MENTAL HEALTH AND PSYCHO-SOCIAL SUPPORT FOR CHILDREN IN CRISIS AND EMERGENCY SITUATIONS

Manual for professionals



Council of Europe Consultation Group on the Children of Ukraine

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MENTAL HEALTH AND PSYCHO-SOCIAL SUPPORT FOR CHILDREN IN CRISIS AND EMERGENCY SITUATIONS

Manual for professionals

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Key Terms and Definitions

Child	Child refers to any human being below the age of eighteen years.[1]
Confidentiality	Confidentiality is the obligation that information about an individual will not be disclosed or made available to unauthorised persons without prior permission. There may be limits on confidentiality for children in accordance with their best interests as well as mandatory reporting obligations.[2]
Informed consent	The voluntary agreement of an individual who has the capacity to take a decision, who understands what they are being asked to agree to, and who exercises free choice. When obtaining informed consent, practitioners must share, in a child-friendly manner, information on; services and options available, potential risks and benefits, personal information to be collected and how it will be used, and confidentiality and its limits. Informed consent is usually not sought from children under age 15.[3]
Informed assent	The expressed willingness to participate in services. Informed assent is sought from children who are by nature or law too young to give consent, but who are old enough to understand and agree to participate in services. When obtaining informed assent, practitioners must share, in a child-friendly manner, information on; services and options available, potential risks and benefits, personal information to be collected and how it will be used, and confidentiality and its limits.[4]
'Mental health and psycho-social support' (MHPSS)	Refers to any type of local or outside support that aims to protect or promote psycho-social well-being and/or prevent or treat mental disorder.[5]
Psychological distress	Unpleasant feelings or emotions that can impact a person's level of functioning and ability to navigate and participate in social interactions. Sadness, anxiety, distraction, disruption in relationships with others and some symptoms of mental illness are manifestations of psychological distress.[6]
Separated child	A child who has been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.[7]
Unaccompanied child	A child who has been separated from both parents and other relatives and is not being cared for by an adult who, by law or custom, is responsible for doing so.[8]

[1] According to the United Nations Convention on the Rights of the Child (UNCRC) Article 1, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.
[2] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.303.
[3] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.308.
[4] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.308.
[5] IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, p. 1.
[6] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.312.
[7] Recommendation CM/Rec (2019)11 of the Committee of Ministers and Explanatory Memorandum on Effective guardianship for unaccompanied and separated children in the context of migration, p.12.
[8] Recommendation CM/Rec (2019)11 of the Committee of Ministers and Explanatory Memorandum on Effective guardianship for unaccompanied and separated children in the context of migration, p.12.

Chapter 1: Introduction

Outline

1.1. The impact of crisis and emergency situations on children
1.2. Children's rights and protection in crisis and emergency situations
1.3. Key guiding principles
1.4. Purpose of this manual

1.1. The impact of crisis and emergency situations on children

1. Crisis and emergency situations include armed conflict, terrorism, migration and forced displacement, civil unrest, health and economic crises, natural disasters and climate change. In all these situations, **children's enjoyment of their human rights** is at greater risk and there can be both a short-term and longer-lasting, harmful impact on the lives and development of children, from infancy and childhood through to adolescence and adulthood.

2. The **child protection risks** children face during crisis and emergency situations can include separation from parents and caregivers, trafficking, radicalisation through extremist groups, physical or sexual abuse, deprivation of liberty, such as administrative detention, psycho-social distress or mental health issues, injury and death, economic exploitation, forced displacement, and lack of access to basic services, including health and education. Risks depend on **risk factors**, which are considered the root causes of potential risks, such as the nature and scale of the crisis or emergency, the number of children affected; existing sociocultural norms; patterns of pre-existing child protection risks; the level of community preparedness; socio-economic hardship, and limited stability and capacity of the State before and during the crisis.[9] **Protective factors** can mitigate and prevent risks. Protective factors include the resilience of children, their families and communities, socio-economic conditions to meet basic household needs, the availability and accessibility of support services, and the enforcement of child-friendly legislation. Examples of protective and risk factors are shown in the table below. Certain factors can be both risk and protective – for example schools, which are normally protective can be attacked, destroyed or occupied by conflict parties and families living under extreme pressure may lack the capacity to provide the usual care and protection, or in some cases may neglect or harm their own children.

[9] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019.

Examples of Protective Factors	Examples of Risk Factors
Caregiving in early life by at least one consistent and responsive caregiver.	Premature birth, birth anomalies, low birth weight, or pre- or post-natal exposure to environmental toxins.
Ability to form and sustain meaningful connections to at least one other person throughout life.	Lack of caregiving by consistent and responsive caregivers during early life.
Ability to regulate emotions.	Loss or lack of opportunities to develop the capacity for problem solving, learning, and adaptation.
Opportunities to develop the capacity for problem solving, learning, and adaptation.	Loss or lack of opportunities to acquire sequentially growing skills and knowledge according to the requirements of culture.
Opportunities to acquire sequentially growing skills and knowledge according to the requirements of culture.	Unmet basic needs (such as limited access to adequate nutrition, shelter, clean drinking water, clothing appropriate to climate, and medical care).
Access to effective formal and non-formal education.	Family separation, either temporary or permanent, due to death or inability to continue care on the part of one or more parents or main caregivers (for instance, as a result of forced removal, incarceration, deportation, armed conflict, extreme deprivation or persecution, injury, or physical or mental illness).
Age-appropriate opportunities to contribute to family and community well-being.	Exposure to structural, social, or interpersonal violence (including racism, caste or ethnic discrimination and marginalisation, gender discrimination, state-sponsored violence, community violence, family, or intimate partner violence, or physical, sexual or emotional abuse).
A sense of self-esteem and self-efficacy.	Lack or loss of access to effective formal and non-formal education.
Ability to make/find meaning in life.	Loss of community connections.
Opportunities to exercise a growing capacity for agency and judgement in the cultural context.	Harmful social or gender norms.
Participation in culture, ritual, and communal systems of belief, leading to a sense of belonging.	Forced displacement.
Hope, faith, and optimism.	Absence or non-enforcement of legal and normative frameworks aiming to protect children from abuse, neglect, exploitation, and violence.

3. **Resilience** is the ability to overcome adversity and positively adapt after challenging or difficult experiences. Children's resilience relates to their strengths and coping capacities as well as to the pattern of protective and risk factors in their social and cultural environments.

4. Children's success in addressing and coping with their situation depends on the patterns of risk and protective factors in their social environments and on their own strengths and abilities. Vulnerability results from multiple risks facing children with limited protective factors in place, such as children living with or caring for a sick single parent, children with disabilities with a limited support network, and children from the Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) community in a discriminatory environment; while having close peers, the ability to seek help, and/or good decision-making, and problem-solving skills will help children overcome adversity. Specific strengths and vulnerabilities also relate to children's age and gender. Younger children depend on their primary caregivers for basic needs and may not fully understand disruptions caused by a crisis. Older children and adolescents can address some of their own basic needs but face a greater likelihood of problems such as family separation, trafficking, child labour and exploitation, including sexual violence and abuse.[10]

1.3. Children's rights and protection in crisis and emergency situations

5. The protection of children is governed by complementary and mutually reinforcing international and national legal and policy frameworks. These include standards governing the protection of children set out in the United Nations Convention on the Rights of the Child (UN CRC) and its Optional Protocols, the European Convention on Human Rights (ECHR) and the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, " the Lanzarote Convention", as well as other international and European human rights instruments.[11] Examples of rights and standards of the UN CRC and ECHR of particular relevance in crisis and emergency situations are: life and survival, protection of violence, protection and assistance of children deprived of their family environment, enjoyment of the highest standards of health, education, liberty and security, recovery and reintegration of victims of armed conflict and protection and assistance when seeking refugee status.[12]

6. In the context of crisis and emergency situations, the Council of Europe's aims include mapping the existence of possible new vulnerable situations arising and developing measures to target the protection of children, supporting member states in building strong child protection systems adjusted to the crisis, and developing and promoting standards on human rights for children in migration. The Council of Europe assists in developing capacities and tools to support member states in protecting children in armed conflicts and reintegrating and rehabilitating children returning from armed conflict and also provides guidance during public health crises and exchange of good practices among member states.[13]

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[10] Save the Children, Mental Health and Psycho-social Support Technical Guidance, Draft 8, p.4.

[11] OHCHR, Convention on the Rights of the Child; Council of Europe, European Convention on Human Rights; Council of Europe, Reykjavik Declaration; Council of Europe Strategy for the Rights of the Child (2022-2027); Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, 'Lanzarote Convention', 2010; Council of Europe Convention on Action against Trafficking in Human Beings, 2005.

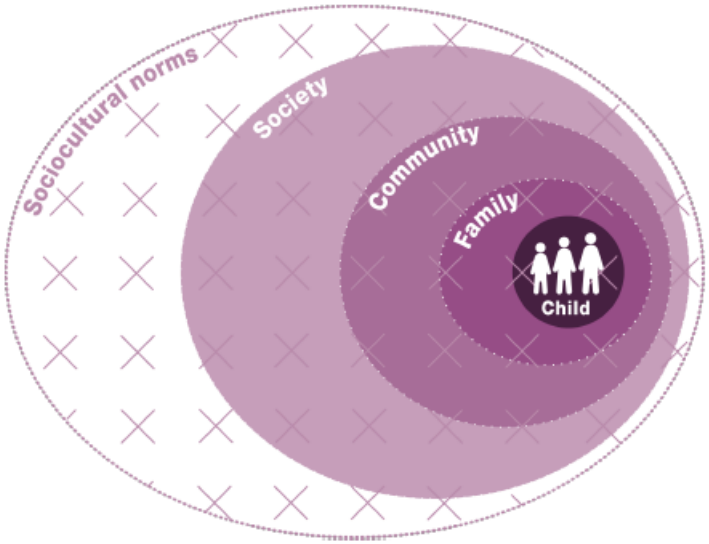
[12] Council of Europe Strategy for the Rights of the Child (2022-2027), p. 45; The Committee on the Rights of the Child monitors implementation of the UN CRC and it's Optional Protocols on involvement of children in armed conflict and on the sale of children, child prostitution and child pornography.

[13] Council of Europe Strategy for the Rights of the Child (2022-2027), pp. 45-47.

7. Child protection interventions in crisis and emergency situations seek to prevent and respond to all forms of abuse, neglect, exploitation and violence and promote the physical and emotional health and well-being of children, their families and communities and save lives. Effective child protection builds on resilience of children and their families and existing capacities within communities and strengthens preparedness before a crisis occurs to prevent and mitigate risks. Child protection in crisis and emergency situations involves interventions of local, national and international child protection actors. It also includes efforts of non-child protection actors who seek to prevent and address abuse, neglect, exploitation and violence against children, through working across sectors and integrated programming.

8. Applying a 'Socio-Ecological Model' to child protection aims to design integrated approaches working at and jointly with four levels. This approach helps illustrate the interaction between the child, the internal or psychological factors, and the outer world surrounding the child, the external or social factors.

Four levels of the child protection socio-ecological model.[14]



9. The closest level represents the immediate family, which has the biggest influence on children's physical, cognitive, emotional, and social development. The next level is represented by the extended family and the closest social networks. This includes family members, neighbours, cultural groups, and other groups interacting with children. After this level there is the community, including school, recreational centres, social and health services, and other community services. The next level represents the society and involves the broader economic, political, cultural, and social context, including the socio-economic factors, availability of services, conflict, marginalisation of social groups, as well as the legal framework and policies.

10. The Socio-Ecological Model also illustrates that risks and protective factors exist at all levels of children's safety and well-being. Families, other close relations and peers, communities and the wider

[14] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.163.

society have direct influence on children's well-being and development and can be sources of resilience and support for children and their protective environment. They can play significant roles in preventing and responding to risks. However, traditional and social norms, when not in the best interests of children, can also have a negative impact on the protection of children and lead to increased risks and harmful outcomes, such as family separation. As a result of crisis and emergency situations families and communities often face distress and additional risks, pre-existing child protection risks are exacerbated, leading to reduced support and protection of children.

11. In crisis and emergency situations it is important to reduce risk factors and build on and strengthen protective factors such as support of caregivers and communities. Positively influencing social norms relating to the care and protection of children or particular groups of children can help to address harmful practices. Furthermore, it is important to focus efforts on strengthening child-friendly laws, policies and institutional structures as well as funding for child protection and social welfare services.[15]

1.3. Key guiding principles

12. The protection of children is grounded in children's rights; in particular, **the right to protection from violence, abuse and exploitation** and **the right to family unity and identity**. Responses to crisis and emergency situations must promote children's right to life, survival and development, including children's physical, psychological, emotional, social, and spiritual development, as well as their **right to safety, well-being and dignity**. Helping affected communities, including children, to claim their rights through information and documentation, and supporting efforts to strengthen respect for rights are integral to these efforts.

13. Responses to crisis and emergency situations should promote and support equity, **non-discrimination** and **inclusion** and support States and communities in protecting children, without discrimination on the basis of age, gender, disability, race, nationality, legal status, sexual orientation or any other reason. It is important to analyse and address causes of discrimination and exclusion, as well as the impact on violence, abuse and exploitation. Obstacles to accessing assistance impartially must be proactively identified and addressed to ensure it is provided in proportion to need and without discrimination. Everyone involved in responding must be aware of their own values, beliefs, and unconscious biases about childhood and the roles of the child and the family.

14. **The best interests of the child** must be a primary consideration in all actions and decisions directly or indirectly affecting groups or individual children, as well as in all child protection support given to authorities and other actors. Children have the right to have their best interests assessed and taken into account as a primary consideration in all actions or decisions that concern them, both in the public and private spheres.

15. The **participation** of children and their communities must be promoted and supported, and children should be enabled to express their views freely and their views must be given due weight in accordance with their age, maturity and abilities. Children must be provided with the time and space to meaningfully participate in all decisions that affect them, including during emergency preparedness

[15] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, pp.167-174; The Alliance for Child Protection in Humanitarian Action, Understanding Risk and Protective Factors in Humanitarian Crises: Towards a Preventive Approach to Child Protection in Humanitarian Action, 2021.

and response. The aim of child protection action is also to build upon children's **resilience** and strengths by preventing, mitigating and addressing risk factors and by strengthening the protective factors that support and encourage resilience. Participation of children is key to building resilience.

16. All measures necessary must be taken to enhance the safety of children and families and to avoid exposing them to harm, including abuse, neglect, violence and exploitation, as a result of the actions of actors working in crisis and emergency situations, in line with the do no harm principle. Interventions must be provided in ways that enhance the safety of children, their families and communities, avoid exposing them to further harm, reduce the risks they may face and meet their needs with dignity.

17. **Prevention** and taking early action where children are at risk, to mitigate those risks and prevent harm must be prioritised, when possible.

18. Child protection risks often have multiple and interconnected causes requiring a **multisectoral and integrated approach** and comprehensive response to holistically address children's needs.

19. **States** are the primary actor responsible for the protection of children, including forcibly displaced children and should be supported in the enhancement of national **child protection systems**, and the provision of non-discriminatory access to services to all children under the States' jurisdiction.[16]

1.4. Purpose of this manual

20. This manual aims to promote positive mental health and psycho-social well-being and to prevent and address psycho-social distress and mental disorders experienced by children in the context of crisis and emergency situations. It aims to increase understanding of mental health and psycho-social support needs of children and strengthen capacity to provide MHPSS.

21. The target audience of the manual is professionals working with children affected by crisis and emergency situations. The term 'professionals' refers to all practitioners and volunteers of various backgrounds and training, working with and/or for children and their families/caregivers in different settings, all of whom have a role, depending on their competency and the capacity for supervision. (See chapters 4.2 and 6.1)

22. The primary focus of this manual is on levels three and four of the 'Intervention pyramid for mental health and psycho-social support in emergencies.'[17] (See chapter 4.3) These interventions are normally undertaken by psychiatrists, psychologists and support workers such as community-based psycho-social support staff, social workers and healthcare workers. Interventions within levels one and two of the Intervention pyramids are equally important – guidance pertaining to professionals working at these levels should be further defined as the manual is adapted to the context and needs of each emergency.

[16] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, page 37-48; IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, pp. 9-16.
[17] IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, p.12.

23. Implementation of the manual requires collaboration and coordination with various humanitarian actors and other institutions. Children in need of mental health and psycho-social support, and their families, may be receiving support from or be linked into other services, for example, children receiving case management may have been referred for MHPSS; or children and their families may need referral for case management, specialised or additional support or services. Furthermore, MHPSS should be integrated into other relevant sectors of an emergency response and into broader child protection systems and structures including primary and secondary health care. Emergency coordination and referral mechanisms and the child protection systems and related institutions will be different in each context. (See chapter 4.3)

Chapter 2: The impact of crisis and emergency situations on children's mental health and well-being

Outline

2.1. Overview of the impact on children's mental health and well-being
2.1.1. Child development
2.2. Recognising signs of distress in children
2.3. Mental disorders (mental neurological or substance use (MNS) conditions)
2.3.1. Acute Stress (ACU)
2.3.2. Post-Traumatic Stress Disorder (PTSD)
2.3.3. Prolonged grief disorder
2.3.4. Depressive disorder
2.3.5. Self-harm and suicide
2.3.6. Harmful use of alcohol and drugs
2.3.7. Anxiety disorders

2.1. Overview of the impact on children's mental health and well-being

24. Mental health and psycho-social problems are highly interconnected. The IASC Guidelines on Mental Health and Psycho-social Support (MHPSS) in Emergency Settings illustrate this as follows:

Problems of a predominantly *social nature* include:

- Pre-existing (pre-emergency) social problems (e.g. extreme poverty; belonging to a group that is discriminated against or marginalised; political oppression);
- Emergency-induced social problems (e.g. family separation; disruption of social networks; destruction of community structures, resources and trust; increased gender-based violence); and
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms).

Problems of a predominantly *psychological nature* include:

- Pre-existing problems (e.g. severe mental disorder; alcohol abuse);
- Emergency-induced problems (e.g. grief, depression and anxiety disorders, including post-traumatic stress disorder (PTSD));
- Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution).

Thus, mental health and psycho-social problems in emergencies encompass far more than the experience of PTSD.[18]

[18] IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, p.2.

25. The potential impact of crisis and emergency situations on the mental health and psycho-social well-being of children is widely recognised. As outlined in the introduction, the resilience of children; their strengths and coping capacities, as well as the presence of protective and risk factors, will greatly determine the scope and nature of the impact on their mental health and well-being. A focus on resilience in crisis and emergency situations is important as the majority of individuals exposed to traumatic events do not develop psychological conditions, and symptoms of distress amongst children improve without clinical intervention over time in many cases.[19]

26. Psychological distress reactions are to be expected in children affected by crisis and emergency situations. Often described as 'normal reactions to abnormal or highly stressful events' these will often resolve once basic needs are met, children feel safe and secure and receive general support. It should not be assumed that every child is 'traumatised' as this can undermine coping mechanisms; similarly, this terminology could lead to stigmatisation. Emotional, cognitive, behavioural and somatic reactions are all likely; anxiety, including panic attacks, crying excessively, or becoming agitated, aggressive, or withdrawn. Regression to an earlier stage of development, for example, nocturnal enuresis (bed wetting) or thumb sucking, is common in younger children.[20] Children with existing mental health problems may become more severely unwell either as a direct result of their experiences or because appropriate care and support is not available.

