Assessment Report

Psychological Assessment Report

Understanding Psychosocial Problems and Needs of Children in Flood Affected Areas Districts Swat, Muzaffargarh and Rajanpur

December, 2010

Save the Children

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ACRONYMS

CFS	Child Friendly Space
CPC	Child Protection Center
DAP	Draw A Person
D.G. Khan	Dera Ghazi Khan
FAA	Flood Affected Areas
IDP	Internally Displaced Person
KPK	Khyber Pakhtunkhwa
NDMA	National Disaster Management Authority
NGO	Non Governmental Organization
PTSD	Post Traumatic Stress Disorder
PSP	Psychosocial Support Programme(s)
SDQ	Strengths and Difficulties Questionnaire
WASH	Water, Sanitation and Hygiene

Executive Summary

Immediately after the floods began, Save the Children initiated reliefs operation in the provinces regions of Punjab, Sindh, Khyber Pakhtunkhwa (KPK) and Balochistan. According to the National Disaster Management Authority (NDMA), more than 20 million people have been affected by the devastating floods in Pakistan. As the water recedes, it leaves behind a trail of destruction and shattered lives across the country. More than 1.8 million houses are damaged or destroyed; infrastructure is in shambles as bridges and roads have been swept away; and livelihoods have been severely disrupted. The level of devastation is massive, setting the affected areas of the nation back by decades.

This psychological assessment report was carried out to identify the psychological and behavioral problems of children after the floods. The assessment was also meant to suggest solutions and recommendations for the identified psycho-behavioral problems. Major findings of this report will be significant in the following respects:

- It will act as a reference for identifying psychosocial issues in children of flood affected areas in the provinces of KPK and Punjab, including factors contributing to these issues
- It highlights problems, assumptions and risk factors in relation to children between the ages of 5 – 15, both in camps and host communities.

Major assessment tools used were the 'Strengths and Difficulties Questionnaire' (SDQ) and the 'Draw A Person' (DAP) technique. Since the report aimed at suggesting opportunities for long-term psychosocial support, sufficient information regarding the existing context, diversities and representation from the worst affected floods areas were given due consideration for devising the methodology. To make the data representative, the assessment was conducted in Muzaffargarh and Rajanpur districts of Punjab province and in Swat district of Khyber Pakhtunkhwa (KPK) province.

The SDQ revealed that 9 (15%) children had been badly affected because of behavioral and psychological problems, while 33 (55%) have been moderately affected and 18 (30%) children were normal. Meanwhile, the DAP found four major psychological issues experienced by children: aggression which has been reported in 52 (87%) children, shyness and lack of expression in 45 (75%), adjustment problems to the current situation in 42 (70%) and feelings of insecurities and fear of water, people, open places, and darkness in 44 (73%) children.

Another contributing factor, which affected the children's' reactions to flood, was the mental and physical health conditions of the parents. Children's needs are highly compromised when their parents are experiencing high levels of stress. It was also noted that most of the parents are unable to deal with their children's changed feelings and insecurities properly after the flood and as a result, children suffer from behavioral and psychological problems including anxiety, depression and phobias.

1. Introduction

The floods in Pakistan began on July 27th, 2010, following heavy monsoon rains. The flood caused unprecedented losses and damages to Pakistan's infrastructure, industry, houses, communications, and roads. This resulted in a creating a phenomenal humanitarian crises. According to the National Disaster Management Authority (NDMA), the floods have claimed nearly 2000 lives, 1.8 million houses have been damaged and more than 20 million people have been affected in over 30 districts. An area of at least 160,000 km^2 has been ravaged by floods. Over 2.2 million hectares of crops have been destroyed and over 10,000 schools have been damaged[1].

On July 27, heavy rains started falling on most parts of Khyber Paktunkhwa (KPK) Province, impacting more 1.5 million people, and severe damage to 156,934 homes. According to NDMA, over 1,000 people have been killed in KPK and 176,272 homes damaged. Particularly people of Upper Swat encountered major devastation; they were already suffering from the effects of the conflict, even before these monsoon floods occurred. While the infrastructure and social mechanisms had already been destroyed due to conflict, the flood has intensified an already difficult situation.

In Punjab, Districts Dera Ghazi Khan (D.G. Khan), Rajanpur, Rahim Yar Khan, Layyah, Bhakkar and Muzaffargarh are the worst hit of flood water, causing extensive damage to the standing cotton crops there. NDMA reported over 100 deaths in Punjab with 500,000 houses damaged. In Rajanpur district of Punjab province, three tehsils (Rajanpur, Jampur and Rojhan) were badly affected. Similarly, in Muzaffargarh district, more than 700,000 people were forced to evacuate from their homes within 24 hours after the district government announced the arrival of the floods from loudspeakers in mosques. The worst hit were the 350,000 persons displaced from Daira Din Pannah, Kotaddu, Sanawan, Gurmani and Mahmood Kot who had taken shelter in relief camps, along roadsides and in homes with other relatives.

The physical consequences of flood were quite evident in terms of death, disabilities, and displacement; however, the psychosocial consequences were less obvious. Where the major focus remained on meeting food, shelter, WASH and health needs at one end, the well-being of children and those rendered vulnerable also became the central concern in the days and weeks following the flood. Moreover, the need of psychosocial support and counselling was evident when assessing the emotional and mental state of adults and children alike. Many organizations have launched initiatives of psycho-social support in the relief phase for communities and individuals to help them cope with their emotions and restore well-being.

Often the most critical decisions affecting the lives of hundreds of thousands of children, are taken with very little the knowledge and understanding of the prevailing situation. This assessment has been carried out to identify the psychological / behavioral problems which have resulted after the floods and propose solutions and recommendations, however, before moving to findings, a homogenous understanding of the concepts has been provided below.

[1] [1] www.ndma.gov.pk, retrieved on October 27, 2010

2. Understanding the Concepts - Psychosocial Support and Child Development

2.1 Psychosocial Support

The concept of *psychosocial support* is centred on having attitudes and skills which enable people to deal with any situation. If children continue to doubt their own selves, the environment becomes inhibiting for them, then the circumstances, changing contexts and issues will haunt them and retard their progress in life. Psychosocial support, as it is commonly misunderstood, is not about mental illness or instability. It deals with the quality of support and relationships children are provided with to enable the development of their emotional resilience and confidence. The reason psychosocial and emotional development of children becomes so important is that it provides the foundation for their confidence to adapt to situations and to apply themselves to reach their full potential.

2.2 Child Development

Child development is a result of inherited genes but also due to environmental factors and learning. It mostly involves an interaction between individuals, groups and communities. The psychosocial support programmes emphasize on aspects such as strengthening social environments that nurture children's physical, cognitive, emotional, and social development at various levels; with the family, community and other children. Social and moral development plays an important role in Child Development as well. They are also one of the five main domains of holistic development (physical development, cognitive development, linguistic development, social and moral development and emotional development). It refers to the process where children develop relationships with their culture, the people around them and the environment in general. Each person connected to the child, including parents, family members, caregivers, teachers, friends and others play important roles in their development.

2.3 How Children are affected[2]

The prime effect of a disaster on children and adolescents is the disruption of their lives, whether through injury, death, or destruction (of home, school, or community). This leads to a loss of reliability, cohesion, and predictability, which affects children of all ages.

