Module 2

Recognizing mental health difficulties of children/adolescents relevant to health emergencies & crisis situations

Learning Objectives

Upon completion of this Module participants should be able to:

- Recognize signs and symptoms of mental health difficulties among children and adolescents.
- Describe and differentiate risk and protective factors for mental health difficulties among children and adolescents.
- Differentiate between symptoms of specific mental disorders among children and adolescents.

Unit 1

Common mental health difficulties in children and adolescents relevant to health emergencies & crisis situations

Topic 1: Introduction

During mass-casualty events, one-third of the victims will be children (UNISDR, 2007). Those events range from severe weather events linked to climate change and environmental pollution (e.g., floods, earthquakes, cyclones, wildfires, hurricanes, tsunamis, volcanic eruptions), over industrial accidents (chemical spills, gas leaks, explosions, fire, and water problems) and diseases, through war-related or economic displacements, and terrorist attacks producing health emergencies and crisis situations.
Health emergencies and crisis situations affect children and adolescents more profoundly than adults. They may have concerns regarding their own safety and the safety of their caregivers, but also their peers and other community members. Children observe what is happening, but also how their caregivers are behaving and reacting to stress. They may talk about their worries and feelings or might behave differently as a reaction to the stress that they are feeling. If they behave in a manner that seriously affects their ability to successfully perform at school and their peer relationships, they are not being “bad”. Rather they have a problem managing their feeling of stress and anxiety.
Their symptoms might range from mild to severe, and can appear for shorter or longer periods of time. It is important to recognize the early signs and symptoms of emotional and behavioural problems because early prevention is important in minimizing the risk of children developing significant mental health problems. With continuing help and support, most children and adolescents eventually return to their typical functioning.

Topic 2: Overview of signs and symptoms of mental health difficulties among young children and older children and adolescents, as well as an overview of early warning signs of mental health issues

Signs and symptoms of mental health difficulties among children and adolescents can be classified in ~~to~~ two broad categories: internalized and externalized.
The Internalized problems are defined as emotional symptoms turned toward the individual and are characterized by anxiety, depressive and somatic symptoms.
The Externalized problems are defined as emotional symptoms turned towards individual’s surrounding and are characterized by impulsive, disruptive conduct, substance use, and other addictive symptoms.

Internalized symptoms include:

- Being nervous or irritable
- Withdrawing
- Loss of pleasure in activities which previously brought joy
- Eating more or less than usual
- Sleeping more or less than usual
- Feeling afraid, lonely, sad, unloved, or unwanted, feeling worthlessness or guilty
- Low self-esteem or a negative self-image
- Difficulty thinking, concentrating, making decisions, or remembering and difficulty completing tasks (e.g., homework)
- Headaches, stomach aches, and other physical symptoms that are not related to any physical illness
- Fatigue/lack of energy
- Suicidal thoughts, intentions, plans

Externalized symptoms include:

- Avoiding participation in social activities
- Difficulties maintain friendships and peer rejection
- Dysfunctional social behaviours
- Fighting and behaving aggressively
- Self-harm (e.g., wrist cutting)

Younger children might experience issues such as:

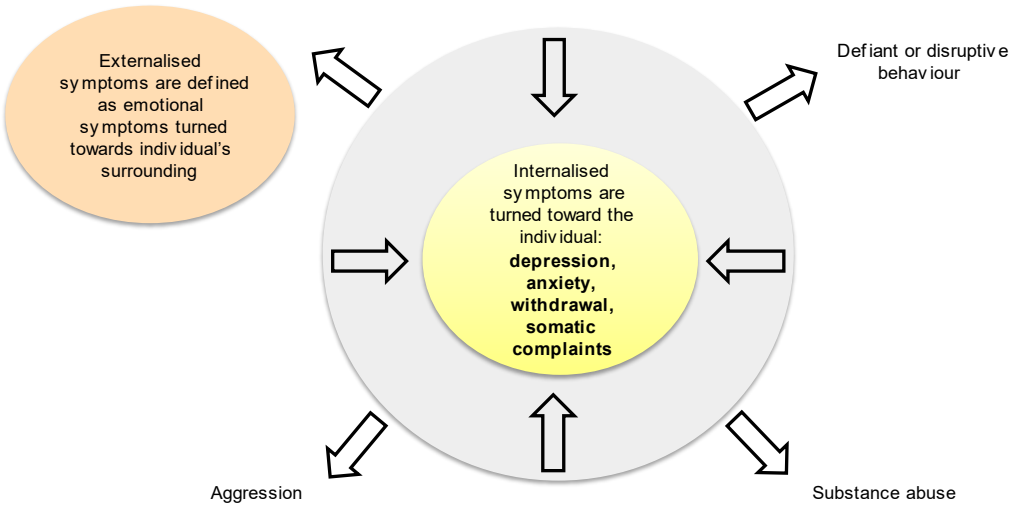
- Desire of things must be done as they want
- Social regression (loss of previously obtained social skils, like play skills and emotional expressiveness)
- Intense preoccupation with the details of the event, wanting to always talk about what happened, hear that the event might happen again
- Playing in violent ways
- Hitting you or others
- More tantrums
- Clinginess with teachers or caregivers
- Regression, or going back to an earlier stage of development

- Bedwetting or other toileting issues
- Baby talk
- Desire to be carried or rocked
- Having nightmares
- Over- or under- reacting to physical contact, sudden movements, or loud sounds such as sirens and slamming doors
- New fears and/or fears about safety

Older children and adolescents also show problems such as:

- Frequent absence from school
- A decline in grades
- Defiant or disruptive behaviour; getting into arguments
- Running away from home
- Substance abuse

Interplay between externalised and internalised symptoms



Interplay between externalised and internalised symptoms

Activity 1

Please read the following real case scenario and try to recognize the signs and symptoms of mental health difficulties.

Daniel is a five-year old boy who lives with his mother. He recently started to behave like he used to behave at much younger age – occasionally he would wet his bed during the night or have similar accidents during the day, he had a hard time falling asleep, so his mother had to return to his bedroom during the night, and he insisted that his mother feed him during meals. Going to kindergarten and separating from his mother also became a problem. The kindergarten teachers noticed he was more likely than usually to behave aggressively toward his peers – pushing them or taking away their toys and arguing.

