During the 1991 Gulf War, following threats by an Iraqi spokesman to “burn out half of the state,” SCUD missiles were launched from Western Iraq and hit densely populated areas in Israel. In response to this threat, homes created sealed rooms and citizens were instructed to carry gas masks and other protective measures with them at all times. Children (some sleeping in their parents’ bedroom) were awakened by sirens at night, hurried to the sealed rooms, and required (sometimes against their will) to put on gas masks. After missile attacks, people were instructed to remain in their sealed rooms for long periods of time, while the nature of the attacks was investigated to determine if there was a danger of chemical or biological agents. Closure of the schools for the first three weeks of the war deprived children of the social support of their peers, the reassurance of their teachers, and the steadying influence of familiar structures and routines at precisely the time when they most needed them. (For extended descriptions of this case see Ben-David & Lavee, 1992; Klingman, 1992a; Solomon, 1995).

A war is a large-scale protracted active crisis, frequently characterized by an acute and continuous sense of urgency, commotion and uncertainty, extreme fluidity, and often also by a sense of forthcoming calamity. Wars are not single events; rather, they can be viewed as complex emergencies that have histories of disparity, power imbalance, or discrimination. Alarming numbers of children and adolescents worldwide are (or have recently been) experiencing wars, civil strife, and large-scale terrorism. The impact of war on young people tends to be studied and discussed in the professional literature in terms of posttraumatic stress disorder (PTSD). However, PTSD is not the only possible psychological consequence of war for youths. A whole spectrum of concurrent psychological symptoms has been indicated, including general anxiety, nervousness, worry, fear of recurrence, guilt, psychosomatic complaints, sleep difficulties, depression, behavioral problems, and grief (Jacobs & Prigerson, 2000; Klingman, 2000a, 2000b; Klingman, in press; Paardekooper, 1999). War may also have indirect
consequences, including economic damage that affects parents' ability to take care of their children. All youths in war zones grow up in an atmosphere of constant fear, violence, and hatred. Some take an active part in fighting—attending violent demonstrations, throwing stones at troops, or enlisting as fighters. Adolescents may be especially keen on active fighting, thinking it will earn them adult respect.

War-related symptomatology is also typical for war refugees and displaced people, sometimes referred to as the “forgotten victims of war.” About half of the world’s refugees and displaced people are children and adolescents. These youths may have experienced many events that cause severe emotional and physical trauma (e.g., destruction of their own homes, violence against individuals and the whole community). They may later be faced with additional adjustment matters, such as unfamiliar surroundings, new sets of norms, isolation from natural support systems, parental vulnerability, new school standards, new languages, and more (Jones & Rutter, 1998).

This chapter aims to draw conclusions from recent war experiences and from the professional literature and to offer some general guidelines for interventions with school populations. I will not enumerate all potential strategies, procedures, and tools because many are similar to interventions used in other kinds of disasters and are discussed elsewhere in this book. Some of those interventions I discuss may still overlap, but I wish to stress their particular relevancy to, and/or unique implementation for, war situations.

Unique Crisis Issues

All crises present problems that challenge the coping resources of its victims. The nature and consequences of war, however, present numerous unique challenges to students and schools.

War Is Constant, Prolonged, and Fluid

Unlike most other disasters, war entails living under constant and prolonged threat exposure; wars can continue for weeks, months, and years. Such long duration is a factor associated with psychological trauma. In addition, because war may present constantly changing conditions, fluidity of circumstances is typical and may require constant adaptation of existing, or development of new, coping strategies.

Anticipatory Period

Frequently, the eruption of war is predictable. Thus, an anticipatory guidance program can be initiated to help youths and schools cope with impending emergencies beforehand. These preparatory activities, however, may in themselves become psychologically traumatic (e.g., details regarding unconventional warfare and learning to wear gas masks) and require crisis intervention assistance.
Unique Stimuli

Wars present exposure to unique stimuli. For example, they may require youths to cope with unprecedented and, thus, unpredictable issues related to chemical and bacteriological war, or to face “conventional” war’s cruel activities and civilian atrocities (e.g., in former Yugoslavia, harming woman and children was even a strategy of war). Such adversity has a cumulative effect. As young people experience these adversities of war they are likely to sense a foreshortened future, because their “assumptive world” has changed (Janoff-Bulman, 1992). Consequently, it is essential to assist students in dealing with their futures as well.

Physical Injury and Disfigurement

Wars may result in the injury (and disfigurement) of many young people. Bronfman, Campis, and Koocher (1998) reviewed the clinical issues involved in traumatic injury. They indicated that children must deal with loss of control, loss of self-image, dependency, stigma, isolation, intense emotionality, and fear of death. Crisis intervenors must help the young person’s psychological processing of the injurious event as a central issue and assist caregivers in managing their own feelings regarding the injury. Youths who have lost significant others through violent war acts, especially if they witnessed the event, may have difficulty mourning. The emotional numbing and avoidance of trauma reminders commonly generated by such events make it difficult to come to terms with a loss.