[2] Sources of information include The American Academy of Child and Adolescent Psychiatry (www.aacap.org) and Psychosocial Issues For Children And Families In Disasters: *A Guide For The Primary Care Physician* by American Academy of Paediatrics (www.aap.org)

Development Considerations in response to Crisis in Children and Adolescents				
	Infants	**Early Childhood**	**Middle Childhood**	**Adolescents**
Developmental Considerations	Object permanence, establishing trust	Magical thinking, egocentric, no concept of time	Logical thinking, conception of time, differentiation of self from others	Establishing independence, abstract thinking, feelings of omnipotence
Effect of crisis	Destroys routine, loss of loved ones	Destroys routine, loss of loved ones	Destroys routine, loss of loved ones	Loss of lifestyle, loved ones
Result of crisis	Regression, detachment	Posttraumatic play, withdrawal, apathy	Learning problems, anxiety, somatic complaints, anger, posttraumatic play	Risk taking, somatisation (persistently complain of varied physical symptoms that have no identifiable physical origin), depression, anger, hostility to others
View of Disaster	No comprehension	Reversible	Understand loss as a consequence of injury and illness	Full understanding

3. Purpose of the Assessment

The main purpose of the assessment was to understand the range and extent of psychological / behavioral problems of children resulting from the recent crisis, and diagnose the factors contributing to any change, positive or negative, in the psychosocial state of children.

The assessment found that an attitude towards "why it happened to us" oscillates between acceptance of flood as a natural disaster and emotions of anger, resilience, indifference, uncertainty, hopelessness and eagerness to gain stability. Either way, the psychosocial state of children has been affected not only by their personal experience of the flood and subsequent losses but also greatly because of the attitudes of people and commotion surrounding their environment as relief and rehabilitation work continues.

It is expected that the findings of said report will be of significance in the following aspects:

- It will act as resource material for identifying psychosocial issues in children of flood affected areas in the provinces of KPK and Punjab, including factors contributing to these issues and their implications for adjustment that leads to healthy living.
- It highlight problems, assumptions and risk factors in relation to children between the ages of 5 – 15, both in camps and host communities.

Traditionally, in the initial response to crisis, psychosocial support programmes are launched with short-term initiatives, which do not respond to real issues. It is essential to understand the far-reaching implications of psychosocial support that contribute to addressing the behavioral and psychological problems of children. The assessment of psychological impacts in children after crisis will draw attention of humanitarian agencies on the seriousness of these issues and will result in concrete and high-quality actions both in the short and long run.

4. Assessment Methodology

The methodology used for the assessment was designed in consultation with Save the Children teams working in the flood affected areas. Major assessment techniques used were participatory observation, home visits and informal interviews and for psychological assessment of children, Draw-a-Person (DAP) test and Strength and Difficulties Questionnaire (SDQ) were used. Since the report aimed at suggesting opportunities for long-term psychosocial support, therefore, sufficient information regarding the existing context, diversities and representation from the worst affected floods areas were given due consideration while devising the methodology. To make data representative the assessment was conducted in Muzaffargarh and Rajanpur districts of Punjab province and in Swat district of KPK province.

The main aim of the study was to address the psychological problems of children that can impact their adult life. Children belonging to different social strata were included such as school going, out of school, disabled and working children. The study focused on the age group of 5 – 15 years, which are the main development years in any child's life, having lifelong impact. The assessment process was facilitated by a psychologist. To make report more comprehensive the following data collection strategies were employed:

4.1 Participatory Observation

The assessment team used participatory observation in gathering information for the assessment. The observer became part of the regular activities in the child friendly space, aimed to ensure the familiar presence within the children to closely observe their behaviour during activities, interaction with peers, and reaction towards different situation. These findings were similar to the findings of projective and non projective assessment tools for making a hypothetical but comprehensive picture of children personalities and responses.

4.2 Home visits

Visiting families in the affected areas in their homes helped in establishing rapport with the parents and enabled interaction with all members of the family in an informal way. It was important to fill in the Strengths and Difficulties Questionnaire (SDQ) from the parents. This also provided very valuable information about how the flood affected their lives, and what kind of support they require to reinforce the psychosocial support network.

4.3 Informal Interviews

Informal / unstructured interviews were conducted with the informants, parents, CFS supervisors, and children to explore perceptions, experiences and priorities of community. Views were collected from males and females both.

4.4 Behavioural / Psychological Assessment

A separate set of tools were also used to assess the psychological state of children. The following were three main techniques used for eliciting responses from children about their experiences and consequently assessing the current state of well being. A detailed description of each technique is provided below:

- Demographic Form: Each respondent was initially required to fill this form in order to collect basic information about the age, sex, number of siblings; birth order and family structure of the respondent (see Annex 1).
- Draw A Person (DAP) test: The DAP test can be used to generate a large number of hypotheses relating to a person's self concept, ego ideal, level of adjustment, impulsiveness, anxiety, contact with reality and conflict areas. The children above age six were asked to make a drawing of any person they wanted on an A4 size paper (see Annex 2).
- Strengths and Difficulties Questionnaire (SDQ): This tool was administered with the key informants (parents / supervisors) of the children aged six and above. Given that respondents themselves were not able to fill in the questionnaire, the facilitator asked each question and recorded their responses. This tool was used to assess the symptoms of different behavioural / psychological problems of children after the flood and their impact (see Annex 3).

5. Sample Size

The total sample size was 60 children, 30 girls and 30 boys, for both DAP and SDQ in three districts.

Districts	Draw A Person (DAP)		Strengths and Difficulties Questionnaire (SDQ)	
	Girls	Boys	Girls	Boys
Upper Swat	10	10	10	10
Muzaffargarh	10	10	10	10
Rajanpur	10	10	10	10
Sub Total	**30**	**30**	**30**	**30**
Total	**60**		**60**	

6. Limitations of the Assessment

Starting from the planning phase of the said exercise, the team was well aware of the limitations in terms of its scope and context. For instance, to carry out psychological assessment of all children in the selected districts was beyond the scope and means, whereas the sample comprising of 60 children is far from being representative. Therefore, the assessment findings were meant to provide a deeper understanding of psychosocial impact of the flood, and for ensuring internal validity with respect to the experience of relief workers providing psychosocial support, participatory observation, reflective accounts of CFS supervisors and community members.

Another issue emerged when caregiver / key informants of children were approached either at CFS or at home. When children/families in camps were approached, the assessment team was surrounded by various family/camp members who were keen to share their stories. So it was difficult for team to avoid extraneous variables at the time of administration.

It must be mentioned that the findings of the assessment cannot be generalized for the all the flood affected districts of Pakistan.

7. Discussion and Key Findings

7.1 Overview of Current Scenario – Child Protection Needs and Psychosocial Problems

Prevalence of psychological problems depends greatly on underlying causes. The sudden rise in psychological problems and increase in symptoms of distress are by products of any crisis. It is therefore imperative to correlate findings of the psychological assessment with child protection needs of the assessed population. Save the Children conducted a child protection needs assessment in flood affected areas of districts Swat and Muzaffargarh to learn about the needs of children [3].

Besides psychosocial concerns in the affected children, the following child protection issues were found in varying levels:

- Child labor
- Sexual abuse
- Physical abuse
- Access to basic services
- Lack of play / recreational facilities (only for boys)
- Early marriages (only for girls)
- Privacy and security (only for girls)

In the case of child labor, 57% of the 8-12 years old boys in Swat were involved in labor, while shockingly, 100% of the 12-18 years old boys assessed in Swat were involved in one form of labor in the district. At the same time, 43% of the 8-12 years old boys in Muzaffargarh were involved in labor, while 43% of the 12-18 years old boys assessed in Muzaffargarh were also involved in one form of labor in the district.

In the case of early marriages 57% of the assessed girls between the ages of 12-18 years reported cases of early marriages in Swat while 50% of the same age groups in Muzaffargarh also reported early marriage cases. Shockingly, 57% of the 8-12 years old girls in Muzaffargarh also reported instances of early marriages.

