist what is it about rocket engines that make them more efficient than airplane engines. He replied, “Well, with rockets, there’s not a single engine but multiple engines.” He went on to say, “There could be three, six, or even nine engines and what these engines do is interact. They compensate for one another.” He went on to say, “That the technical name for this interaction is gimble.” G-I-M-B-L-E, gimble. He opined that when this process of gimbling took place it produces maximal thrust, maximal efficiency, and maximal

direction. I enthusiastically replied, “What a metaphor for mental health professionals in times of crisis.” To get the job done with children with respect to cultural competence we need to be able to conceptualize, assess, and treat them and doing this in a way that we’re gimbling. That is we’re working together as counselors, as psychologists, paraprofessionals and professionals to fully address the needs of children with diverse backgrounds and experiences. No matter how challenging your work becomes remember there is always hope and the famous Hebrew proverb “Out of darkness comes light” should continually serve as reminders to us that our good work is not in vain. Julie.

Ms. Liu: Thank you Dr. Jones. What incredible information. Our next presenter is Dr. April Naturale, a specialist in traumatic stress with 25-year history in health, mental health administration who currently serves as a Senior Advisor to the SAMHSA DTAC. She directed the New York 9/11 disaster mental health response and spent several in the Gulf Coast after the large-scale hurricanes had devastated the area. She helped along SAMHSA National Suicide Prevention Lifeline and recently directed the BP Deepwater Horizon Oil Spill Distress Helpline as well as the 9/11 Healing and Remembrance Program. Please welcome Dr. Naturale.

Dr. Naturale: Thank you, Julie, and thank you Dr. Jones. Your talk was very informative. I learned a lot and there certainly is a lot to know about working with children and disasters. So we appreciate people’s attention to this podcast today and we hope that it’s informative. As Dr. Jones said, one of our biggest considerations is that adults tend to underestimate the impact of disasters and trauma on children but there are other factors that can influence how they respond. One of those of course is their developmental level. We know that children under the age of 5 tend not to be able to really perceive what’s going on around them unless they can read what’s going on with their caregivers. So it’s important to gauge the response of the caregivers as well as the children’s proximity to their caregivers during the event. For example, if something happened and the children became frightened and there were no caregivers around they could feel worse and more frightened. Of course, if the children themselves were exposed to the event and they had an injury or there was damage caused to the physical surroundings children can be much more affected. As Dr. Jones talked about all of the cultural innuendoes and the implications of how different cultures perceive health, mental health, trauma, and wellness will impact how the children perceive what’s going on around them. Their culture, their religious beliefs, their spiritual beliefs, all of these concepts about when something bad happens, what’s the cause, what does it mean to be healthy, and of course what is mental illness. Some cultures are much more tolerant of people who have higher symptomatology of certain mental illnesses than others. And of course very importantly the children’s previous mental health status or the mental health status of those in their immediate family that they might be exposed to. Their health status can also make them feel a little bit more vulnerable and frail when some type of a trauma happens. Younger children may not understand the event itself and so again, they’re

going to respond to their caregiver's emotions. But they will go into some of the same reactions that you can see in children a little bit older. They may regress to something like sucking their thumb or even go back to wetting the bed when they have already progressed past that developmental stage. A trauma can cause them to go back to those events and regress for a little bit. They may start to fear strangers again as they did when they were 2 or 3 years old, and darkness, and they might create monsters in their mind and create a difficulty going to sleep or even going into their bed. It's very common for younger children to become clingy. They want to stay nearer their parents; they want to be in touch with their parents, holding their hand, hanging onto their leg, anything that helps them to feel more secure. Then we also hear very much from parents that children will repeatedly express the trauma in their play and often will tell exaggerated stories of what happened. Some adults complain about this and feel like it's not good for the children to repeat this in their play, but it is a very common response and can help children to process what's happened, especially when they have the ability to change the end of the story and make it much more positive than what happened in real life. Younger children's—some of those reactions that are similar to those than adults are changes in eating and sleeping habits. One of the most common complaints we hear from every age range about trauma is difficulty sleeping, difficulty falling asleep or even staying asleep. Some people complain about eating more and others complain about losing their appetite. These are some of the same symptoms that you see in children. Then in younger children who have fewer language skills, it's more common for them to complain about something physically, their arm hurts, their leg hurts, their stomach hurts when there is no physiological reason for the pain. You may take them to the doctor and find out there is absolutely nothing wrong with them physically. Sometimes this is their way of trying to express emotional pain when they don't have the language to say how they feel but rather can say that something hurts, an arm or a leg or headache or stomachache. Then the symptoms that are very common in children are withdrawn behavior or isolation and they pull themselves away from everybody else, not want to play with friends, not want to spend time with family. Some children do become aggressive. They may act out, not knowing how to express themselves. This is not unusual when children have difficulty talking about what's happening when they're upset or afraid or if they've been in close proximity to an event and need to get some stress hormones out of their body. This is also what you see in children who exhibit more hyperactivity. They may just run around the house in circles just trying to get the energy out of their body not knowing how to use their speech to do so and those who do have speech might regress. Again, you might see them have a little bit more difficulty than before or they may even forget some of their words. It's not unusual for children to become disobedient either whereas they may have been really quite good and responded to parents' instruction before. Again, they might become aggressive, yelling, running around, and not listening to parents as much as they did before. Again, that's often a stress response, and they use their body as a way of being able to deal with the stress especially in the form of running around or becoming more hyperactive, yelling, screaming, or crying. Now older children and youth can go one way or the other. They might actually regress like some of the younger children do or they