Hints: Signs and symptoms of mental health difficulties include regressive behaviour, like bet wetting, problems falling asleep, asking to be fed, separation problems and aggressive behaviour.

Activity 2

Please read the following real case scenario and try to recognize the signs and symptoms of mental health difficulties.

Claire is a 10-year-old girl who lives with her parents and two younger siblings. Recently her mother noticed that she is quieter than usual, and often appears to be sad or lacking will to engage in activities she previously enjoyed. She avoids going to dance classes, saying she feels tired and exhausted. Her friends call her less often than before and she rarely initiated to hang out with them herself. She seems most contempt while spending time alone in her room and listening to sad music. Her siblings say she often talks back to them and has somewhat violent outbursts. Her schoolteacher notices that she seems absent in spirit during class, as if she doesn't follow the lectures. She often misses her deadlines for completing school tasks and had unfinished homework. On a few occasions she busted in tears for no particular reason during class.

Hints: Signs and symptoms of mental health difficulties include social withdrawal, sadness, withdrawal from previously joyful activities, talking back and violent outbursts, lack of concentration, lower academic achievement, mood swings

Activity 3

Please indicate which of the following signs and symptoms can be classified as internalized or externalized.

Signs and symptoms	Internalized	Externalized
Eating more or less than usual		
Feeling afraid		
Fighting and behaving aggressively		
Headaches or stomach aches		
Difficulties maintain friendships and peer rejection		
Fatigue/lack of energy		
Avoiding participation in social activities		

Hints:

(1) Internalized signs and symptoms: eating more or less than usual, feeling afraid, headaches or stomach aches, fatigue/lack of energy;

(2) Externalized signs and symptoms: fighting and behaving aggressively, difficulties maintain friendships and peer rejection, avoiding participation in social activities

Activity 4

Please indicate which of the following signs and symptoms are more specific for younger or older children.

Signs and symptoms	**Younger children**	**Older children**
Frequent absence from school		
Clinginess with teachers or caregivers		

Substance abuse		
Lower grades		
Going back to an earlier stage of development		
Bedwetting or other toileting issues		
Wanting to be carried or rocked		

Hints:

(1) Younger children: clinginess with teachers or caregivers, going back to an earlier stage of development, bedwetting or other toileting issues, wanting to be carried or rocked.

(2) Older children: frequent absence from school, substance abuse, lower grades.

Unit 2

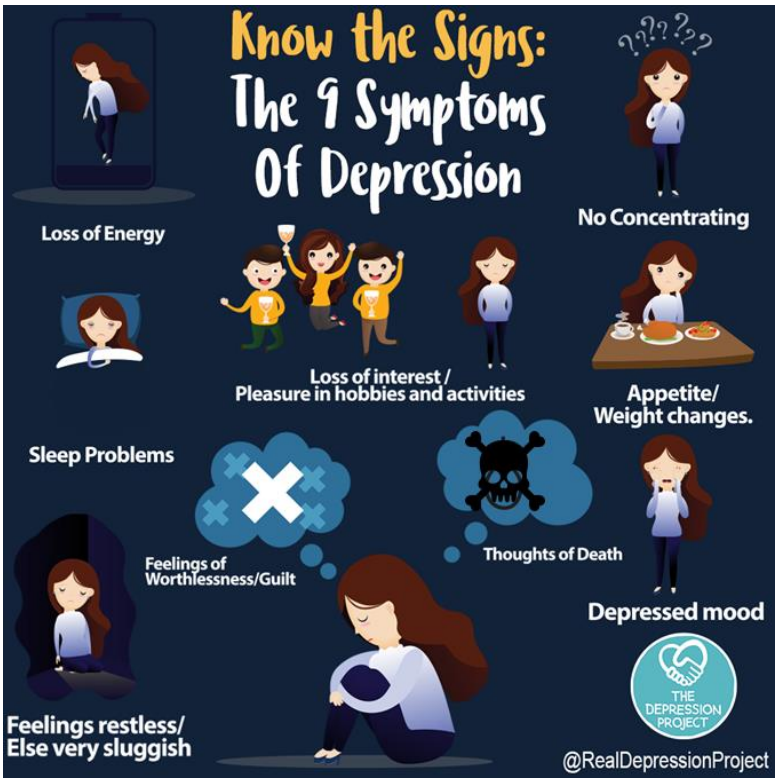
Recognizing the signs of specific mental health disorders in children and adolescents

Topic 1: Introduction

The extent of the problem

Mental health disorders in children and adolescents are a major concern. They are more common than we would think, as epidemiological studies show that, for example, up to 13% of adolescents aged from 12 to 17 in the US suffer from depression, 9.4% of children in the age group from 3 to 17 have ADHD (Monaco, 2021), and 6.5% of children and adolescents suffer from anxiety disorders (Creswell et al., 2020). Around 50% of mental health conditions start before the age of 14 and around 75% of them start before the age of 18 (Aguirre Velasco et al., 2020). The prevalence of most common mental health disorders in youth has been on the rise during past decades (Monaco, 2021).

Early recognition of mental health disorder symptoms in children and adolescents is crucial, as they adversely impact their academic, professional, and social activities and quality of life (Fusar-Poli, 2019) and have a long-term negative impact into their adulthood (Kowadenko & Culjak, 2018).



How can teachers help

However, it is estimated that around 75% of adolescents with mental health issues are not receiving treatment (Children Commissioners, 2016). This is often because children and adolescents are reluctant to seek help (Divin et al., 2018), but it is also because they cannot recognize their problems on their own. Teachers and other educators can recognize mental health symptoms in children and adolescents and encourage them to seek help. For them to be successful at this, there is a need to increase their mental health literacy.

Studies show that teachers can be solid at recognizing externalizing problems but have issues in detecting internalizing problems. They often view their students as healthy and underestimate their problems (Undheim et al., 2016). Some studies show that teachers, after a small amount of training, can become fairly accurate in detecting psychological difficulties in children, even in the case of internalizing symptoms (van den Broek et al., 2021).