With regards to access to basic services, the following results were found:

Food: Although there were reports of food distributions taking place, the majority of respondents mentioned that the food received was insufficient and they did not possess access to fresh fruit and vegetables.
Water: Lack of access to safe drinking water was found in both districts. In Muzaffargarh, children are walking long distances to collect water while access to toilets and hand washing facilities is severely limited.
Clothing: Children's appearance in both districts is extremely poor. They do not possess new clothes and the clothes they were dressed in are filthy and torn. Children, particularly in Swat, expressed the need for winter clothing and were extremely worried about the onset of the winter season.
Shelter: In the worst affected areas, houses have been completed destroyed. Families reported sleeping in the open air or living in tents. Respondents in both districts mentioned that

[3] Save the Children – Post Floods Child Protection Needs Assessment Report, Districts Muzaffargarh & Swat, Pakistan, October 2010

families were sharing shelters, which has led to overcrowding and a lack of privacy for women and girls.
Health Care: Lack of health services was a major issue. The assessment found cases of diarrhea, skin diseases, eye infections, malaria, TB and one suspected case of cholera in children. Lack of services for pregnant women was also a serious concern.
Education: In both districts, the majority of schools have been damaged or completely destroyed. In Swat, some schools are open but are not easily accessible to children due to the damage to roads. Education for girls is even more limited.

In Swat, 22 (43%) 8-12 years old boys had limited to no access to services listed above, while 17 (38%) boys between the ages of 12-18 years also problems accessing necessary services. At the same time, 24 (50%) girls of 8-12 years had problems of accessing needed services while 21 (43%) girls between the ages of 12-18 years had limited to no access to services.

In Muzaffargarh, 31 (57%) 8-12 years old boys had limited to no access to services listed above, while 28 (57%) boys between the ages of 12-18 years also problems accessing necessary services. At the same time, 17 (57%) girls of 8-12 years had problems of accessing needed services while 25 (50%) girls between the ages of 12-18 years had limited to no access to services.

(*For further reading please refer to Save the Children – Post Floods Child Protection Needs Assessment Report, Districts Muzaffargarh & Swat, Pakistan, October 2010*)

7.2 The Strengths and Difficulties Questionnaire (SDQ)

The results of 'Strengths and Difficulties Questionnaire' indicated the following percentage of psychological problems on 5 different clinical scales. The file scales which are scored in SDQ are:

1. Emotional Symptoms Scale,
2. Conduct Problems Scale,
3. Hyperactivity / lack of attention Scale,
4. Peer problems Scale, and
5. Prosocial Scale.

Three point rating scale has been used in SDQ to score the level of functionality in children, namely: Not true, Somewhat True and Certainly True. In SDQ, the 'Somewhat True' is always scored as 1, but 'Not True' and 'Certainly True' varies between 0 and 2 scores (see Annex 3).

The tables and graphs below depict details of responses on different SDQ scales:

SDQ Scales	Normal	Borderline	Abnormal
Emotional Symptoms	15 (25%)	28 (47%)	17 (28 %)
Conduct Problems	22 (37%)	30 (50%)	8 (13%)
Hyperactivity/ Concentration	18 (30%)	35 (60%)	7 (12%)
Peer Problems	22 (37%)	34 (57%)	4 (7%)
Prosocial Behaviour	12 (20%)	37 (62%)	11 (18%)
Total Difficulty	18 (30%)	33 (55%)	9 (15 %)

7.2.1 Graphical Representation of Psychological Problems –SDQ

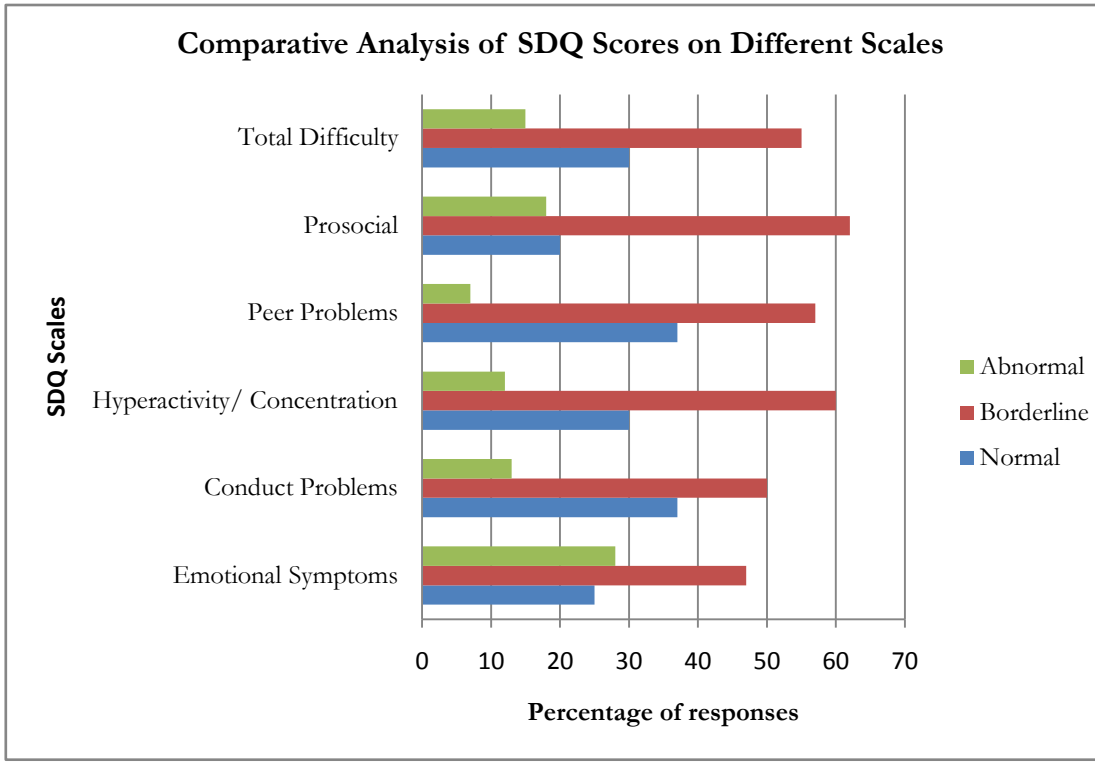


Table 1: Percentage of different psychological problems based on the SDQ

A "total difficulties score" was calculated based on the scoring of the subscales of SDQ. This helps in measuring the average ratio of the problems and symptoms at five subscales at normal, borderline and difficulty level. It also helps in drawing a picture about the adverse effects on children's personal level of functioning, interaction patterns and interfering of symptoms with friendship, family life and leisure activities. It is indicated by the analysis of all subscales that 9 (15%) children are found in abnormal band, meaning those whose social and personal life have been badly affected because of their behavioural and psychological problems. 33 (55%) fall in the category of borderline, meaning the moderately affected and 18 (30%) children are normal, meaning their behavioural problems do not interfere with their personal and social life (see Figure 1)

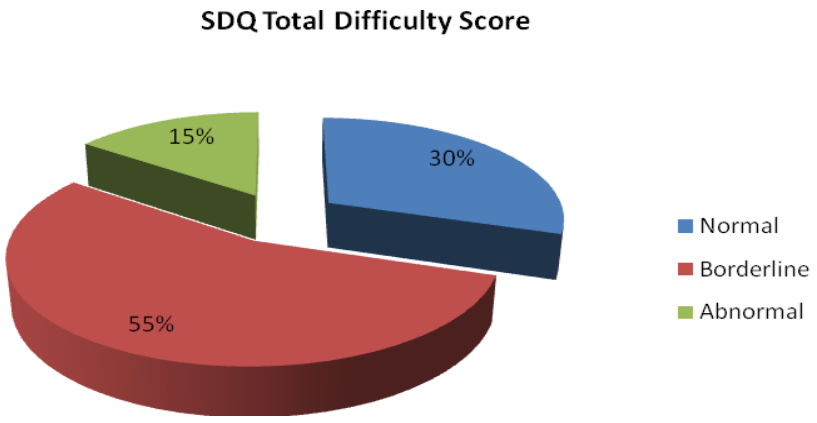


Figure 1: SDQ Total Difficulty Score

7.2.2 Responses of Children on SDQ (Normal, Borderline and Abnormal)

i. SDQ Scores – Abnormal

The data showed that emotional symptoms scale was found in 17 (28%) children in the abnormal band, which is quite significant since emotional symptoms of SDQ include somatic complaints, worries, tearful feelings, nervousness as well as fear and insecurities. Moreover, signs and symptoms of prosocial behaviour were recorded in 11 (18%) of the respondents in the abnormality level, which is characterized as lack of empathy, not sharing their feelings and possessions with others, lack of supportive attitude and isolation (see Figure 2). Abnormality level indicates the comparatively high frequency of maladaptive behaviour in children and this affects their everyday living, however, if they do not receive psychological assistance or psychosocial support at acute stage of problem, they are at risk of psychological disorders such as anxiety, depression or Post Traumatic Stress Disorders (PTSD).