might, especially in the case of teenagers, they might start to act like adults and take on the responsibilities that they feel like an adult should be taking on in the house. So you'll see it in one way or the other in terms of children who are over the age of 6, they're tweens and into the teenage youth. The issue that they suffer with is that they have so many other things happening in their body in terms of changes physically and hormones that when you add stress to that and all the different types of stress hormones that move through a person's body after a trauma it really makes them feel much more out of control and feeling out of control is one of the things that makes it hard for us to deal with trauma. It's not unusual for older children and youth also to be looking for more attention from their caregivers. Now in your tween and your teen population they may act like they don't really want your attention but the bottom line is they want to feel cared about and loved just as much as the younger children. So it may be more difficult for adults to deal with the issue but spending time with the tweens and the teens even if they're not very verbal or if they seem unhappy about it it's important to have a supportive presence. The other issue that we hear about from adults and when they describe what's going on with their teens and their older youth is this denial of any reactions or any ability to really verbalize what's going on to them with their parents. So the teenager will say, "I'm fine. I'm okay. Nothing is wrong." These are pretty typical of teens to begin with. When they don't know how to deal with their stress, it's very, very common for them to move into that denial of reactions. Because adults tend to underestimate the reactions of children to begin with it's really important not to fall into agreeing with a teen that there is no reaction. Don't go hand in hand with their denial and say, "Oh, okay, he's fine. There is nothing wrong with him. He can go about his business. I don't have to pay any special attention to them." I think that's the wrong way to go and that instead adults should in fact continue to provide special attention to their youth and teens during a traumatic event and especially for a few weeks afterwards. Again, older children and youth may be the type who are argumentative just because they're going through a developmental stage where they're resisting authority to begin with. So they may do this even more so during a trauma. They might start arguments at home, at school, and really have great difficulty. One of the things that can be helpful at this time is to talk to children about what kind of structures they would put in place and what they think might help them to cope better. One of the more frightening pieces about working with older children and youth after a trauma is the risk of behaviors such as testing the use of alcohol or illicit drugs. This is a problem even when there isn't a trauma or a disaster. So it's especially important for adults and other caretakers to be very much present with the children especially right after the trauma and make sure that there is adult attention to what the children are doing on a daily basis, who they're with, and what their emotional and physical state seems to be like at the times when they return from not being with any adults. We have to be on alert and make sure that we're attentive to whether or not the children are engaging in alcohol or drugs or other risky behaviors, going to places that they're not supposed to be, getting in the car with someone they're not supposed to. So we need to pull up all our skills in working with youth and teens, talking to them on a regular basis, checking in with them and again making sure that we're a supportive presence so that they feel comfortable