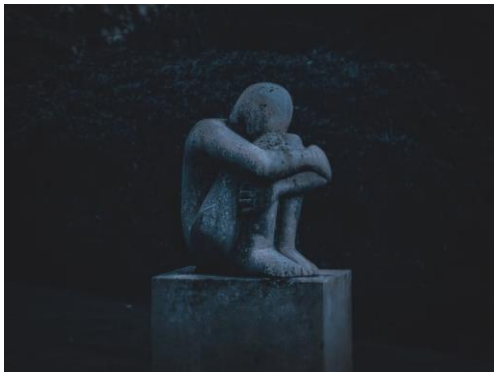
Topic 2: Basic signs for recognizing internalizing and externalizing disorders in children and adolescents

As already stated in Unit 1, mental health difficulties in children and adolescents can be classified into two broad categories: internalizing and externalizing difficulties.

The most common internalizing mental disorders in children and adolescents are **mood disorders** (e.g., depression), **anxiety disorders** and **stress-related disorders** (Elia, 2021). Most common externalizing disorders are **Attention-Deficit/Hyperactivity Disorder** (ADHD), **conduct disorder** and **oppositional defiant disorder**.

Recognizing depression

Most significant mood disorder in children and adolescents is depression. Depression was present within a one-year interval in around 13% of US adolescents (Monaco, 2021). In children, the prevalence was lower, around 2% (Abela and Hankin, 2009).



According to DSM-5 (APA, 2013), depression can be manifested by the following symptoms:

1. Depressed mood, most of the days and nearly every day.	6. Fatigue or loss of energy nearly every day.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day nearly every day.	7. Feelings of worthlessness or excessive and inappropriate guilt.
3. Significant weight loss or weight gain (in children, this can be a failure to make the expected weight gain).	8. Diminished ability to think or concentrate or indecisiveness, nearly every day.
4. Cannot sleep or sleeps too much nearly every day.	9. Recurrent thoughts of death and suicidal ideation or attempting suicide.
5. Psychomotor agitation (e.g., pacing, hand-wringing or inability to sit still) or psychomotor retardation (slowing down mental and physical activities).	

One must report 5 out of 9 symptoms over a 2-week period to be diagnosed with major depression, but fewer symptoms can point to depression as well, if a person is impaired in their academic, social, and other functioning (Martin et al., 2017). Most important symptoms are: 1. depressed mood and 2. loss of interest or pleasure, and at least one of these symptoms must be present for a person to be diagnosed with depression. In children and adolescents, the depressed mood can manifest itself as irritability as well.
Besides the described symptoms, there are additional emotional and behavioural changes that can help us recognize depression in children and adolescents (Mayo Clinic, n.d.). Additional emotional changes can be low self-esteem, fixation on past failures, extreme sensitivity to rejection or failure and ongoing sense that life and the future are grim and bleak.
Additional behavioural changes can be the (ab)use of alcohol or drugs, frequent complaints of unexplained body aches and headaches, social isolation, poor academic performance or frequent absence from school, less attention to personal hygiene or appearance.

Depression versus sadness

As depressed mood is the one of the most important features of depression, it is important to differentiate it from **sadness**. Sadness can occur because, for example, a child's family member gets very sick from a communicable disease. Sadness is usually caused by a specific trigger, and one can find some relief in crying, venting, or talking out frustrations (Fitzgerald, 2019).

Regular sadness usually fades with time. Depression is a long-term mental illness that requires professional treatment with psychotherapy and medication. In depression, a

person feels sad or hopeless about everything. It is important to note that a person can be sad because of something and depressed in general at the same time, one does not exclude the other.

Depression versus grief

Similar is the difference between depression and **grief** (APA, 2013). A child can go through a period of grief if, for example, their family member dies from a health threatening emergency. In grief, the dominant feelings are emptiness and loss, whereas in depression it is persistent depressed mood and the inability to feel happiness or pleasure.

Grief is likely to decrease in intensity over days or weeks and occurs in waves, which are called “pangs of grief” (APA, 2013). These pangs tend to be connected to the thoughts or reminders of the deceased. Although the person who griefs is in pain, grief can be accompanied with positive emotions and humour. Conversely, depression is characterized by pervasive misery and unhappiness.

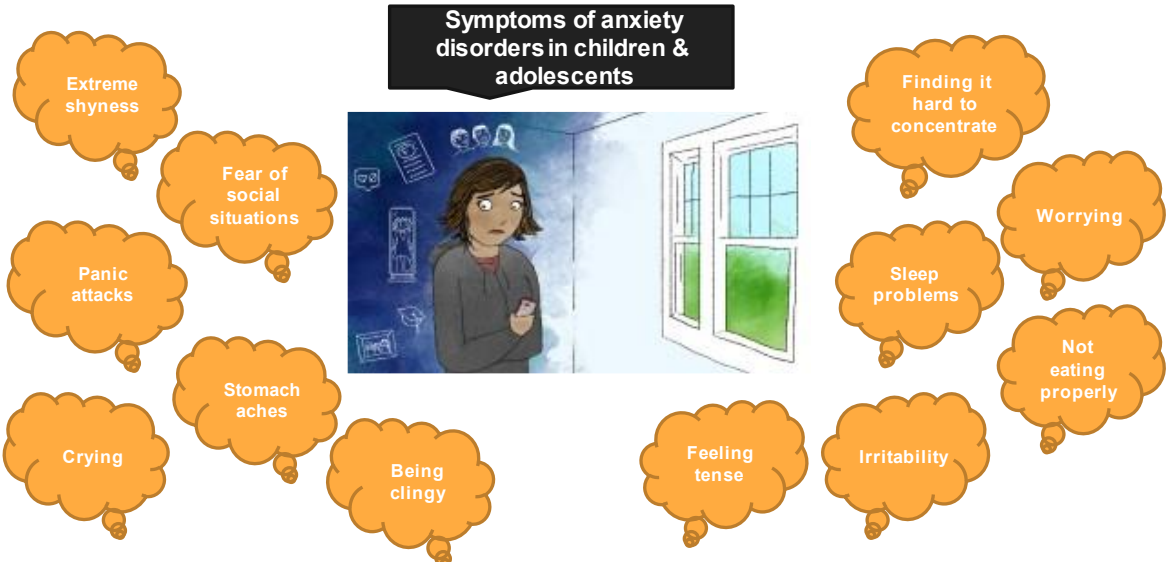
Persons in grief often think about and remember the deceased, but in depression the thoughts are self-critical and pessimistic, and the person feels worthless. If negative thoughts about oneself are present in grief, this is only because the person thinks they failed the deceased in some way (e.g., they didn’t visit enough or tell the person how much they loved them).