It is important to mention that abnormality level of SDQ does not confirm the diagnosis or presence of psychological disorder; it only gives an idea of severity of behavioural problems of the respondents.

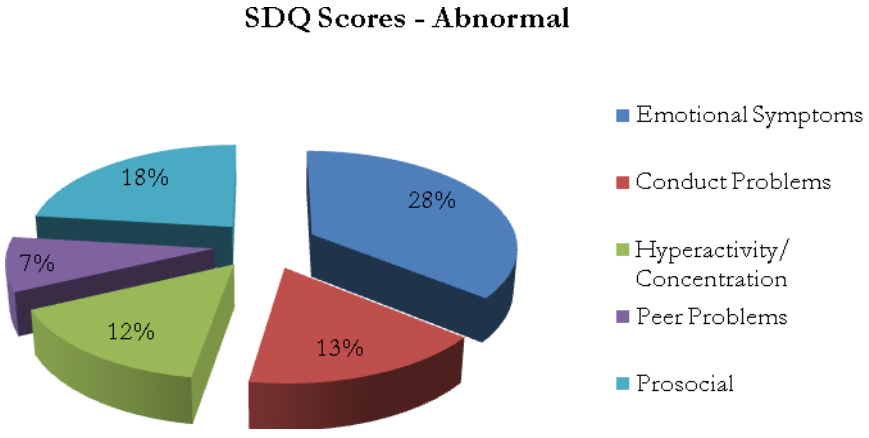


Figure 2: SDQ Score – Abnormal

ii. SDQ Scores – Borderline

Scores at borderline level show significant presence of psychological and behavioral symptoms of children. 35 (60%) children were reported with hyperactivity/concentration problems, 37 (62%) were found with prosocial issues while 34 (57%) had peer problems (see Figure 3). Major behavioral problems of children at hyperactivity scale are restlessness, overactivity, thinking too much before acting and fidgeting while the prosocial scale is characterized by lack of empathetic attitude, rude and agressiveness to youngsters, isolation and lack of altruistic behavior. In peer problems, children who remain solitary, prefer to play alone, having issues of interaction with other children such as bullying are identified.

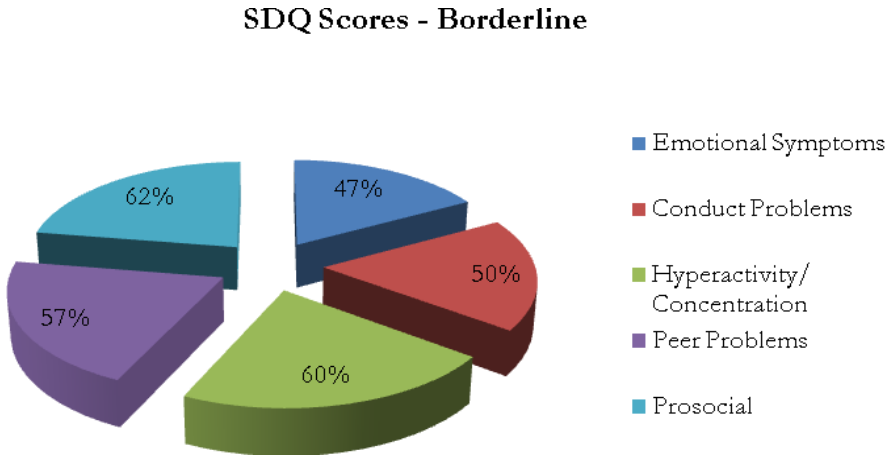


Figure 3: SDQ Scores – Borderline

iii. SDQ Scores – Normal

During the process of administration of SDQ and gathering information from key informants, it was observed that children who had received immediate support from humanitarian agencies, local NGOs or the government and had access to basic facilities and were able to cope with the challenges of post floods situation were in far better condition than those who did not. Moreover, in few areas of Upper Swat the pre-floods functioning Child Friendly Spaces (CFSs) and their trained facilitators contributed greatly in bringing children back to normalcy. Life skills training to children in areas of Upper Swat played a major role in managing behavioural problems and resulted in healthy social interaction with peers at the CFS.

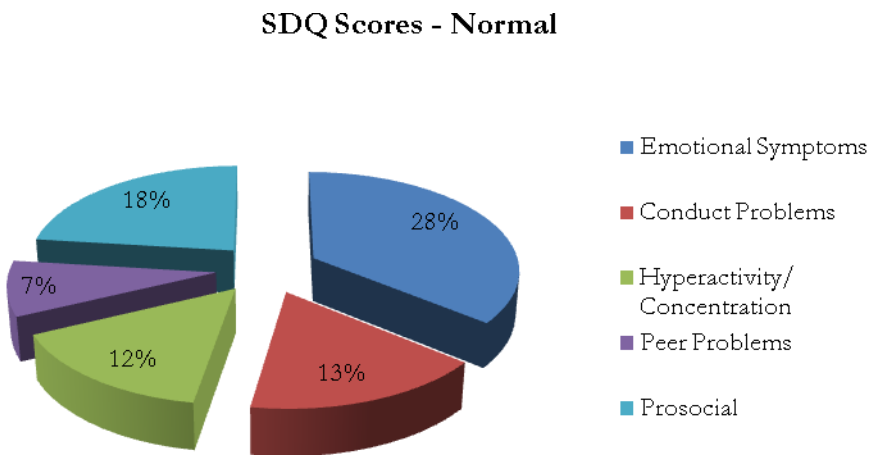


Figure 4: SDQ Scores – Normal

The descriptive analysis of SDQ also revealed that children of affected areas with high damages had significant behavioural or emotional difficulties affecting their functioning, family life, friendship, learning and leisure activities. The degree of direct exposure to the flood experience appears as a major contributor to the severity of symptoms, manifestation of anxiety, and depression. The results of SDQ raise some concerns about the high frequency of behavioural problems among children. The psychological assessment further demonstrated that children who are residing in camps or in open air without any support and aid are still exhibiting the signs of symptoms of prosocial behaviour, emotional symptoms like crying spells, recurrent nightmares, sadness, a sense of helplessness and hopelessness and adjustment issues with peers. Frequency of all the problems was quite high in children from different flood affected areas of KPK and Punjab.

7.3 Analysis from 'Draw A Person' (DAP)

The most frequent problems in children aged 5 -15 years of age were revealed by the projective analysis technique called 'Draw A Person' (DAP).

It is important to share that these findings reflect what kind of problems are most common in children, however, in order to draw a final conclusion there is a need to administer a complete test battery (e.g., intelligence, psycho-neurological test, achievement test, personality tests including projective and non-projective techniques)

The child is provided a comfortable location to draw and move around freely on a blank sheet of paper. While administering the DAP, minimal instructions are given for drawing a person, such as, "*draw a whole person of any type you want, making sure it's a whole person and not a cartoonish figure.*" Younger children can be told, *"Draw a man or woman or a boy or girl, whichever you want to draw."* There is no time limit to complete the task. Observations are made by the researcher to learn how the child copes with the overall task – level of confidence, hesitancy, anxiety, avoidance, impulsiveness and repeated erasures – together with comments made by the child during the task.