27. Less commonly, children can also manifest more extreme forms of distress or trauma such as depression, self-harm and suicidal thoughts or attempts.[21]

28. Given the diversity of experiences and the range of potential impacts on people, including children, the IASC Guidelines note that "An exclusive focus on traumatic stress may lead to neglect of many other key mental health and psycho-social issues." Other discussions highlight the way in which the experience of war depends on social, cultural and political aspects of their situation while a focus on trauma can sideline the social dimensions.[22]

29. Some children do develop mental disorders, particularly if they have been exposed to violent conflict, exposure has been ongoing over long periods, they have suffered the loss of or separation from loved ones including parents or caregivers, or where the mental health and well-being of parents/caregivers has been significantly affected. Research on mental health changes during conflict has shown, amongst other factors, association between parental distress and poor mental health of their children including PTSD, as well as an association with behavioural problems, particularly in adolescents.[23]

30. Conduct related disorders such as poor impulse control and high levels of reactive aggression can also be seen as a response to experiences in crisis and emergency situations.[24]

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[19] IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, p.2.
[20] Mental Health and Psycho-social Support Rapid Situational Analysis Report - Izium District, Kharkiv Oblast, Ukraine, October 2022, p.13.
[21] Mental Health and Psycho-social Support Rapid Situational Analysis Report - Izium District, Kharkiv Oblast, Ukraine, October 2022, p.13; Refugee Rights Europe, Supporting the Mental Health and Wellbeing of Young People Seeking Asylum, 2021, p.12; UK Trauma Council, Childhood Trauma, War, Migration and Asylum, 2024.
[22] Bracken & Petty et al, Rethinking the Trauma of War, Save the Children 1998.
[23] McElroy, E., et.al, European Child & Adolescent Psychiatry, Change in child mental health during the Ukraine war: evidence from a large sample of parents, 2023; Martsenkovskyi D, et.al., Parent-reported posttraumatic stress reactions in children and adolescents: Findings from the mental health of parents and children in Ukraine study, 2024.
[24] Cahill et al, Adolescents in Emergencies, University of Melbourne, 2008, p.10.

31. If appropriate support is not available, symptoms of severe distress persist or significantly limit or interfere with normal daily functions, for example going to school or engaging in social activities; or if difficulties are managed with harmful coping strategies; this can in turn influence emotional, behavioural, cognitive and physical development. Furthermore, the consequences of severe distress or trauma on the developing brain can lead to grave long-term consequences for affected children. (See chapter 3)

2.1.1. Child development

32. Child development is the process by which children grow and become social and functional members of society. As they mature, children acquire social skills and the ability to develop and maintain relationships; they learn problem-solving skills, acquire capacity and agency, cognitive reasoning and coping strategies. Children are expected to achieve certain developmental milestones at each stage of development – infancy and early childhood, middle childhood and adolescence. The well-being of the newborn child and their subsequent development is closely linked to the mental and physical well-being of the mother throughout pregnancy (pre-natal period) and the postpartum period (up to 6-8 weeks after childbirth).

33. Crisis and emergency situations have the potential to interrupt the process of child development at any stage, but if children are affected by crises during either period of rapid brain development – early childhood and adolescence, there can be more profound and long-lasting effects. For example, secure attachment to primary caregivers is essential to infants' emotional development. It influences their sense of personal security and their ability to manage emotions later in life. Experiences during infancy and early childhood set the foundation for the child's entire life course. (See chapter 3)

34. As adolescents transition from childhood to adulthood, they undergo significant physical, social and psychological changes including neurological development – leaving them particularly susceptible to the impact of adverse events they are likely to face in crisis and emergency situations. The potential impact on mental health is even greater for adolescents who are already vulnerable; for example, due to a disability or other long-term conditions, pregnancy, having a child/children, child marriage, being orphaned, identifying as a Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) person or belonging to a minority ethnic group or other groups who may face discrimination or exclusion.[25]

35. Early adolescence (11-14 years) marks a crucial period for the development and onset of mental health problems, which often manifest as disorders in the course of adulthood if they are not dealt with early on.[26] Depression, anxiety and behavioural disorders are among the leading causes of illness and disability among adolescents and suicide is one of the three leading causes of death among older adolescents.[27] Eating disorders: anorexia nervosa and bulimia nervosa, disorders which include psychotic symptoms, self-harm and risk-taking behaviours including substance abuse and sexual risk

[25] Council of Europe, Parliamentary Assembly, Mental health and well-being of children and young adults, 2023, para 12.
[26] Mental disorders at the beginning of adolescence: Prevalence estimates in a sample aged 11-14 years.
[27] WHO Guidelines on mental health promotive and preventive interventions for adolescents, 2020, foreword.

taking also emerge during adolescence. Risk-taking behaviours can be an unhelpful strategy to cope with emotional difficulties and can severely impact an adolescent's mental and physical well-being.[28]

36. In addition to any pre-existing conditions or vulnerabilities, adolescents may face particular challenges in crisis and emergency situations relating to their age and gender; for example, Sexual & Gender Based Violence (SGBV), Sexually Transmitted Diseases (STDs), unwanted pregnancy and (the worst forms of) child labour, including trafficking, recruitment into armed forces and armed groups and radicalisation by extremist groups are potential risks for adolescents and youth, all of which may lead to severe distress and predispose them to mental disorders.[29]

2.2. Recognising signs of distress in children

37. Many children suffering from extreme/acute distress are unable to understand, recognise or verbalise their thoughts, feelings and beliefs about themselves, others and the world around them. They may wonder how safe the world is and who they can trust; they may feel troubled or guilty about the way they are behaving, for example becoming easily angry or irritable. As well as the direct impact on their emotions, the following areas of children's lives may be affected:

- home life: relationships with family/carers and peers
- education: relationships with adults and peers as well as their ability to concentrate, engage and learn
- social life: relationships with those they spend time with and ability or motivation to participate in activities

38. Whilst every child will react differently, common signs of distress can be divided into five categories described below.[30]

- Regressive behaviours
- Fear and avoidance reactions
- Re-experiencing reactions
- Hyperarousal reactions (related to a heightened sense of current threat)
- Physical/somatic reactions

(Chapter 2.3 sets out when such reactions are sufficiently severe or long-lasting to meet the criteria for clinical diagnosis of a mental disorder.)

[28] WHO Fact Sheet, Mental Health of Adolescents, 2024.
[29] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.30, p.46.
[30] See also: IFRC Reference Centre for Psycho-social Support, Common reactions to distressing situations and extreme stress.

39. Regressive behaviours are common, especially among younger children. This is not done intentionally but is driven by their unconscious need for more comfort, care and attention through behaving in ways more appropriate for children younger than their developmental age. Examples include:

- Becoming more dependent on adults (clinginess, tearfulness, symptoms of separation anxiety).
- Thumb-sucking.
- Fearing the dark.
- Bedwetting, also called nighttime incontinence or nocturnal enuresis.

40. Fear and avoidance reactions involve deliberate avoidance of thoughts, memories, activities or situations that are a reminder of a distressing event. Avoiding or forgetting painful memories is a way of blocking out the associated painful emotions and is a normal and healthy coping mechanism. However, if they persist, avoidance reactions can hinder recovery and lead to loneliness and isolation; for example, by trying not to feel anything a child may find it difficult to sustain healthy relationships with family or peers. Examples include:

- Appearing anxious to avoid people or places that remind them of their experiences.
- Not wanting to think about or talk about what happened to them.
- Struggling to cope with things that remind them of their distressing memories.
- Forgetting important aspects of the terrifying event (amnesia).
- 'Shutting down' (emotional numbing).
- Repeatedly undertaking rituals and habits that make them feel safe, e.g. counting, avoiding cracks in the pavement.

41. Re-experiencing or re-living events is a common reaction involving repeated and unwanted recollections of the event as if it is happening in the present. Intrusive memories can help people regain a sense of control over their environment. However, they can also lead to such a high state of arousal that feelings and memories are blocked and the event cannot be processed. Examples include:

- Flashbacks or nightmares re-enacting the event.
- Frightening dreams without clear content.
- Intrusive memories or images accompanied by intense fear or horror.
- Losing focus from current activity due to intrusive memories/images.
- Replaying or drawing the events repeatedly.
- Acting out what they have witnessed in all its intensity.
- Engaging in joyless repetitive play in which themes or aspects of the distressing experience are re-enacted.
- Emotional and physiological reactions to certain reminders (cues) of the event such as smells, images, sounds, or similar emotional triggers.

42. Hyperarousal reactions refer to a heightened sense of current threat where the affected child is constantly on edge and alert to danger and may have a strong reaction to loud noises or unexpected movements. Examples include:

- Sleep disturbance such as nightmares, fear of sleeping alone, or difficulty getting off to, or staying asleep.
- Difficulties in concentration.
- Unable to relax or settle down.
- Hypervigilance and an exaggerated startle response, restlessness.

- Excessive irritability or angry outbursts and difficult interpersonal relations.
- Sudden mood changes.

43. Physical/somatic reactions relate to the physiological reactions that can occur following exposure to distressing events and are common in children and adolescents as a way of expressing their emotions. These persistent problems have no identified organic cause and symptoms often improve when children are given an opportunity to express their emotions through activities such as play, drawing, or talking. Medical causes should be ruled out. Examples include:

- Repeated headaches or stomach aches, generalised aches and pains.
- Chest pains, racing heart, shallow breathing, dizziness.
- Sleep disturbance.
- Problems with appetite, nausea.

Distress reactions at different ages/developmental stages are described in the box below.[31]

Physical reactions (all age groups)

Note that the signs below may also be signs of physical illness, so please take your child to see a doctor to rule out any physical condition.

- Tiredness
- Stomach-ache
- Tight chest
- Dry mouth
- Muscle weakness
- Shortness of breath
- Dizziness
- Shaking
- Headaches
- General aches



Age	Reaction	
0-3 years	- Clinging to their caregivers more than normal - Regressing to former (younger) behaviours - Changes in sleeping and eating patterns - Higher irritability	- Increased hyperactivity - More afraid of things More demanding More frequent crying
4-6 years	- Clinging to adults - Regressing to former (younger) behaviours - Changes in sleeping and eating patterns - Higher irritability - Poorer concentration	- Becoming more Inactive or more hyperactive - Stop playing - Take on adult roles - Stop talking - More anxious or worried
7-12 years	- Becoming withdrawn - Frequent concern about others affected - Changes in sleeping and eating patterns - Increasingly fearful - Higher irritability - Frequent aggression	- Restlessness - Poor memory and concentration - Physical symptoms/ psychosomatic - Frequently talks about the event or repetitive play - Feels guilty or blames themselves
13-17 years (teens)	- Intense grief - Shows excessive concern for others - Feelings of guilt and shame - Increasingly defiant of authority	- Increased risk taking - Aggression - Self-destructive - Feeling hopeless

Children who demonstrate these signs over a prolonged period of time will need specialist support.

- Withdrawn or very quiet with little or no movement
- Hides or shies away from other people
- Does not respond to others, does not speak
- Extreme and constant worry
- Physical symptoms of not feeling well; shaking, headaches, loss of appetite, aches, and pain
- Aggressive, trying to hurt others
- Confused or disoriented

[31] UNICEF, Common Signs of Psycho-social Distress in Children.

2.3. Mental disorders (mental neurological or substance use (MNS) conditions)[32]

44. Most of the information used in this sub-chapter is based on the following documents where further information can be found:

- World Health Organisation, mhGAP Humanitarian Intervention Guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies, WHO 2015;
- National Institute for Health and Care Excellence (NICE) Guideline: Self-harm: assessment, management and preventing recurrence, 2022;
- National Institute for Health and Care Excellence (NICE) Guideline, Suicide prevention, 2019;
- National Institute for Health and Care Excellence (NICE) Guideline, Post-traumatic stress disorder, 2018;
- National Institute for Health and Care Excellence (NICE) Guideline, Depression in children and young people: identification and management, 2019.

45. Mental disorders, including those described below, may be present in children irrespective of their exposure to distressing events. Within any population, there are likely to be children who are already suffering from, or might go on to develop, a range of mental health conditions. However, the losses and stress children experience during crisis and emergency situations may result in grief, fear, guilt, shame and hopelessness which for some children may lead to mental disorders, particularly those described below, where symptoms are more troubling and prolonged than might be anticipated as 'normal reactions to abnormal or highly stressful events.'

46. Mental disorders and psycho-social problems amongst the general population are projected to increase within crisis and emergency situations. Whilst not providing disaggregated data by age, according to the IASC Guidelines on MHPSS in Emergencies: "on average, the percentage of people with a severe mental disorder increases by 1 per cent over and above an estimated baseline of 2–3 per cent. In addition, the percentage of people with mild or moderate mental disorders, may increase by 5–10 per cent above an estimated baseline of 10 per cent". In most situations natural recovery over time (i.e. healing without outside intervention) will occur for many – but not all – survivors with mild and moderate disorders.[33]

47. Children with mental health conditions can be especially vulnerable during and after crises and need access to mental health and psycho-social support and clinical care. Early recognition and treatment are important – increasing evidence suggests that mental health issues in childhood and adolescence can result in a number of problems later in life including in relation to learning, behaviour, and health.[34] If not already under the care of a psychiatrist/mental health team, children with symptoms of mental disorders should be referred for assessment and clinical management where possible. Anyone working with affected children should be provided with regular supervision sessions and be supported with self-care. (See chapter 6)

[32] Other MNS Disorders such as Psychosis are not included in this Manual. Further information can be found in World Health Organisation, mhGAP Humanitarian Intervention Guide (mhGAP-HIG), 2015.
[33] IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, p.123.
[34] UNICEF, Mental Health and Psycho-social Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice, 2021, p.14.

2.3.1. Acute Stress (ACU)

Significant Symptoms of Acute Stress
People with these symptoms may present with a wide range of non-specific psychological and medically unexplained physical complaints. These symptoms include reactions to a potentially traumatic event within the last month, for which people seek help or which causes considerable difficulty with daily functioning, and which does not meet the criteria for other conditions.
World Health Organisation, mhGAP Humanitarian Intervention Guide (mhGAP-HIG), 2015, p.13

48. Any of the symptoms described in chapter 2.2 *Signs of Distress* may be present in children with an acute stress reaction: regressive behaviours, fear and avoidance reactions, re-experiencing reactions, hyperarousal reactions and physical/somatic reactions and these could be more severe and long-lasting. Additionally, there may be dissociative symptoms relating to the body e.g. medically unexplained paralysis, inability to speak or see, functional (dissociative) seizures or risk-taking behaviours in adolescents.[35]

49. Acute Stress may be diagnosed if a potentially traumatic event has occurred within approximately one month, the symptoms started after the event and the child is experiencing considerable difficulty with daily functioning because of the symptoms, or seeking help for the symptoms.

2.3.2. Post-Traumatic Stress Disorder (PTSD)

50. PTSD is widely associated with the experience of conflict or other distressing events. Yet, as already noted, mental health and psycho-social problems in emergencies encompass far more than PTSD. Measuring the incidence of PTSD amongst children affected by crisis and emergency situations is complex due to the nature of the context, limited mental health care in many settings and various other factors.[36] Information in the box below refers to the rates of PTSD globally, but is not specific to crisis and emergency situations, nor does it differentiate between adults and children:

- An estimated 3.9% of the world population has had post-traumatic stress disorder (PTSD) at some stage in their lives.
- Most people exposed to potentially traumatic events do not develop PTSD.
- Feeling supported by family, friends or other people following the potentially traumatic event can reduce the risk of developing PTSD.

Many people feel extreme fear during or after witnessing or experiencing potentially traumatic events, such as war, accidents, natural disasters or sexual violence. Most people exposed to such events will experience distress but will recover naturally with time. Some people continue to experience a range

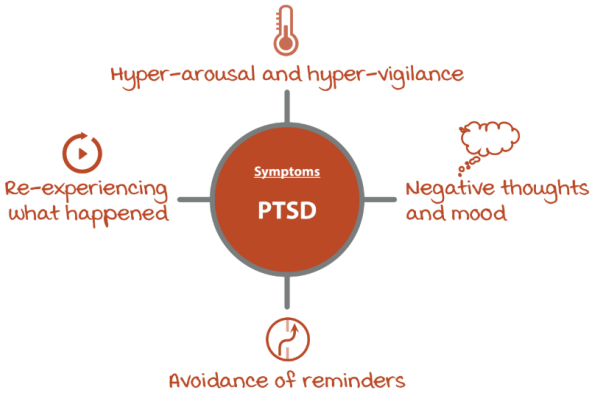
[35] Dissociative symptoms: Feeling like the world is unreal; detached from yourself, your body and the world around you, forgetting about certain time periods, events and personal information, feeling uncertain about who you are.
Functional or non-epileptic seizures are episodes of uncontrolled movements, sensations or behaviour. But unlike epileptic seizures, dissociative seizures are not caused by abnormal electrical activity in the brain. Previously called pseudoseizures, this term is now considered outdated.
[36] UNICEF, Mental Health and Psycho-social Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice, 2021, p.15.

of mental health conditions that can persist for months or even years, including PTSD, depressive disorders, anxiety disorders and substance use disorders.[37]

51. PTSD can develop as a result of traumatic events; a wide range of traumatic experiences can be causes of PTSD. PTSD, if left untreated, can become chronic, and while not definitive, several studies highlight the importance of early intervention with a range of MHPSS approaches in preventing the development of symptoms of PTSD.[38]

When a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after a potentially traumatic event, the person may have developed post-traumatic stress disorder (PTSD).
World Health Organisation, mhGAP Humanitarian Intervention Guide (mhGAP-HIG), 2015, p. 27

52. Symptoms of PTSD can be divided into groups as follows:[39]



53. As with Acute Stress, any of the symptoms described in *2.2 Signs of distress* may be present in children with PTSD: regressive behaviours, fear and avoidance reactions, re-experiencing reactions, hyperarousal reactions and physical/somatic reactions, as well as dissociative symptoms relating to the body such as functional (dissociative) seizures or risk-taking behaviours in adolescents. Other symptoms can include emotional dysregulation (difficulties in controlling one's emotions and moods), interpersonal difficulties, problems in relationships or negative self-perception (e.g. feeling diminished, defeated or worthless).[40]

54. In particular, children with PTSD may exhibit symptoms such as:

- dreams of the trauma, which may then change into nightmares
- re-living the trauma in their play, e.g. a child involved in a road traffic accident might re-enact the crash with toy cars
- sleeping problems; this may include secondary enuresis or separation anxiety, e.g. children insisting on sleeping in their parents' bed
- losing interest in things that they previously enjoyed
- expressing the belief that they will not live long enough to grow up

[37] WHO Factsheet on PTSD, 2024.
[38] UNICEF, Mental Health and Psycho-social Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice, 2021, p.14 and pp.16-20.
[39] Psychology Tools, Understanding PTSD p.2.
[40] National Institute for Clinical Excellence, Post Traumatic Stress Disorder, 2018, p.53.

2.3.3. Prolonged grief disorder

55. Grief is the emotional suffering people feel after a loss and is a normal reaction which is usually self-limiting. Loss can refer to a bereavement i.e. the death of a family member, friend or other important people in the child's life, or the loss of their home, community or country or a combination.