School Closure

During most wars schools are closed for extended periods, and students are often confined to homes or crowded public shelters. This situation creates emotional and behavioral difficulties that caregivers may not know how to confront. Moreover, consulting with mental health professionals is often impractical due to war circumstances (e.g., curfew or travel limitations). Thus, it is likely that young people most in need are unable to gain access to community-based mental health support. As a result, alternative consultation pathways (e.g., via mass communication channels) need to be considered, established, and offered effectively by mental health caregivers.

Effects on Mental Health Professionals

War has a tremendous impact on everyone. Mental health personnel may even find it hard to dissociate themselves from the war ordeal, because they are exposed to the same continuous war conditions as their clients. Thus, caregivers involved in crisis intervention need long-term debriefing sessions and support systems of their own; “helping the helper” measures are crucial for war-related intervention.
Changes in Working Assumptions

In the face of war-related demands, routine professional roles must be set aside and most working assumptions underlying common school-based psychological interventions do not apply. Basic working assumptions must change because wartime mental health assistance is heavily based on the assumption that most dysfunctional phenomena that manifest themselves during war are not necessarily pathological or irreversible (i.e., that numerous behaviors considered “unhealthy” in nonwartime conditions are “natural” in wartime). It is also believed that the failure to resolve acute stress responses, or the inability to modulate distress at the time, may be critical in determining long-term outcomes (Klingman, 2000b; McFarlane, 2000). Therefore, assistance must be predominantly preventive and focus proactively on fostering healthy adaptation, enhancing situation-specific coping, and promoting stress tolerance, both for individual pupils and the school system.

New Teaching Demands

In wartime, the school’s local context takes on an important psycho-educational dimension. Teaching demands shift in emphasis to address a variety of critical incidents (e.g., grief and mourning) and immediate pupil and situation-specific needs, such as introducing awareness of landmines and unexploded bombs, how diseases are transmitted, and how to maintain healthy lifestyles (e.g., training in relaxation techniques).

Damaged or Destroyed Infrastructure and Schools

During war, basic infrastructure, such as the economy, public health, medicine, education, social, and psychological services, may become restricted, impaired for a prolonged period, or even collapse. When access to community-based mental health services is disrupted, schools may become the only organized place where students can obtain mental health assistance. However, in times of war the school may be damaged or destroyed. In such cases the reopening of schools can be a challenging task. An important role for crisis intervenors may be assisting in reopening schools and resuming school activities, or assisting in creating alternative schooling arrangements. School mental health professionals may be called upon to provide diverse tasks. First of all, it is of paramount importance that schools reorganize to continue or resume some or all of their activity as soon as possible. School mental health professionals have an important role in assisting with the reorganization process or with the establishment of alternative schooling arrangements (e.g., informal study-and-recreation groups or club groups, distance learning through which students can be contacted and approached). This intervention differs radically from common peacetime models of organizational development and consultation. School mental health professionals must provide ongoing assistance to reopened schools. This assistance includes helping schools adapt to new circumstances and considering the war-related immediate mental health needs of pupils, educators, and the administrative staff.
Cultural and Developmental Issues

Children and adolescents should be allowed great latitude in choosing how they cope. Cultural, gender, and developmental differences should be considered as critical intervention dimensions (Hobfoll et al., 1991). Given the cultural differences within and between groups, generalizations must be made cautiously, while recognizing the many common responses and needs. This is true for the choice of both intervention strategies and tools. Substantial literature and accumulated experience now suggest the importance of contextual factors in shaping the experience of and response to war stress and trauma. Thus, the delivery of mental health interventions in non-Western settings must take into account prevailing cultural norms, including spiritual or religious involvement, basic ontological beliefs, and related issues (e.g., personhood and social connectedness, community, and illness). For example, in non-Western communities idioms of distress are likely to be quite different from Western conceptions (for further discussion of these issues, see Brackman & Petty, 1998; Sandoval & Lewis, 2002). This is an important point to mention because mental health professionals from other countries are often called on to assist in war-torn countries via UNICEF (e.g., Berk, 1998). Psychologists and counselors also need to be aware of, and sensitive to, whom in a given culture are acceptable providers of help (Hobfoll et al., 1991).

Children’s cognitive development influences their interpretations of war events. Younger children tend not to be fully aware of the realistic threats, dangers, and potential harm. Thus, they tend to be better protected from emotional reactions and depend on parents and caregivers (e.g., teachers) to feel secure. In addition, younger children do not talk easily about their traumatic experiences; however, they are more likely to give graphic accounts of these experiences. There are many anecdotal accounts of younger children’s drawings and play involving themes about trauma they experience (Yule, 1998). As children get older, they are more able to understand the implications of their situation. They tend to respond even more to the world beyond their families. Adolescence is a time when sociopolitical influences on identity are particularly powerful. Issues of self-identity, group/national loyalty, and ideology become more compelling, as well as thinking about the future. Moreover, political ideology and commitment may buffer adolescents’ experience of war by allowing them to interpret their experiences as a “necessary evil” that must be endured if certain objectives are to be achieved (Garbarino & Kostelny, 1993; Muldoon & Cairns, 1999). Thus they should receive ongoing, updated, age-appropriate information, as well as opportunities to discuss these issues. If many children are connected to the Internet, they may be able to communicate with both adults (teachers, school counselors, and others) and age-mates via e-mail or bulletin boards (where messages are left for all others to read). The parties involved may even be in various parts of the world (Robson & Robson, 1998).
Crisis Intervention