Analysis of DAP indicates behavioral or psychological problems but does not confirm the presence of any specific psychological problem. In the present DAP analysis, the respondents birth order[4], age consideration, background of past and current situations, and the description of the drawing itself, meaning who the person drawn is, what he/she is doing (female/male), why has the subject drawn the particular person and other related probing questions are asked in accordance with the answers of the subject. The DAP interpretations and psychological problems are studied along with the findings of Strengths and Difficulties Questionnaire (SDQ), subjective statements, observation and case studies, which helped in drawing a hypothetical picture of a child's personality.
Most common psychological problems identified in the DAP test are mentioned in the following table:

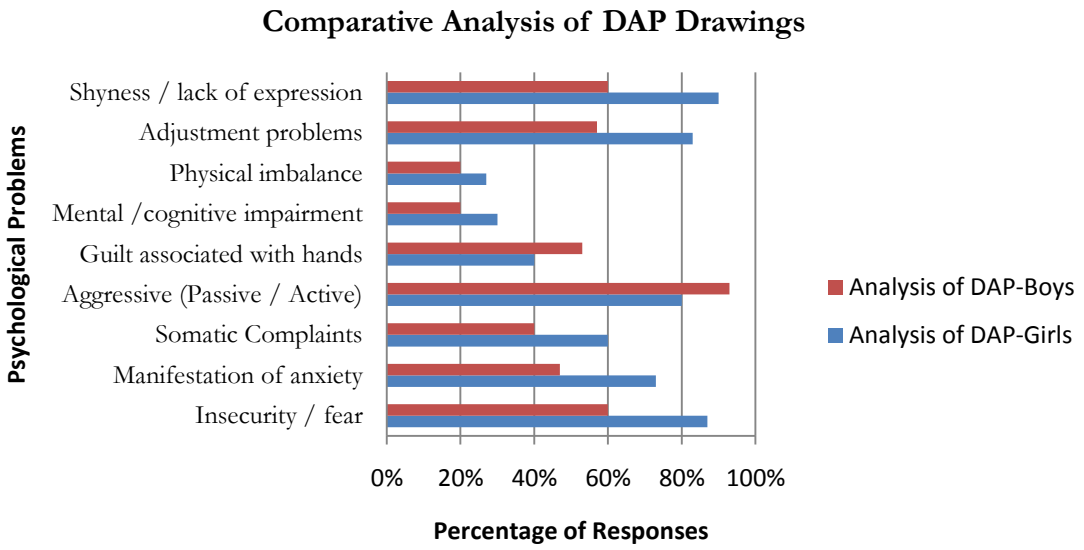
S#	Problem Identified	Girls	Boys	Total
1.	Insecurity / fear	26 (87%)	18 (60%)	44 (73%)
2.	Manifestation of anxiety	22 (73%)	14 (47%)	36 (60%)
3.	Somatic Complaints	18 (60%)	12 (40%)	30 (50%)
4.	Aggressive (Passive / Active)	24 (80%)	28 (93%)	52 (87%)
5.	Guilt associated with hands	12 (40%)	16 (53%)	28 (47%)
6.	Mental /cognitive impairment	9 (30%)	6 (20%)	15 (25%)
7.	Physical imbalance	8 (27%)	6 (20%)	14 (23%)
8.	Adjustment problems	25 (83%)	17 (57%)	42 (70%)
9.	Shyness / lack of expression	27 (90%)	18 (60%)	45 (75%)

Table 2: Common psychological problems in boys and girls (Analysis of DAP)

[4] The number at which the child is in his siblings – whether he/she is the eldest child or second or third in his family

DAP analysis found insecurities / fear in 26 (87%) girls while shyness / lack of expression was found in 27 (90%) of the girls. Similarly 25 (83%) girls are facing more difficulties in adjusting to the current crisis situation, which results in the manifestation of anxiety. Meanwhile, the common problems of boys are associated with expression of aggression found in 28 (93%) which is symptomatic of behavioural problems while 18 (60%) are suffering from insecurities and fear and 18 (60%) are also experiencing lack of expression.

7.3.1 Psychological Problems – A Comparative Analysis of DAP



Four major psychological issues/problems experienced by children (both girls and boys) during and after flood are: aggression which has been reported in 52 (87%) children, shyness and lack of expression in 45 (75%), adjustment problems to the current situation in 42 (70%) and feelings of insecurities and fear of water, people, open places, and darkness in 44 (73%).

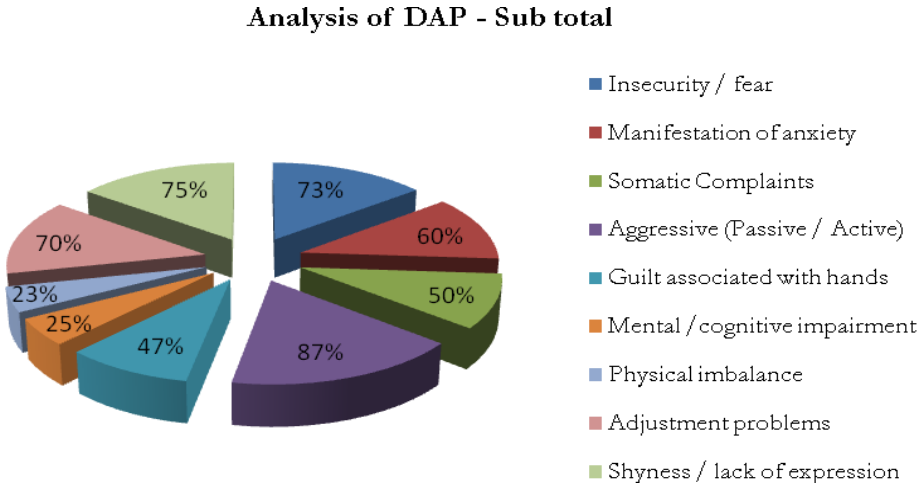


Figure 5: DAP findings

Another contributing factor, which affected children's reactions to floods, was the mental and physical health conditions of the parents. Children's needs are highly compromised when their parents are suffering from a highly distressed state. It was also noted that most of the parents are unable to deal with their children's feelings and insecurities properly after the floods and due to this children are suffering from behavioral and psychological problems and other related symptoms of anxiety, depression and phobias. The suffering from reactions to traumatic situations varied in accordance with the age level, security, previous understanding of how the world works, birth order, personality type, primary and secondary needs, family structure and attachment with other family members.

7.4 Psychological Effects of Flood on Children

Children's distress after the flood is primarily due to the cumulative effect of multiple external factors and stimuli which cause stress, known as *stressors*. The subsequent secondary effects of mass destruction, displacement and abrupt collapse of community life also contribute in increasing stress in affected children. Through the use of participatory observation at CFS, home visits and informal interviews with children, CFS supervisors and community members, the following multiple stressors were found in children suffering from distress:

a) **Psycho-physiological Stressors:** including strange and terrifying growling noises of water, sights of buildings collapsing, the odour of water, and pain due to injuries.

> "I can't sleep at night, the horrible sounds of water and tides scare of water. Whenever I touch water it seems like it will become a water ghost!"
>
> - *10 years old boy at a Child Friendly Space in Upper swat*

b) Information Stressors: is the haunting of not knowing enough and fearing the unknown, such questions as, "What is going on?", "How can I escape?" and the announcements made by the district administrations for escaping from the floods. The panic and confusion of adults had left most of the children's important questions unanswered.

