A.L. Venger,
E.I. Morozova

PSYCHOLOGICAL SUPPORT FOR CHILDREN AND TEENAGERS
AFTER THE BESLAN TRAGEDY

Development of this manuscript was supported by Cooperative Agreement No. 118-A-00-06-00050-00 from the United States Agency for International Development (USAID). The contents of this manuscript and the opinions expressed herein are solely the responsibility of the authors and do not necessarily represent the views of USAID or Keystone Human Services.
# TABLE OF CONTENTS

INTRODUCTION .................................................................................................................. 3

Chapter 1. SITUATION IN THE CITY AND CONDITIONS OF WORK ........ 5

Chapter 2. THE CONDITION OF THE VICTIMS ......................................................... 10
   2.1. Typical reactions of children and teenagers to psychotraumatic situation ....................................................... 10
   2.2. Psychological disorders in children and the teenagers who have endured the Beslan tragedy ....................................................... 18
   2.3. Regression as a result of psychological trauma ................................................................. 22

Chapter 3. ANALYZING DRAWINGS AS THE METHOD of DIAGNOSING THE MENTAL CONDITION OF CHILDREN AND TEENAGERS .... 27
   3.1. Drawing as a method of diagnostics of a mental condition ............... 27
   3.2. Signs of a psychological trauma in children's drawing .................... 41
   3.3. Drawings of Beslan children and teenagers ........................................ 52

Chapter 4. TASKS OF PSYCHOLOGICAL SUPPORT AT DIFFERENT STAGES OF EXPERIENCING PSYCHOTRAUMA ..................... 60
   4.1. Basic forms of psychological aid ................................................................. 60
   4.2. Tasks for socially-psychological rehabilitation of victims ................. 64
   4.3. Tasks for psychological work with families ............................................. 65

Chapter 5. CULTURAL APPROACH TO PSYCHOTHERAPY AND PSYCHOLOGICAL CORRECTION .................................................. 67
   5.1. The general principles of the Cultural approach ..................................... 67
   5.2. Restoration of previously mastered activities ....................................... 74
   5.3. Correction of acute anxiety: work with a talisman ............................... 78
   5.4. Substitute situation of development for Beslan first-graders .......... 83

Chapter 6. ART THERAPY IN WORK WITH STRESS ............................................. 87
   6.1. General characteristics of art therapy techniques ............................... 87
   6.2. Art therapy at the initial stage of psychological correction of stress 94
6.3. The “Fear Destruction” technique .............................................. 95
6.4. The “Harmonization of a Drawing” technique .......................... 102

Chapter 7. WORK IN THE REHABILITATION CENTER ...................... 105
7.1. The general issues of the organization of work in the Center ...... 105
7.2. Initial stage of work ..................................................................... 110
7.3. Restoration of Activity ................................................................. 111
7.4. Normalization of activity and release of aggression ................. 114
7.5. Examples of work with children at the Rehabilitation Center ....... 118

Chapter 8. PSYCHOLOGICAL REHABILITATION OF THE FAMILY ..... 126

Chapter 9. GROUP WORK WITH TEENAGERS ................................. 132
9.1. The Discovery Program .............................................................. 132
9.2. Group work with Beslan senior pupils .................................... 143

Chapter 10. ISSUES OF ORGANIZATION OF PSYCHOLOGICAL
            SUPPORT TO VICTIMS OF CATASTROPHES .......................... 147

REFERENCES .................................................................................. 153
INTRODUCTION

The terrorist attack in Beslan in Republic of North Ossetia/Alania surpassed in its cruelty and brutality everything that had occurred before. On September 1, 2004, a group of terrorists captured 1128 people (more than half of them – children) and kept them hostage for three days in the building of Beslan school # 1. During the entire time, they neither gave the hostages food nor water. The standoff with the terrorists ended with an explosion, a fire and a storming of the building. More than 300 hostages died, and those who survived were wounded during the storming.

In this book we describe our experience of providing psychological help to the victims. We hope it is useful for experts who work with children and teenagers who have endured various psychological traumas – not necessarily as heavy as that one suffered by Beslan hostages.