Recognizing anxiety disorders

Anxiety disorders are present in around 3% of 6-year-olds, 5% of teenage boys and 10% of teenage girls (Elia, 2021). There are different anxiety disorders. Generalized anxiety disorder, panic disorder, separation anxiety disorder, social anxiety disorder and specific phobias are among most common anxiety disorders in children and adolescents (Creswell et al., 2020).

Although there are too many individual anxiety disorders to delve into details, there are general outward signs that we can use to recognize anxiety in children and adolescents (National Health Service, n.d.). A child or an adolescent might have an anxiety disorder if it is:

- finding it hard to concentrate
- not sleeping, or waking in the night with bad dreams
- not eating properly
- quickly getting angry or irritable and being out of control during outbursts. This might be similar to oppositional behaviour, but it can be the consequence of anxiety and triggering the fight-or-flight mechanism (Boorady, n.d.).
- constantly worrying or having negative thoughts
- feeling tense and fidgety, or using the toilet often ("Not all that moves is ADHD").
- always crying (continued on the next slide)
- being clingy and experiencing strong anxiety when separated from the primary attachment figure (e.g., the mother), being too worried about losing the primary attachment figure
- complaining of stomach aches or feeling unwell
- experiencing panic attacks
- being extremely shy and withdrawing from new situations or from people
- feeling an inappropriate amount of fear when exposed to observation and possible assessment in different social situations; being afraid of: public speaking, oral exams, stating your opinion in front of a larger group of people, talking with peers, eating or playing in front of other children



Some amount of anxiety is normal for every child, but it becomes an issue when anxiety and fear are not proportional to the level of threat, and they start to interfere with children's everyday lives. Anxious children can become withdrawn and try in all ways to avoid things or situations that cause the anxiety.

Children may have anxieties that will go away on their own or with the help of parents, however, anxiety disorders have a serious negative impact on the children's and adolescent's quality of life and on their functioning and should be treated by professionals (National Health Service, n.d.).

It is assumed that anxiety disorders stem from a combination of factors: some children are born more anxious and less able to cope with stress, they can pick up the behaviour from being around anxious people and they can become more prone to developing the disorder by experiencing stressful events, some of which may be related to mental health emergencies as well (e.g., frequently moving house or school, parents arguing, death of a close relative, being seriously ill or injured, bullying or exams in school, abuse or neglect).

Recognizing stress-related disorders

There are different trauma and stress related disorders in children and adolescents (Children's Hospital in Philadelphia, n.d.; APA, 2013). Post-traumatic stress disorder, acute stress disorder and adjustment disorder are the most common ones.

Post-traumatic stress disorder (PTSD) is characterized by **persistent, intrusive, and frightening thoughts and memories**, flashbacks or dreams featuring traumatic event or events. These traumatic events should be extreme, e.g., actual or threatened death, serious injury or sexual violence happening to the person or to a close family member (in which case death or injury must be violent or accidental) or witnessing a traumatic event as it occurred to others. Other PTSD symptoms include:
- persistent **avoidance of stimuli** associated with traumatic events (memories, thoughts, people, places, conversations)
- alterations in **cognitions and mood** associated with the traumatic event (blaming oneself, persistently being in a negative emotional state, being less interested to participate in significant activities, having less ability to experience positive emotions)
-alterations in **arousal and reactivity** associated with the traumatic events, such as angry outbursts, reckless or self-destructive behaviour, hypervigilance, problems with concentration and sleep disturbance.

Acute stress disorder has symptoms that are similar to the PTSD but occurs within the first month after exposure to trauma. With prompt treatment and social support, its progression to PTSD can be prevented.
Adjustment disorder assumes developing unhealthy emotional and behavioural reactions in response to an identifiable stressor, which occurs within 3 months of its onset. Affected children and adolescents may display depressed mood or nervousness or they may behave so that they violate the rights of others.
Trauma and stress-related disorders may be especially relevant in the context of health emergencies. A review of studies (Loades et al., 2021) found that self-isolation in the context of different infections in children carries a risk for developing acute stress disorder, adjustment disorder or even post-traumatic stress disorder.

Recognizing externalizing disorders

Externalizing disorders, also known as behavioural disorders or externalizing behaviour disorders, include attention deficit hyperactivity disorder (ADHD), conduct disorder (CD), and oppositional defiant disorder (ODD) (Samek and Hicks, 2014). Because their symptoms are more visible, they are usually noticed more often by teachers than internalizing disorders such as depression and anxiety (Undheim et al., 2016).

ADHD has three main subtypes, the inattentive type, the hyperactive-impulsive type, and the combined type, which is a combination of the former two types (APA, 2013; Leonard, 2021).
A child with inattentive type ADHD can:
-have difficulties paying attention
-become easily distracted
-have difficulty focusing on tasks, for example longer tasks such as reading
-start tasks but forget to finish them
-appear not to listen to instructions or to forget them

A child with hyperactive-impulsive type ADHD can:
-have difficulties remaining seated
-fidget a lot by tapping the hands, feet, or moving around in the seat
-run around or climb things when this is not appropriate
-frequently interrupt conversations or games
-have difficulty waiting for their turn
-have trouble talking or playing quietly

Oppositional defiant disorder usually first appears during preschool years and rarely after early adolescence. Its prevalence is around 3.3% (APA, 2013). Its characteristics are:
-angry and irritable mood, in the sense that a child often loses temper, is touchy or easily annoyed or is often angry and resentful

-defiant behaviour, in the sense that the child often argues with adults, often actively defies or refuses to comply with requests from adults or with rules, often deliberately annoys others or often blames others for his or her mistakes or misbehaviour
-vindictiveness, in a sense that a child has been spiteful or vindictive at least two times over 6 months
Some of these behaviours are normal for children, but if they occur more often than it is suitable according to the cultural norms and the child's developmental level, this may point to a disorder.