> "We were so confused about what to do and where to go, there was no shelter to live in, no food to eat, everyone was saying just leave your houses and save your lives, but no one was saying where should I go and live if I will leave my home. Now we are living in a camp. I do not like this – I miss my room and my books. I don't want to live here but we have no other choice."
>
> - *Girls at a CFS in displaced peoples camp in Muzaffargarh*

c) Emotional Stressors: Including threats of death and damage; the fear for one's self and for parents; frustration due to witnessing helpless adults and lack of support, affection and

> "Boys are better than girls as they can move outside and roam around, whereas girls stay at home and have to suffer every moment of pain and stress. We are directly affected by the problems facing communities and the pressures of adults and parents are continuously influencing us."
>
> - *Girls at a CFS in Muzaffargarh*

nurturance from parents and caregivers.

d) Social Stressors: including the sudden realization that one has no home, and no school, play area, friends and other people for support. Even after three weeks of the floods, the assessment found children are still experiencing recurrent, intrusive flood-related recollections of stagnant water, smells, sounds, dreams and persistent thoughts of destruction. Young children continue to experience a strong fear of water, rains, and open places since they go to toilet at night in the camps as well as fear of darkness and strangers. It was reported by parents and supervisors that children are still experiencing crying spells, numbness, clingingness (physical attachment) and recurrent nightmares. They also express lacking any support and feelings of helplessness, sadness and hopelessness. They continued to exhibit aggressive behaviour, withdrawal, a decrease in social interaction, anxiety reactions to floods and numerous other somatic complaints.

> "Children prefer staying at CFS, and it is still very difficult to send them back in the evening. The rubble of damaged homes depresses them and whenever they are hopeless whenever they talk about their future. They think that rebuilding of their homes is impossible because they do not have any resources."
>
> - *Female CFS Supervisor in Rajanpur*

8. Recommendations

Based on the findings of the assessment, certain recommendations have been made keeping in mind the current situation, feedback and concerns of communities, parents, Child Friendly Spaces (CFSs) supervisors and children.

> *Opening of CFS in relief phase is "the restoration of life" for children of flood affected areas. According to them, this initiative of NGOs had enhanced a sense of direction for parents, in the camps or outside, about where their child should be. It is much better to send children to Child Friendly Spaces rather than hunting down trucks loaded with food and shelter aid. Such programmes should be taken to every camp of IDPs and to host communities in order to ensure access to safe environment to larger number of children.*
>
> - *Parents at a village in Upper Swat*

- CFS facilitator deals with a diverse group of children in terms of chronological age, experience, and aptitude, which should be focused for achievement of desired outcomes of CFS instead of building school like environment. They need to be trained on CFS and concepts and psychosocial support to deal with challenging behaviours of children.

- CFS for children should be equipped with learning corners, and different types of play/ games which promote life skills in children and provide psychosocial support to them. The CFS facilitators should be trained to facilitate children in using these resources and helping them socialize with their peers.

- Facilitators should focus on the physical and social environment of each child both in the CFS and at home. Childcare practices should be promoted by families and supervisors. The environment should be favourable to ensure the development of success and enhance the potentials of children. It is important to plan activities and incentives according to the needs and interests of the child and help children achieve a sense of success and confidence by positive reinforcement and appreciation.

- CFS facilitators should have time to reflect on their own work and also share personal concerns and issues. This can be achieved through group discussions with colleagues or by organizing various trainings for them. Facilitators neither have to act as superhuman beings without real emotions nor have the frustrations of their personal life to be taken out on children in CFS.

- The good principles of CFS include positive psychological and emotional support. It is important, through individual and group discussions, to identify harmful practices for children's psychosocial wellbeing. Such practices need to be used as reference point not only at the personal level but also for evaluation of facilitators conduct and attitude.

- Parental counseling can play a vital role. Mother's awareness sessions should be conducted regarding psychosocial issues, psychological reactions/behaviors of children suffering from psychological problems, stress and others. It is important to inform parents that they should not punish children or mishandle their demanding behavior but rather make them feel safe and secure. Group counselling sessions should also be arranged for adolescents and parents according to age groups and gender so that more sharing and catharsis could take place after the crisis.

- Encourage children to talk about their problems due to the crisis and to provide an opportunity to express about their experiences in a safe and accepting environment. Number of expressive techniques such as role playing, storytelling, making of activity charts and play and art techniques can be used to further listen to their feelings. These activities help children build support networks, social competence, and positive self-identity.

- Group activities that require cooperation and dependence on one another should be planned for children with a particular perspective on their problems and current scenario. Setting up the routines and assigning responsibilities to children by keeping in view their personality types and aptitude. If done in an appropriate manner, it will help in reshaping the child's personality in a positively. Healthy change in behavior can be strengthened by acknowledging and affirming children's expressions through reinforcement and regular feedback.

- Facilitators must focus on the child's social interaction patterns and try to link up the child with peers and adults. They should create activities and situations for child behavior modification that provide opportunities for social interaction, organize events and activities that integrate and unite not only children but also form a strong bond with adults as well. It is important to know that facilitators should not force children to do anything they do not want to, they must eliminate obvious causes of irritable behaviors in children, avoid situations which are known to produce conflict and facilitate a friendly, interactive, and creative environment in the CFS.

- Through interesting and well planned activities, children must be allowed to practice different life skills that can help sustain good behaviors applicable throughout life. The objective of life skills learning should be holistic development of children to enable them in creative thinking, understanding them and managing appropriate attitudes, behaviors and values, to be able to develop relationships and to interact successfully with peers and

adults. They will also have confidence to participate and contribute in CFS and the wider community.

- Developing water corners in CFS to reduce fear of water from children's mind. The CFS facilitators can expose children to water through involving children in water games. To develop water corners, a safely constructed water pond with small objects such as stones and boats can be made for children to reduce their fear of water. Through these games children will learn to express their fears and other feelings about the floods.

9. Annexes

Annex 1: Description of Psychological Assessment Techniques Used

Instruments:
Various instruments were used to collect data in the assessment. A demographic form (below) was designed to collect basic information about the age, sex, number of siblings, birth order and family structure of the respondents. For psychological evaluation, projective technique called Draw-A-Person (DAP) was used while the Strengths and Difficulties Questionnaire (SDQ) was used as a non-projective tool.

Furthermore, the respondents were asked about their perceived level of threat to life during and immediately after the floods, the type and amount of losses they experienced, their current state of psychological wellbeing, psychological support, and their level of fear of flood through the DAP technique and the SDQ. Behavioral and psychological issues, losses from injury to oneself; damage to one's house and other property losses were also assessed. The difficulty level and occurrence of major symptoms and psychological problems were evaluated at different scales through the SDQ.

Save the Children

Demographic Form

Date: _____

Name (optional): _____

Age: _____ Grade/Class: _____

Birth Order: _____ No. of Siblings: Female/ Male: _____

School Name: _____

Family Structure (Nuclear/Joint): _____

Parent's Status: Dead/Alive/Single parent: _____

Current place of living (tent): _____ (home): _____

Tick 'X' on the Test Administered:

Test Administered: DAP ( )

Strengths and Difficulties Questionnaire ( )

Annex 2: Draw-A-Person (DAP)

Projective Techniques:
DAP is a projective technique, which aims to reveal a person's frame of reference or personality. The frame of reference is made up of personal and subjective perceptions of the world. "The projective hypothesis is that an individual will project onto a vague stimulus his or her conflicts, feeling and needs"[5]. Projective techniques, which are inherently inferential, are used in conjunction with objective assessment tools as they could be "controversial and lack psychometric soundness"[6] and are thus not a primary measure for making decisions about the person. Projective techniques are widely used and offer the skilled therapist or researcher valuable insights into intra-psychic and emotional functioning of a person.

Drawings:
The use of children's drawings as a diagnostic instrument has a long history. Previous to this, drawings were mostly used to specify the cognitive development of children[7]. In 1949, Machover's Draw-A-Person (DAP) was the first to extend the focus of drawing techniques into personality interpretation[8]. Koppitz extended this use further by creating objective scoring system for development and emotional indicators. [9]

The use of drawings in an assessment method that is used to reveal information about the subject's inner world, individual feelings and personality structures, in a manner, which may not be possible through direct communication[10]. Although forms of assessment with higher level of reliability and validity may be preferable, there are clinical situations where it is useful to analyze the DAP by specific indicators to obtain a rough index of the child's adjustment[11]. Drawings too are said to be particularly useful to assess the emotions of children. They are also useful when there is language incompatibility or the evaluation of sensitive areas of physical/sexual abuse or trauma is concerned. Thus in terms of this research, drawing assessment are appropriate and provide insight to emotional functioning.