coming to us instead of going to these risky behaviors. Some children might stop doing their schoolwork. They might feel it's not important anymore. If they've lost a loved one they especially feel that their grief is so overwhelming that they can't focus on anything like schoolwork or chores at home. It's really up to the adults to reiterate to them that their most important job at these times is to attend to their schoolwork and to participate in the family by doing some of those chores that they've been assigned to. Of course 1 or 2 days after a trauma it's all right to loosen up and let their chores go but the most important thing for many children is to get back into a routine. To feel like they're part of the family and participating and to feel like their schoolwork is something important to them so that they can move forward and have choices in their later life. Another issue that we hear that happens especially with teens is that they are in this place where they're not quite adults but after a trauma they might want to be adults and act like adults and as a way of dealing with their helplessness or their guilt because they can't take on these roles they start acting like adults. These are the kids who might stop their parents from going out, saying, "Where are you going? Who are you going with?" Almost a role reversal. It's important to stay in touch with the children and communicate with them as much as possible and it's very important to tell them that the trauma is not their fault. That the parents and children together, along with help from the community, will deal with whatever has come and that it's nobody's fault when a disaster or a trauma happens. The good news is that most children really are quite resilient and that means that they're able to get back to feeling okay pretty soon after a trauma. This is really the norm although we're certainly very concerned when there are children who do have serious responses. We just don't want to pathologize. That is we don't want to start diagnosing or looking for problems when there aren't any. Many children have these innate abilities to move forward, to look on the bright side, to get back to their routine, and to stay connected. Those are important types of qualities that we want to enhance in children. We can also teach these qualities in children. Help them to think about what is the way that they can cope well. How can they participate in the family and in the community? How can they acknowledge the good things that people did after a trauma to help everyone to get back to their normal way of being, even if that's changed and it's a new normal? With all kinds of support from parents and caregivers and teachers, children really can move forward and recover fully from a trauma. As Dr. Jones noted earlier, working with schools is an important way to reach children. Of course they're in the classroom a good part of the day; the teachers have their attention and the kids need to feel that teachers support them and recognize when they're going through a trauma either an individual one in the family or a community trauma like a disaster. Again, the most important way to help children is to bring them into the process of discussing and coping with the trauma. Making sure that adults are attending to them, having a supportive presence, and helping the children to feel connected, to feel cared about, and of course to feel loved. Research tells us that one of the most important ways than anyone, child or adult, can recover is with their social supports from the community. So as many supports can be implemented in the community as possible are the best way to go. Parents and caregivers don't have to go this alone. They can elicit support from teachers, from other caregivers in the community, after school program staff

and faith-based leaders, those are out there in the community and who are willing to help, as we all are to see children move through a trauma and recover as soon as possible. So what is the role of parents and caregivers? Well, one of the more important things we can do is tolerate their expressiveness. Most of the children like to talk about what happened and as we mentioned earlier they might talk about it over and over and over again. They might draw about it and they might be playing about it. We have to accept their ability to express and the need to express through all these different modalities. Many children like to write, to draw, to sing, different ways. Again, we know from the research that moving their body, doing things can help anyone to recover from trauma and this is especially so with children who are not inhibited and able to express themselves. If there are ways that we can help them by encouraging them to draw, to write about their story, or maybe to write a letter to somebody who was helpful, to talk with others and to do fun things as well, we have to give them permission to celebrate. To go back to having joy and being expressive about the good things that are happening in their life after a trauma. Many children do want to talk to adults about what's happened to them and we need to let them do that. We also need to let them do that in a way that will accept their feelings and validate for them that their experience is real and true for them. We shouldn't be telling them what's the right or the wrong way to feel. We should especially be giving them the messages that of course you're going to feel upset or sad or even stressed and that crying is okay. It is a way to relieve stress and grief. So our job as parents and teachers and caregivers and other responders like disaster behavioral health responders is again to pay attention and recognize that children do have responses and to be good listeners. Not only about the information that the children are telling us but about what they're not telling us and what their needs might really be underneath the words that they're saying to us. We should look at what kinds of positive interactions the children can experience after a trauma. What do they know, hear, or see on television and the Internet. Remember, lots of them get news from the Internet these days. Allow them to ask questions and talk about how to limit access to television and the Internet so they're not constantly hearing about the trauma but can do more positive things like getting back to their routine, going to chorus, going to their faith-based activities, and playing with friends. Doing the things that will help them to recover in a quicker period of time. That's not to say that they're not going to have times when they might go back to feeling sad or distressed, most especially when there's been a serious loss in the family. It's important more than anything to let them move between these different ways of being. Not letting trauma take over the family discussion all the time or not let it be part of the classroom discussion for long periods of time either. Limit the amount of time that you process what happened and again get children back to normal routines. Adults can really help children to see the good that comes out of trauma by looking at the heroes who responded, help and support from people in the community, neighbors who came over and asked if everybody was okay or who brought a meal, and the children can actually better cope by helping each other. Very often, they feel like they want to do things for their parents, for others, and for responders, like when we see them writing letters to the fireman or the policeman who may have helped in an event. Adults can really encourage these kinds of things, suggest these