Preventive Crisis Intervention Principles

Exposure to war may result in immediate or long-term impairment of mental health, or both. Prevention efforts are designed to keep pupils from developing long-term mental impairment by finding ways to reduce risk factors (Klingman, 2000b; Klingman, in press; Neria & Solomon, 1999). Preventive intervention can be divided into three categories: universal, selective, and indicated (Marzek & Haggerty, 1994). Universal preventive interventions are proactive measures developed for whole school populations that have not been identified on the basis of individual risk. These interventions include preparatory or anticipatory guidance and stress inoculation programs (Durlak, 1998). Selective interventions may be targeted to the whole school population or subgroups when the risk for developing posttraumatic symptomatology becomes imminent. In practice, mass screening for individual symptoms and behaviors that may predict PTSD are included in this category. Indicated preventive interventions are targeted toward individuals who are identified (preferably by school-based counseling groups) as manifesting early, minimal but detectable, symptoms foreshadowing PTSD. The aim is to prevent onset of a disorder by a decrease in situation-specific risk factors and an increase in protective factors.

Those working in prevention often emphasize the utility of a risk and protective paradigm (Durlak, 1998), within which protective factors fall in three broad domains. The first domain includes characteristics of the child (e.g., cognitive skills, coping skills, and personal sense of competency and control). The second area includes a strong positive relationship with at least one parent and the quality of the child’s interactions with their environment (young people, especially adolescents can also support each other in wartime). The third domain involves aspects of the mesosystem and exosystem, such as school-home relations, social support network, and regulatory activities.

A preventive approach also emphasizes the salutogenic rather than the pathogenic response to stress and crisis. The salutogenic orientation (Antonovsky, 1979, 1980) focuses on those who are located toward the positive end of the health-ease/dis-ease continuum (i.e., remain psychologically well despite extreme adversities). Experience strongly suggests that some positive changes may emerge during times of war. War may become a great integrator (Breznitz, 1983), increasing social cohesion among pupils and among the teaching staff. Under stress they support each other more than during other times; traditional barriers between student groups break down. Moreover, war often brings out a strength and energy unlike anything seen at other times; older students may show extraordinarily successful and sometimes very courageous behaviors. There is also more readiness on the part of educators to consult with school mental health professionals about their own welfare, as well as about their students’ difficulties. These behaviors are consistent with the recent stress literature calling attention to the resiliency phenomenon (e.g., Garmezy, 1985; Higgins, 1994).
The continuity principle serves as a generic guideline for preventive intervention in wartime. It stipulates that war can cause extreme disruption in the life course that may shatter basic schemata such as beliefs in one’s invulnerability, trust in people, and faith in the predictability, manageability, and meaningfulness of the world (Klingman, 2000b; Klingman, in press; Omer & Alon, 1994). At least part of children’s reactions is due to interruptions of school roles and activities. Thus, school-based preventive intervention aims first to achieve organizational continuity, restoring the connection between students and their community, by preserving old roles and focusing on pre-war resources and routines. The students are approached in or through their respective schools (i.e., a natural environment). The school system is helped to regain control and resourcefulness in adapting to the new situation, return quickly to routine functioning (however partial under the circumstances), and reestablish communication channels with its pre-war (i.e., familiar) community services. Personal continuity is restored through age-appropriate emotional and cognitive work that relates to the student’s pre-war life, experience of the war, and (emphasizes) its meaning for the future. This work includes causal explanations for the war, reconstructing the meaning of one’s life around the setbacks, and gaining a sense of mastery by exerting behavioral control over some of the threat-related events and (even more so) some aspects of everyday life. Functional continuity is restored by encouraging pupils to take relevant external action to resume their pre-war roles and routines as well as to try new ones tailored to the war situation. Interpersonal continuity concerns establishing interpersonal support by restoring social (e.g., classroom) bonds and enhancing the solidarity of the group as an antidote to war experiences.

Community-Focused Interventions

Media, telephone hotlines, and cyberspace are unique forms of community-focused intervention in wartime. These forms allow relatively easy access for individuals seeking advice or help. In addition, they place a strong emphasis on preventive intervention techniques adapted to massive use during prolonged, large-scale crisis.

**Open telephone lines.** An open telephone line for students was set up during the Gulf War in Israel. Because it was operated by the school system, no stigma was associated with it as was often the case with mental health centers (Raviv, 1993). In the majority of cases, it was possible to assist callers by providing information, encouraging them to continue coping, and labeling their fear reactions as “healthy” (Noy, 1992). A lesson learned from this war was that these open lines should also be established for teachers so they can obtain advice about their students’ war-related problems.