This book provides description of the condition of children and teenagers asking for our help the psychotherapeutic techniques and approaches applied, and the organizational forms of work. We have concentrated attention on practical aspects of psychological help to the victims. The theoretical questions concerning stressful and post-stressful conditions and their correction, are covered only to the degree necessary for understanding of the practical material. This also explains the minimum number of literary references given in the book.

Unfortunately, working conditions in Beslan did not allow us to use the standardized techniques of evaluation of psychological condition of children before and after psychotherapy. The challenge was not only in the lack of time, but also in local authorities’ attitude. Therefore, for the purpose of revealing the aftereffect of psychological trauma, its influence on the condition of children and teenagers we considered it necessary to conduct questionnaire survey of their parents and teachers. However the permission to carrying out such questioning had not been given to us: apparently, the refusal was caused by the general attitude of the authorities to restrict the information on the situation in
Beslan. Therefore we were compelled to confine ourselves to the data on observations, conversations and informal tests – in particular, drawings.

We wish to express deep appreciation to those who helped and continue to help us in this work. Successful rehabilitation work in Beslan would be impossible without constant support of V.P.Karginov, the Head Physician of the Central District Clinical Hospital of Beslan, V.C.Baskaev, the Deputy Head Physician, T.N. Ryzhovoa, the Senior Psychiatrist of the North Ossetia/Alania Republic. We are sincerely grateful to our Beslan and Vladikavkaz colleagues: F.V.Bagaeva, A.V.Borodina, A.A.Dzansolov, L.M.Kallagova, M.T.Kanukova, I.E.Marzaev, T.V.Naskidaeva, V.A.Plieva, E.V.Ryzhova, M.M.Sosranova and others. We are grateful also to the organizations and private sponsors, whose financial support made it possible to organize the system of psychological help to Beslan children and teenagers, in particular, Keystone Human Services and the United States Agency for International Development.
CHAPTER 1. SITUATION IN THE CITY AND CONDITIONS OF WORK

At the time of the tragedy there were no psychological services in Beslan. The population did not have experience in applying for psychological help. For the entire city with population of 30,000 people there was only one psychiatrist serving both adults and children. Among local psychologists, there were almost no specialists who had adequate qualifications in the field of clinical and/or child psychology. The number of qualified specialists who arrived from other cities was obviously insufficient. Accordingly, there were four child psychologists from V.P. Serbsky Institute (under the guidance of E.G. Dozortseva) who worked in Beslan for the first few days after the tragedy.

We started our work on September 13th, 2004, ten days after the release of the hostages.¹

By that time the group of Dozortseva already returned to Moscow, and almost until the end of the month, the two of us were the only child psychologists working in Beslan. The work was done in cooperation with a group of psychiatrists from Moscow Research Institute of Psychiatry of the Russian Federation (RF) Ministry of Health and Social Development and psychotherapists from Rostov community organization “Women of the Don”.

Our work was conducted in the outpatient clinic of the only city hospital. At night we worked at the same place – in the hospital ward – which allowed us to receive clients from nine in the morning till eight or nine at night. After that, we conducted home visits. The community already knew that there were Moscow specialists (Dozortseva’s group mentioned above) in the outpatient clinic, and many came with the intention of meeting them. The outpatient clinic doctors recommended other hospital visitors to consult a psychologist. We

¹ The work was conducted by a group of psychiatrists and psychologists led by Z.I. Kekelidze, the deputy director of the V.P. Serbsky State Science Center of Social and Forensic Psychiatry.
conducted a number of sessions with doctors describing the symptomatology that indicates that a child requires psychological aid.

The overwhelming majority of the children we worked with had rather light physical traumas – burns, fragmentation wounds, light concussion. Many of them coming to the hospital for procedures (changing bandages, etc.) received psychological aid right there, in the play room that we created at the outpatient clinic. Children with more serious wounds were being treated at Vladikavkaz hospital or in other cities (Moscow, St. Petersburg) therefore, we had no opportunity to render psychological aid to them.

From then up to about November 2004, there was no normal life in the city.