kinds of things, and help the children to carry them out. Exposure is one of the biggest concerns that we have after a trauma. So it's good to know that it's okay for children to see adults sad or crying in response to a trauma, but we want to protect children from emotions that are too intense. We certainly want to refrain from expressing ourselves in ways that might frighten children like yelling or hitting the wall or throwing furniture. Sometimes adults do these things to release their own stress and this can be very scary for children. It can actually increase their traumatic responses. As we mentioned before we want to make sure that children understand that they're not to blame for what happened. These events happen all the time, the most common one being a motor vehicle accident, and these days with a 40 percent increase in the natural disasters in this country there are many, many things that are out of our control. So another thing that we can do is try to model for children how to take care of themselves. If we tell children they have to go to bed early but we're up all night and unable to get up in the morning because we're too sleepy children are going to see and remember that. So if we set routines and follow them ourselves it's more likely that the children will engage in them as well. So surprisingly children really are very capable of using different coping skills and pretty sophisticated ones from taking deep breaths or doing the color breathing exercises that have been laid out for children or even more sophisticated things like gentle stretching or even yoga. Children are really good at these things and if we teach them and give them these skills then they'll have them to call on in the future as they grow up. So what can we do? We can encourage children to participate in activities, move around, play with others, have joy, get stress hormones out of their body just like adults need to. Certainly avoid hitting, isolating, abandoning, or making fun of children who are upset after a traumatic event has happened. This can really cause them to stop expressing themselves and stop the recovery process. Everybody processes trauma differently, and so one child may react very differently than another and shouldn't be made fun of or in any way be punished because of their responses. Again, let children know that you care about them. Spend time with them and even do special things that might make them feel special like playing a game with them, taking them for a walk. Most importantly with your teens especially and now even your tweens is do stay in touch. Even though they do the "I'm okay—I'm fine" thing, check with them in nonintrusive ways. Make sure that they know that you're around and that you are available for them.

Dr. Jones: Yeah, just another caution. I think it's real important that we don't push kids in talking about their thoughts, their feelings, and emotions regarding the trauma. I think so often in our quest as mental health professionals and parents we try to prevent further distress. But in doing so we inadvertently push them to talk about the event and things that they're not really ready to talk about. We really need to follow the kid's lead and move at their own pace or to move at their pace. Children should also be allowed to remove themselves from group discussions or activities that they do not feel comfortable with. I think it's also important that there's a need to, as April was pointing out, the need to monitor signs of distress or discomfort. For example when one sees

a child exhibiting signs of anxiety, they may be disassociating, being fidgety, irritable, stiffening up, or crying you should consider other means through which to interact with him or her.

Dr. Naturale: Great points Dr. Jones. Thanks so much for bringing those up. We do know that it's very important not to force anyone, children or adults, but especially children when they feel like they cannot respond or interact or hear about the trauma. It's a smaller percentage of children that have trouble being expressive but it is important that we recognize and not mandate that they participate in discussing the trauma. Thanks for bringing up that important point. So to summarize, as Dr. Jones said earlier, culture extends to all different groups. It can be ethnicities, organizations, schools, faith-based organizations. Culture is really a group that defines themselves as such. So whenever we work with any population we have to pay attention. Look at that scale of cultural awareness and see where you are and what you can do to improve yourself as a disaster behavioral health professional in increasing your cultural awareness. What do you need to look for in a particular group to help you to understand how their culture is influencing how they're responding to the trauma? Adults can model and show children how to take care of themselves. They do what we do. They don't often listen to what we say but they will copy what we do and we need to be very aware of this. Also, look at how children are different and how they address cultural barriers to healing. Certain cultures may help children to deal with difficulties, may have different ways of coping, different rituals or processes that they want the children to go through as a group and as individuals. We need to be very aware of these so that we can understand how the children will move through the process and that we don't inhibit that process. Real quickly an example that I can give you is when I was doing training in Africa I was talking to a group of young adults about becoming independent and how they can take care of themselves and move into being grown up independent people and I had all these blank stares looking at me. Later on the master trainer explained to me that in this culture there is no such concept as independence and I had missed it. I had studied a lot about the culture and just missed that they really don't go to the concept of independence at all. Everything is done in the group, family, and community setting. So we need to be aware of differences of how culture influences how children are responding and what barriers are to helping them. Most importantly, as we've said over and over again, as adults it is our responsibility to attend to children. To listen to them, to help them to feel safe, cared about, and loved. So we hope this information has been helpful, and I am going to turn the rest of the podcast back to Lori.