**Fiber optics and communication satellites.** The astonishing velocity with which technological innovations advance necessitates considering their possible use for the benefit of children and adolescents, parents, and teachers in wartime, especially when schools are closed. The Internet serves as means for retrieval of information and for communication. It permits home-based, fast access to vast amounts of information.
from the best experts. Among the Internet’s many applications are: (a) updated age-
appropriate information on current events; (b) the interpretation of war-related terms
and of some of the factors that led to the war; (c) information and details regarding the
 provision of psychological services; and (d) professional discussions serving support sys-
tem groups (e.g., teachers and mental health professionals) simultaneously. Alternative
modes of communication have already made it possible for many young people
throughout the world to converse instantaneously. Internet communities, or “wired
neighborhoods,” make it possible for children and adolescents to interact without leaving
home or shelter. Social virtual reality may have much in common with sociodrama and psychodrama by allowing children and adolescents to build a character and
environment of their own choice and then live out for a while (whenever the need is felt) within this environment. It offers youths an opportunity to use screen graphics to
build a safe, adult-free world with their own architecture and objects. This outlet may
serve as a possible escape valve for anxiety and anger. By devising their own charac-
ters, with which they can interact, children and adolescents are given opportunities for
self-expression and to explore the social aspects of situations. They also experience tak-
ing control (Duncum, 2000; Turkel, 1995).

The use of new computer technology for interactive mutual support programs is
another option to consider. For example, children and adolescents may exchange
drawings, poems, free writing, and jokes through a website. Such an interactive pro-
gram can serve as a source of empowerment for children and adolescents (Byers, 1996).
Some mental health applications may include guidance in self-help, as well as advising
and giving answers in real-time. (For an extended discussion of the potential of cyber-
counseling, see Bloom and Walz, 2000.)

Mass media intervention. Whereas hotlines and the Internet contain elements
more similar to selective and indicated preventive interventions, mass media interven-
tion belongs to the category of universal preventive intervention. Community tele-
vised programs enable access for a passive audience. Such programs aim at increasing
sensitivity, openness, tolerance, and flexibility in response to the war stress. During the
Gulf War in Israel, a children’s TV program relevant to the current situation was pro-
duced each day that enabled the transmission of informative as well as supportive mes-
sages that served the immediate needs of viewers (Raviv, 1993). Similarly, in Bosnia,
a children’s radio program was set up in which local children served as moderators and
discussed their feelings; other children were encouraged to call in and give their opin-
ions (Berk, 1998).

School-Focused Interventions

As with other crises, during war school interventions need to emphasize a team
approach. Specific issues to be addressed at the school level include student safety, the
need to establish structure and routine, and flexible learning centers.
Establishing a response team. It is not likely that school administrators alone can address all important war-related issues, nor is it likely that they can consider the necessary mental health perspective in the fluctuating situation. Thus, a response team should be established. This school team, appointed by the school principal, undertakes the following war-related tasks: (a) communications and records, (b) information and briefings, (c) liaison with support agencies, and (d) welfare support. The team helps in reevaluating the situation, mobilizing and adapting available resources to the new reality, and advising how to mobilize the natural as well as the community organizational support systems. An inter-school support team is usually established in which the principal and some staff members of a less affected school lend support to another school. The team works closely with the school principal to offer advice and support and any practical help needed. Although advice and support are always welcome, the principal and staff should be respected and encouraged in their need to retain control of the school’s operation. If some schools are located in relatively remote areas or lack resources to handle an extreme or prolonged crisis situation, a regional response team can be established.

A crisis management manual. One major task for the team is constant updating of the teachers’ crisis management manual or kit. This manual addresses the following: (a) school safety and precautionary measures; (b) school evacuation procedures and (detailed) alternative evacuation plans; (c) debriefing procedure instructions and suggestions; (d) descriptions of the expected “normal” war-related behavioral and emotional stress reactions by age; (e) guidance on how to identify, monitor, and deal with stress responses; (f) steps to take to ensure successful adjustment when injured students return to school; (g) principles and guidelines regarding pupils’ preparation for attending funerals and making visits to wounded peers and/or school staff in hospitals and homes; (h) a list of the available support resources and their contact numbers, also indicating the functions of each emergency and psychological and social support service; (i) suggestions about mental health aspects to be integrated into everyday teaching as well as into school social life; (j) samples of relevant teaching tools; and (k) blueprints to advise parents. Graphic representations (e.g., diagrams) are an integral part of the manual. Administratively, it is most important that all the emergency data held on computer are backed up daily and stored in a separate building.

Pyramid procedure. During times of war, mental health services are best delivered by using the team approach referred to as the pyramid procedure intervention. Using this procedure a core of mental health workers are debriefed and guided in groups. They in turn train a larger group of caregivers who train teachers and parents (Gal, 1998; Macksoud, Haber, & Cohn, 1996). This procedure results in more manageable mental health caseloads. Mental health professionals form their own peer support group, their school interventions are limited to smaller (and thus more accessible) school populations (e.g., school management teams, educator groups), and they have a smaller variety of assignments. Thus, they can reach out indirectly to every student (and potentially to students’ families as well).
As mentioned earlier, in wartime, mental health professionals countrywide are psychologically vulnerable. By adopting the pyramid procedure, and using professionals from other unaffected (or less affected) places, “helping the helpers” becomes more feasible. Gal (1998), for example, gives an account of one such project in the former Yugoslavia. The program involved intensive training in various trauma-relief issues along with debriefing sessions dealing with the helpers’ own stress and burnout.