The clannishness and close ties between neighbors, characteristic for North Ossetia, as well as in general for cultures the Caucasus, played a double role. On the one hand, they created an opportunity for mutual emotional and material support. Accordingly, none of the children who lost parents were put in an orphanage; all of them were taken in by relatives or friends. On the other hand, the degree of mutual infection with negative experiences was heightened. Elements of a communal way of life promoted a wide circulation of secondary traumatization. As a result, an acute condition was observed in many people who were not hostages and did not lose close relatives.

The identification of victims was ongoing. There were funerals almost daily (either a body had not been identified earlier, or the person died from wounds in hospital). According to the local customs, there were commemorations for the deceased victims every week within 40 days after the funeral. Practically the entire population of the city was in mourning.

In opposition to this, while organizing psychological rehabilitation of the children, we aimed to create an isle of normal children's life to overcome the descent of children and parents gripped by tragic experiences into painful memories.
The Center for Psychological Aid to Children and Teenagers of Beslan at Beslan Hospital became such an “isle.” The center had been organized on our initiative during the first days of our work. For this purpose, the hospital administration provided physical therapy exercise room in the outpatient clinic branch and a small additional room (the cardiosurgeons’ staff room). Toys and other materials that were purchased by private citizens – residents of Boston (USA) – were sent to Beslan as part of international humanitarian aid – were used to equip the Center.

After finishing the work at the Rehabilitation center, in the evening, the trips to the houses of children who were in particularly difficult psychological condition, were conducted. We received information on such children from local doctors, as well as from the requests made on «a hot line» telephone. The Beslan psychologists working on «a hot line», were at the polyclinic, in the office next to us. It allowed them to constantly maintain close contact with us and request professional support and supervision.

Local psychologists-volunteers were also helping us in the work at the Rehabilitation center, however during the initial period their help was not regular nor sufficiently effective. They required constant support and recommendations, were afraid to work independently and did not have qualification adequate for that purpose. Basically it was the two of us who did the work.

Parallel to the psychocorrectional work, lectures within the cycle of thematic improvement «the Psychological and psychiatric help at emergency situations» for psychologists, doctors, and average medical personnel, and also additional training seminars for local psychologists assisting us, were conducted. In October 2004, they were part of the group of North Ossetian psychologists who studied psychological trauma in Moscow, in the training organized by Keystone Human Services (USA) together with the “Association of Experts on the Problems of Children, (AEPCh)”and the Moscow Lions Club.
Further some additional short-term professional development courses were organized for them.

Subsequently, two psychologist salaries were included in the outpatient clinic staff for the work in the Center. Based on these salaries, four specialists, who had previously been working under our management were hired (each on half salary) at the Center.

After our departure from Beslan in October, 2004, they continued the work at the Center independently, with our supervision. Now the supervision of the activity of the local psychologists working in the Center, is carried out from a distance – by phone and via Internet, and directly – during the periods of our trips to Beslan (in the first year – once in one and a half months, further – once in a quarter).

In the first weeks after the tragedy (September-October 2004), the Center worked daily from 9 a.m. to 8 p.m. Later on, hours of operation became less intense – six days a week (Sunday – the day off) from 10 a.m. to 5 p.m. The center works in this mode at the present time. In recent years, the operations of the Center have expanded considerably – work with mentally ill children, family consultations, etc.

The Center’s operations are conducted in constant interaction with administration of the outpatient clinic and Ministry of Health of the Republic of North Ossetia – Alania. The head psychiatrist of the Republic of North Ossetia – Alania, T.N. Ryzhova, supervises the Center’s operations from the Ministry.

Since December 2004, the Center’s payroll was additionally paid for by the British Charity Aid Foundation (CAF) in the framework of the project “Support to the Rehabilitation Center of Children and Teenagers of Beslan” (with the support of the NGO Association of Experts on Problems of Children). Since the summer of 2006, financial and organizational support has been provided to the Center by Keystone Social-Educational Foundation of Social Support to Children & Families and its parent organization, Keystone Service
Systems as part of the “Comprehensive System of Care for Children and Youth in the North Caucasus” project supported through a cooperative agreement from United States Agency for International Development (USAID).