Some children and adolescents with oppositional defiant disorder symptoms eventually develop conduct disorder. Median one year prevalence of conduct disorder is 4% (APA, 2013).
Children and adolescents with conduct disorder violate basic social rules and the rights of others. These behaviours are much more severe than those in oppositional defiant disorder.
Symptoms of conduct disorder can include:
-aggression, which can result in physical fights, bullying behaviour, threatening and intimidating others, stealing from a victim, using a weapon (e.g., a broken bottle, a knife) or being physically cruel to people and animals and forcing someone into sexual activity
-destruction of property, like setting fires or damaging possessions
-deceitfulness or theft, for example stealing items of nontrivial value, lying to obtain goods and services
-significant rule-breaking, such as not going to school, running away from home or staying out despite parental prohibitions

Children and adolescents with conduct disorder can have difficulties feeling empathy, or suffer from another condition, such as anxiety or ADHD (APA, 2013). They may falsely interpret intentions of other people as mean (Ogundele, 2018).
Like other disorders, conduct disorder causes significant impairment in social, academic or occupational functioning. Specifically, these children and adolescents are sometimes suspended or expelled from school, start early with substance use and engage in reckless acts, and can come into contact with the legal system.
It is theorized that the oppositional defiant and conduct disorders are caused by a combination of a difficult child temperament and ineffective parenting practices, which leads children to interact with parents aggressively and defiantly. This aggressive strategy leads to sibling conflict, rejection by prosocial peers and academic setbacks in early childhood. Children then associate with other deviant peers, which reinforces their antisocial behaviour and attitudes during adolescence (Samek and Hicks, 2014).

A note on comorbidities

At the end, it must be noted that, in internalizing and internalizing disorders, comorbidity (i.e., co-occurrence of the disorders) is more of a rule than an exception. For example, having an anxiety disorder can lead to depression. Also, having ADHD can lead to depression, as well as having oppositional defiant disorder or conduct disorder (Martin et al., 2017).

Activity 1

Case study 1

Janice is a 15-year-old girl who was an enthusiastic teenager, enjoyed socialising and doing extracurricular activities. However, once she was diagnosed with type one Diabetes and prescribed the insulin pump therapy, she became withdrawn from friends and family. She lost interest in the activities she previously enjoyed. She slept poorly, lost weight, and constantly felt sadness and lack of energy. She loathed herself and considered herself worthless, and generally had a pessimistic outlook on life.

Questions:
Is Janice likely suffering from a mental health disorder? Which one? Which symptoms that she shows do you think could be noticed in classroom? Would you refer her to a psychologist?

Answers: Yes, Janice is suffering from depression, and she should be referred to a psychologist. Symptoms like weight loss, lack of energy, sadness and a pessimistic outlook on life can be noticed in the classroom.

Activity 2

Case study 2

Jack is a 10-year-old boy from a supportive family. He was shy and reserved in preschool but managed to integrate well in school, made friends and succeeded academically. However, he complained multiple times that he had a severe abdominal pain in the morning and missed school for about 20 times during the previous year because of the pain. He avoided school trips because he was afraid that the bus would crash. He had difficulty falling asleep and was unable to sleep at all before a test. He was worried that he and members of his family would die, demanded that the house must be secured in the evening to an unnecessary extent, and constantly sought reassurance from his parents, which was at times burdensome for them. During COVID-19 his symptoms additionally worsened.

Questions:
Is Jack likely suffering from a mental health disorder? Which one? Which symptoms that he shows do you think could be noticed in classroom? Would you refer him to a psychologist?
Answers: Yes, Jack is suffering from an anxiety disorder and he should be referred to a psychologist. Symptoms such as missing school because of unspecified abdominal pains, avoiding the school trips because of being afraid that the bus might crash, not being able

to sleep before a test, and even being worried that he and his family members would die, can be noticed in school.

Activity 3

Matching symptoms to disorders

Symptoms	Disorders
The adolescent looks sad constantly, looks like they don't find much interest or joy in any activity.	ADHD (hyperactive-impulsive)
The child looks tense, fidgets, often asks to go to toilet. Displays clingy behaviour with parents, mentions many worries.	Oppositional defiant disorder
The child has difficulties remaining seated, frequently interrupts conversations or games.	Adjustment disorder
The child often argues with adults, often actively defies, or refuses to comply with requests from adults or with rules.	Depression
The child looks sad after returning from self-isolation imposed by COVID-19 and has angry outbursts toward other children.	Anxiety disorder

Correct answers:
The adolescent looks sad constantly, looks like they don't find much interest or joy in any activity. ->Depression
The child looks tense, fidgets, often asks to go to toilet. Displays clingy behaviour with parents, mentions many worries. -> Anxiety disorder
The child has difficulties remaining seated, frequently interrupts conversations or games. -> ADHD (hyperactive-impulsive)
The child often argues with adults, often actively defies, or refuses to comply with requests from adults or with rules. -> Oppositional defiant disorder
The child looks sad after returning from self-isolation imposed by COVID-19 and has angry outbursts toward other children. -> Adjustment disorder

Unit 3

Risk and Protective Factors for Mental Health Difficulties among Children/ Adolescents

Topic 1: Introduction

Children and adolescents are vulnerable population with respect to their physiological and psychological capacity to prepare for, or respond to, the effects of health emergencies and crisis situations (Codreanu, Celenza, & Jacobs, 2014). The psychosocial effects of extreme events are resulting from a complex range of primary (arising directly from crisis' situation) and secondary stressors (indirectly related to crisis' situation) (Department of Health, 2009). While most children and adolescents will experience relatively transient distress after exposure to health emergencies and crisis situations followed by the processes of adaptation, some of them will experience more severe mental health difficulties which in some cases may require intensive and long-term interventions and treatment (NATO/EAPC, 2009; Department of Health, 2009). It is important to be acquainted with information about children's typical reactions and symptoms that could indicate a need for further evaluation. Understanding of the differences between groups of children and adolescents, exposed to health emergencies and crisis situations, who do or do not develop mental health difficulties (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012) is related to addressing factors associated with situation risk and exposure, but also with examination of risk and protective factors within individual, his/her experiences, and environment.