Draw-A-Person (DAP):
Koppitz proposed a method of analyzing the Draw-A-Person (DAP) using specific signs and terms as emotional indicators. A rough index of psychological adjustment may be obtained by analyzing the DAP using either emotional indicators or global measures, that is, overall impression such as the quality or bizarreness of the drawing. The DAP technique can be used to generate a large number of hypotheses relating to a person's self concept, ego ideal, level of adjustment, impulsiveness, anxiety, contact with reality and conflict areas.

DAP is conducted by seating a child comfortably at an uncluttered table or desk with enough room to move freely. The child is provided with a blank sheet of paper size 8 ½ x 11" or an A4 paper with 2 pencils and an eraser. The instruction given to the child is "*draw a*

[5] Wodrich, D.L., & Kush, S.A. *Children's Psychological Testing: A Guide for Nonpsychologists*. 2nd ed. Baltimore, MD: Paul H. Brookes. 1990.
[6] Ibid
[7] Goodenough, F.L. & Harris, D.B. *Measurement of intelligence by drawings,* New York: Harcourt, Brace and world, Inc. 1926.
[8] Machover, K. *Personality projection in the drawing of the human figure,* Springfield III: Charles C Thomas. 1949.
[9] Waskow IE, Parloff MB. *Psychotherapy Changes Measures*, Washington, DC: US. 1975.
[10] Ibid
[11] Yama (1990) in Hilson, M.J., Segal, D.L. & Hersen, M. *Comprehensive Handbook of Psychological Assessment,* John Wiley & sons, Inc. 2004

whole person of any type you want, making sure it's a whole person and not a cartoonish figure." For younger children who may not understand the meaning of "person" instructions can be: *"Draw a man or woman or a boy or girl, whichever you want to draw."* Instructions should be kept to a minimum. The manner in which children are able to contain the ambiguity is also relevant – do they ask for further guidance or can they work with minimal instructions given?[12]

There is no time limit for completing the task. Observations are made by the therapist or researcher to learn how the child copes with the overall task – level of confidence, hesitancy, anxiety, avoidance, impulsiveness and repeated erasures – together with comments made by the child during the task.

Interpretive Considerations of DAP[13]*:*
Koppitz summarized some of the items that are expected in approximately 86% to 100% of the drawings in children of the ages 5 to 12. Boys and girls mature at different rates and certain differences can be found in their drawings. For example, five year old boys usually include six basic items on their drawings: head, eyes, nose, mouth, body and legs while five year old girls can be expected to draw at least seven items: head, eyes, nose, mouth, body, legs and arms. The omission of any of these parts must be considered clinically significant.

Six year-old boys can be expected to draw arms as well as head, eyes, nose, mouth, body and legs while six year old girls include head, eyes, nose, mouth, body, legs, arms, feet and hair. Seven year old boys differ from six year olds in that they usually include two dimensions on arms while girls draw two dimension arms and legs as well. Eight and nine year old boys reveal the same ten expected items on their drawings: head, eyes, nose, mouth, body, legs, arms, feet, and two dimensions on arms and legs, while girls can be expected to draw 12 items: head, eyes, nose, mouth, body, arms, legs, feet, hair, two dimensions on arms and legs, and neck.

Ten year old girls can be expected to draw a head, eyes, nose, mouth, body, arms, legs, hair, feet, two dimensions on arms and legs, neck and arms pointing down. Eleven years old girls do not differ much from ten years old girls on their Human Figure Drawing (HFDs), and 12 and above are different in making arms at shoulder, knee is exceptional on HFDs of this age group.[14]

The interpretive procedures involve the following four steps[15]:

1) *Using Objective Measures*: A qualitative rating system consistent with research findings is advocated to increase the validity.
2) *Overall Impression*: This is largely an intuitive process. There is evidence that such a global, impressionistic approach is more effective than quantitative systems in differentiating children with mood disorders from normal controls.

[12] Ibid
[13] Koppitz, E. M. *Children's Human Figure Drawings*. New York, USA: Grune & Stration, Inc. 1968.
[14] Ibid
[15] Waskow IE, Parloff MB. *Psychotherapy Changes Measures,* Washington, DC: US. 1975.

3) *Consideration of Specific Details*: Once a global consideration has been made, therapists or researchers can make a rational analysis of different details in the drawing. This might include the meaning associated with unusual aspects of features, such as size of the drawing, detailing, line quality, or breast emphasis. However, this detailed analysis should be made cautiously since very few individual signs have received clear empirical support.
4) *Integration*: This implies the integration of the hypothesis about the drawing as a whole. It also implies integration of hypothesis regarding this drawing with other instruments of assessment or test results to gain verification of particular hypotheses through repeated findings on a variety of instruments. The final phase is one reality testing which is intended to increase the incremental validity of assessment data.

Annex 3: Strengths and Difficulties Questionnaire (SDQ)[16]

The strength and difficulties questionnaire (SDQ) is a structured instrument (below) that is used for screening the child and adolescent psychological problems and contains 25 questions that consist of 5 subscales including the emotional symptoms scale, hyperactivity scale, peer problem /relationship scale, conduct problem scale and pro-social behaviours scale with further 5 items in each. All 5 subscales scored before working on the total difficulty score. The questionnaire has 3 forms: parent-report, teacher-report and self-report. The parent / teacher report form was used in the present study.

Impact supplement of SDQ
The SDQ used in the assessment is a two-sided version with 25 items on strengths and difficulties on the front page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, inquires further about chronicity, distress, social impairment and burden to others. This provides useful additional information for therapists or researchers with an interest in psychological cases and determinants of service use (Goodman, 2001)[17].

SDQ interpreting symptoms scores
For interpretation convenience, the scores of SDQ are categorized as normal, abnormal and abnormal. Using these categories only gives a rough and ready method for detecting disorders – combining information from SDQ symptoms and impact scores from multiple informants is better, but still far from perfect[18]. 'Normal' scale indicates that the symptoms neither interfere with routine life nor do they affect daily functioning. 'Borderline' indicates slightly raised behavioral or psychological problems, however, these are not disorders and unlikely to be clinically significant. 'Abnormal' means high substantial risk of clinically significant problems and if unaddressed, they can causes serious psychological issues.

[16] Goodman, R. (2001), Psychometric properties of the Strengths and Difficulties Questionnaire (SDQ). Journal of the American Academy of Child and Adolescent Psychiatry, 40, 1337-1345. (This article includes up-to-date psychometric information on this scale.)
[17] Goodman R (1997) "The Strengths and Difficulties Questionnaire: A Research Note." *Journal of Child Psychology and Psychiatry*

Strengths and Difficulties Questionnaire

The 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. Somewhat True is always scored as 1, but the scoring of Not True and Certainly True varies with the item, as shown below scale by scale. For each of the 5 scales the score can range from 0 – 10 if all 5 items were completed. Scale score can prorated if, at least 3 items were completed.