Teachers, who serve on the frontline of student mental health, feel personal stress and burdens of their own war experiences and, in addition, professional insecurity when confronting the effects of war among their pupils. By employing the “pyramid” procedure, school mental health professionals can meet with groups of teachers at their schools for combined debriefing and empowering workshops. These workshops consist of (a) debriefings (e.g., Mitchell & Everly, 1996), (b) relaying information from trauma psychology, (c) developing realistic work goals, (d) facilitating their ability to help students’ cope, and (e) teaching the identification of PTSD. Such a workshop empowers teachers who, in turn, directly intervene with their pupils. Team building and group support (as well as self-help) are promoted, and the teachers, who voluntarily return to the ongoing teachers’ group meetings led by the school mental health professional, also deal with their own distress.

**Student safety.** A crucial step in preventive crisis intervention in the school setting is introducing precautionary or safety measures. Students should be fully, and in an age-appropriate way, briefed on the precautionary measures taken by the school as well as the standards of behavior expected from students. Promoting safety also involves teaching students to be alert to dangers around them, avoiding certain areas, and taking certain steps when caught in dangerous situations. For example, children may be attracted by the colors of unexploded cluster bombs or mines. Younger children may have no knowledge of mine danger. Even youths who grow up surrounded by mines and unexploded bombs may become desensitized to them, and some adolescents think it is brave to be seen handling explosives.

**Establishing structure and routine.** Another crucial crisis intervention step is establishing structure and, consequently, a sense of relative stability, which can be achieved by having schools return to familiar routines as well as by creating new war-related ones. Wherever and whenever possible, a return to pre-war school and classroom procedures (although flexible to accommodate the changing circumstances) should be implemented.

**Recreational activities.** Organizing in-school, or in-town, recreational activities is an option, especially when schools have to close down. For example, following a terrorist massacre of high school students in Israel, surviving students avoided school and/or classrooms, teachers were not functioning well, and parents were anxious and upset. Students who had returned from the hospital added to the overall state of anxiety by frequently crying, openly recounting their terror dreams, and stating they did not feel safe anymore. As the school year came to a close, mental health consultants
recommended planning a summer camping program adopting “camping activities.” Use of such recreation programs can help communities cope and facilitates reaching out to students in need (Yanoov, 1976).

**Flexible learning centers.** When schools were instructed to close down for an unknown period of time during the Gulf War, Israeli educators planned flexible learning centers. The aim of these centers was to continue school-pupil contact (this program was in accord with the continuity principle) by establishing meetings with pupils and providing them with flexible learning and recreational opportunities. Pupils were provided learning tasks and materials, tutoring, and debriefing in small groups. The assignments were planned so they could be carried out both in and outside the school (as the conditions permit), with teams ready to go upon request into shelters. Such a school-based team includes teachers and a school counselor. An alternative to this may be distance-learning programs.

**School Reorganization and Consultation**

Organizations, like individuals, tend to resort to familiar behaviors even when they no longer work. They tend to continue well-learned responses in the face of crisis, which may lead to poor adaptation to the changing demands. The extent and severity of school response depend on the proximity of the school to the location of a strike or the physically devastating conditions and/or on the population affected. School staff absenteeism because of mobilization of teachers, travel difficulties for teachers who live quite a distance from the school, family burdens (e.g., as a consequence of the other parent’s absence, damage to property), and preoccupation and concerns with their own children’s safety will also impair the school’s capacity to function.

When defense mechanisms fail to guarantee equilibrium, the usual resistance to change is (at least temporarily) minimized, so that long-standing differences and objections disappear (at least for some time), cooperation is improved, innovative arrangements are willingly tried out, and the need for mental health expert help is more apparent. Thus, school mental health professionals should first respond to school reorganization and crisis management utilizing considerable on-the-spot initiative and creativity. The long-term ends of school organizational change (e.g., leaving the responsibility for change with the clients) must be sidestepped. It is only through adapting the school’s responses into war-related adaptive responses that educators will be able to exercise leadership and reach out to their pupils. School mental health professionals are in a position to observe and analyze the mental health aspects of school functioning and provide decision makers with reliable and relevant information.

A noted difficulty is when mental health professionals take a “surrogate leadership” position (Babad & Salomon, 1978); they may be perceived as a threat to the designated school leadership. Another difficulty is that direct intervention may reinforce anticipation of mental health professionals’ “omnipotence.” Thus, it is important that inter-
ventions are as indirect as possible, behind the scenes, bolstering natural support systems rather than displacing them (Caplan, 1976).

Given the reality of war situations, in which school mental health professionals are requested to guide school staff in implementing interventions, they may have to move skillfully among consultation modes. It is plausible that in wartime coercive-directive consultation, where decision making is unilateral rather than shared (as in the collaborative-directive approach; see Gutkin, 1999) is the method of choice. The consultants may need to be directive in their approaches to generating intervention plans. In addition, when selecting among intervention options crisis intervenors may rely primarily on their own judgment.

Classroom-Focused Interventions

The most widely used group or classroom crisis intervention is structured debriefing (Brock, 2002; Mitchell & Everly, 1996). The few controlled studies of crisis debriefing with children suggest it has a beneficial effect in treating PTSD-related response (see review by Perrin, Smith, & Yule, 2000). In the context of in-classroom prolonged war-related stress, debriefing is often best when integrated into classroom procedures and programs, employing teaching tools and techniques.