Topic 2: Definitions and categories of risk and protective factors for mental health difficulties triggered by health emergencies and crisis situations

Risk factors are factors that make it more likely (or increase probability) that people will experience negative outcomes (NIDA, 2020). Risk factors are measurable and predictive, and many risk factors are modifiable - they are subject to change through intervention (ACAY, 2015).

Protective factors are factors that make it more likely that people will experience a desired outcome. Protective factors promote successful coping and adaptation to life situations and change. Protective factors are not simply the absence of risk factors; rather, they lower the probability of undesirable outcome (e.g., Benard, 2004). They may change, buffer, or reduce outcomes of risk factors (ARACY, 2015). All people have some combination of risk and protective factors.

Risk and protective factor are usually grouped into (https://ctb.ku.edu/en/table-of-contents/analyze/choose-and-adapt-community-interventions/risk-and-protective-factors/main):

- a. environmental factors – those that occur in the persons' social and physical environment and are specific to group of people in each community (e.g. household, town, living conditions, friends' norms and behaviour)
- b. individual factors - personal experiences or aspects of a person (or group) (e.g. impulsivity, resilience, attachment).

Risk factors are not necessarily causes of a negative outcome, and they must be assessed in conjunction with protective factors. Influence of those factors on human behaviour is interactive (they do not act in isolation) and changes over the life span.

Crisis situations related risk and protective factors for mental health difficulties in childhood and adolescence

Crisis situation-related protective factors for mental health difficulties in childhood and adolescence

Category	**Factors**
Experience before crises situation	• Educational curricula which include risk analysis, awareness and reduction, and disaster management (promotion of activities that increase preparedness and reduce risk) • Informed public about existing disaster plans at local and/or governmental level • Engagement of the community in discussions about risk, disaster plans and response • Participation in local disaster drills • Having (family) safety plans before a disaster or emergency happens • Psychoeducation to children and adults about normal reactions to disasters and stress management techniques • Learned relaxations skills
Experience during crisis situation	• Indirect involvement

	• Giving children responsibility to care for others and encouraging active coping (e.g. took on a caregiver role towards toy) • Take action directly related to the disaster (but in safe environment)
Economy	• Restoration of homes or property • Securing permanent accommodation
Emotions	• Positive self-talk or healthy distraction • Directing one's energy to age-appropriate activities that promote competence • Provide children with opportunities to talk about what they went through or what they think about it • Giving children opportunity for sharing concerns and asking questions
Health	• Access to adequate psychosocial or healthcare
Education and Schooling	• Perceived sense of safety at school and belonging • Achievement of competence in the host country's language
Media	• Limiting exposure to media coverage of traumatic events and aftermath • Providing children with simple and age-appropriate information that they can understand what is going on • Credible, current and helpful information
Family	• Availability of family resources • Stable parents and caregivers' reactions to adverse events • Parents and caregivers deal with emergencies with confidence • Parents transmit a sense of resilience to their children • Good parental mental health, particularly in mothers

	• Family cohesion and perception of high parental support
Society	• Community resilience ability to respond and recover to adversities • Low peer violence and discrimination • Living and socialising alongside other people of the same ethnic origin • Support of parents, friends, neighbours and the social infrastructure • Perception that social support was adequate • Adherence to traditional values of family hierarchy according to age and sex
Leisure and recreation	• Leisure and relaxation activities

Crisis situation-related risk factors for mental health difficulties in childhood and adolescence

Category	**Factors**
Experience before crises situation	• Lack of information about experiences of migration or exile • Previous adverse events (e.g. episode of emergency, exposure to violence) • Little connectedness to the neighbourhood • Absence of knowledge and awareness of risk or unrealistic risk perceptions • Previous adverse, traumatic, or stressful event
Experience during crisis situation	• Direct involvement • Have suffered physical injury (especially head) • Higher degree of perceived personal threat during traumatic exposures • Direct and indirect exposure to violence

	• Longer duration of exposure
Economy	• Problems with restoration of homes or property • Continuing to live in temporary accommodation • Loss of possessions - including items of sentimental value, house, financial aid
Emotions	• Fear for the loss of a loved one (a family member, close friend, or pet) • Fear of the unknown • Fear of recurrence of an extreme event • Attempt to actively resolve uncontrollable interpersonal stressors (e.g., parental conflict or illness)
Health	• New or continuing health concerns or conditions • Lack of access to psychosocial or healthcare • Lack of access to prescription medication
Media	• Conflicting information • Repeated exposure to mass media coverage of the emergency and aftermath (e.g., images of a disaster, negative reports)
Family	• Separation from parents, families and/or caregivers • Loss of a family member, close friend, or pet • Breakdown of relationships and loss of intimacy • Breakdown in familiar routines and living conditions • Changes to household composition • Physical and mental abuse and neglect of partners or children
Family	• Sense of uncertainty transmitted by parents and/or caregivers • Poor communication within family • Parental worries about financial problems

Society	• Physical separation from friends • Disruption to social networks and relationships • Reduction in level of social support • Big cultural differences • Perceived discrimination
Leisure and recreation	• Disruption to leisure and relaxation activities
Changes in the view of the world or oneself	• Uncertainty of their own health • Change of routine, lifestyle, life conditions • Loss of control and agency • Loss of aspirations for the future goals

General risk and protective factors for mental health difficulties in childhood and adolescence

General risk factors for mental health difficulties in childhood and adolescence

	Individual	**Family**	**School, neighbourhood, and community**
EARLY CHILDHOOD	- Difficult temperament: frequent irritability, low adaptability, irregular habits - Insecure attachment to parents - Motor, cognitive or language impairments - Premature birth - Social inhibition or hostility to peers - Head injury - Aggressive behaviour	- Harsh discipline - Maternal stress - Parental substance abuse - Poor parental mental health - Parental neglect and abuse - Cold and unresponsive mother behaviour - Marital conflict - Family dysfunction	- Poverty - Poor-quality childcare services - Lacking a medical home - Living in a neighborhood in poor condition