When significant symptoms of grief persist over an extended period, people may develop prolonged grief disorder. This condition involves severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain and considerable difficulty with daily functioning for at least 6 months.
World Health Organisation, mhGAP Humanitarian Intervention Guide (mhGAP-HIG), 2015, p. 17

56. Factors that can influence the impact of grief and predispose children to developing prolonged grief disorder include the following:

- The loss was unexpected or sudden.
- The impact of the loss has a considerable impact on the child's everyday life.
- The availability of care and support in particular from family members.
- Where there are multiple losses e.g. a child has become separated from parents/caregivers and had to flee from her or his home.
- Whether the current environment is stable or there is ongoing change (displacement, being on the move).

57. Symptoms of grief include the following, many of which are similar to those seen in Acute Stress:

- sadness, anxiety, anger, despair.
- yearning and preoccupation with loss.
- intrusive memories, images and thoughts of the deceased.
- loss of appetite, loss of energy.
- sleep problems and trouble concentrating.
- social isolation and withdrawal.
- medically unexplained complaints (e.g. palpitations, headaches, generalised aches and pains).
- culturally specific grief reactions (e.g. hearing the voice of the deceased person, being visited by the deceased person in dreams).

58. These symptoms may be considered significant where the onset was after the loss and cause considerable difficulty with daily functioning (beyond what is culturally expected).

2.3.4. Depressive disorder

59. Depression is a broad diagnosis that can include different symptoms in different people. However, depressed mood or loss of pleasure in most activities, are key signs of depression. Depressive symptoms are frequently accompanied by symptoms of anxiety, but may also occur on their own.

A **diagnosis of Depression** may be made in children when the following are present:

Mild depression if there is persistent sadness or low mood (or irritability) with either anhedonia (inability to feel pleasure in normally pleasurable activities) or tiredness, plus two associated symptoms (four symptoms in total). Associated symptoms are:

- Reduced concentration and attention.
- Reduced self-esteem and self-confidence.
- Ideas of guilt and unworthiness.
- Bleak and pessimistic views of the future.
- Ideas or acts of self-harm or suicide.
- Disturbed sleep.
- Diminished appetite.

Moderate depression if there is persistent sadness or low mood (or irritability) with either anhedonia or tiredness, plus three or four associated symptoms (five–six symptoms in total).

Severe depression if there is persistent sadness or low mood (or irritability), anhedonia, and tiredness, plus four or more associated symptoms (seven or more symptoms in total).

Be aware that:

- The mood change must last throughout the waking hours (although some may improve gradually through the day, only to return to feeling depressed on waking), and both the mood change and concurrent symptoms must persist for at least two weeks.
- Depression should only be diagnosed when the symptoms and signs lead to significant personal suffering and are accompanied by observable social impairment, although social impairment may be less obvious in children and young people with mild depression.

National Institute for Clinical Excellence, How should I make a diagnosis of depression in a child or young person?, 2020

60. Adolescents suffering from depression may show signs of risk-taking behaviours, for example using drugs /alcohol as a form of self-medication and/or engaging in risky sexual behaviour such as having multiple partners, not using birth control methods and concurrent use of drugs/alcohol. This may be a means to regulate mood, achieve need for intimacy and self-validation.

61. Depression can be a very, serious and debilitating condition and urgent referral for psychiatric assessment, diagnosis and risk management is essential. In circumstances where specialised care is not available or accessible anyone working with children suffering from moderate-severe depression should always consult with their supervisor and have ongoing regular supervision. (See chapter 6).

2.3.5 Self-harm and suicide

62. **Self-harm** is when somebody intentionally damages or injures their body. It is a way of expressing deep emotions such as low self-esteem, or a way of coping with traumatic events, such as the death of a loved one. Self-harm is an expression of personal distress, rather than an illness, although it can be linked to other mental health conditions such as depression. There is evidence of a clear link between suicide or suicidal thoughts and people who have previously self-harmed. However, not everyone who self-harms want to end their life; self-harm has been described as a way of managing or coping with severe emotional distress. Some children who self-harm may unintentionally kill themselves by accident, but not all children who exhibit self-harming behaviours are at high risk of suicide.

63. Self-harm has been documented in children as young as five years old.[41] Some reasons why children self-harm include:

- Living with physical illness or mental health problems.
- Stressful or upsetting experiences: relationship problems, losing a loved one, bullying, abuse or money worries.
- Intrusive thoughts.
- Problems with how they feel about themselves which may be related to racism or homophobia, sexuality or identity, having low self-esteem or body image worries.
- Self-harm feeling 'normal' among peers.
- Seeing images of self-harm online.
- Drinking alcohol or taking drugs.

64. Children have expressed that they self-harm:

- to show how they feel without speaking.
- to be distracted from how they are feeling.
- to cope with, or escape from, painful feelings, thoughts or memories.
- to punish themselves for something.
- to stop feeling disconnected from themselves or the world.
- to create a reason to look after themselves, like caring for wounds.
- to manage thoughts of suicide.[42]

65. Mental health conditions, acute emotional distress and hopelessness are common in crisis and emergency situations. When providing MHPSS, it is important to be aware that some children may be at greater risk of **suicide** or self-harm. The nature of adverse events experienced together with the risk and protective factors will determine the vulnerability of each individual child, but the following have been identified as additional risk factors for suicide:

- Vulnerable groups who experience discrimination, such as refugees and migrants, indigenous peoples, LGBTI persons.
- Experiencing conflict, disaster, violence, abuse or loss and a sense of isolation.
- Feelings of loneliness, hurt, grief, guilt or rejection, for example feeling or being abandoned by principal caregiver, separation from friends, girl-/boyfriends, end of a love relationship, ongoing bullying, death of a loved one or significant person.

[41] Self-harm in children 12 years and younger: characteristics and outcomes based on the Multicentre Study of Self-harm in England - PMC.
[42] MIND, Understanding Self-Harm

- Feelings of shame or confusion e.g. struggling with sexual orientation, unwanted abortion or unwanted pregnancy.
- Alcohol and other substance use disorders.

66. Suicide attempts may have been considered or planned for some time or happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses. People, including children who are self-harming/thinking about self-harm or suicide may not communicate how they are feeling. Any of the following signs whether directly observed, reported by others (e.g. family member, teachers) or communicated by the child, should be taken seriously and acted upon urgently:

- visible distress or extremely upset
- extremely apathetic or lethargic
- withdrawn/unwilling to communicate
- expressing feelings of profound hopelessness or sadness
- expressing a desire to die or talking about giving up
- angry or erratic behaviour, extreme agitation
- increased risk-taking behaviour
- past attempts of self-harm e.g. medication / deliberate drug overdose, self-inflicted wounds
- speaking about plans for self-harm, suicide

67. There is still a taboo around talking about self-harm and suicide which can make it even harder for children experiencing these feelings to open up and feel understood. Many people worry that asking someone if they feel suicidal or are planning to end their life might indirectly encourage the person who is feeling suicidal to act on their feelings. However, research has shown that speaking openly about suicide decreases the likelihood of the person acting on their feelings.

68. Urgent referral for psychiatric assessment and risk management is essential when working with children who are self-harming or at risk of suicide. In circumstances where specialised care is not available practitioners should always consult with their supervisor and have ongoing regular supervision. (See chapter 6).

2.3.6. Harmful use of alcohol and drugs

69. Adolescents /pre-adolescents struggling to cope with the stress, loss or pain of living through a crisis or emergency may turn to alcohol or drugs as a way of self-medicating or escaping the reality of their lives. Regular use of alcohol or drugs (e.g. opiates such as heroin, cannabis, amphetamines, khat, diverse prescribed medications such as benzodiazepines and tramadol) can lead to various problems including withdrawal (physical and mental symptoms that occur upon cessation or significant reduction of use), dependence and harmful use (damage to physical or mental health and/or general well-being).

70. Signs indicating potential drug use include:

- appearing to be under the influence of alcohol or drugs (e.g. smelling of alcohol, looking intoxicated, being agitated, fidgeting, having low energy, slurred speech, unkempt appearance, dilated/constricted pupils)
- signs of intravenous (IV) drug use e.g. injection marks, skin infection
- moody and unpredictable
- erratic, irrational or aggressive behaviour
- loss of motivation e.g. not attending or doing poorly at school

2.3.7. Anxiety disorders

71. Feelings of anxiety are inevitable in crisis and emergency situations due to amongst other things uncertainty, lack of information and fear about what the future may hold. However, people, including children, with anxiety disorders often experience fear and worry that is both intense and excessive and frequently accompanied by physical tension and other behavioural and cognitive symptoms. These feelings are difficult to control, cause significant distress and can last a long time if untreated. Anxiety disorders interfere with daily activities and can impair a person's family, social and school or working life.

Anxiety disorders are the world's most common mental disorders and symptoms often begin in childhood or adolescence, so for some children this may have been a pre-existing problem while in others the crisis or emergency may have precipitated the onset of the disorder.
Symptoms of anxiety disorders may include:

- trouble concentrating or making decisions
- feeling irritable, tense or restless
- experiencing nausea or abdominal distress
- having heart palpitations
- sweating, trembling or shaking
- trouble sleeping
- having a sense of impending danger, panic or doom.

Anxiety disorders increase the risk for depression and substance use disorders as well as the risk of suicidal thoughts and behaviours.

There are several different kinds of anxiety disorders, including:

- Generalised Anxiety Disorder (persistent and excessive worry about daily activities or events).
- Panic Disorder (panic attacks and fear of continued panic attacks).
- Social Anxiety Disorder (high levels of fear and worry about social situations that might make the person feel humiliated, embarrassed or rejected).
- Separation Anxiety Disorder (excessive fear or worry about being separated from people with whom the person has a deep emotional bond).
- Specific Phobias (intense, irrational fears of specific objects or situations that lead to avoidance behaviour and significant distress) and
- Selective Mutism (consistent inability to speak in certain social situations, despite the ability to speak comfortably in other settings, primarily affecting children).

People may experience more than one anxiety disorder at the same time. Symptoms often begin during childhood or adolescence and continue into adulthood. Girls and women are more likely to experience an anxiety disorder than boys and men.[43]

[43] WHO Factsheet, Anxiety Disorders.

Chapter 3: Brain development and the impact of distressing and traumatic experiences

Outline

3.1. Brain development in early childhood
3.1.1. Childhood trauma and the developing brain
3.2. Brain development in adolescence

72. Human brains are built through a process that begins before birth and continues into adulthood. Simple neural connections and skills develop first, followed by more complex circuits and skills – billions of connections forming across different areas of the brain enabling communication between neurons that specialise in various functions. New connections in the brain can form throughout life but the early years are critical for establishing a healthy foundation, with implications for interconnected cognitive, emotional, and social abilities. After a period of especially rapid growth in the first few years, the brain refines itself through a process called pruning, making its circuits more efficient. The way brains develop is sometimes referred to as 'brain architecture.'[44]

73. The developing brain is shaped by the interaction between genes, experiences, and the timing of these interactions during development. Experiences during 'sensitive periods' of development play an exceptionally important role in shaping the capacities of the brain.[45] Sensitive periods occur at different ages for different parts of the brain, however early childhood - ages 0-5 years and adolescence are key periods for brain development.

3.1. Brain development in early childhood

74. The foetal brain is developing rapidly during pregnancy (pre-natal stage) and is influenced by the physical environment of the mothers' uterus, and the environment beyond it. Depression and stress in pregnancy can cause changes that are genetically passed on to future generations. These trauma-related consequences can negatively affect child outcomes and development, with effects persisting throughout the life course.[46] Stress in pregnant mothers – measured through levels of the stress hormone, cortisol – have been linked to changes in infant brain development of the amygdala, which is involved in children's social and emotional development.[47]

75. A vital ingredient in a young child's growth and learning (and brain development) is the "serve and return" interaction that takes place in the early years between children and their parents/caregivers. For example, when children reach out through pointing or making sounds, and the adults respond by returning these gestures or sounds. This process helps children develop language,

[44] Harvard University, Center on the Developing Child, Brain Architecture.
[45] Harvard University, Center on the Developing Child, The Timing and Quality of Early Experiences Combine to Shape Brain Architecture, 2007.
[46] Inter-Agency Working Group on Reproductive Health in Crises, Collaborating for Maternal Mental Wellbeing: Technical Brief on Perinatal Mental Health in Humanitarian Settings, 2023, p.5.
[47] University of Edinburgh, Stress during pregnancy may change brain development in babies, 2020.

cognitive, and social skills and actively builds a child's brain. Where there is an ongoing lack of response from the significant adult/s, the child's developmental process can be interrupted with negative implications on learning, behaviour and health.

76. Many other influences and experiences from a child's developmental environment also interact with their genes to shape brain architecture. An important factor is the amount of stress in a child's life. There are different kinds of stress that children can experience: (i) positive stress, (ii) buffered (sometimes known as tolerable) stress, and (iii) harmful stress (sometimes known as 'toxic' stress). Positive stress is caused by challenges that can help children develop – like their first day at school; buffered stress is caused by situations that could damage development, but the effects are reduced by having supportive positive relationships such as strong adult support when a loved one dies, and harmful stress which is caused by experiences such as prolonged exposure to traumatic situations, abuse or neglect. Strong and persistent activation of the body's stress response systems (i.e., increases in heart rate, blood pressure, and stress hormones such as cortisol and cytokines) can result in the permanent disruption of brain circuits during the sensitive periods in which they are maturing. This can potentially lead to lifelong problems in learning, behaviour, and both physical and mental health.[48]

77. Early experiences can also shape the development of 'executive functioning skills' which regulate the flow of information and enable children to focus on tasks, plan and prioritise. These skills are closely related to self-regulation, and they are typically applied together to help children gain greater control over their thoughts, actions, and emotional responses.[49]

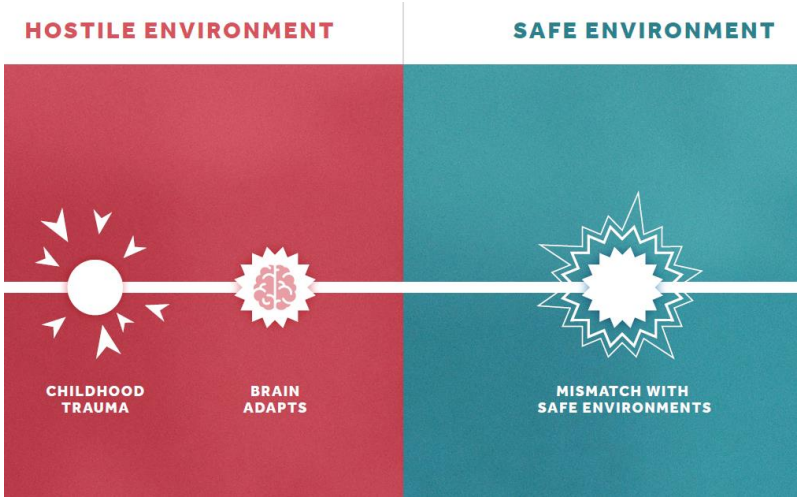
78. The capacity of parents/caregivers to provide appropriate care and nurturing and to act as a buffer against adverse experiences in the environment is vital for healthy brain development. Poverty, the effect of crisis or emergency situations or other problems can overload the mental and emotional capacity of parents/caregivers to take care of their children's basic needs with negative impacts, either due to lack of development of critical areas of the child's brain or of early adaptation as a survival mechanism which can become problematic later in life.

3.1.1. Childhood trauma and the developing brain

79. The section below is based on The Guidebook to Childhood Trauma and the Brain.[50]

80. Children – and their brains – adapt to survive. As already noted, when a child grows up in an environment where there is violence, abuse, neglect or other forms of harmful stress, their brains will be shaped by those experiences. In adverse environments the brain may develop in ways which help the child survive; however, these same changes may make a child more vulnerable to developing mental health problems in future everyday environments, as shown in the diagram below.[51]

[48] Harvard University, Center on the Developing Child, The Timing and Quality of Early Experiences Combine to Shape Brain Architecture, 2007, p.8.
[49] Harvard University, Center on the Developing Child, Building the Brain's "Air Traffic Control" System: How Early Experiences Shape the Development of Executive Function, 2011, p.1.
[50] UK Trauma Council, Childhood Trauma and the Brain, 2020.
[51] UK Trauma Council, Childhood Trauma and the Brain, 2020.



81. The brain has been described as a collection of interdependent brain systems, each with a particular role or function. Together, these brain systems enable navigation of a complex physical and social world. The brain is also a learning organ meaning that prior experiences shape brain development in ways that can help with future challenges. Understanding these adaptations is helpful to make sense of why children behave as they do and for psychological interventions to target relevant areas of the brain. Extensive research has been undertaken into three of these systems: the threat, reward and memory systems.

82. **The threat system** in the brain allows individuals to detect and respond to danger, for example to step back instantly from a speeding car or avoid an angry person; stress and threat are a normal part of life – everyone needs to activate a 'fight-or-flight' response at times to remain safe.[52]

83. Childhood trauma is associated with a **heightened** response to threat cues in the amygdala. The amygdala is a small almond shaped structure deep inside the brain that plays a key role in processing emotions, especially fear. Changes in the threat system may reflect adaptation to childhood trauma; scientists believe exposure to childhood abuse, compared to experiences of neglect or deprivation, has the greatest impact on the threat system. Studies have also linked experiences of more severe or chronic abuse to unusually low brain activation in the threat system. This may be understood as threat avoidance. Clinically this might be seen as 'cutting off' or dissociation.

84. These brain changes can lead a child to become hypervigilant, or highly alert, to threat around them. This can create several difficulties for children, including:

- Struggling to pay attention to other things – making it harder to learn and develop important skills.
- An increased intensity in their interactions with others.
- Reduced ability to regulate emotions.
- Finding everyday challenges and stressful events harder to manage than their peers.
- Increased reactivity to social rejection.
- Withdrawing or feeling anxious even in safe environments, reducing opportunities to learn new things and build relationships.
- An increased risk of symptoms of anxiety and depression.

[52] The fight or flight response is an automatic physiological reaction to an event that is perceived as stressful or frightening.

85. **The reward system** helps with learning about positive aspects of the environment, motivates behaviour, and guides decision-making. From the earliest years, a child's brain is able to learn what is rewarding and how to elicit rewards – a carer's smile, as well as basic rewards such as food. Abuse and neglect create a world where rewards such as these are inconsistent or absent. This may reduce the brain's responsiveness to rewards.

86. The brain regions that comprise the reward system include the brainstem, striatum and frontal regions. These brain regions use dopamine, an important chemical in the brain, to communicate when processing reward. Research shows **that** children who have experienced abuse and neglect have reduced sensitivity in these regions compared to their peers when processing reward cues, possibly reflecting adaptation to a world where reward is infrequent or unpredictable and managing the likelihood of constant disappointment. Other studies have demonstrated that the reward system is important in depression; not surprising given how important reward is in motivating behaviour and exerting effort in everyday life.

87. Scientists have suggested that these changes may be associated with:

- An increased risk of depression, particularly in adolescence.
- Difficulty in successfully negotiating everyday social interactions and maintaining stable social support networks.
- Problems in reward learning – that is, learning about new sources of reward.
- Reduced motivation to pursue daily activities.
- Reduced ability to experience pleasure.

88. **The memory system** allows individuals to learn new things, and store information about the past to help with new challenges in the future. Everyone relies on memories of past experiences to deal with situations in daily life – this is autobiographical memory. Associative memory is the ability to learn associations between new things. Memory is crucial in planning, problem solving, decision-making and in regulating emotions and developing a positive sense of self. Experiences of neglect and physical abuse can create negative memories that can be overwhelming and influence the creation of new memories.