Free (and creative) writing. This strategy can serve as one means of catharsis by eliciting a direct expression of feelings and thoughts, and also by articulating and confronting difficult memories. Recent research indicates that emotional disclosure through writing about stressful events appears to have psychological and health benefits (Pennebaker, 1993). Students embrace the opportunity to disclose details of stressful situations and worries, and respond positively to such intervention. Thus, it is both feasible and valuable to give young people the opportunity to write about sources of, and responses to, stress (Reynolds, Brewin, & Saxton, 2000). It is also a means of evoking positive memories and of producing something valuable (i.e., activity, a sense of control, a sense of mastery). Free writing may also allow students to recreate their world in a new, more livable way. In-vitro exposure (such as using ambiguous photographs to trigger free writing) is one possible intervention strategy for eliciting expression of feelings when needed. Sharing of writing products enables classmates to recognize that they may not be alone in their affective response to the adversities of the war (Klingman, 1985: Phillips, Linington, & Penman, 1999). Research with children suggests that free writing is a practical procedure to use with schools in war zones and may readily be incorporated into the school curriculum (Klingman, 1985).

Bibliotherapy. This approach involves reading and discussing literary texts relevant to current problems and can also be used as a group or classroom method. With this technique students can observe war-related stressors at an emotional distance, which allows them to recognize and incorporate needed changes (e.g., in perceptions, behaviors, coping strategies) without experiencing direct personal threat. The biblio-
therapy process includes identification with a story character, projection (of one’s own feelings and thoughts onto this story character), catharsis, and introspection. Literary means of expression, especially working with metaphors, were found to be useful for children under war stress in both Israel and the former Yugoslavia (Klingman, 1992a; Kubovji, 1974; Zotovic, 1998). It may also serve as a diagnostic method for uncovering children’s feelings of helplessness, lack of trust in the future, locus of control, coping style and resources, and other variables. Public libraries became a natural place for guided reading, or bibliotherapy, during the war in Croatia (Sabljak, 1999).

A combined bibliotherapy and free writing group intervention for children from the former Yugoslavia was studied by Krkeljic and Pavlicic (1998). Children in a group setting were asked individually to write a six-piece story. They (1) chose a hero, (2) assigned him or her with a task to fulfill, (3) wrote about the obstacles that stood in the way of carrying out the task, (4) discussed who or what could help the hero, (5) told how the hero would cope, and then (6) told what happened. The stories produced were dominated by heroes ready to fight, descriptions of endangering situations, war topics, revenge and, to a lesser degree, dealt with helping people in need and protection from the enemies. Two months later, when the prospects for the future were more certain and clear, these children were asked to write a six-piece story again. This time the hero characters lost their original aggressive touch, relying more on their own resources than on weapons, and the themes produced dealt with protective, social, and practical positive goals in addition to containing aggressive elements. Characters and situations produced can partly be understood as symbols of the circumstances that affect the children’s psychological life, indicating the difficulties they are exposed to and the problems they have to solve. Certain computer games may add a new dimension to bibliotherapy by giving the operator some control over the characters’ action. Students should be given the opportunity to play out their accumulated feelings of frustration, insecurity, aggression, fear, and confusion. They may actually experience first-hand encounters and events with which they are required to cope as a part of the game, and they can repeatedly play it until they master coping.

**Broad-spectrum coping enhancement program.** Active war situations call for “instant” skill training that is more explicit, direct, and prescriptive than during non-war situations. Following Lazarus’ (1976, 1989) comprehensive and systematic range of intervention strategies, a flexible, broad-spectrum, multimodal coping and resiliency intervention program has been developed for school-based group and/or classroom intervention in war zones (Lahad, Shacham, & Niv, 2000). The six core modalities of an individual’s coping style (for which the acronym BASIC Ph was given) are Beliefs (e.g., coping by making reference to self-efficacy), Affect, Social (support seeking), Imagination, Cognition, and Physiology (e.g., relaxation, recreation, situation-related activity). Although anyone can potentially employ any of the six strategies, everyone has a preferred mode of coping already developed and refined through childhood. This preferred coping style reflects a combination of modalities. For example, a child whose primary coping style is Social and Imagination might seek social support from an imaginary figure, such as Superman. Working with students in wartime using the BASIC Ph
is useful for (a) encouraging them to utilize their preferred modalities and expand them to deal with stress, and (b) introducing them to alternative modalities or helping them with alternative options within their preferred ones during various stress experiences. Inappropriate use of resources or mismatch between resources used and specific stressful situations are mapped and become the object of corrective interventions. This model has been used for both preparatory guidance and intervention in wartime.

**Nonverbal and noninterpretive interventions.** Expressive arts can serve as self-help therapeutic media employed by nonmental health caregivers in consultation with school mental health professionals. The war situation exacerbates excited affect and stimulates powerful projections and fantasies. Nonverbal media, through their sensory quality, may be an especially helpful intervention. Recent research has found that traumatic experiences are encoded in encapsulated nonverbal imagery (Stone, 1998). Noninterpretive art intervention enables students to spontaneously depict how they (a) experience the situation, (b) go through catharsis, (c) progressively approach the traumatic reminders, (d) get a sense of distance from the feelings by objectifying and containing them in art form, (e) talk about the images and feelings “out there,” and (f) re-frame feelings to give some meaning to the confusion of the external environment (Stone, 1998). It opens lines of communication among young people themselves, as well between student and teacher, mental health professionals, and other caregivers.