In May 2005, there was a need to search for new premises for the Center since the physical therapy room where it had been located until then was needed for its original purpose. The hospital administration provided new space – two small rooms on the ground floor – which needed serious repair. The Vladikavkaz-based architectural studio Style renovated the rooms at no expense. The necessary construction materials were bought for the funding from the Dutch Lions Club.

During the entire period of the implementation of the project, support was also rendered by an American charity Russian Children’s Welfare Society (RCWS). Thanks to this organization, material aid was rendered to the most needy families. In April-May, 2005, RWCS also funded an exhibition at the Beslan House of Culture of drawings made by children during art therapy sessions at the Center of Psychological Rehabilitation of Children and Teenagers. This exhibition not only promoted awareness of the Center’s work, but also had great psychotherapeutic value. Seeing the interest of exhibition visitors in the works, the children became confident of their worth, which was very important for increasing their self-esteem and self-respect.
Chapter 2. THE CONDITION OF THE VICTIMS

2.1. Typical reactions of children and teenagers to psychotraumatic situation.

Regular studying of consequences of a psychological trauma at children and teenagers has begun rather recently. Already in the 1980s, an opinion was expressed that the catastrophe experience does not lead to essential disturbance of mental development (Quarantelly, 1985). It was supposed that, thanks to plasticity of children's mentality, negative influence of psychotrauma can be rather easily overcome without any special psychological help. However, the subsequent research have not confirmed these assumptions. It has been established, what even after two years after the endured psychotrauma children and teenagers still experience considerable psychological disorders the intensity of which does not decrease as time goes by (McFarlane et al. rem., 1987; Yule et al., 1999; Nader, 2004).

During the last decades the consequences of both, local and mass psychotraumatic situations have been more widely studied. *Local psychologically traumatic situations* affect individuals or individual families. This can be an accident, a fire, a life- or health-threatening situation, serious illness of the individual or his or her relatives, death of a relative or a family member. Perhaps, the most traumatic cases are violent deaths and suicides. The death of a parent is especially traumatic for a child. The psychological trauma is particularly deep in cases when the child witnessed the death.

Intrafamily and extrafamily violence is becoming a source of deep psychological trauma. Sexual violence (rape) results in especially deep psychological trauma. Family conflicts often serve as a source of psychological trauma – especially divorce.
Mass psychologically traumatic situations involve large groups of people. It can sometimes be a whole city or even a region. The causes could be

- natural disasters (flooding, earthquake, hurricane, a tsunami, volcano eruption, etc.)
- man-made accidents (vehicle accidents, destruction of buildings, industrial accidents, large fires, etc.)
- social disasters (military activities, acts of terrorism, large-scale political crises, etc.)

The basic symptoms of a psychological trauma are similar, no matter whether it is caused by a local or mass psychologically traumatic situation, or whether it is generated by natural, man-made or a social disaster. Nevertheless, in cases of mass disasters, the expression of these symptoms is particularly strong. In recent decades in our country, there have been repeated disasters involving the whole cities or regions (natural disasters, man-made accidents, war, mass capture of hostages, etc.). In such cases, there is the mutual infestation with negative experiences resulting in secondary traumatization. A source of secondary (informative) traumatization can be the influence of mass media – for example, viewing telecasts from the site of a calamity.

Consequences of psychological trauma are defined not so much by its character, but by the intensity (in particular, they do not depend much on whether psychotraumatic situation was local or mass). However, it is necessary to remember that the reasons of psychological traumas and crises almost never lie entirely outside person’s mentality. Even, what one would think to be a purely external, objective event leads to crisis not by itself, but as a result of its specific perception. There is a bigger or smaller resistance towards traumatic influences. The event generating crisis in one person, can be rather easily endured by the other person.
Nevertheless, there are some typical for the majority of victims basic stages of the experience of a psychological trauma. These are –

1. Shock stage.
2. Stabilization stage.
3. Recovery stage.
4. Personal and social integration stage.

1. **Shock stage.** The first reaction to a deep psychological trauma is a state of shock, susceptibility to which is especially high among children. It can manifest itself in the form of pathological lethargy or, on the contrary, chaotic pathological arousal.