89. The memory system is distributed across a network of brain regions, including the temporal and frontal areas. This includes the hippocampus, a key brain structure involved in storing memories. Several studies have pointed to differences in the function of the hippocampus in children who have **experienced** abuse and neglect with decreased activation of the hippocampus during positive autobiographical memory recall as well as decreased hippocampal activation during associative learning.

90. Scientists have suggested that these changes may be associated with:

- Problems recalling the details of everyday positive and negative personal memories.
- Changes to emotional learning mechanisms, including how children learn about threat and reward in their environments. These changes may increase the risk of mental health problems over time.
- Difficulties with planning, making decisions and social problem solving compared to peers.
- A tendency to focus on negative memories and thoughts - this may increase the risk of developing a negative self-concept.

91. Whether a child goes on to experience ongoing difficulties throughout their life and / or develop mental disorders depends on many factors – the resilience of the child and the interplay of risk and protective factors. However, the changes described in the threat, reward and memory systems may mean everyday life takes a greater toll which plays out in the following ways:

- Greater susceptibility to stress – children have a heightened response to 'everyday stress' leading to anxiety and have less ability to deal with stress.
- Greater likelihood of experiencing additional stress - children may behave in ways that others find challenging, for example overreacting or misinterpreting social interactions and having greater difficulty in regulating emotions. This can lead to conflict and new stressful experiences.
- Reduced social support over time – children lose friends and struggle to maintain relationships, losing self-confidence and agency. With fewer friends and relationships with adults who can support them, children become more vulnerable to mental health problems.

3.2. Brain development in adolescence

92. Adolescence is a period of rapid development during which an individual experiences profound physical, social and psychological changes and during which the maturing brain is highly susceptible to environmental influences. The brain finishes developing and maturing in the mid-to-late 20s.[53] The part of the brain behind the forehead, called the prefrontal cortex, is one of the last parts to mature. This area is responsible for skills like planning, prioritising, and making good decisions; the "reasoning" area of the brain, involved in emotional and impulse control.

93. Adolescents do not always understand, and have the ability to rationalise, all the emotions that they experience and face. Teenage brains are also wired to seek reward, act out, and otherwise exhibit immaturity, but this will change as they become adults. High risk behaviours are common, and addictions can develop, as the reward elements in the brain become more highly triggered. Judgment can be impaired owing to the increased levels of hormones in their bodies, new experiences, peer pressure and emotions.

94. During this period of intense brain development in adolescents there is great potential for positive interventions to influence health and development, but this also means that negative experiences during this period, such as being affected by a crisis or emergency, can have a significant impact. Adolescents have been found to present an increased physiological response to stress compared to children and adults. Early adolescence (10-14 years of age) has been identified as a particularly significant period, with research demonstrating that population stressors, including war and famine, experienced at this age are more strongly associated with a decrease in total life span than stressors experienced at any other age of childhood.[54]

[53] National Institute of Mental Health, The Teen Brain: 7 Things to Know, 2023.
[54] UNICEF, Mental Health and Psycho-social Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice, 2021, pp. 15-16.

Chapter 4: Mental health and psycho-social support (MHPSS) for children – overview and good practice

Outline

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4.1. Guiding principles for professionals providing MHPSS

95. Most organisations and professional bodies will have their own principles/staff codes of conduct which should include the guiding principles set out below. Organisations, staff and volunteers should comply with these principles, in addition to the key guiding principles set out in chapter 1, in all their practice.

- Be aware of and follow **safeguarding policies and procedures**. All organisations should have a 'child safeguarding' or 'child protection' policy, procedures and related implementation plan that seek to prevent staff/volunteers from harming children. A child safeguarding policy explains an organisation's commitment to keeping children safe from any possible harm caused by staff, operations or programmes.[55]
- **Do no harm** in all activities, interventions, research and other psychological work.
- Seek **informed consent or informed assent** from children and/or parents and/or caregivers, before providing support or interventions.
- Respect **confidentiality and managing, sharing and storing information** on individual cases according to agreed-upon data protection and information-sharing protocols, ensuring that children and caregivers are aware of their rights.
- **Collaborate and work in partnership** with other professionals and agencies to ensure psychological, physical, social welfare, educational, vocational and legal needs are addressed as holistically as possible.
- Be aware of the **context** –and consider the social, economic, legal and political contexts, which can impact on both the child and his/her family.

[55] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.65; Council of Europe, Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, 'Lanzarote Convention', 2010, Article 5.

- Ensure mechanisms and capacity is in place for the provision of **regular, formal supervision** to support effectiveness and ethical practice, enable monitoring of cases and promote well-being.

4.2. Competencies

96. The integrity, skills and competencies of staff and volunteers directly affect the quality, safety and outcomes of mental health and psycho-social interventions. Managers / supervisors must ensure that everyone engaged in the provision of MHPSS for children has the appropriate training, qualifications and experience. Many interventions can be carried out by staff or volunteers without formal qualifications; for example, leading parent support or emotional regulation groups; provided relevant training and supervision mechanisms are in place to ensure interventions meet quality standards and do no harm.

97. The World Health Organisation and UNICEF have developed competency assessment and monitoring tools, available in a programme called **EQUIP – Ensuring Quality in Psycho-social and Mental Health Care:**

EQUIP comprises:
- Tools to assess competencies that can be used alongside your existing training and supervision
- A dashboard for real-time monitoring and evaluation to track your helpers' improvement
- e-Learning resources on competency-based assessment, training, and supervision

WHO & UNICEF Ensuring quality in psychological support (EQUIP), 2021

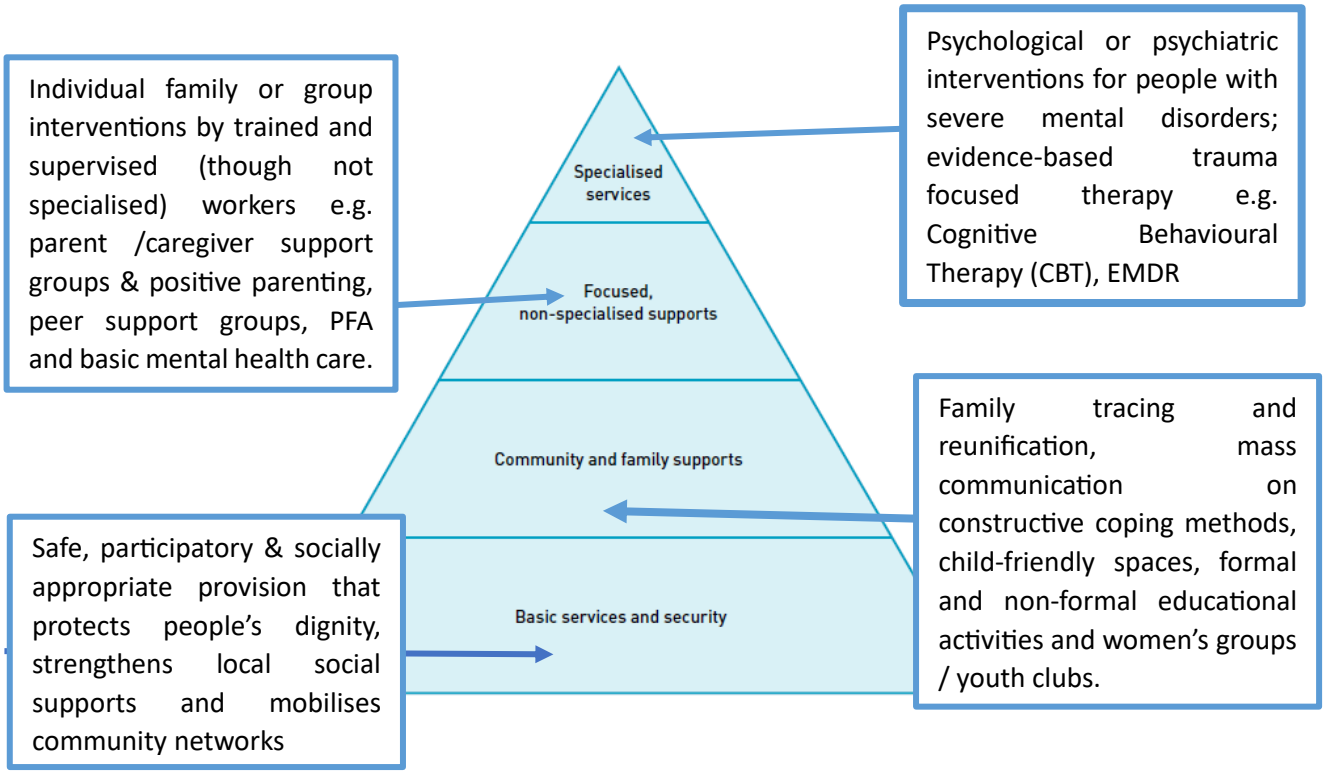
98. Further information on the assessment of competencies and support to capacity building can be found in the following resources:
- Support MHPSS competencies of staff and volunteers - Relevant guidelines, standards and tools
- Recommended training topics on basic psycho-social support skills for frontline workers and community leaders

4.3. The importance of multilayered and integrated MHPSS

99. As we saw in chapter two, mental health and psycho-social problems are highly interconnected and in crisis and emergency situations, encompass far more than the experience of PTSD. People, including children, are affected in different ways and require different kinds of support. The IASC Guidelines illustrate this through an intervention pyramid for MHPSS in emergencies presenting four levels of support which are equally important and need to be provided concurrently.[56] The intervention pyramid is shown below with examples of MHPSS for children and their families at each layer. Only small numbers of an affected population will need specialised services, particularly where support at the other layers is effective. Level four interventions are also likely to be the most challenging to implement; there is limited guidance on how to deliver culturally sensitive mental health interventions in unstable environments/ crisis and emergency situations and capacity may be limited.

[56] IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, p.12.

Intervention pyramid for mental health and psycho-social support in emergencies[57]



100. Links between MHPSS, child protection and health care are essential to ensure a cohesive emergency response and integration of MHPSS into broader child protection systems and structures, including primary and secondary health care. MHPSS providers should work with child protection, health and other sectors as relevant, as well as government ministries (where appropriate) and broader child protection systems and structures to promote a coordinated, holistic MHPSS response. In emergency and crisis situations these links are established through relevant inter-agency, multisectoral coordination mechanisms and working groups where, for example, referral mechanisms and pathways can be shared. Coordination mechanisms and structures will depend on the type and scale of the crisis or emergency situation; localised emergencies will probably be managed at a local level by the emergency services, local authorities and local resilience partners while more significant or serious emergencies may be coordinated by central government. Where an emergency is of sufficient scale to overwhelm government capacity, or where highly specialised assistance is required, international assistance may be requested by the government.

101. International emergency coordination involves multiple actors, including the UN Office for the Coordination of Humanitarian Affairs (OCHA), Inter-Agency Standing Committee (IASC), and national emergency operation centres (EOCs). OCHA leads the UN's humanitarian response, coordinating assessments, needs assessments, and resource mobilisation. IASC ensures inter-agency decision-making, while national EOCs manage the response at the country level. The European Civil Protection Mechanism and UNDAC (United Nations Disaster Assessment and Coordination) system provide examples of international and regional mechanisms for rapid disaster response.[58]

[57] Adapted from the Intervention pyramid for mental health and psycho-social support in emergencies, IASC Guidelines on Mental Health and Psycho-social Support in Emergency Settings, 2007, p.12.
[58] OCHA, We coordinate; IASC, The IASC in focus; European Civil Protection and Humanitarian Aid Operations, EU Civil Protection Mechanism.

4.4. Inclusion and non-discrimination

102. MHPSS providers should take care to ensure their support and services are available and accessible to all children who may be vulnerable as a result of crisis and emergency situations (children affected by migration, internally displaced children, Roma and Traveller children, children in conflict areas, children with disabilities, LGBTI children or children living in poverty).[59] Potential obstacles to accessing support must be identified and measures taken to address these and adapt ways of working accordingly. For example, adopting a flexible scheduling approach that supports the participation of children who have other responsibilities such as children who work, who are carers and children who are parents. (See also chapter 4.5)

103. *Outreach is essential to ensure the most vulnerable children access MHPSS through raising awareness of services available. Efforts should be made to address the stigma which can be associated with mental illness through developing appropriate messaging. In some contexts/cultures children may be reluctant or ashamed to attend groups* associated *with mental illness or issues such as SGBV so consideration should be given as to how such groups are characterised or identified.*

4.4.1. Children with disabilities

104. The UN estimates that around 10% of children worldwide have some form of disability. 'Persons with disabilities' include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis.[60] *Children* with disabilities vary in their impairments and abilities; also, some impairments are visible, and others are not.

105. Children with disabilities may face increased vulnerability to certain safety threats and may be at greater risk in crisis and emergency situations. For instance, those with physical or mental disabilities are statistically more likely to be survivors of sexual violence; children with intellectual disabilities, in particular, are nearly five times more likely to be subjected to sexual violence than others their age.[61] Children with disabilities are also more likely to be abandoned or separated from their caregivers, especially during an attack or sudden displacement. This is of particular concern for children living in residential care.

106. Children with disabilities have the same human rights as all children - inclusion of children with disabilities may require adjustments such as selecting alternative meeting venues or conducting home visits. Reflecting on barriers, whether physical or related to communication and attitudes, is crucial. Ways of working may need to be adjusted applying Universal Design features and Reasonable Accommodation measures.[62] Examples include ensuring information on MHPSS and psychoeducation materials are available in multiple (oral and pictorial) and accessible formats (Braille and large print, accessible web content by screen reader including image description, easy-to-read versions, plain text

[59] Council of Europe Strategy for the Rights of the Child (2022-2027) Anti-Discrimination Approach, p.48.
[60] Convention on the Rights of Persons with Disabilities, 2006, Article 1.
[61] UNICEF, Protecting children with disabilities during armed conflict.
[62] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, pp. 30-31; Universal Design and Reasonable Accommodation see: Council of Europe Disability Strategy 2017-2023, p.14.

accompanied by pictures, simplified versions of information, sign language videos, audio recordings, voiceovers, captions) through the most appropriate channels (radio, SMS, emails, TV, etc.) when required.[63] (See also chapter 4.8.3)

4.5. Child participation

107. Children have the right to be heard, participate and have their views given due weight in accordance with their age and maturity in all decisions affecting them. Children also have the right to freedom of expression, information and opinion as guaranteed under articles 10 of the ECHR and 13 of the UN CRC.[64]

108. Children affected by crisis and emergency situations who need MHPSS must be provided with the time and space to meaningfully participate in decisions and to fully engage in any interventions offered. This is not only a child rights obligation but also nurtures hope, which enables children to think about the possibility of positive change. Children should participate (in accordance with their age and maturity) in decisions relating to the type of support offered and who should be included/ involved in any intervention e.g. parent/caregiver/teacher. This will require the provision of child-friendly information in their first language regarding recommended option/s for support; (what/who providing/how/when/for how long); goals of recommended option/s; likely outcomes including any potential risks or negative impact as well as the risks of not having the offered support. Special attention and additional support must be given to children who may face additional challenges or barriers to participate in decision-making processes (including but not limited to, children with disabilities, the type of mental health problem and linguistic or cultural barriers). The level of child participation depends both on his or her age, evolving capacities, maturity and on the importance of the decision to be taken.[65]

109. Decisions should be based on their best interests, in a process involving the children themselves and their parents/caregivers where appropriate.[66] Reasons to include parents or caregivers include:

- They are responsible for the overall and ongoing care and protection of the child.
- They are likely to be useful informants.
- Children may feel more comfortable if they are present/involved.

110. However, there may be circumstances where it is not advisable to include parents or caregivers in decision-making or support interventions offered to a child, for example:

- At the request of the child.
- There are concerns about potential harm from the parent/caregiver.
- The child is separated from family and does not wish for current caregiver to be present, or he/she is unaccompanied.

[63] IASC Information Note on Disability and Inclusion in MHPSS, 2024, Table 3. Universal design and reasonable accommodation p.19.

[64] Council of Europe Strategy for the Rights of the Child (2022-2027), p.39.

[65] Council of Europe Guidelines on child-friendly health care, 2011, p.9.

[66] For guidance and suggestions on Best Interests see: UN High Commissioner for Refugees (UNHCR), 2021 UNHCR Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child, May 2021.

111. In addition to or in place of a parent/caregiver the child may wish for a trusted adult (e.g. another family member or friend) to be involved.

112. Where there is a conflict between the wishes of the child and his or her parent/s/caregiver regarding the need for and/or type of support, the best interests of the child should be a primary consideration based on a formal best interests' assessment, where possible conducted using multidisciplinary methods. All such decisions should be made by professionals on a case-by-case basis.[67]

113. Further information on child participation can be found in the following resources:

- Children's participation in decisions about their health, Council of Europe (2024)
- Listen – Act – Change - Council of Europe Handbook on children's participation, (2020)
- Child Participation Assessment Tool, Council of Europe (2016)
- Participatory Assessment with Children and Adolescents, UNHCR (2012)

4.6. Initial assessment

114. An initial assessment meeting/consultation is the first opportunity to begin the process of taking a history, assessing needs and considering possible forms of support/interventions for the child and his/her family/caregivers. The socio-ecological model shows the importance of the wider network for children's psycho-social well-being; where appropriate and possible, in addition to supporting children, efforts should be made to strengthen the protective capacities of teachers, parents, caregivers and others who have direct contact with children.[68]

115. Before meeting with a child, it is important to consider the following:[69]

- Are there any special considerations or safety/security issues related to e.g. trafficked children or links to extremist groups?[70]
- Are there any special considerations for children who are known to be survivors of SGBV – for example to ensure they have information on their rights and any procedures such as relating to reporting, medical care etc?[71] [72]
- Is the gender of support person/therapist a consideration, for example in the case of survivors of SGBV or due to issues relating to a child's sexuality?
- Does the child have a disability or any specific needs? If so, what needs to be considered to ensure accessibility and facilitate communication? (See chapter 4.4 and 4.8.3)

[67] Council of Europe Guidelines on child-friendly health care, E. p.8; For further guidance see UN High Commissioner for Refugees (UNHCR), 2021 UNHCR Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child, May 2021.

[68] Council of Europe, Reykjavik Declaration, 2023.

[69] Developed to support professionals in carrying out investigative interviews in presumed cases of trafficking in children; this handbook provides useful information on memory in child development and interview techniques: Handbook for forensic child interviews in presumed cases of trafficking, 2024.

[70] For further information on protection and support in the context of trafficking see: Council of Europe, Guidance note on the entitlement of victims of trafficking, and persons at risk of being trafficked, to international protection *and* Creating a Cycle of Protection - Guiding Principles and Key Considerations for Developing Comprehensive, Child-Centred Cooperation To Identify, Support and Assist Trafficked Children, 2024.

[71] Council of Europe, Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, 'Lanzarote Convention', 2010, Article 14.

[72] Council of Europe, Handbook on the protection of children against sexual exploitation and sexual abuse in crisis and emergency situations, 2022.

- Is there a need for translation? if so, it is better to use a non-family member where possible.
- If a child has been referred by a mental health practitioner, do they have a diagnosed mental disorder?
- Are there urgent needs / assessments to be undertaken in the first meeting e.g. risk assessment?
- What is required regarding informed consent/assent? This will depend on the age, ability and circumstances of the child.