	- Sexual victimization	- Parental loss - Single parenthood	
MIDDLE CHILDHOOD and ADOLESCENCE **MIDDLE CHILDHOOD and ADOLESCENCE**	- Frequently feeling anxious or scared - Impulsiveness - Depressiveness or apathy - Negative self-image - Shyness - Insecure attachment to parents - Lack of social skills: aggressive, impulsive, passive, or withdrawn, poor problem-solving - Poor school achievement - Poor commitment to school - Sexual victimization - Traumatic or stressful events In middle childhood: - Deficits in impulse control and behavioural self-control - Sensation-seeking - Behaviour problems - Attention deficit/ hyperactivity disorder	- Substance abuse among parents or siblings - Poor parental mental health - Poor parenting (rejection, hostility, lack of warmth, highly criticizing parents, harsh discipline) - Parental neglect and abuse - Parental loss - Marital conflicts or divorce - Family dysfunction - Parental overcontrol or permissive parenting - Parents reinforce threat appraisals and avoidant behaviours - Parent-child conflicts	- Peer rejection or alienation from peers - Deviant peer group - Poverty - Stressful community events (e.g., violence) - School-level stressful events - Easy availability and access to alcohol
	In adolescence: - Female gender (risk factor for depression)		

	- Extreme need for approval - Favourable attitudes toward drugs or early substance use		

General protective factors for mental health difficulties in childhood and adolescence

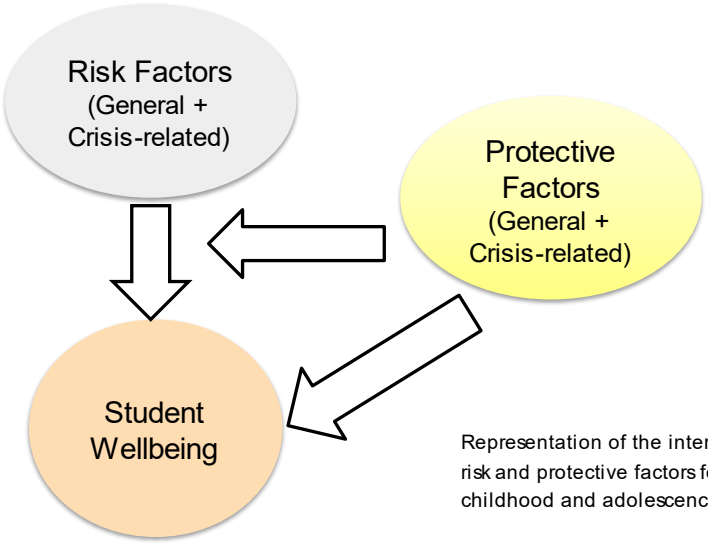
	Individual	**Family**	**School, neighbourhood, and community**
EARLY CHILDHOOD	- Good self-regulation - Secure attachment to parents - Good communication and language skills - Ability to make friends and get along with other people	- Parental responsiveness, support, protection from harm and discipline - Adequate socioeconomic resources for the family	- Support for early learning - Supplementary services for disadvantaged children (e.g,, feeding, medical screening) - Low ratio of caregivers to children - Regulating quality and of health and social care
MIDDLE CHILDHOOD and ADOLESCENCE	- Mastery of academic skills - Ability to make friends and get along with other people - High self-efficacy - Optimism - Emotional self-regulation - Interpersonal connections in contexts such as school, with peers, in sport clubs, religion groups etc.	- Parental support - Authoritative child-raising (involvement, warmth, support of autonomy, clear rules, expectations, and structure) - Good family climate	- Availability of social support outside the family (e.g., friends, teachers, community groups, sport clubs) - Healthy peer groups - Effective classroom management - School policies and practices against bullying - High academic standards

Topic 3: Interrelations among individual, social, and environmental level risk and protective factors for mental health difficulties triggered by health emergencies and crisis situations

Characteristics of protective and risk factors (e.g. ACAY, 2015; NIDA, 2020; Hawkins et al., 1992; SAMSHA, 2015; https://nbhc.ca/news/protective-and-risk-factors-explained):

- Risk and protective factors are multidimensional – they exist in at individual and environmental level.
- Some risk and protective factors will remain constant throughout one's lifespan (static) while others may change (temporal).
- All people have some combination of risk and protective factors.
- Many factors are related to multiple outcomes.
- Outcomes of risk and protective factors vary with regard to many other factors within (e.g. age) and outside the person (e.g. living conditions).
- Different factors have a greater or lesser influence on behaviour at different stages in a person's life.
- Outcomes of some risk and protective factors are general (e.g. related to health in general, or diverse health problems), while of others are pretty specific (e.g. related to only on health problem).
- There is cumulative effect of risk factors - the more risk factors a person has, the greater the likelihood they will have a given health problem.
- There is cumulative effect of protective factors – the more protective factors a person has, the greater the likelihood they will lessen/buffer/ balance the effect of risk factors for a given health problem.
- Person with the same set of risk factors will probably not experience the same difficulties.
- Exposure to even a significant number of risk factors does not necessarily mean that health problem will certainly occur.
- Absence of risk factors do not mean that person will never develop health problem.

We still know little about how to build accurate individualised risk prediction (Danese, Smith, Chitsabesan and Dubicka, 2020). There is no standard, empirically verified set of risk or protective factors to assess specific outcomes since these factors are highly context-specific (The Alliance for Child Protection in Humanitarian Action, 2021).



Representation of the interaction effect of the potential risk and protective factors for mental health difficulties in childhood and adolescence

Activity 1

Please analyse the real case scenario and conduct risk-assessment analysis by answering the questions in the table.