   In the first case, the child is pale, inactive (up to and including stupor); his or her movements are slowed down. General restraint and tension are reflected in his or her pose. Facial expressions are poorly pronounced (“mask-like face”). The look can be neutral, sad or frightened. Speech is poor and quiet (up to and including a barely audible whisper). Selective or total mutism\(^2\) is sometimes observed. Reaction to all external influences is acutely weakened. The child cannot answer questions, does not pay attention to peers who try to engage him or her.

   Given pathological arousal, heightened, but not purposeful, motor activity is observed. The child can run, flit around a room, shout and weep loudly. Aggressive or destructive activities are possible. Given pathological arousal as well as at pathological lethargy, reaction to any external influences is acutely diminished.

   Consequently, a general characteristic of a state of shock in both of its forms is absence of purposeful activity and a decrease in contact with the outside world. Acute vegetative reactions, acute sleep disorders, refusal of meals are also typical for this stage.

\(^2\) Selective mutism is a refusal to use speech in certain situations (for example, with unfamiliar adults), total mutism – total refusal to use speech, temporary dumbness.
2. Stabilization stage. At this stage, a person’s ability to perform purposeful activity returns, though its efficiency is still essentially lowered. In favorable conditions (if, as a whole, the psyche of the person is steady enough, if the necessary psychological aid and support has been provided to him or her), the return to a normal condition starts. In the more acute cases, this stage is characterized by the occurrence of symptoms of PTSD described above. For children, and sometimes for adults, regression (return to forms of behavior typical for earlier age groups) is characteristic at this stage.

PTSD (Post Traumatic Stress Disorder) arises as the delayed, postponed or long term reaction to influence of long and especially heavy stress (Horowitz, 1990). Diffusion of disease is rather high (to 80 % of victims). PTSD can also develop in situations when no sharp stressful condition are observed directly after psychotrauma. Its first displays can be delayed for some months – up to half a year, and in some cases – even more. The probability of occurrence of PTSD , if generally lowere if psychological help has been provided right after psychotraumas.

PTSD is a chronic disorder with a fluctuating pattern of symptom intensity. It can proceed during several years, and sometimes - all of one’s life, with periodic aggravations. It includes the following symptoms:

- **Repeated experience of traumatic event** in compulsive ideas, memories, dreams (often having a character of a nightmare). Fear to fall asleep (owing to an anticipation of nightmares). Sensation of illusory repetition of the event, involuntary vivid visualisation ("flashback").

- Request of silence, supersensitivity to sounds (**hyperacusis**), fear of loud sounds (**acusis fobia**).

- **Anxiety**. Constant sensation of threat, fear of a physical or mental attack on the victim and family members.
- Symptoms of increasing agitation shown in infringements of a dream, irritability, difficulties of concentration of attention.
- Sense of guilt before with regard to the victims. It is accompanied by depression, self-effacement, doubts in the ability to love, trust, enjoy a life.
- Constant avoidance of stimulus connected with trauma and blocking of emotional reactions, catalepsy.
- Lowering in positive feelings, interest in activity.
- Character changes: occurrence of the rising aggression, irritability, exasperation, propensity to violence. It leads to difficulties in dialogue with close people and in employment adaptation.
- Infringements in social, professional, educational or other important spheres of ability to live. Quite often alcoholism or drug addiction arise.
- Victims do not realize the connection between the health problems and the stress experienced in the past, which they would not like to recollect.

PTSD is put as a diagnosis in case when the duration of the course of frustration takes more than 1 month.

Regress is typical for children at the stabilization stage, that is return to the forms of behavior typical for earlier age periods. Sometimes regress (occurrence of children's forms of behavior) happens to adults as well.

Many researchers report that children who have experienced psychological trauma consistently reproduce what they have gone through in different forms – in vivid, frightening visualizations, in repeated games with the traumatic event, as a theme in nightmares. Children expect and are afraid of a real repetition of this event (Terr, 1991; Webb, 2004).