116. Decisions on appropriate MHPSS should take into account the child's life history and experience before as well as during / after the crisis or emergency and consider any cultural, religious, traditional or social norms as well as issues including the following:

- Pre-existing mental health problems and/or difficult early life experiences including childhood trauma.
- The experience of the child as a result of the crisis or emergency situation; for example, poverty, family separation, violence/death of loved ones, loss of/destruction of home, trafficking, (worst forms of) child labour including recruitment into armed forces or groups, radicalisation by extremist groups or SGBV.[73]
- The current circumstances e.g. issues related to health or disability, care status (accompanied, separated, or unaccompanied), caregiving arrangement – is this a stable setting or is there potential for further change or displacement? Is there good support from family / caregivers or wider community?

117. Where children are too young or otherwise unable to provide background information and direct informants are not available, enquiries should be made about the general circumstances and background from members of the same community (where possible) in addition to desk research.

118. **Adolescents:** Based on an extensive review of universal and targeted interventions delivered to children exposed to specific adversities, WHO Guidelines recommend that 'psycho-social interventions should be provided for adolescents affected by humanitarian emergencies. These interventions are particularly beneficial for preventing mental disorders and may be considered for reducing substance use in these populations.' The guidelines are based on evidence from studies of interventions delivered to 10–19-year-olds and considered a broad range of interventions from relaxation techniques/stress management to trauma focused individual therapies. For adolescents with high levels of trauma exposure, trauma-focused cognitive behavioural therapy (CBT) has shown positive effects on reducing symptoms of depression, anxiety and stress.[74]

[73] Resources on MHPSS for survivors is available on this link: MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence.

[74] WHO Guidelines on mental health promotive and preventive interventions for adolescents, 2020, p.xi.

4.7. Measuring mental health and well-being and the effectiveness of MHPSS

119. Psychological measures and screening tools; questionnaires that have been designed to measure an aspect of **children's** mental health and well-being or their experience of support can be used to get a better understanding of what a child is experiencing and to track how these changes over time, or to assess the impact of an intervention or a service.

120. The measures used must be age appropriate and take account of barriers related to culture, disability and literacy. Practitioners should be competent to administer, score and interpret findings. Due to the sensitive nature of some of the questions, careful consideration should be given to the following in order to abide by the principle of Do No Harm before administering these tools:[75]

- Can you provide a clear rationale for using the measure e.g. will this enable the child to access appropriate support?
- Will completing the questionnaire influence decisions on the type of support offered? What difference could this information make to decisions on clinical judgement and management?
- Can you ensure sufficient time is available for questions, follow up and a debrief to explain the findings and implications of any measures proposed and provide reassurance/support on what the scores mean?
- Will the measure be used later to review and recognise progress?

121. Further information and a selection of tools for use with children can be found in the following resources:

- Information and guidance on the use of psychological measures and tools: Child Outcomes Research Consortium (CORC)
- Tools for children in common use, such as the Strengths and Difficulties Questionnaire (SDQ) can be found on this link: Outcome and Experience Measures, Child Outcomes Research Consortium
- A Compendium of Tools for the Assessment of the Mental Health and Psycho-social Wellbeing of Child, 2014

122. Measurement of MHPSS can also involve the development of standard indicators for use at programme or project level, for example the percentage of children and their caregivers who report improvement in their mental health and psycho-social well-being following completion of an intervention, as well as monitoring and evaluation of a programme, project or intervention to demonstrate positive or negative, direct or indirect changes that have occurred and targets reached or not reached, while providing lessons for consideration in future work.

123. Further information on developing indicators and monitoring and evaluation can be found in the following resources:

- The Common Monitoring and Evaluation Framework for Mental Health and Psycho-social Support in Emergency Settings: with means of verification (Version 2.0), IASC

[75] For guidance on working with children from different cultures see the Child Outcomes Research Consortium (CORC) booklet: Understanding and addressing the challenges of outcome measurement associated with differences in culture. CORC. The CORC also provides detailed information on the use of experience and outcome tools as well as a link to training for practitioners: training for using outcome measures.

- Developing and implementing a monitoring and evaluation (M&E) system
- Contextualizing and Measuring Child Well-Being in Humanitarian Action, Child Protection Humanitarian Alliance, 2021

4.8. Communicating with children

124. Good communication is fundamental to ensure the full participation of the child and promote good outcomes from all therapeutic interventions. It is the responsibility of the service/support worker to adapt their communication to the individual child and his/her family and community. This also implies addressing any cultural differences that influence communication. In the case of cultural perspectives which might impact negatively on full participation of the child, every effort should be made to try to resolve differences to ensure child participation regardless of their gender, age, disability, ethnicity, religion, nationality, or other circumstances.

4.8.1. Key communication skills when providing MHPSS

125. **Non-verbal communication:** Communication involves words, body language, and tone of voice – it is estimated that up to 90% of communication is non-verbal. An awareness of one's own non-verbal communication is essential as well as carefully observing the way children are communicating through their body language.

✓Calm, relaxed, open body language and soft tone of voice	X Rigid or tense body language – legs/arms crossed
✓Sit or be at the child's level, facing the child	X Stand over the child
✓Appropriate facial expressions according to what the child is expressing	X Scowling, frowning, yawning, extreme or aggressive hand gestures
✓Use eye contact carefully to avoid making the child uncomfortable	X Inappropriate touch or crowding his or her personal space

126. **Active listening**: Helps the **child** feel heard, understood and encourages him or her to keep talking or participating, for example:

- Acknowledgement using words or signs.
- Asking for clarification or further information.
- Mirroring: copying or repeating something a child has said, imitating his or her gestures.
- Summarising – paraphrasing what he or she has said.

127. **Talking together and asking questions:** Asking questions in the right way helps a child relax and communicate freely. There are three kinds of questions: closed questions, leading questions and open questions.

- Closed questions only require a simple answer such as yes or no. These questions can be useful e.g. 'how many brothers and sisters have you got?', but they do not encourage a child to talk freely.
- Leading questions 'suggest' the answer e.g. 'you are feeling much better now, aren't you?' Most children would not like to disagree so will answer yes even if this is not the case.

- Open questions and comments allow and encourage children to express themselves and open up and don't suggest a right or wrong answer e.g. 'what happened next?' 'what's it like living there?'

128. Generally, most people use a combination of closed questions – to establish facts, and open questions to encourage expression.[76]

129. **Responding with empathy:** Children need to know that you recognise and acknowledge their perspective and can understand their emotions. Phrases like 'that must have been really hard for you,' 'you were very brave to do that' will reassure him or her that you are listening and care. Some reassurance is needed for example, 'I have known other children who felt like you – its normal after what you have been through' without minimising the seriousness of their situation or saying, 'you will get over it soon.'

130. **Talking about separation and death:** When children become **separated from their families,** they feel grief mixed with anxiety because they don't know if their relatives are alive or whether they will ever see them again. They may worry about who will care for **them**. It is important to be honest with such children and keep them fully informed. For example, if family tracing efforts are continuing, children should be kept up to date without raising false hopes; children in alternative care arrangements need to know how long these will continue. Talking about and remembering their family might be difficult for children in alternative care - they need to have opportunities to share these memories so that the value of their past is not forgotten.

131. **If family members or close friends are missing or dead**, it is important to find out (from other family members/caregivers/friends) what the child has been told / understands. It is always preferable to be honest with children of all ages when talking about death; sticking to the facts and using clear language, especially with young children who may not understand the meaning of euphemisms such as referring to someone 'being lost' or having 'passed away.'

132. A child's reaction to the death of a loved one will vary depending on their age and previous life experiences, their relationship with the person who died, how other family members are responding and the culture and society in which they live. There are no specific stages in which different emotions or behaviours should appear. The information below is a general guide to common ways in which children grieve:

- **Small children under the age of 5 years** often do not understand that death is permanent and may ask if the person who has died is coming back. They may exhibit other, often regressive behaviours such as clinging to their caregiver or wetting the bed. These behaviours are very common and will usually stop after a certain amount of time has passed.
- **Children between the ages of 6 and 11 years** start to understand that death is forever (though some 6-year-olds will still struggle with this concept) and may worry that other loved family members and friends will die. They may start to ask more questions and want to understand what happened. They may show their grief through anger and experience physical aches or pains.
- **Children from around the age of 12 years** understand that death is irreversible and happens to everyone, including themselves. They are often interested in understanding why things

[76] Save the Children, Communicating with Children: Helping children in distress, 2000, pp.12-13.

happen. Their reactions will vary and can include apathy, anger, extreme sadness and poor concentration.

133. When talking to children about death it is helpful to check for any "magical" thinking; children may think that they are responsible for the loss; for example, they may think that their loved one died because they were naughty or because they were upset with them. Children of all ages may feel guilty, so check to see if they feel responsible in any way.[77]

134. Wherever possible children should be involved in mourning or burial ceremonies, where culturally appropriate. Children should be supported to express their feelings through talking, writing, drawing etc. and their emotions should be accepted as normal. At the same time, children should be encouraged to continue with a routine e.g. going to school and taking part in regular activities.[78]

4.8.2. Communicating with children of different ages

135. The following table can be used to guide communication for children of different ages. However, every child is different, and children affected by crisis and emergency situations may go backwards in their communication and behaviour, making it necessary to adapt accordingly. More detailed information on developmental stages can be found in the Alliance for Child Protection in Humanitarian Action, Protection in Humanitarian Action Frontliners' Getting Started Learning Package, Facilitators, 2021, pp. 30 – 32.

3-5 years old • Enjoy make-believe play • Ask many questions using words like 'what' 'where' and 'why' • May communicate through games and stories • Enjoy expressive activities such as dancing, music, puppets and play	**6-11 years old** • Use language for different purposes such as asking questions or persuading • Share and discuss more complex ideas • Understand other points of view and show that they agree or disagree • Start conversations with adults and children they do not know
12-14 years old • Keep a conversation going by giving reasons and explaining choices • Use language to predict and draw conclusions • Able to use sarcasm and understand when others are being sarcastic to them • Know that they talk differently to friends than to teachers and can easily adjust their style	**15-17 years old** • Know when they haven't understood and will ask to be told again or have something explained. • Tell long and very complicated stories • Good at understanding individual instructions • Adjust their style of speaking to different situations and audiences

[77] For more information see: Communicating with children about death and helping children cope with grief.
[78] Save the Children, Communicating with Children: Helping children in distress, 2000, pp. 57-59.

4.8.3. Communicating with children with disabilities

136. Everybody, regardless of their abilities, is able to communicate in some way. Children and/or their family members should be able to provide guidance on the preferred mode of communication, for example sign language. Where there are barriers to communication, efforts should be made to research how these can be overcome, for example by using different techniques or tools. Always address children with disabilities as you would another child of their age whilst keeping content simple and clear.

137. Below are some tips for communicating with children with different disabilities. Many tools and ideas for communication can be found online and products to help with communication are widely available e.g. Widgit. (See also chapter 4.4.1)

Children with a visual impairment

- Use his or her name when addressing and speak directly to the child, not to adults assisting or accompanying.
- Use a normal speaking voice (unless you know there are hearing issues as well).
- Provide spoken information (describe what you see, read out text).
- Check if written information can be provided in braille or in audio format.
- If you need to touch, tell him or her first.
- Keep the space clear of unnecessary obstacles and familiarise the child with layout, whereabouts of toilets etc.

Children with a hearing impairment

- Check communication tools/arrangements for preferred means of communication before meeting e.g. hearing aids and spare batteries, sign language interpretation or facilities for writing e.g. text messaging.
- Use an external interpreter rather than family members where possible if sign language is needed; in case harm from family is suspected this is essential.
- Try to minimise background noise.
- Many children depend on lip reading so ensure you face the child directly, speak slowly and clearly and support with non-verbal communication.
- Never shout at a deaf child and if more than one person is present ensure only one person speaks at a time.

Children with a speech impairment

- Allow the child plenty of time to speak without cutting off or finishing the sentence for them
- Ask them to repeat and check understanding e.g. "you said you want to go to school? Is that right?"
- Consider alternative forms of communication, for example, using symbol boards, writing, or texting.
- If you are having difficulty understanding, see if they can tell you in another way, for example by:
    - showing you what it is
    - using actions or gestures
    - drawing what it is
    - describing it – What is it like? Where would you find it? What is it for?

    - using a different word
    - telling you the sound the word starts with.

Children with an intellectual disability

- Use accessible language (avoid jargon or long words, use plain language, and provide context).
- Ask open questions; questions that don't have a simple yes or no answer.
- Check that you understand what he or she is saying by repeating/paraphrasing.
- Be prepared to use different communication tools – drawing, picture books/flash cards.
- Follow his or her lead and go at his or her pace.
- Use gestures and facial expressions.

Chapter 5: MHPSS for children in crisis and emergency situations-focused and specialised support and services

Outline

5.1. Psychological First Aid (PFA)
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  5.2.1 Supporting the mental health and well-being of parents/caregivers
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5.1. Psychological First Aid (PFA)

138. Psychological first aid has been recommended by many international and national expert groups, including the Inter-Agency Standing Committee (IASC) and the Sphere Project. In 2009, the World Health Organisation's (WHO) mhGAP Guidelines Development Group evaluated the evidence for psychological first aid and psychological debriefing and concluded that PFA, rather than psychological debriefing, should be offered to people in severe distress after being recently exposed to a traumatic event.[79] PFA is suitable for children of all ages; information and guidance on supporting children of different age ranges is included in the resources listed below.

Psychological first aid describes a humane, supportive first response suitable for children and adults in crisis. It supports long-term recovery by helping individuals to:

- Feel safe, connected, calm and hopeful;
- Access social, physical and emotional support; and
- Feel able to help themselves and their communities.[80]

139. PFA can be provided by anyone, not only professionals and it includes the following:
  - Providing practical care and support.

[79] World Health Organisation, Psychological first aid: Guide for field workers, 2011.
[80] The Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child Protection in Humanitarian Action, 2019, p.136.

- Assessing needs and concerns and helping people to access basic needs e.g. food, information.
- Listening but not pressuring to talk.
- Providing comfort and reassurance.
- Protecting people from further harm.

140. PFA is for distressed people who have been recently exposed to a serious crisis event, both adults and children. Not everyone who experiences a crisis event will need or want PFA whilst others may need more advanced or different kinds of support such as medical support, help from local authorities, community or religious leaders.

141. Although people may need access to help and support for a long time after an event, PFA is aimed at helping people who have been very recently affected by a crisis event as a first line response. PFA is usually provided wherever the contact is made, e.g. at the scene of a disaster or other emergency or wherever it is safe and ideally, quiet and private.

142. Further information on PFA can be found in the following resources:

- World Health Organisation, Psychological first aid: Guide for field workers, 2011
- World Health Organisation, Psychological first aid: facilitator's manual for orienting field workers, 2014
- Save the Children, Psychological First Aid Training Manual for Child Practitioners, 2013
- Save the Children, Psychological first aid for children II, Dealing with traumatic responses in children, Training Manual, 2017
- Summary of Psychological First Aid for Children: An online course introducing the concepts and steps involved in providing support to children following a distressing event. It includes activities that focus on the core elements of PFA and how to apply them in a humanitarian context.

Psychological First Aid: Field Operations Guide (second edition) describes an advanced form of psychological first aid because it was developed for use by previously trained mental health professionals. The guide describes PFA as an evidence-informed modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism in order to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. Although designed for western disaster settings, this guide provides helpful information and tips on providing PFA to children and adolescents.
National Child Traumatic Stress Network, Psychological First Aid (PFA) Field Operations Guide: 2nd Edition, 2006

5.2. Interventions for parents/caregivers

143. Parent/caregiver distress has been strongly linked to mental health changes and behavioural problems in children.[81] In recognition of the negative impact of compounded stress on caregivers during crisis and emergency situations and their crucial role in strengthening children's well-being and mental health, interventions for parents/caregivers should aim to (i) support the mental health and well-being of parents/caregivers and (ii) strengthen parenting skills.

[81] For example, McElroy, E., et.al, Change in child mental health during the Ukraine war: evidence from a large sample of parents, European Child & Adolescent Psychiatry, 2023.

5.2.1. Supporting the mental health and well-being of parents/caregivers

144. Where possible, parents/caregivers should be provided with a range of psychoeducation materials relating to their own emotional needs, encouraged with self-care, for example through participation in activities outside the home where available; yoga or mindfulness programmes or support groups in the community such as parents, women's/men's groups and safe spaces (for expectant mothers/mothers and lactating women).[82]

145. MHPSS for pregnant girls and women is particularly important; the perinatal period (from pregnancy until around one year after childbirth) is an acute phase when women and girls may experience a new onset of mental health and psycho-social concerns, or a re-occurrence or exacerbation of prior mental distress or disorder. [83] The additional hardship and stress of crisis or emergency situations may further increase the potential for maternal stress leading to negative impacts on the developing foetus.

146. Child-friendly spaces and nursery groups/creches allow parents/caregivers the time and space to focus on their own well-being.

147. Focused group or individual MHPSS support such as stress management/relaxation interventions may be needed for some parents/caregivers. If more specialised support is needed, the following evidence-based individual and group interventions developed by the World Health Organisation (WHO) have been effective in helping parents and caregivers in crisis and emergency situations:

- PM+ (Problem Management Plus) – a brief, individual intervention for adults (e.g., caregivers) with prolonged, disabling distress.
- GROUP IPT (Group Interpersonal Therapy) – a group activity useful in different age groups to help participants better understand and manage depression.
- THINKING HEALTHY – a support intervention for mothers with perinatal depression.

5.2.2. Strengthening parenting skills

148. Interventions that are associated with positive mental and social outcomes for children include those that (a) are organised by age group and (b) promote positive caregiving behaviours, particularly nurturing, responsive and consistent care in early childhood. Parenting programmes that target caregivers of adolescents can strengthen child and caregiver relationships and reduce risks to adolescents. Home visiting programmes implemented by trained staff can reduce abuse, neglect, exploitation and violence against children. 'There is emerging evidence that group-based parenting interventions have worked well, including in humanitarian contexts, as have opportunities for parents to practice positive parenting skills.'[84]

149. Information about stress reactions of children at different ages and developmental stages (psychoeducation) and strategies to support them with positive parenting knowledge and skills, can

[82] A template and guidance for running support groups for refugees can be found on the IFRC Reference Centre for Psycho-social support: IFRC, EU4Health project: Support groups for Ukrainians living in Europe: Guidance note.
[83] Collaborating for Maternal Mental Wellbeing: Technical Brief on Perinatal Mental Health in Humanitarian Settings, p.7.
[84] UNICEF, Mental Health and Psycho-social Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice, 2021, p.45.

help parents/caregivers re-establish a sense of their own effectiveness in parenting in challenging situations and build their skills in responsive caregiving. Support groups for parents/caregivers of children with MNS disorders, developmental disabilities or serious distress can provide forums for sharing resources, information and strategies.

150. Parents / caregivers of younger children are likely to benefit from capacity-building in Early Childhood Development (ECD) activities such as responsive infant interaction training, 'Minding the Baby' and nurturing care practices.[85]

151. The parenting programmes described below have both been widely implemented, including in crisis and emergency situations.

Parenting Curriculum (Families Make a Difference)
Children need a safe and loving home to grow up happy and healthy. However, research and studies on violence against children have highlighted that the home is where children worldwide are most at risk of violence. For boys and girls growing up amid poverty and crisis, the protective role of a parent is especially critical—and especially difficult. Supporting caregivers with alternatives to violent discipline helps keep children safe and lets them develop to their full potential.