Schwarcz (1982) demonstrated the positive effect of a noninterpretive art program in wartime. An art teacher worked daily with students in their respective age groups, opening channels of symbolic activity that encouraged them to focus openly on their experiences in an active and creative way. Younger children expressed their reactions in their drawings by adding verbal captions. Older youths responded with greater diversity, some directly and dramatically, to the experience of destruction (e.g., “the moment when the houses disintegrated”) and others to the personal implications (e.g., “my house destroyed and my brand new bicycle too”). Later drawings also included the shelters that saved them, representing the ambivalence associated with the shelters (i.e., anguish at having to use them and comfort in the security they provide). In the beginning, the art teacher supported the student’s needs for catharsis, permitting them to regress in their drawings in the service of the ego. Later, they were gradually encouraged to move toward topics that are more benign and offered more structured sessions to enhance more cognitive and reality-oriented processes (e.g., writing letters and drawing pictures to send to soldiers). At a later stage, she talked with fourth graders about the nature of a symbol and proposed that they invent a symbol for war and for peace. She introduced sixth graders to Picasso’s Guernica as an example of a symbolic expression of war, and offered seventh graders sketches of the utensils used in the shelters.

Decorating gas mask boxes was popular with children and adolescents of all ages in Israel during the Gulf War. They had to carry these boxes with them at all times, including to school (when it reopened). Besides the advantages of creative art previously mentioned, it helped disguise the frightening contents and rendered the boxes less threatening and more personal (Shilo-Cohen, 1993).
Children and adolescents experiencing war should be encouraged to draw—and write as a way to “unlock the doors” to their inner world by recalling not only the traumatic events, but also happy past memories and creating some “promising” dreams of the future. For examples, see the drawing and writings of children from the former Yugoslavia in the book *I Dream of Peace* (1995).

**Creating psychological communality.** Children and especially adolescents benefit from feeling that they are an integral part of a group and the broader community. In protracted wartime conditions, even hobby groups can fill the young person’s need to be a part of a broader community (Hobfoll et al., 1991). Such groups should be task- and future-oriented, consisting of manageable instrumental activities. In this context, students should be encouraged to get involved in *helpful behaviors* to develop further a sense of control and mastery and, eventually, engage in more effective coping. For example, in the former Yugoslavia, children were organized into Garden Clubs that engaged in finding ways to protect their plants from being ruined when there was an enemy attack (Berk, 1998). In Israel, when schools were closed during the Gulf War, some teachers encouraged their students to keep a log of their war experiences so they could create a class magazine. In it they discussed their experiences; presented their own poems, stories, and drawings; and created humorous cartoons and situation-specific crosswords.

**Anticipatory guidance.** School-based anticipatory guidance includes developing plans to deal with multiple war scenarios. For example, it may involve planning for physical safety measures, engaging in simulations and drills, and establishing different communication procedures. An example of student preparation for unconventional war is illustrated by the response to the impending Gulf War by Israeli schools. From such guidance, students were (a) introduced to the possibility of missile warfare (including chemical and biological scenarios) and to the availability of protective measures against chemical fallout; (b) instructed about student behavioral expectations, especially when staying in the predesignated, confined, sealed rooms or areas; (c) introduced to a gas mask and a protective kit that included atropine (a substance used to counteract the effects of chemical warfare) and a syringe; (d) trained, in controlled gradual exposure sessions, when and how to use the gas mask and, among older children to, self-inject and; (e) psychologically debriefed. Through simulations and training (donning, learning to fasten correctly, and breathing through the gas mask), students gained a sense of competence and a sense of at least partial mastery. Older pupils were also trained in helping others to wear the gas mask. They thus could train others at home and, should war erupt, assist others in need (e.g., the very young, the very old, the handicapped). As it turned out, children and adolescents were observed to be very helpful at home during the war. In some classes students were unable to wear gas masks properly. Feeling trapped, some could not stand wearing them for a long time. Among these students, group desensitization sessions supervised by a school mental health professional were helpful.
In all classes the fear of biological and chemical attack was evident from the many questions students raised during presentations. In facilitating such discussions, teachers were advised to minimize the uncontrollable, threatening aspects of unconventional warfare and instead to stress the controllable safety measures. Older children were also provided booklets prepared by biology and chemistry teachers (with the help of school mental health professionals) explaining in detail the related chemical warfare technical terms.