Name of Child **Age** **Gender**

Emotional Symptoms Scale	**Not True**	**Somewhat True**	**Certainly True**
Often complains of headaches, stomach aches	0	1	2
Many worries, often seems worried	0	1	2
Often unhappy, downhearted or tearful	0	1	2
Nervous or clingy in new situations	0	1	2
Many fears, easily scared	0	1	2

Conduct Problem Scales	**Not True**	**Somewhat True**	**Certainly True**
Often has temper, tantrums or hot tempers	0	1	2
Generally obedient, usually does what adults request	2	1	0
Often fights with other children or bullies them	0	1	2
Often lies	0	1	2
Steals from home or school or elsewhere	0	1	2

Hyperactivity/Inattention Scales	**Not True**	**Somewhat True**	**Certainly True**
Restless, overactive, cannot stay still for long	0	1	2
Constantly fidgeting or squirming	0	1	2
Easily distracted, concentration wanders	0	1	2
Thinks things out before acting	2	1	0
Good attention span sees tasks through to the end	2	1	0

Peer Problems Scale	**Not True**	**Somewhat True**	**Certainly True**
Rather solitary, prefers to play alone	0	1	2
Has at least one good friend	2	1	0
Generally liked by other children	2	1	0
Picked on or bullied by other children	0	1	2
Gets along better with adults than other children	0	1	2

Pro-social Scale	**Not True**	**Somewhat True**	**Certainly True**
Considerate of other people's feelings	0	1	2
Shares readily with other children for example toys, food	0	1	2
Helpful is someone is hurt, upset or feeling ill	0	1	2
Kind to younger children	0	1	2
Often volunteers to help others (Parents, teachers, other children)	0	1	2

Impact Supplement
Do the difficulties upset or distress your child?
Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	**Only a little**	**Quite a lot**	**A great deal**
Home life	☐	☐	☐	☐
Friendships	☐	☐	☐	☐
Classroom Learning	☐	☐	☐	☐
Leisure Activities	☐	☐	☐	☐
Do these difficulties put a burden on you or the family as a whole?	☐	☐	☐	☐

Annex 4: Strengths and Difficulties Questionnaire (SDQ) – Urdu

(Strengths and Difficulties Questionnaire) مضبوطیوں اور مشکلات کا سوالنامہ

(URDU)

ہر شق کیلئے، براہ کرم دیکھ لیں کہ بات درست ہے یا بالکل درست ہے یا بالکل درست ہے کے خانے میں نشان لگائیں۔ اس سے ہمیں مدد ملے گی اگر آپ تمام شقوں کا جواب بھی ممکن طریقے سے جواب دے سکیں دیں چاہے آپ کو بالکل پکا یقین بھی نہ ہو یا شق آپ کو احمقانہ نظر آئے! براہ کرم جوابات پچھلے چھ مہینوں کے دوران اپنے بچے کے رویہ کی بنیاد پر دیں۔

آپ کے بچے کا نام : ---------- لڑکا / لڑکی

تاریخ پیدائش : ----------

	بالکل درست نہیں ہے	کچھ درست ہے	بالکل درست ہے
دوسرے لوگوں کے احساسات کا خیال رکھنے والا	☐	☐	☐
بے آرام، ضرورت سے زیادہ بھرتیلا، ایک جگہ پر زیادہ دیر کیلئے نہیں ٹھہر سکتا	☐	☐	☐
اکثر سر درد، پیٹ میں درد یا متلی یا قے آنے کی شکایت کرتا ہے	☐	☐	☐
دوسرے بچوں کے ساتھ خوشی سے چیزیں بانٹ کر کھیلتا ہے (چیزیں شیئر کرنا، کھلونے، پنسلیں وغیرہ)	☐	☐	☐
اکثر غیظ و غضب والے مزاج یا گرم مزاجی کا مظاہرہ کرتا ہے	☐	☐	☐
قدرے تنہا پسند ہے، اکیلے کھیلنا پسند کرتا ہے	☐	☐	☐
عام طور پر کہنا مانتا ہے، عموماً بالغ افراد جو کرنے کیلئے کہتے ہیں کرتا ہے	☐	☐	☐
بہت سی پریشانیاں ہیں، اکثر پریشان نظر آتا ہے	☐	☐	☐
اگر کسی کو چوٹ لگ جائے، پریشان یا بیمار محسوس کر رہا ہو تو مدد کرتا ہے	☐	☐	☐
مستقل بے قرار یا بل کھاتا ہے	☐	☐	☐
اس کا کم از کم ایک اچھا دوست / سہیلی ہے	☐	☐	☐
اکثر دوسرے بچوں کے ساتھ لڑتا ہے یا دھمکیاں دیتا ہے	☐	☐	☐
اکثر ناخوش، بے دل یا اشکبار ہوتا ہے	☐	☐	☐
عام طور پر اسے دوسرے بچے پسند کرتے ہیں	☐	☐	☐
بآسانی توجہ بھٹک جاتا، مجموعی توجہ بنا لینا بھٹک جاتا ہے	☐	☐	☐
نئے ماحول میں گھبرا جاتا یا بھٹ جاتا ہے، اعتماد بآسانی کھو دیتا ہے	☐	☐	☐
چھوٹے بچوں کے ساتھ رحم دل ہے	☐	☐	☐
اکثر جھوٹ بولتا ہے یا دھوکے بازی کر جاتا ہے	☐	☐	☐
دوسرے بچے اس کو نشانہ بناتے یا دھمکیاں دیتے ہیں	☐	☐	☐
دوسروں کی مدد کرنے کیلئے اکثر اپنی خدمات پیش کرتا ہے (والدین، اساتذہ، دوسرے بچے)	☐	☐	☐
عمل کرنے سے پہلے چیزوں پر غور کرتا ہے	☐	☐	☐
گھر، سکول یا کسی اور جگہ سے چوری کرتا ہے	☐	☐	☐
دوسرے بچوں کے مقابلے میں، بالغ افراد کے ساتھ بہتر دوستی بنا سکتا ہے	☐	☐	☐
بہت سے خوف، بآسانی ڈر جاتا ہے	☐	☐	☐
کام کو ختم کرنے تک نہیں چھوڑتا، توجہ دینے کی مدت اچھی ہے	☐	☐	☐

براہ کرم ورق الٹیں ۔ دوسری طرف تھوڑے سے اور سوالات ہیں

عمومی طور پر، کیا آپ سمجھتے / سمجھتی ہیں کہ آپ کے بچے / بچی کو درج ذیل ایریاز میں سے ایک یا ایک سے زیادہ میں مشکلات کا سامنا ہے: جذبات، ہمہ تن توجہ، رویہ یا دوسرے لوگوں کے ساتھ دوستی وغیرہ کر سکنے میں؟

نہیں	ہاں - معمولی مشکلات ہیں	ہاں - بالکل مشکلات ہیں	ہاں - شدید مشکلات ہیں
☐	☐	☐	☐

اگر آپ نے جواب ہاں دیا ہے، براہ کرم ان مشکلات کے متعلق مندرجہ ذیل سوالات کا جواب دیجئے۔

یہ مشکلات کتنے عرصے سے موجود ہیں؟	ایک مہینے سے کم	1 - 5 مہینے	6 - 11 مہینے	ایک سال یا زیادہ
	☐	☐	☐	☐

* کیا یہ مشکلات آپ کے بچے / بچی کو پریشان یا رنجیدہ کرتی ہیں؟

بالکل نہیں	صرف تھوڑا سا	کافی حد تک	بہت زیادہ
☐	☐	☐	☐

* کیا مشکلات آپ کے بچے / بچی کی روزمرہ زندگی کے مندرجہ ذیل ایریاز میں مداخلت کرتی ہیں؟

	بالکل نہیں	صرف تھوڑا سا	کافی حد تک	بہت زیادہ
گھریلو زندگی	☐	☐	☐	☐
دوستی	☐	☐	☐	☐
کلاس روم میں سیکھنا	☐	☐	☐	☐
لیژر یعنی فرصت کے اوقات کی سرگرمیاں	☐	☐	☐	☐

* کیا مشکلات آپ یا آپ کی فیملی یعنی گھرانے پر مجموعی طور پر کوئی بوجھ ڈالتی ہیں؟

بالکل نہیں	صرف تھوڑا سا	کافی حد تک	بہت زیادہ
☐	☐	☐	☐

دستخط: ---------- تاریخ: ----------

ماں / باپ / دیگر (براہ کرم وضاحت کریں:)

مدد کرنے کیلئے آپ کا بہت شکریہ