There have been over three decades of research on the effectiveness of parent training programs to improve child behaviour, eliminate behaviour problems, and prevent and mediate child abuse and neglect. The IRC curriculum revolves around the following core concepts: Positive Parent-Child Interactions, Emotional/Empathetic Communication, Supportive Guidance and Consistent Routines, Nonviolent Discipline: The Correct Use of Time Out and Cognitive and Social Skills.
International Rescue Committee, Parenting Curriculum (also known as Families Make the Difference, FMD)

Caregiver Support Intervention (CSI) aims to strengthen the quality of parenting skills by lowering stress and improving psycho-social well-being among refugee caregivers of children aged 3–12 years, while also increasing knowledge and skills related to positive parenting. The CSI is a nine-session psycho-social group intervention delivered by non-specialist providers. It is intended for all adult primary caregivers of children in high-adversity communities, rather than specifically targeting caregivers already showing signs of elevated distress.
War Child Holland, Caregivers Support Intervention

Resources for parents/caregivers

152. A wide range of resources for parents/caregivers can be found on the links below. (Compiled in response to the Ukraine Crisis, many of the materials are widely applicable in crisis and emergency situations):

- Parents and caregivers are heroes: protecting our children in a crisis, 2023
- MHPSS.net. Emergency Briefing Kit for Receiving Countries – Ukraine Humanitarian Crisis, 2022

Examples include:

- Caring for your child through conflict and displacement (UNODC and UoM, 2017)
- Ukraine response: Helping children and parents cope (Various authors, 2022)

[85] Minding the Baby (MTB) is an intensive and preventive home-visiting programme developed by Yale University that helps first time mothers aged 14–25. The focus of the intervention is to reduce negative infant and maternal outcomes and strengthen the attachment relationship.

- Caring for your child in crisis situations (UNODC)
- IASC, Mental Health and Psycho-social Support, Humanitarian Response in Ukraine and Neighbouring Countries, 2022

5.3. Interventions for children: community-based / non-specialised support

153. Accessible and inclusive child-friendly spaces, community-based activities such as youth groups, art and drama, recreational and sports groups all have a significant role in providing basic MHPSS and opportunities to identify and refer children in need of more focused or additional support.

5.3.1. Resilience programmes

154. Resilience amongst children in crisis and emergency situations has multiple sources, including individual factors such as hope, temperament, self-regulation, self-efficacy, and cognitive competence. Children who demonstrate the strongest resilience are identified as most frequently having a combination of biological resistance to adversity and strong relationships with the important adults in their family and community. Interventions that best promote resilience include those that encourage positive relationships with caregivers and peers, consistent parenting, social frameworks that promote meaning, intelligence, high emotional self-regulation, and self-efficacy or mastery[86].

155. Although widely implemented, no systematic reviews have been identified which focus specifically on resilience interventions with children in crisis and emergency situations. However, the importance of giving children back power, a sense of agency and hope for the future, which are some of the aims of resilience programming, has been highlighted in relation to positive outcomes.

156. There are many examples of resilience programmes for children – see below for information on two resilience programmes – one for children and one for youth, which have been widely implemented including in crisis and emergency situations:

The Children's Resilience Programme: Psycho-social support in and out of school is a nonclinical psycho-social and protection methodology that focuses on children's positive coping and resilience. The Child Resilience Programme comprises 8-16 structured workshops for children 10-16 years old. The same 1-2 facilitators conduct the activities once or twice a week, for the same group of children. The programme can be implemented for children in and out of school, e.g. during or after disasters, in situations of armed conflict, for children affected by HIV, or as part of preventative social work. Improve cooperation and peaceful interaction between children.
The objectives of the workshops are to: improve the motivation to play, problem solving and positive attitude to others; enhance positive expectations for the future; enhance impulse control (in relation to aggressive behaviour and/or risk-taking behaviour and enhance capacity and awareness about self-protection and protection of peers.
IFRC & Save the Children Denmark, The Children's Resilience Programme: Psycho-social support in and out of schools, 2012

[86] UNICEF, Mental Health and Psycho-social Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice, 2021, pp.25-26.

Youth Resilience Programme: Psycho-social support in and out of school has been developed by Save the Children as an independent continuation of the Children's Resilience Programme. The programme is a nonclinical psycho-social and protection methodology and framed within the concept of 'I AM,' 'I CAN' and 'I HAVE' to capture the complex interaction of individual and social factors that facilitates resilience. The heart of the programme is a series of 8-16 structured workshops implemented by the same 1-2 facilitators once or twice a week, for the same group of young individuals aged ~14 and above.
The workshops aim to help young people to: resume normal, routine activities during or in the aftermath of crisis events; have strong personal and social skills to adapt to and cope with adversities; feel good about themselves and confident in their own abilities; make good and safe life choices; be more social and act as role models to other children and young people; trust others and feel comfortable about sharing feelings and thoughts, solve problems without violence and seek help from others (i.e. peers and adults) when needed and have stronger awareness about who can help.
Save the Children Denmark, The Youth Resilience Programme: Psycho-social support in and out of school, 2015

5.3.2. Psychoeducation

157. Psychoeducation involves learning about mental health and well-being and finding ways to manage and cope with any difficulties; it can help to normalise levels of stress, confusion and feelings of hopelessness. Understanding what is happening is often a key step to being able to do something differently and psychoeducation is effective when used with children directly, parents/ caregivers (as through parenting programmes) or other trusted adults in a child's life.

158. Individual or group settings can be used for psychoeducation interventions with children. Information about psychological concepts, specific problems, and the relationships between thinking, emotion, and behaviour is shared and discussed. For example, children can learn how to understand and regulate emotional triggers and reactions, understand stress and how to manage stressful situations or identify protective factors in their lives. Psychoeducation is an important element of Cognitive Behavioural Therapy (CBT), a type of talking therapy that aims to manage problems by changing how people think and act) (See chapter 5.4).

159. Psychoeducation can be effective in relation to a range of problems or conditions and can be adapted for all age groups. Play is an effective vehicle for explaining therapeutic concepts to children: information can be tailored so it is age appropriate and provides a way for them to engage with the idea.

Resources on psychoeducation:

- Appendix 1 Psychoeducation exercises for children
- IFRC Reference Centre for Psycho-social Support, Psycho-social support in emergencies brochures/handouts/posters, 2013
- MHPSS.net. Emergency Briefing Kit for Receiving Countries – Ukraine Humanitarian Crisis, 2022 (compiled in response to the Ukraine Crisis, many of these materials can be widely used in crisis and emergency situations)

5.3.3. Emotional regulation

160. Children who struggle to regulate their emotions may be prone to angry outbursts and other extreme emotional responses. Internalised psychological distress, such as depression and anxiety, as well as the impact of harmful stress on the developing child's brain can all lead to difficulty in regulating emotions.

161. Effective emotional regulation is essential in enabling an appropriate response to life's challenges and preventing people from becoming overwhelmed or acting impulsively. It promotes resilience and mental health, while difficulties with regulation can lead to various challenges that can have a profound effect on well-being, relationships, and ability to function in society.

162. Emotional regulation interventions can be used with children of all ages to help them recognise and exert control over their own emotional state by introducing calming, relaxation and grounding techniques such as breathing exercises or mindfulness, therefore disengaging with the intensity of the emotion and re-focusing negative thoughts using imagery or self-compassion and focusing on strengths.

163. Examples of evidence-based techniques like mindfulness, cognitive reappraisal, and breathing exercises are available for use with children of different ages or can be adapted accordingly. For example, working with young children to practice creating a "safe place" in their imagination. This allows children to use visual imagery in a positive and proactive way and can serve as a secure base in imagination to which children can return, helping to calm them and give them a sense of control. Simple breathing exercises such as 'belly breathing' can be used with children from the age of five years old while more focused mindfulness is suitable for older children. Cognitive reappraisal, which involves shifting attention to interpretations of experiences that generate positive emotions and open a path to problem-solving can also be useful in regulating emotions. Although mainly used with older children and adults, some studies have shown potential for using this technique with children from five years of age.[87]

Resources on emotional regulation:

- See, Appendix 2 Emotional Regulation and Grounding Exercises
- World Health Organisation, Doing What Matters in Times of Stress, 2020
- Train Your Brain: Understanding Ourselves, a model to help understand and regulate emotions
- Positive Psychology, Mindfulness Worksheets for Children and Youth
- Belly Breathing, Mindfulness for Children
- Yoga for Children

[87] See for example: Cognitive Reappraisal in Children: Neuropsychological Evidence of Up-Regulating Positive Emotion From an ERP Study.

5.3.4. Expressive activities

164. Expressive interventions use forms of creative expression such as art, music, movement and dance to help children express their emotions, share and process feelings and memories that may be hard to put into words.

165. Expressive activities can be designed or adapted for children of all ages/developmental stages – simple drawing activities can be used as a way of helping younger children identify their emotions and manage anxiety whilst the process of developing a drama production can be healing as a way of developing trust, in addition to creating a space to share stories of war and displacement. More specialised approaches such as psychodrama, which can be emotionally challenging for participants, should only be implemented by experienced facilitators with carefully selected participants in specific circumstances.[88]

166. 'Evidence suggests that creativity-based programmes incorporating the arts, such as theatre, music, dance, drawing, and writing poetry, can aid in the recovery of displaced adolescents. A systematic review of significant findings of arts-based interventions found they led to reductions in symptoms of depression, anxiety, PTSD, functional impairment and peer problems among refugee and asylum-seeking children.[89]

167. There are numerous examples of creative activities designed for use in crisis and emergency situations. See below for information on programmes/collections of resources which have been widely implemented:

Boxes of Wonder: A manual presenting the use of an innovative conceptual framework for structuring programmes of direct work with children on the move to facilitate the creation of meeting spaces for children and practitioners. They offer thematic frameworks for activities, ideas, and materials that are available and highly relevant for children, for example puppet making, storytelling, mapping their journey etc.

'The programme of support has the potential to support the child in developing their inner strengths – the feeling of self-esteem, self-respect, sense of control and self-regulation, independence, capacity for active participation in the events around him/her, nurturing of hopes for the future, as well as capacities to connect and interact with others, to establish relationships, solve problems and resolve conflicts, provide support to others, and similar.'
Save the Children, Boxes of Wonder: Creation of the program with children on the move, 2018

Healing and Education Through the Arts (HEART): The Healing and Education through the Arts (HEART) program is an arts-based approach to providing psycho-social support for children, youth, and adults around the world.
HEART uses expressive arts to help children – in schools, child-friendly spaces, youth centres, and at home – process and communicate feelings, experiences, or ideas in an emotionally supportive environment where they can connect with peers and caring adult facilitators.

[88] Psychodrama is a type of experiential, action-based therapy in which people explore issues by acting out events from their past.
[89] Refugee Rights Europe, Supporting the Mental Health and Wellbeing of Young People Seeking Asylum, 2021, p.19.

Children and youth aged 3 – 25, along with parents and caregivers, receive support through HEART. Through drawing, painting, music, drama, and many other art forms, children create, express, support, and learn!

HEART has a strong evidence base, both from decades of global research on the impact of the arts on stress reduction, well-being, learning, and development, as well as from recent evaluations of the program in different settings around the world.
Save the Children, Healing and Education Through the Arts (HEART)
HEART at Home: These materials were adapted during Covid 19 pandemic for parents/caregivers to use at home with children. Guidance and a wide range of materials are provided, and the purpose is to give children a chance to express themselves, however they like, and for that expression to be met with support and understanding from caring adults. Information is provided on how to facilitate the activities and also how to manage emotions and support children.
Save the Children, HEART At Home: Guidance for parents/caregivers to support children with expressive arts at home, 2020

The Adolescent Kit for Expression and Innovation: A package of guidance, tools, activities, and supplies to support adolescents ages 10-18, especially those who are affected by humanitarian crises.

The Kit aims to bring about positive change in adolescents' lives through arts and innovation. The activities offer adolescents the chance to express themselves, explore and connect with people and places around them, and design and carry out projects to make positive change. In the process, adolescent girls and boys develop key competencies and new skills that help them to cope with stressful circumstances, build healthy relationships, and engage positively with their communities.

The Kit promotes bringing groups of girls and boys ages 10-18 together in a safe space on a regular basis to have fun, cope with difficult experiences, learn, and take action together. It draws from good programmatic approaches in psycho-social support, life skills education, project-based learning, child protection, social cohesion and peacebuilding.

The Kit can be used by anyone involved in managing programmes or working directly with adolescents in humanitarian and vulnerable development contexts. This includes staff across different sectors, teachers, facilitators and youth volunteers. All or part of the Kit can be integrated into programmes for adolescents in areas such as child protection, education and youth development.
UNICEF, The Adolescent Kit for Expression and Innovation

The Laughter and Play Manual has been developed by Clowns Without Borders Sweden in collaboration with Plan International. The games and exercises in this manual have been created and curated specifically for adolescent girls and boys between the ages of 10 and 19 years, who are living in emergency and protracted crisis settings. It can also be used as a stand-alone resource for group-based activities in safe spaces, youth groups and broader adolescent programmes.
Plan International & Clowns without Borders, Laughter and Play: Games and creative exercises for adolescents in crisis settings, 2020

5.4. Interventions for children: specialised support

168. The following section provides information regarding evidence-based management of mental disorders for children.[90] Information is based on the following documents where further information can be found:

- World Health Organisation, mhGAP Humanitarian Intervention Guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies, WHO 2015;
- National Institute for Health and Care Excellence (NICE) Guideline: Self-harm: assessment, management and preventing recurrence, 2022;
- National Institute for Health and Care Excellence (NICE) Guideline, Suicide prevention, 2019;
- National Institute for Health and Care Excellence (NICE) Guideline, Post-traumatic stress disorder, 2018;
- National Institute for Health and Care Excellence (NICE) Guideline, Depression in children and young people: identification and management, 2019;
- National Institute for Health and Care Excellence (NICE) Guidance, Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, 2014;
- National Institute for Health and Care Excellence (NICE) Guidance, Drug misuse prevention: targeted interventions, 2017;
- National Institute for Health and Care Excellence (NICE) Guidance, Anxiety disorders, 2014.

5.4.1. Acute Stress (ACU)

169. According to WHO Guidelines on the management of conditions specifically related to stress there is no evidence to support recommendations on early psychological interventions/psychological therapies for children and adolescents with acute traumatic stress symptoms associated with significant impairment in daily functioning.[91]

170. A response to children with Acute Stress would therefore comprise PFA, psychoeducation, general psycho-social support to child and parents/caregivers and group or individual interventions as described above (chapter 5.3).

171. In the case of bedwetting in children as a symptom, the following can be offered:

- Check the history of bedwetting to confirm that it started after experiencing a stressful event and advise/refer for medical check to rule out medical cause e.g. urinary tract infection.
- Explain:
    - Bedwetting is a common, harmless reaction in children who experience stress.
    - Children should not be punished for bedwetting because punishment adds to the child's stress and may make the problem worse. Caregivers should avoid discussing in public and embarrassing the child.

[90] Therapeutic interventions with limited evidence, such as Animal Assisted Therapy / Canine Assisted therapy, are not included although research highlights the potential for effectiveness in certain disorders, see for example: Jones et al, Incorporating animal-assisted therapy in mental health treatments for adolescents: A systematic review of canine assisted psychotherapy. PLoS One. 2019.

[91] World Health Organisation, Guidelines on conditions specifically related to stress, 2013.

- Carers should remain calm and emotionally supportive.
- Where appropriate, carers can be trained on simple behavioural interventions using rewards: avoiding excessive fluid intake before sleep, toileting before sleep, dry nights.

5.4.2. Post-Traumatic Stress Disorder (PTSD)

172. Prevention of PTSD: **Active monitoring or individual or group trauma focused CBT Intervention** can be offered for children with Acute Stress Disorder or those who have been involved in a significantly traumatic event within the last month. **CBT should be:**

- based on a validated manual and delivered by trained practitioners with ongoing
- supervision
- typically, be provided over 5 to 15 sessions
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve restructuring trauma-related meanings for the individual
- provide help to overcome avoidance

"Trauma-focused CBT" refers to a specialised form of Cognitive Behavioural Therapy (CBT) designed to help individuals, particularly children and adolescents, cope with the psychological impact of traumatic experiences. It involves techniques like psychoeducation, cognitive restructuring, gradual exposure to trauma-related memories, and skill building to manage distress, all delivered in a trauma-informed approach.

173. Treatment of PTSD: **Psychoeducation** adapted to the age / developmental stage of the child for example advise to:

- Continue their normal daily routine as much as possible.
- Talk to trusted people about what happened and how they feel, but only when they are ready to do so.
- Engage in relaxing activities to reduce anxiety and tension.
- Avoid using alcohol or drugs to cope with PTSD symptoms.

174. **Psychological therapies** for the prevention and treatment of PTSD in children; these should be conducted only by trained and supervised therapists.

175. **Individual trauma - focused CBT intervention** for children which should be:

- based on a validated manual and delivered by trained practitioners with ongoing supervision.
- typically, be provided over 6 to 12 sessions, but more if clinically indicated e.g. multiple traumas.
- adapted to the child's age and development.
- involve parents or carers as appropriate.
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning.
- involve elaboration and processing of the trauma memories.
- involve processing trauma-related emotions, including shame, guilt, loss and anger.
- involve restructuring trauma-related meanings for the individual.

- provide help to overcome avoidance.
- prepare them for the end of treatment and plan for booster sessions if needed.
- particularly in relation to significant dates (for example trauma anniversaries).

176. **Eye movement desensitisation and reprocessing (EMDR)** for children aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event, only if they do not respond to or engage with trauma-focused CBT.

EMDR stands for Eye Movement Desensitisation and Reprocessing. It involves using side to side eye movements combined with talk therapy in a specific and structured format to help process negative images, emotions, beliefs, and body sensations associated with traumatic memories. EMDR helps to see things from a different perspective and relieves symptoms such as flashbacks, upsetting thoughts or images, depression, or anxiety.

EMDR is recognised by the National Institute for Health and Care Excellence (NICE) in the UK as a treatment for post-traumatic stress disorder (PTSD), and the World Health Organisation (WHO), which also recognises it as an effective treatment for children.

5.4.3. Prolonged grief disorder

177. **Psycho-social support** e.g. stress management/relaxation as described above (chapter 5.3). Depending on the age of the child, discuss and support culturally appropriate mourning processes. Answer questions by providing clear and honest explanations that are appropriate to the child's level of development. (See also chapter 4.8.1)

178. **Psychoeducation** adapted to the age / **developmental** stage of the child for example:
- People may react in different ways after major losses. Some people show strong emotions while others do not. Crying does not mean you are weak.
- People who do not cry may feel the emotional pain just as deeply but have other ways of expressing it.
- You may think that the sadness and pain you feel will never go away, but in most cases, these feelings lessen over time.
- Sometimes a person may feel fine for a while, then something reminds them of the loss, and they may feel as bad as they did at first. This is normal and again these experiences become less intense and less frequent over time.
- There is no right or wrong way to feel grief. Sometimes you might feel very sad, and at other times you might be able to enjoy yourself. Do not criticise yourself for how you feel now.

5.4.4. Depressive disorder

179. **Psycho-social support** e.g. stress management/relaxation **as** described above (5.3).

180. **Psychoeducation** adapted to the age/developmental stage of the child, for example:
- Depression is a very common condition that can happen to anybody, and this does not mean you are weak or lazy.