Real case scenario (adapted from: Onyut, Neuner, Schauer, Ertl, Odenwald, Schauer, & Elbert, 2005)

I grew up with both my parents. I have younger sister and brother. My mother was young and I loved her a lot. I was her first-born and her favourite. She even told me so. My father was hard working. He had a shop close by in the market. He would usually leave in the morning and return home in the evening. Sometimes when he came home, he played with us in the evening. We played football together. Those were good times. I do not know how old I was then; I just remember that I was very young... I don't remember the year, but I was still young... It was early in the morning. A group of about 10 civilian men came to our house. They were armed with guns...I stood very near to my parents. I was so scared. Suddenly I heard the sound of bullets. One of the soldiers had started shooting. The moment I saw that he pulled the trigger and heard the first bullet, I panicked. I started running. I felt such great fear. I ran inside the house and tried to hide myself behind a door in one of the rooms. I was shivering, fearing, thinking, they will also come for me, they will come and kill me'. I still have a heart beat now, when I recall that moment. After some time it went quiet outside. I still stood behind the door, silent, not moving. After a while I slowly moved towards the window and peeped out. What I saw was terrible. My mother and my father had been hit by the bullets. They were both lying on the ground. My mother had fallen on top of my father. They both had blood on their clothes. My mother had blood

on her face and her stomach. They were not moving anymore, they had died. Until that day, I had never seen a dead person. I felt horror. I was so afraid of them, shocked by what I saw. I only thought of running away, leaving this place. I escaped through the back of the house and jumped over the fence. This was the last time I have seen my parents and the last time I had been in our home. While fleeing, I joined strangers in the street. So many people were trying to flee. I simply ran with them. On the way, I met very many militia men dressed as army men. They told us to lie down on the ground. I started crying. The rest were silent. One of them knocked me with the butt of the gun on the soft part of my head. Then I kept quiet. They wanted to kill everyone...but let us go. People continued running, and when they reached their destination, they branched off from the road. It was night time by then. I was alone. I hated my life. I followed the road and finally fell asleep under a bush. I had given up about life by then. I felt like I had died as well. I knew about the danger of wild animals and lions, but I did not care...This is how I came to other town. I saw a group of people from my town and went to greet them. They took me in and I lived with them for a few weeks. They also showed me how to register as a refugee. I remember the day I came to Refugee Camp. I was so surprised how people can live in a place like this. I stayed with the one family for about two years in the camp. Finally, Red Cross helped me to build my own house, I was about 14 years then. Since then I live alone. I started going to school. I have learnt how to live by myself. No one can help me anyway. I have never heard about my brother and sister again. Whether they are still alive and if so, where I could find them. But now I am ready to look for them.

	Before (what happened before the event?)	**During** (what happened during the event?)	**After** (what happened after the event?)
Facts What happened? Who (was present)? Where? When? Why?			
Feelings (describe/ list experienced emotions)			

Hints
Facts:

Before - war started and armed civilians were killing people across the country, family was at home, it happened in populated area, it happened several years ago;
During - parents were shot in front of their house while children were present;
After - child flee away from home and joined other refugees, child was physically abused by soldiers, child was situated in the refugee camp and one family took care of he/she, child is currently attending school, he/she lives alone in his/her house, he/she does not know where his/her sister and brother are

Feelings:
Before - happy, calm, safe, satisfied, carefree;
During - fear, panic, horror;
After - feeling dead, despair, hopelessness, surprise, independence, hope

A structured interview model, called the BDA (before, during and after) model, is used to conduct risk-assessment interviews with both groups and individuals. Its purpose is not to eliminate or reduce post-traumatic reactions, but to allow the interviewer to identify those who may be at risk of developing psychological problems. The interview structure focuses on the individual's perception of the event and their emotional and cognitive reactions to it (Onyut, Neuner, Schauer, Ertl, Odenwald, Schauer, & Elbert, 2005).

Activity 2

Please read the following real case scenarios and try to recognize the risk and protective factors for mental health difficulties in children in these examples.

Real case scenario 1

Adam is eight years old and is in the second grade of elementary school. During the coronavirus pandemic, Adam's grandmother with whom he shared a household became seriously ill and ended up in hospital. Adam often asked his parents about her and was worried about her health even after grandmother recovered and returned home. Due to the accumulated stress during the lockdown, Adam's parents would often argue, and Adam heard many of their fights. Adam's mother suffers from generalized anxiety disorder. During the pandemic, her symptoms worsened due to her mother's hospitalization, and she was overwhelmed with worry and fear that something bad would happen to her family. Despite major changes at home, Adam maintained good grades at school. He has three friends with whom he hangs out and all of them train football twice a week. Football is a sport that Adam enjoys very much.

Hints: Risk factors include grandmothers' illness, parents arguing, and mother's mental health disorder. Protective factors include good grades, relationships with friends, and playing and enjoying football.

Real case scenario 2

Lana is 15 years old. She lives in Croatia, in a town that was recently hit by a series of devastating earthquakes. As a result, Lana's family had to move into temporary accommodation until their house was renovated. The family has financial difficulties because Lana's father has not received a salary for several months. In her early school years, Lana had a hard time separating from her parents and was often worried that something bad might happen to them. Lately, Lana has been feeling sad and empty. Lana has a very good relationship with her mother and the two of them often talk about Lana's feelings. Lana's mother encouraged her to consult a school psychologist about her problems. Lana has been regularly attending counselling with her school psychologist for the last two months. The psychologist gives Lana support and understanding for the issues that bother her.

Hints: Risk factors include earthquake exposure, damage to a home and household dislocation, family financial difficulties, separation anxiety, and female gender. Protective factors good relationship with the mother and regular counselling.

Activity 3

Please indicate which of the following risk and protective factors can be classified as individual; family; school, neighbourhood, and community; or health crisis and emergencies-specific factors.

Risk or Protective Factors	**Individual**	**Family**	**School, neighbourhood, and community**	**Crisis and emergencies-specific**
Child gets good grades in school				
Child is often anxious				
Aggressive sibling				
Positive classroom climate				

Parental job insecurity during the COVID-19 pandemic				
Health issues in early childhood				
Poor neighbourhood				
Family excessively following news about the pandemic				

Hints:
(1) Individual: child gets good grades in school, child is often anxious, health issues in early childhood
(2) Family: aggressive sibling
(3) School, neighbourhood, and community: positive classroom climate; poor neighbourhood
(4) Crisis and emergencies-specific: parental job insecurity during the COVID-19 pandemic, family excessively following news about the pandemic

Further Readings

The Alliance for Child Protection in Humanitarian Action (2021). Identifying and Ranking Risk and Protective Factors: A Brief Guide, https://www.alliancecpha.org

https://www.mentallyhealthyschools.org.uk/risks-and-protective-factors/

https://www.apa.org/topics/resilience/guide-parents-teachers

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