Ms. McGee: All right. Thank you Dr. Jones and Dr. Naturale. Such great information and we know it's going to be helpful to many out there. Before we let you off the hook though I do have a couple of frequently asked questions that come up that we would like to cover. The first one is for you Dr. Naturale. In thinking about working with children how much information about traumatic events do we share with them?

Dr. Naturale: Oh, this is a good one, Lori. I'm not surprised that this is one of the questions that came up. People ask us about this, you know, "Should I lie to my child?" Adults sometimes become very, very stuck on this question and they start to stand on ceremony and say, "Well, I want to be able to tell them the truth." Truthfully, this is not the time to stand on ceremony. We talk about things with children that are fictional all the time. We teach them about things like the Tooth Fairy or Santa Claus or other fictional characters. So right after a trauma is not the time to feel like we have to tell them every last truth. We certainly want to give them information in direct response to whatever questions they ask us but we want to leave out any traumatic gory details. They don't need to know every last little piece of information that might in fact traumatize them even more. The best rule is to just answer what they ask and not elaborate on that. Again as a parent, it's your responsibility a parent or a caregiver, a teacher, a responder to think about what's the developmental level of the child and what can they understand so that we don't make them feel more frightened by our response to their question. I hope that that helps.

Dr. Jones: April, I agree totally. I think what kids really need to know is that their parents or the caregiver is there to take care of them and to protect them. I think so often if a child simply knows that there is someone there if they need them that it brings about a great deal of comfort. To the extent possible parents should also strive to restore the following five domains just bring about a sense of safety for them, calmness, efficacy, connectedness, and hope. These were pointed out by Stevan Hobfoll and a number of his colleagues. But again just knowing that the parent is there, that they're there to protect them I think can be quite beneficial.

Dr. Naturale: Yes, very important, Dr. Jones. Thank you.

Ms. McGee: Great. Thanks to both of you. I have one other frequently asked question. What is one of the most important factors in helping children recover if you have to choose one? Dr. Jones, I'll throw that one to you.

Dr. Jones: I think it's important for children 5 and under the most important recovery factor is response of their caregiver. So often kids model the behavior of the parent. If a parent is cool and calm oftentimes that's the case with the child. However, if mom or dad is losing it, oftentimes children will exhibit similar behaviors. So again, I think modeling the behavior of parents can be very, very important.

Dr. Naturale: I agree and I'd add to that a little bit too, Dr. Jones. Is again as you said earlier really the more important factor, especially for those youth and teens, is the support is there from their caregivers and the reassurance for adults in their lives to say that together, the adults and the children, "we'll manage the events together" and that parents and caregivers will do everything

possible to keep their children feeling safe. I always find it amazing to me, my granddaughter is now going to be 11½ years old and she was born 6 months after 9/11 into a household where we talked about 9/11 all the time. I worked it every day and took very little time off but we were very careful to protect her from this information. So at 10 years old she barely knows the details of what happened at 9/11. It's just a good example of how we really can protect children from trauma.

Ms. McGee: Great, that's so helpful and we appreciate you taking time to share your thoughts with us. Again this podcast is brought to you partially by SAMHSA DTAC. So I'm just going to share a few words about us. We were established by SAMHSA to support the States, Territories, and Tribes to deliver an effective behavioral health response to disasters. As such, we have as part of our collection of resources and materials and the technical assistance we provide the Disaster Behavioral Health Information Series or the DBHIS, which contains themed resources and toolkits about all sorts of DBH topics specific to populations or by disaster. So you see a couple listed here, "Children and Youth Resource Collection," and "Languages Other than English." These two are highlighted as part of this Cultural Awareness: Children and Youth podcast. Additionally, other resources that we have listed for you here, the National Center for PTSD, the National Child Traumatic Stress Network Learning Center, Disaster and Distress Helpline. They have a toll-free number and also a text feature. The website Ready.gov, which is FEMA's planning and preparedness website, and again at SAMHSA DTAC, our toll-free number and website listed here, [samhsa.gov/dtac](http://samhsa.gov/dtac). Our presenters thank you again, Dr. Naturale and Dr. Jones, Ms. Liu, and myself, Lori McGee. We are putting our contact information up here. If you have any questions please feel free to email us. I just want to say thank you again to all of our presenters and to SAMHSA for sponsoring this podcast. To all of you out there listening who assist in the wake of disasters we thank you.

[End of podcast.]