- The negative attitudes of others (e.g. “Pull yourself together”) may relate to the fact that depression is not a visible condition (unlike a wound) and the false idea that people can easily control their depression by sheer force of will.
- People with depression tend to have unrealistically negative opinions about themselves and their future. Your current situation may be very difficult, but depression can cause unjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the depression improves.
- Even if it is difficult, you should try to keep to a regular routine, be as physically active as possible and spend time with trusted people.
- You should be aware of thoughts of self-harm or suicide. If you notice these thoughts, you should not act on them but should tell a trusted person and come back for help immediately.

181. **Psychological therapies** – a full **assessment** of needs should be undertaken to determine the choice of psychological therapy. This should include:

- The circumstances of the child and their family members or carers.
- Their clinical and personal/social history and presentation.
- Their maturity and developmental level.
- The context in which treatment is to be provided.
- Comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities.
- Availability of trained therapists.[92]
- There is limited evidence of efficacy for children aged 5-11.

182. The following are recommended by NICE / WHO for children with mild depression:[93]

- **Digital cognitive–behavioural therapy (CBT);** the use of digital tools, platforms, or devices to deliver or enhance CBT.
- **Individual or group CBT.**
- **Group non-directive supportive therapy (NDST);** where the therapist primarily focuses on providing a supportive environment for individuals to discuss their concerns and experiences, without actively directing the conversation or offering specific solutions, essentially letting the individuals lead the discussion and gain insight from sharing with others in the group.
- **Group interpersonal psychotherapy (IPT**)**;** a form of psychotherapy that focuses on relieving symptoms by improving interpersonal functioning. A central idea in IPT is that psychological symptoms can be understood as a response to current difficulties in everyday relationships with other people.
- **Attachment-based family therapy;** a type of psychotherapy that helps family members repair relationships and feel more secure, based on the idea that early childhood experiences with caregivers’ shape how people relate to others as adults.
- **Problem solving counselling;** helps people find their own solutions to problems.
- **Behavioural activation;** focuses on improving mood by engaging again in activities that are task-oriented and used to be enjoyable, despite current low mood. It may be used as a stand-alone treatment, and it is also a component of cognitive behavioural therapy.

[92] There is increasing evidence that brief psychological treatments for depression can be done by trained. and supervised lay/community workers (WHO MH Gap p.23).

[93] See NICE Guideline, Depression in children and young people: identification and management, 2019, pp. 17-18 for detailed guidance on suitable therapy by age.

183. The following are recommended by NICE for children with moderate/severe depression:[94]

- **Family-based IPT;** family-based interpersonal psychotherapy is an evidence-based psycho-social intervention for depression in preadolescents.
- **Family therapy;** also known as systemic therapy, involves a therapist working with the child and his/her family to address the impact of depression on the family dynamic, improve communication and provide support, potentially leading to better management of depressive symptoms for the individual by addressing the wider family system contributing factors.
- **Psychodynamic psychotherapy;** a type of psychotherapy that helps people understand how their current feelings and behaviour are shaped by their past experiences, unconscious mind, and impulses.
- **Individual CBT** (for at least 3 months)
- **IPT-A** (IPT for adolescents)
- **Brief psycho-social intervention**

184. **Antidepressant medications** may be prescribed for children over 12 years of age for moderate/severe depression in combination with psychological therapy where medical supervision and the capacity for monitoring is available.

5.4.5. Self-harm and suicide prevention

185. Talking with the child about self-harm and suicide where this is observed or suspected may help them to openly communicate their distress and may allow an opportunity to develop a safety plan. It is important to be non-judgemental and calm – asking open-ended questions and allowing them the time they need (see below **How to talk to a child about suicide**). Unless there is imminent danger of severe harm or suicide, trying to force someone to stop self-harm before they are ready to, may make them feel worse or increase their risk. However, where there is a risk of serious self-harm or suicide children should be referred for urgent psychiatric assessment; in circumstances where specialised support is not available practitioners should always consult with their supervisor urgently to discuss risk management.

186. **Support / management** of children relating to self-harm and suicide includes the following:

- Medical assessment / treatment as necessary.
- Psycho-social assessment to try to develop a collaborative therapeutic relationship, begin to develop a shared understanding of the reasons for how they are feeling/acting and to ensure the appropriate care is provided.
- Risk formulation – 'a collaborative process between the person who has self-harmed and a mental health professional that aims to summarise the person's current risks and difficulties and understand why they are happening to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources.95
- Safety plan – a written, prioritised list of coping strategies and/or sources of support that the person who has self-harmed can use to help alleviate a crisis. Components can include

[94] See NICE Guideline, Depression in children and young people: identification and management, 2019, pp.19-21 for detailed guidance on suitable therapy by age.
[95] NICE Guideline, Self-harm: assessment, management and preventing recurrence, 2022, p.42.

recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods.

- Dialectical behaviour therapy adapted for adolescents (DBT-A) in the case of significant emotional dysregulation/frequent self-harm, where there are trained and supervised therapists experienced in this intervention.
- Medical care for children who have attempted suicide and 24-hour monitoring.
- Psycho-social support: DO NOT start by offering potential solutions to the child's problems. Instead, try to instil hope. For example:

  '*Many people who have been in similar situations – feeling hopeless, wishing they were dead – have then discovered that there is hope, and their feelings have improved with time.'*
- Help the child to identify reasons to stay alive and search together for solutions to the problems.
- Follow-up sessions which should continue for as long as self-harm / suicidal thoughts and plans persist.[96]

How to talk to a child about suicide

Explain that you would like to ask some questions which may be difficult to answer - provide reassurance that it's ok to talk and share difficult feelings.

Start with asking how they are feeling now, try to create opportunities for children to talk by asking open ended questions, these are questions that invite someone to say more than 'yes' or 'no', such as *'How have you been feeling?'* or *'What happened next?*

Allow children plenty of time to answer – don't pressure them.

Some ideas for things you could say include the following:

Sometimes, when children are feeling [sad/confused/scared/unhappy], it can be really difficult for them. Especially if you feel like this a lot - children might try to find a way to make it stop. For example, by hurting themselves.

Try to gently explore whether they have any suicidal thoughts or intentions, for example:

Do you ever feel like it's too much and that you want to give up? Do you ever wish you could go to sleep and just not wake up? How often have you felt this way and for how long have you felt this way?

Have you ever had feelings before that you wanted to end your life? When did you have these thoughts? For example, during the last 48 hours, past week, past month, etc. How often do you have these thoughts and how long do they last?

Have you ever made any plans to end your life? If yes, can you share a bit about the plan you made?

Have you ever tried to harm yourself in the past?

187. Further **information** on Suicide and harm prevention can be found in the IFRC Reference Centre for **Psycho-social** Support Guide: IFRC Suicide Prevention, 2021

[96] World Health Organisation, mhGAP Humanitarian Intervention Guide (mhGAP-HIG), 2015, p.51.

5.4.6. Harmful use of alcohol and drugs

188. If harmful alcohol or drug use is suspected, concerns should be raised with the child, without being judgemental, giving them the opportunity to speak openly and in confidence if they feel able to.

189. **Support / management** of children relating to self-harm and suicide includes the following:

- Medical care for physical consequences of harmful alcohol or drug use. Where possible refer to specialist drug and substance misuse services.
- Assess whether the child sees alcohol or drug use as a problem and if he or she is ready to do something about it.
- Motivate to stop alcohol or drug use, e.g.:
- Ask about the perceived benefits and harms of alcohol or drug use. Do not be judgemental but try to understand what motivates the child to use alcohol or drugs.
- Challenge any exaggerated sense of benefit from alcohol or drug use and highlight some of the negative aspects and harm both short and long-term e.g. depression, potential for dependency, risk of physical harm e.g. overdose, damage to vital organs
- Acknowledge that giving up alcohol or drug use is hard and provide assurance that you are there to provide support. If he or she is ready to try to stop, discuss various strategies and agree on a way forward.
- If he or she is not ready to give up alcohol or drug use, offer ongoing support.
- Psychological therapy for children aged 10-17 years where trained and supervised therapists are available: **Individual CBT or family therapy**.
- Referral for skills training for children at risk of drug misuse where available.

5.4.7. Anxiety disorders

190. Psychological interventions are essential treatments for anxiety disorders and refer primarily to talking therapy with professionals or supervised lay therapists. These interventions can help children learn new ways of **thinking**, coping, or relating to their anxiety, to others or to the world and teach them how to face the situations, events, people or places that trigger their anxiety.

191. **Psychological interventions** include both low-intensity interventions incorporating self-help approaches and high-intensity psychological therapies in particular CBT adapted to the specific disorder. Interventions can be provided to individuals or groups, in person or online; they may also be accessed through self-help manuals, websites and apps.

192. **Self-care** can play an important role in supporting treatment and reducing symptoms of anxiety disorders, for example:

- Regular exercise, even if it's just a short walk.
- Regular eating and sleeping habits as much as possible and eat a healthy diet.
- Stress management and relaxation techniques, such as slow breathing and progressive muscle relaxation and mindfulness.[97]

[97] World Health Organisation, Doing What Matters in Times of Stress, 2020.

Chapter 6: Supervision and self-care

Outline

6.1. Supervision
6.2. Self-care
    6.2.1. What is stress?
    6.2.2. Signs of stress
    6.2.3. Protective factors and self-care

6.1. Supervision

193. Everyone providing mental **health** and psycho-social support to children should be receiving regular and formal supervision. This is essential when engaged in psychological therapy.

194. 'The recommended practice for Practitioner Psychologists involves engaging in regular supervision/consultation to promote safe and effective practice, focusing on enhancing practice quality, promoting diversity and inclusion, protecting well-being, and continuous professional development through reflective practice and appropriate supervision models.

195. This includes obtaining supervision from qualified and experienced professionals, following specific guidelines for supervision training, maintaining flexibility in supervision approaches, ensuring consultative supervision for Independent Practitioners, and prioritising ethical and legal compliance in service provision.'[98]

196. Comprehensive guidance for supervision of psychologists can be found in the following resource: The British Psychological Society, Supervision Guidance for Psychologists, 2024

197. The IFRC Planning and Workshop Guide has been developed for Red Cross and Red Crescent National Societies and includes the information and resources needed to design and facilitate a workshop when setting up supportive supervision. Materials can be found on the IFRC Reference Centre for Psycho-social Support or see link: Supportive Supervision: Planning and workshop guide for Red Cross and Red Crescent National Societies

6.2. Self-care

198. Providing support to others who are undergoing emotional distress can be very rewarding and satisfying but it can also have a negative impact on a professional's mental health. Self-care is essential for all those involved in providing MHPSS to children and their families This requires awareness of the stressors in their own lives, as well as learning tools and methods to cope with, and prevent some of the negative impacts of stress.

[98] The British Psychological Society, Supervision Guidance for Psychologists, 2024.

6.2.1. What is stress?

199. Stress is a state of psychological and physical arousal that comes about as a result of a threat, challenge, or change in one's environment.

- **Functional stress:** is common to everyone and part of everyday decision-making and problem solving. This type of stress is normal and manageable and can motivate people to be more productive.
- **Negative stress:** occurs when stress lasts too long, happens too often and is too severe; it is the reaction to a challenge, demand, threat or change that **exceeds an individual's coping resources and results in distress**. There are **three types of negative stress**; cumulative, critical incidence and vicarious trauma.
- **Cumulative stress** is the result of prolonged, accumulated, unrelieved exposure to a variety of stressors – when not recognised and managed it can lead to 'burnout.' Cumulative stress stems from two main sources: internal and external. Internal refers to personal characteristics – e.g. being a perfectionist; external refers to the working environment, type of work, colleagues etc.
- Critical incident stress is caused by an extraordinary event which provokes stress in almost everyone involved – it is sudden and disruptive, involves actual or perceived threat or loss, causes a sense of vulnerability and disrupts a sense of being in control and perceiving the world as safe and predictable.
- **Vicarious trauma, also called secondary trauma or indirect traumatisation** is a process which occurs when a worker begins to identify with children/families in a way that changes their thoughts, feelings and behaviour that parallels those of the person who experienced the trauma.

6.2.2. Signs of stress

200. It is important to be familiar with and able to recognise signs of negative stress and burnout - these are described in the table below:

PHYSICAL (bodily reactions)	**COGNITIVE (thoughts and efforts to understand)**
• Headaches	• Problems with decision/priorities
• Indigestion	• Loss of concentration, easily distracted
• Throbbing heart	• Tunnel vision/ Constricted thoughts
• Breathlessness	• Bad dreams or nightmares
• Feeling sick	• Worrying
• Muscle twitches	• Muddled thinking
• Tiredness	• Making mistakes
• Vague aches or pains	• Less intuitive
• Skin irritation or rashes	• Less sensitive
• Susceptibility to allergies	• Persistent negative thoughts
• Excessive sweating	• Impaired judgement
• Clenched fists or jaw	• More short-term thinking
• Fainting	• Hasty decisions
• Frequent colds, flu or other infections	• Tired of thinking
• Recurrence of previous illness	• Obsessive thinking
• Constipation or diarrhoea	• Increased distractibility/loss of interest

• Rapid weight gain or loss • Extended fatigue • Frequent physical complaints • Sleep disorders • Appetite changes • Nausea, gastro – intestinal distress • Sweating, shivering • Faintness, dizziness • Muscle tremors/weakness • Elevated heartbeat, respiration • Uncoordinated movements • Extreme fatigue/exhaustion •	• Feeling indispensable/obsessions • Diminished tolerance for ambiguity • Rigid, inflexible thinking • Racing, circular thoughts • Slowed thinking • Memory problems • Confusion • Difficulty making decisions • Intrusive images • Loss of perspective • Intrusive memories • Preoccupation with an event
EMOTIONAL (feelings)	**BEHAVIOURAL (actions)**
• Anxiety • Feeling alienated from others • Desire to be alone • Negativism/cynicism • Suspiciousness/paranoia • Depression/chronic sadness • Feeling pressured/overwhelmed • Diminished pleasure • Rapidly shifting emotions • Numbness, anxiety, fear • Self-blame, shame • Exhilaration, survivor joy • Anger, sadness • Helplessness/feeling overwhelmed • Detachment, feeling unreal • Disorientation • Numbness • Feeling out of control • Mood swings, feeling unstable • Anxiety, fear of recurrence • Irritability, hostility • Fragility, feeling vulnerable	• Irritability • Anger displacement, blaming others • Reluctance to start/finish projects • Social withdrawal • Absenteeism • Unwillingness/refusal to take leave • Substance abuse, self-medication • Disregard for safety/risky behaviour • Startle reaction/restlessness • Sleep and appetite disorders • Difficulty expressing oneself • Arguments • Withdrawal • Excessive black humour • Slowed reactions/accident proneness • Inability to rest or to let go • Avoiding reminders of an event • Social relational disorders • Difficulty connecting with “outsiders” • Lowered activity level • Increased use of alcohol, drugs (self-medication for depression, anxiety)
SPIRITUAL (beliefs and values)	
• Doubting value system/religious belief • Questioning major life areas (Profession, employment, lifestyle) • Feeling threatened and victimised • Disillusionment • Self-preoccupation	• Profound loss of trust • “Why me” struggle • Increased cynicism • Loss of self-confidence • Loss of purpose • Renewed faith in a higher being • Profound existential questioning • Loss of belief in co-operative spirit of mankind

SIGNS OF BURN OUT

Emotional exhaustion constitutes the main sign of burn out. The signs of cumulative stress have intensified and become chronic.

- Chronic sleeping disorders and exhaustion.
- Deterioration of mental capacities, loss of memory and efficiency.
- Loss of self-esteem, focus on failure.
- Profound disillusionment, sometimes rejection of values.
- Unwilling to take leave, risk taking.
- In some cases, panic or paranoia and depression.

201. **Burnout** occurs as prolonged exposure to emotionally demanding situations with inadequate support gradually depletes an individual's natural resources for dealing with stress and strain. Like the signs of stress, signs of burnout can manifest in different ways depending on the individual. Burnout will resolve as long as people are given the time, space and support to recover.

6.2.3. Protective factors and self-care

202. **Protective factors** help to balance negative stress and prevent burnout – these include:

- Positive coping habits
- Social support
- Optimism and healthy self-esteem
- Spirituality
- Adaptability
- Curiosity and openness to experience
- Talents/natural abilities
- Meaning-making – the process of understanding and giving meaning to work beyond an individual experience; identifying the motivation and passion involved

203. Self-care is important to ensure there are sufficient **protective** factors in place and maintain a healthy work/life balance and good mental health and well-being.

204. **Self-care** strategies include:

- Humour, socialising and other hobbies
- Good sleep, diet and exercise
- Breathing and relaxation exercises
- Reflecting on feelings and building work-life barriers
- Self-awareness and making positive efforts to change

205. An example of a self-care plan for professionals is shown below – writing a plan can help in maintaining self-care and can also be used as part of **supervision**.

SELF-CARE PLAN

In the next __ months I will make self-care a priority in my life because:

_____

_____

Not taking care of me, has the following impact on my life:

_____

_____

When I take good care of myself, I notice:

_____

_____

The following people/places/activities bring me pleasure and comfort:

_____

_____

My strategies and plans for self-care (both personally and professionally) are:

✓on a daily/weekly/fortnightly basis I will:

_____

_____

✓on a regular basis I will:

_____

_____

✓in the next three - six months I will:

_____

_____

To be shared with coach, mentor and / or supervisor.

To be review regularly…… at least monthly.

206. Resources on self-care and stress reduction:

- IFRC, Reference Centre for Psycho-social Support, The well-being guide, Reduce stress, recharge and build inner resilience, 2022
- IFRC Reference Centre for Psycho-social Support, Take Care of Yourself, 2020
- Guidance on staff and volunteer care

Key Points: MHPSS for children in crisis and emergency situations

KEY POINT 1: Children's enjoyment of their human rights is at greater risk in crisis and emergency situations, and they can face a range of child protection threats. The impact on children can be harmful in both the short and long-term and will depend on the nature of the crisis or emergency, the protective factors in their lives and their resilience.

KEY POINT 2: The protection of children is governed by complementary and mutually reinforcing international and national legal and policy frameworks. These include standards governing the protection of children set out in the United Nations Convention on the Rights of the Child (UN CRC) and its Optional Protocols and the European Convention on Human Rights (ECHR) as well as other international and European human rights instruments.

KEY POINT 3: Crisis and emergency situations have the potential to impact children's mental health and well-being. Psychological distress reactions are to be expected in children affected by crisis and emergency situations; these will often resolve once basic needs are met, children feel safe and secure and receive general support. Less commonly, children can also manifest more extreme forms of distress or trauma, and some children may go on to develop mental disorders including moderate to severe depression, PTSD or anxiety disorders, especially where basic support to their well-being is not available and accessible.

KEY POINT 4: The impact on mental health and well-being can be greater for those children affected by crisis and emergency situations during critical periods of their development. Crises have the potential to interrupt the process of child development in children of all ages, but experiences during 'sensitive periods' of development play an exceptionally important role in shaping the capacities of the brain. The pre-natal stage, early childhood - ages 0-5 years and adolescence are key periods for brain development.

KEY POINT 5: Obstacles to accessing MHPSS must be identified and addressed to ensure the appropriate level of support is available to all children. It is the responsibility of the MHPSS provider to adapt their ways of working and communication to facilitate the participation of, and interventions with all children, including those with different disabilities and in different situations.