Unconventional warfare is a complex issue often beyond the comprehension of younger children; direct frontal explanation and the introduction of the mask, and especially wearing it, can increase fears and raise confusion and uncertainty. Thus for the very young, story-and-coloring booklets were specially developed by school psychologists (in cooperation with kindergarten and elementary school teaching experts and artists) to help the children learn basic war-related concepts and basic safety measures and to deal with the anxiety and noncompliance associated with gas masks. One such story-and-coloring notebook (Lahad & Lahad, 1991) consists of a story that creates a psychological framework for discussion about gas masks and chemical warfare. It uses illustrations of alien-like, funny-looking space clown figures visiting a cave in which the air is polluted and thus difficult to breathe. They meet a rabbit that teaches them, through vicarious modeling, how to use a (gas) mask until the air is clean. The book includes a page on which the child can paint a gas mask. The illustrated story creates a psychological framework for discussion about gas masks and the practicalities involved in wearing them. This also enabled a gradual exposure of the young children to the impending unconventional warfare, giving information using terminology that is close to the child’s world, and offered an opportunity to discuss feelings with an emphasis on coping and functioning in the event of using gas masks. A teachers’ manual guides teachers on how to relate, via the illustrated story, to various war-related aspects, such as the social implications (e.g., everyone wearing the black gas mask looks alike, experiences restriction in movement, and encounters difficulties in communicating), the emotional implications, and the operational or practical implications. Another story-and-coloring book was developed to help children who show noncompliance and fear (Klingman, Ginsburg, & Markman, 1991). It made use of a child’s teddy bear for which the child prepares a gas mask and deals with the teddy’s anxiety. It focuses on coping statements “so that neither of them is too afraid,” and was designed for use both in the anticipatory period and during wartime.

Individual-Focused Interventions

Although school-based mental health professionals are less engaged in longer-term wartime individual and small group treatment, they may become involved in such. For older children, classical conditioning treatment (e.g., systematic desensitization and flooding) can be effective in treating PTSD (Saigh, Yasik, Oberfield, & Inamdar, 1999). With younger children the war-related interventions more often combine classical conditioning with selected elements of both dynamic and cognitive-behavior
therapies. Some such (group and individual) clinic-based war-related interventions are summarized elsewhere (Klingman, in press). It is more common for school mental health professionals to find themselves involved in individual treatment within emergency crisis intervention. Parent-implemented treatment via consultation procedures may become practical. The use of a coercive-prescriptive consultation to parents in wartime emergency was demonstrated regarding a five-year-old Israeli child's refusal to use a gas mask during the Gulf War. The parent's difficulty with his behavior (e.g., tantrums, removing the gas mask when it was put on) was complicated by the urgency of the situation (given the high probability of chemical missile warheads). A short-term, family-focused, cognitive-behavioral intervention was the method of choice. The treatment procedure combined consultation with the parents regarding their own anxiety and response to the child, and guided them in procedures of contact desensitization and cognitive-behavioral prompts through bibliotherapy, play, and behavior modification. This case study (Klingman, 1992b) highlighted the possible role of a school psychologist as a consultant in indicated preventive intervention. The psychologist utilized the child's parents (i.e., the natural support system) in the natural setting (i.e., the home), adhering to the continuity principle, within a three-day (short-term, emergency) crisis-intervention, in the midst of a war.

Summary and Concluding Remarks

Children and adolescents must have a framework within which they can place their war experiences, assimilate them, and accommodate their life schemas to make some kind of sense out of them. In wartime, schools may be the best and, often, the only place to provide for the mental health needs of youths. In addition schools, or alternative organized learning and/or recreation settings, are important because they provide a sense of relative stability. It is a place where it is legitimate also to think of other things and get actively involved with purposeful activities to achieve success, experience self-control, and think about the future. Intervention by schools is also one of the best operationalizations of the continuity principle. However, schools are organized in terms of a stable community and thus it may be hard for them to meet the special needs of pupils and staff in emergencies. Thus, in wartime, or as soon as possible following it, reorganization and adaptation of the school system to the new demands become a priority, and assisting the school in these matters is an important role for crisis intervenors.

This chapter highlights the importance of communitywide mass communication as a means of outreach. Schools and/or alternative educational systems are the best organized or supervised delivery system, especially for resiliency promotion on behalf of a community's young people. Teachers have an advantage in reaching out to children and adolescents to promote resiliency. In addition, for those young people who receive little (or no) support at home, a relationship with an understanding adult (who can give affection and help them make sense of their experiences), often the teacher, can have a powerful protective effect.
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War-related intervention should be preventive, supportive, and protect children and adolescents from secondary adversity. It aims at “normalizing” and structuring a setting so as to give students a sense of psychological and physical security, and also to support parents. This typically involves school reorganization, the adjustment of school policies, and an emphasis on group or classroom creative activities. From a prevention frame of reference, it is resiliency building that characterizes the prime task of wartime intervention. When it occurs spontaneously, resiliency should be strengthened; when it does not, it should be systematically taught.

Unlike most other disasters, war is a protracted rather than a short-duration event and often is predictable. Because war can be anticipated, it is possible to engage in preparation to help children and adolescents cope. In addition, more objective methods can be designed while planning for war-related psychological intervention, with regard to mass screening, diagnosis, and the evaluation of changes. Assessment of students’ response and coping should be ongoing, continuously conducted throughout the entire intervention, and involve a long-term follow-up evaluation process.

This chapter delineated some basic issues facing school mental health professionals during wartime. The issues discussed were based largely on observations and experiences. Different types of war may necessitate different types of interventions. Moreover, beyond strategies, tools, and techniques, it is essential to rely on the professional’s creativity to use all resources available.
References


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Endnote

1For discussion of the use of this booklet as a part of indicated intervention for treating noncompliance during the Gulf War, see Klingman, 1992a.