

Children & War

Trauma team works with young victims of conflicts.

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" War is cruelty and you cannot refine it."

— William Sherman, Civil War general

What are children's reactions to war?

Some idea of what children exposed to war have experienced is captured in these pictures made by children who were survivors of the siege of Sarajevo, Bosnia. The horrors portrayed are also common experiences of children in Armenia, Chechnya, Rwanda and in many of the internal conflicts that are tearing countries apart around the world. When things settle down in Kosovo, children there will be suffering the same post-traumatic reactions and drawing the same kinds of pictures to reflect the horrors that reverberate in their minds.

By visits to their countries and during our summer program here at MU, our teams from the International Center for Psychosocial Trauma have had contact with teachers and other professionals from 11 countries where there is or has been armed conflict that affects children.

A large number of children who have been exposed to death and destruction develop symptoms of post-traumatic stress disorder, or PTSD. With each additional traumatic event, it becomes more likely the child will suffer emotional injury that will far outlast the military action. It is difficult to calculate the damage done to the mental health of children such as those in Sarajevo who were subject to almost daily danger from shelling and sniper fire. Many of the children who are victims of war are also separated from their families or, worse yet, witness brutality toward — and sometimes the death of — family members.

In one study of 791 children, a team led by MU psychiatrist Arshad Husain, director of the psychosocial trauma center found that 85 percent had experienced sniper fire and 66 percent had lost a member of the extended family. 40 percent had developed post-traumatic stress disorder. In a study by other researchers of a sample of 364 displaced Bosnian children between ages 6 and 12, 94 percent were experiencing all three of the major symptoms of PTSD: intrusive thoughts, hyperalertness and avoidance of things associated with the trauma.

As the physical danger diminishes and life slowly regains some semblance of normality, it would be ideal if mental health experts could work directly with children and families. This, however, is rarely possible. In most countries where members of our trauma team have run programs, there are many more traumatized children than there are mental health professionals available to help them. The supply of trained professionals is limited,

and they give their attention to the most severely disturbed. Bringing in counselors and therapists from other countries is not possible because of language and cultural differences.

Who will help the children?

Because there are so few mental health workers in these countries, our teams have found that one effective way of reaching large groups of traumatized children is through the schools. The MU psychosocial trauma center has for the past five years been training teachers and physicians in basic mental health interventions. We focus on teachers because they not only have day-to-day contact with the children, but they have knowledge of child development and experience in encouraging normal behaviors. What they need is training in how to recognize problems and in therapeutic methods they can use.

Given that there are cultural differences in how children express their distress, do we have any reason to believe that techniques developed for working with American children will work with traumatized children from other cultures? Research indicates group-based treatment with traumatized children has a positive impact regardless of cultural background as long as the activities have culturally specific content.

Our own experience in the countries where we have worked with teachers and physicians confirms this. The methods we recommend work with children across cultures, but the teachers must work out content specific to the country involved.

Many children suffering from PTSD will have difficulty functioning in a school setting. Teachers describe students as having short attention spans, exaggerated startle reactions and either emotional lability or lack of affect. The child's ability to concentrate and learn can be increased by incorporating classroom activities stressing relaxation, group support and problem-solving skills.

What can teachers do?

We have found that teachers can quickly learn to use basic stress-management techniques with children. Relaxation exercises can be practiced in brief segments throughout the school day to teach children self-calming. Besides muscle relaxation, they use mental images of a safe place, positive self-talk and social support systems. These small- group projects are designed to improve socialization skills and to draw out withdrawn students.

Teachers also absorb helpful techniques that can be integrated into normal classroom activities. Writing projects or journals become part of a composition class, and the child is given the opportunity to explore his or her reactions to events. Children in art classes can illustrate their feelings as shown in pictures.

Physical education classes can combine expressive movement with games and exercise and give hyperactive children a place to work off excess tension. Role-playing can

become part of reading or drama class and allow anger or other problem behavior to be modified or redirected. A number of our team members are experts in the use of play therapy with traumatized children, an activity that teachers are especially interested in using.

The teachers we have trained report they can see significant improvement in their students' behavior after using the techniques we recommend.

How does working with trauma affect the teacher?

The graphic and painful material that traumatized children discuss or act out affects the teacher. Teachers and other mental health professionals working with trauma victims often develop painful images, thoughts and feelings. This is referred to as vicarious or secondary traumatization. It is especially likely to happen when dealing with serious trauma of children.

Knowing that this is a frequent occurrence, the team runs sessions for teachers on how to take care of their own mental health. When we are training them to use muscle relaxation and safe place with children, we are also having them practice it with themselves and other teachers. During the training we build social support systems among the workers. They know they can discuss what is happening to them with someone who has had similar training and understands the damage and hazards of working with victims.