KEY POINT 6: Mental health and psycho-social problems are highly interconnected in crisis and emergency situations and support should be available to children and their parents/caregivers across all four levels of the IASC pyramid. Where appropriate and possible, efforts should be made to strengthen the protective capacities of teachers and others who have direct contact with children.

KEY POINT 7: Focused and specialised MHPSS encompasses PFA as a first line intervention, strengthening parenting skills and parent/caregiver well-being, community-based support for children such as resilience programmes and evidence-based psychological therapies such as trauma focused CBT.

KEY POINT 8: Everyone providing MHPSS must comply with guiding principles as set out in this Manual/by their organisation and be fully competent for the tasks they undertake.

KEY POINT 9: Providing MHPSS to children and their families in crisis and emergency situations is challenging and emotionally demanding. Regular supervision must be in place to ensure safe and effective practice, and the importance of self-care must be recognised, and self-care practices implemented.

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Appendices

Appendix 1: Psychoeducation exercises for children[99]

MHPSS Activities to support the child to understand and cope with severely distressing experiences

Activity 1: Good and bad stress

Objective of the activity	Recognise helpful stress and harmful stress and identify stressors (what is causing stress)
Time	15 - 20 min
Age	10+ years old
Materials	Paper, pens/crayons, flipchart or whiteboard
Participation	This tool can be used in a one-on-one activity with an adolescent

Guidance

1. Define stress and discuss how it is a part of everyday life—especially for adolescents. Below you can find some examples of how to explain stress.

HOW TO EXPLAIN STRESS

Stress is normal and natural, and it happens to everyone, children, teenagers and adults. Stress can be caused by all sorts of things. Like the time you were studying for a difficult test, or your parents are fighting, etc. You see your body and mind work together as a team. When we feel worried about something, our brain sends a signal to our body. It's called a stress response. The stress response helps get us ready for the things that come our way. We can expect this to show up every time we are facing something new or difficult. This is completely normal. The more we practise something, the better we get at it and the smaller the stress response gets. You build a stronger brain.

For example, when a child has to start in a new school. It can be stressful. You don't know the teachers nor the other children in your class. This feeling can make the child restless, maybe the child cannot sleep well the night before and remains awake while thinking or maybe worrying about the first day of school the next day. What this child is feeling is what we call a stress response.

[99] Source: MHPSS Activity Booklet, Level 3, Child Protection Case Management Training Package for Caseworkers in Humanitarian Settings

For example, when a child needs to give a presentation in front of the whole class. This can be stressful. The child wants to do a good job, but they can be a bit nervous, scared that it might not go well. The child can get a bit shaky, start sweating and find it's hard to focus. What this child is feeling is what we call a stress response.

2. Ask the adolescent to review the list of stress symptoms and circle these that they have shown or felt in the past. Explain that everyone feels and reacts differently, so the symptoms or stress signals are not the same for everyone, but personal.

Activity tools and templates: Activity 9

POSSIBLE SIGNS OF FEELING STRESSED

- Eating or sleeping too much or too little
- Pulling away from people and things (e.g. Playgroups and friends or things they used to like to do such as playing football)
- Having low or no energy
- Having unexplained aches and pains, such as constant stomach aches or headaches
- Having difficulty concentrating
- Feeling helpless or hopeless
- Worrying a lot of the time; feeling guilty but not sure why
- Becoming disruptive or aggressive at home or in the classroom (e.g. Hitting other children or adults)
- Having added conflict with peers or caregivers
- Thinking of hurting or killing yourself or someone else
- Having difficulty readjusting to home life
- Experiment with high-risk behaviours (e.g. Drinking, smoking, or using drugs, including prescription medications)

Activity tools and templates: Activity 9

MY EXAMPLES

3. Ask the adolescent to reflect on when they have felt stressed. What has given them stress in the past and what is giving them stress now. When do they start to worry, stay up at night, start feeling shaky, etc. Provide them a few minutes to think about this and if they wish they can write down their ideas.
4. Explain the difference between good stress and bad stress and provide a series of examples for each type of stress
    - Good stress, short-term stressors that push us to focus and improve performance.
    - Bad stress, chronic stressors that cause anxiety and unpleasant emotions and can make it difficult for anyone to function.

5. Divide a A4 paper or flip chart into two sections: good stress and bad stress.
6. Ask the adolescent to list three examples from their own stressor list on the board.
7. Discuss some examples of good and bad stress
    - Tips for discussion:
        - How can you tell the difference between good and bad stress?
        - For groups: What common stressors did you notice from this activity?
        - How can understanding good and bad stress help you cope more effectively?

Activity 2: The stressed mind

Objective of the activity	Increase understanding of the difference between short term stress and prolonged stress.
Time	15 - 20 min
Age	10+ years old
Materials	Paper, pens, markers or crayons
Participation	This tool can be used in a one-on-one activity with an adolescent

Guidance

1. Explain that there are different forms of stress.
    - Some stress you only feel for a short while, while other stress can take a long time before it goes away
    - Some stress is present at a low level, while other stress can be very intense and fully take over your feeling or thinking
    - Feeling stressed for too long, and/or very intensely can be very difficult, tiring and harmful.
2. Ask the adolescent to think about how they feel, think and function when they are in a calm or more relaxed state and when they are very stressed. Ask them to draw or describe their calm mind (left) and their mind when they are stressed (right).

Activity tools and templates: Activity 10

CALM MIND

STRESSED MIND

3. Ask the adolescent to think about the impact of stress on their well-being, their relationships with others and their self-image.
    - *How can very high levels of stress impact your body, mind, and emotions? Let's brainstorm ways stress can impact you in each of the categories listed.*

Activity tools and templates: Activity 10

	SHORT-TERM STRESS	ONGOING STRESS
Physical Well-being (Eating, sleeping, health, exercise)		
Emotional Well-being (Moods, ability to adapt to change, ability to express emotions)		
Relationship (Trust, how you interact with others, how often you see out others)		
Problem-Solving Skills (Ability to predict what might happen, decision-making skills)		
Self-Concept (Belief in yourself, self-image, self-confidence)		

4. Review the different mind and the different areas together with the adolescent, identify the similarities and differences.

Activity 3: Protectors

Objective of the activity	To help the child understand which protective factors they have in their life.
Time	10 - 15 mins
Age	8+ years old
Materials	Paper of reasonable size (A4, A3 or flipchart), pencils and/or markers. You can write or use the template.
Participation	Activity with the child, but parent or caregiver can join as well.

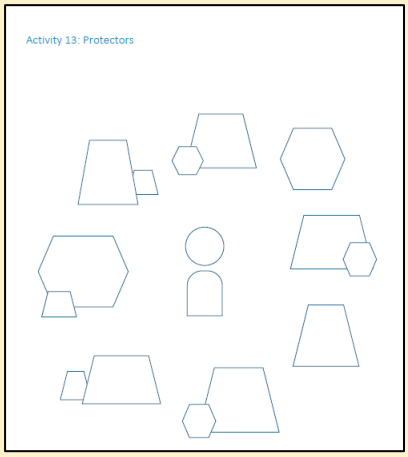
Guidance

1. Explain to the child that there are people, things, places and activities that help you feel better and protected when times are difficult. You can name these protective factors or protectors.
    - *Protectors can be people, things, places or activities that help you feel better and protected when times are difficult. We all have protectors.*
2. Provide some examples of what protectors can be:

People	Places	Activities
● Parents, caregiver ● Other family members ● Your friends ● Your neighbours ● Your teacher ● …	● Home ● School ● Youth club ● Church, mosque or temple ● …	● Playing games with others ● Doing sports with other children ● Going out with your parents, caregiver or family ● …

3. Explain to the child that protectors are different for every child and that you are asking them to think about their own protectors.
4. Ask the child to draw themselves and then to think about their protectors and write them around them.
    - You can help them explore options and think by asking questions or repeating examples. Possible questions:
        i. Who is important in your life
        ii. To whom do you go when you need help?
        iii. With whom can you talk well or easily?
        iv. What are your favourite places?
        v. Where do you like to go?
        vi. What are your favourite activities?
        vii. When you feel sad or angry, is there anything you can do that makes you feel better?
5. Ask the child to also think about themselves, what makes them strong, and to write it on their drawing
    - What are your strengths?
    - What are you good at?
    - What makes you special?

Activity tools and templates: Activity 13



TIP	You can use the drawing available as a template

Appendix 2: Emotional regulation/grounding exercises[100]

Activity 1: My safe space

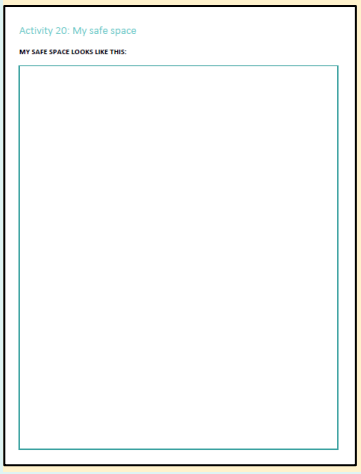
Objective of the activity	To reduce stress and increase sense of safety
Time	15 - 30 mins
Age	6+ years old
Materials	None
Participation	Activity with the child, but parent or caregiver can be included
Note	It is helpful for children to practice creating a "safe place" in their imagination. This gives children practice in manipulating their imagination and using visual imagery in a positive and proactive way. It also serves as a secure base in imagination to which children can return if they need to reduce the emotions being felt as they are carrying out later techniques. It is a non-threatening and fun way to begin working their imagination - using something visual to help calm them and to give children a sense of control. Once children have practiced this activity a few times, they can do it with caregivers to reduce stress at key times (e.g. before bedtime for children who are having nightmares). It is important they practice this in moments where they feel safe. Not when already flooded with emotions.

Guidance

1. Introduce the Concept of a safe space

- Instructions: Have the child stand up and move around, or jump up and down, or shake him/herself so that s/he is refreshed to begin. Come back and make sure that the child is comfortable. Do this in a circle if you involve the caregivers.
- *Sometimes when we are feeling anxious or upset it is helpful to use our imaginations to create nice, happy images and feelings. This can help us calm down or feel less scared.*
- *In this activity, we'll practice using our imaginations to create positive feelings. I'm going to ask you to imagine a place or scene that makes you feel calm and secure and happy. This could be somewhere real that you remember, maybe from a holiday; or it could be somewhere you've heard about, maybe in a story; or it could be somewhere that you invent and make up yourself.*

Activity tools and templates: Activity 20


Activity 20: My safe space

MY SAFE SPACE LOOKS LIKE THIS:

[100] Source: MHPSS Activity Booklet, Level 3, Child Protection Case Management.

2. Select a Safe Place

- Instructions: Suggest some examples here that are relevant to your community. It might be a beach by the sea, or the countryside, or some other peaceful place. As you are giving the following instructions, keep an eye on the child to see if s/he seems to be having difficulties: relaxing in this way may sometimes increase the frequency of negative images. Pace the instructions to give the child time to use their imagination. Adapt these instructions as you wish but give the child time to develop a comprehensive scene and remember to encourage him/her to use all sensory modalities.
- *I'm going to ask you to imagine a place or scene that makes you feel calm and secure and happy. This could be somewhere real that you remember, maybe from a holiday; or it could be somewhere you've heard about, maybe in a story; or it could be somewhere that you invent and make up yourself.*

3. Spending Time in Your Safe Place

- Instructions: As you are giving the following instructions, keep checking if the child is ok pace the instructions to give the child time to use his/her imagination.
- *Take a few deep steady breaths. Close your eyes and carry on breathing normally. Bring up a picture of your safe place and imagine that you are standing or sitting there. Can you see yourself there? In your imagination, take a look around. What do you see? What can you see close to you?*
- *Look at the details of it and see what it is made of. See the different colours. Imagine reaching out and touching it. How does it feel? Now look further away. What can you see around you? See what's in the distance. See the different colours and shapes and shadows.*
- *This is your special place, and you can imagine whatever you want to be there. When you're there, you feel calm and peaceful. Imagine your bare feet on the ground. What does the ground feel like? Walk around slowly, noticing the things there. See what they look like and how they feel.*
- *What can you hear? Maybe the gentle sounds of the wind, or birds, or the sea. Can you feel the warm sun on your face? What can you smell? Maybe it's the sea air, or flowers, or your favourite food cooking? In your special place, you can see the things you want, and imagine touching and smelling them, and hearing pleasant sounds. You feel calm and happy.*

4. Inviting a Helper into the Safe Place

- *Now imagine that someone special is with you in your place. [With younger children especially, this might be a fantasy figure or a cartoon superhero] This is someone who is there to be a good friend and to help you, someone strong and kind. They are there just to help you, and they'll look after you. Imagine walking around and exploring your special place slowly with them. You feel happy to be with them. This person is your helper and they're good at sorting out problems.*

5. Conclude

- *Just look around in your imagination once more. Have a good look. Remember that this is your special place. It will always be there. You can always imagine being here when you want to feel calm and secure and happy. Your helper will always be there whenever you want them to be. Now get ready to open your eyes and leave your special place for now. You can come back when you want. As you open your eyes, you feel calmer and happier.*

6. Discuss

- Instructions: To finish this exercise, ask the child what s/he imagined. Younger children might want to draw out what they imagined. Ask how it made him/her feel. Point out the connection between imagination and feelings. Point out that s/he can have control over what s/he sees in his/her mind's eye, and therefore over how s/he feels. Reinforce that this is a fun thing to do, and that s/he can imagine being there whenever s/he feels miserable or scared, and that it will make him/her feel better. Say that his/her special place will get easier to imagine the more s/he practises it.

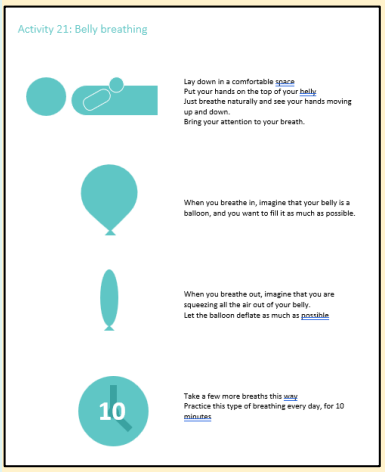
Activity 2: Belly breathing

Objective of the activity	Help the child to reduce their stress, to relax their mind and body through breathing exercises.
Time	10 - 15 mins
Age	6+ years old
Materials	Mat to lay on or a pillow
Participation	Activity with the child, but parent or caregiver can be included
Note	You can do this activity directly with the child, and if possible, include the caregiver so they can do this at home with the child as well. Ask the child for permission to do this activity and to lie alongside them. Do the following sequence with the child. It works well for all ages, but we will propose a few variations below.

Guidance

1. Introduce the activity. Sample script:
    - *"Today we're going to learn a way to help ourselves calm down and control our nervousness and upset feelings. We are going to do a breathing activity that can help you calm your mind and your body. When we get upset, we tend to breathe faster and not as deeply. This does not allow enough air into our lungs, which can make our body feel out of control. Doing this breathing exercise when you are upset will help you get more air into your lungs and will help your body and mind relax. It's also something you can do anytime and anywhere."*

Activity tools and templates: Activity



2. Do the activity together

- Lie alongside the child in a comfortable space and place your hands on top of your belly.
- Ask the child to place his hands on his/her belly too. Now, you can both just breathe naturally and see if you notice your hands moving up and down. *If your breathing—or the child's breathing—is shallow (mainly in the chest), you may not notice much movement, and that's okay.* The point is simply to bring your attention to your breath. *Next, try to engage your belly as you breathe. When you breathe in, imagine that your belly is a balloon, and you want to fill it as much as possible.* (Sometimes children tense up when they are given this instruction, so encourage him/her to let his arms and legs and whole body be loose.) *When you breathe out, imagine that you are squeezing all the air out of your belly.*
- *Let the balloon deflate as much as possible (it's hard to breathe more air into the balloon on the next breath if it's still full with the last breath)*. You can instruct older children to imagine that they are pulling their belly button down to the floor below them. Take a few more breaths this way. You can them ask them:
- Now do you notice your hands moving up and down with each breath?

3. Debrief

- Ask the child (and caregiver). *What does it feel like to breathe this way?* Is it different from how you normally breathe?

4. Give homework

- Ask the child to practice this type of breathing every day, for 10 minutes. Children can practice while they are falling asleep at night or at another time that is right for them. Older children can record these home practices on a form and discuss later with the caseworker. The caseworker should help the child decide when/where the homework will be done, trying to identify likely barriers to practicing on their own. Initially, the practice sessions should be done when the child is calm and can concentrate, not at times of stress and anxiety.

Variations:

For children 3-6 you could put a stuffed animal or toy on the belly for the belly. Watching it move up and down creates a more helpful visual for him.

Older children 7+ can try additional practices for deep breathing. Ask them to try 4–6 breathing, where they make their inhale last a full four counts, and their exhale last a full six counts, or resonant/coherent breathing, where each in-breath and out-breath is the same length, but the breathing is slower (five or six counts to inhale, five or six.

Activity 3: Grounding technique 1: 5 – 4 – 3 – 2 – 1 senses

Objective of the activity	Support the child to stay in the present and to interrupt or cope with distressing thoughts and negative emotions, including fear and anxiety.
Time	10 min
Age	+5 years old
Materials	Candy, gum or a little snack
Participation	Activity with the child, but parent or caregiver can be included

Guidance

1. Explain to the child that we will pay attention to our five senses

2. Ask the child to list five things they can see.
- *For example, look for small details such as a pattern on the ceiling, the way light reflects on the floor or an object you don't easily notice.*

3. Ask the child to list four things they can feel.
- *For example, notice the feeling of the wind or sun on your skin, the feeling of the chair or pillow you are sitting on, or pick up an object and examine its weight and texture. Try to feel four different things.*

Activity tools and templates: Grounding technique 1



4. Ask the child to list three things they can hear.
- *For example, try to hear sounds to which you normally don't pay attention. The sound of the wind blowing trees, voices of people talking outside, the buzz of traffic in the distance. Try to hear three different things.*

5. Ask the child to list two things they can smell
- *For example, try to notice smells in the air around you, or you may search for something that has a scent, such as a bar of soap, toothpaste or a marker. Try to smell two different things*

6. Ask the child to list one thing they can taste
- *For example, carry gum, candy, or small snacks for this step. Pop one in your mouth and focus your attention closely on the flavours.*

Activity 4: Grounding technique - Here and now hand trace

Objective of the activity	Support the child to stay in the present and to interrupt or cope with distressing thoughts and negative emotions, including fear and anxiety.
Time	10 min
Age	+5 years old
Materials	Paper, coloured pencils or markers
Participation	Activity with the child, but parent or caregiver can be included

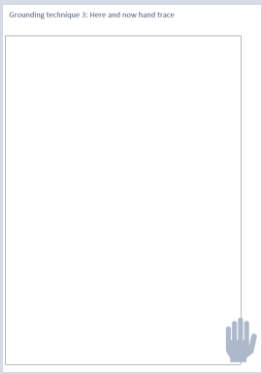
Guidance

1. Ask the child to trace their hand on a piece of paper. They can use a marker or a pen to draw around their handshape.

2. Ask the child to draw or write in their handshape what they see, hear, smell or feel.
    a. *What do you see in this room or place?*
    b. *What do you hear?*
    c. *Do you smell anything?*

3. Once the drawing has been completed, ask the child to decide on a place where they can keep it, in case they want to look at it again.

Activity tools and templates:
Grounding technique 3



ENG

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