W. Yule and R.M. Williams (2001) have conducted detailed analysis of psychological repercussions of psychological traumas occurring in children and
teenagers as a result of disasters and large-scale accidents. They name the following as the most common symptoms:

- *sleep disturbances*
- *difficulties in separation* (striving constantly to be near parents, sleep together with them, etc.)
- *decreased concentration* (in particular, difficulties in concentrating on schoolwork)
- temporary *memory loss*, as well as loss of some earlier skills
- *compulsive thoughts*
- *problematic relationships* with parents and peers
- heightened *vigilance and suspiciousness*
- *loss of faith in the future*
- *fears*
- *irritability*
- *feelings of guilt*
- *depression*
- increased *anxiety*, up to and including panic attacks.

3. **Recovery stage.** At this stage the acute symptomatology gradually disappears, although periodic relapses are possible. At the same time, the personality disorders caused by stress still remain. They are shown in heightened anxiety, sensation of the lack of safety in the outside world, emotional instability. This results in lowered social activity (in comparison with the level of activity before the experienced stress). Difficulties in socializing are observed in many people, especially children. Disturbances of intrafamily relations are frequent. Children often have lowered educational motivation and school progress. At this stage, sensitivity to new stress-inducing situations is still heightened. With many people who have endured psychological trauma,
there arises a predisposition for being a victim – the behavior that leads to person’s often becoming a victim of crimes.

This stage can drag on for a prolonged and indefinite period. In some cases, there is a risk of occurrence of disease which is defined as **chronic personality change after living through a disaster** (F62.0). It is characterized by such symptoms as:

- hostile or the mistrustful relation to the world
- social isolation
- sensation of emptiness and hopelessness
- chronic anxiety, constant feeling of being threatened, “on the edge” type of existence
- estrangement

This condition quite often becomes lifelong. If timely psychological aid is provided, the risk of its occurrence acutely decreases.

4. **Personal and social integration stage.** Reaching (more exactly, reaching the end of) this stage testifies to full recovery from the disorders caused by psychological trauma. The psychologically traumatic event becomes integrated into the person’s life experience. Memories of the event do not bring deep suffering as before, but only some feelings of sadness. Living life to fullest becomes possible for the person.

Accordingly, reactions the following reactions are characteristic for the **shock stage:**

- a stupor or, on the contrary, pathological arousal
- disorders of vital functions (blatant sleep and eating disorders)
- acute vegetative reactions
At the *stabilization stage*, a return to a normal condition starts in favorable cases, and in adverse cases, there is a formation of such symptoms, as the following:

- phobias
- flashback effects
- condition of acute anxiety
- depression, feelings of guilt
- behavioral disorders (aggressive and destructive behavior)
- age regression
- socialization disorders

At the *recovery stage*, there is a gradual recovery from acute symptomatology. Nevertheless, the following remain:

- emotional instability, heightened susceptibility to new stresses
- disturbances in intrafamily relations
- social skills disorders

These disorders are overcome in the next stage – integration.

**Personal integration** includes:

- recovery of personal integrity, feeling of purpose in life
- making plans in life
- recovery from socialization disorders (in particular, intrafamily).

**Social integration** is a recovery of social skills and an active lifestyle.

If no psychological aid is provided, prolonged “fixation” on one of early stages, without movement to the subsequent stage, is possible. A relapse to one of the previous stages is also quite often observed. Usually, it happens under the influence of new stresses or any events reminiscent of the initial psychological trauma. In particular, the anniversary of the psychologically traumatic event frequently becomes a reminder.
2.2. Psychological disorders in children and the teenagers who have endured the Beslan tragedy

The children’s the most widespread concerns were anxiety, sleep disorders and nightmares. Parents described such displays as refusals to eat, behavior disorders, fear of solitude, fear of loud sounds, etc. Many teenagers told of recurring images reproducing separate experienced episodes (flashbacks). Some parents observed increased aggression at children (in particular, in relations with brothers/sisters).

These observations and express diagnostics were evidence of an acutely heightened level of anxiety, avoiding contact with others, of the presence of many children affected by the terrorist attack, of lethargy (up to a stupor and total mutism), of a depressive state most expressed in cases of death of someone in the family. Chaotic, senseless behavior was observed in many children.

A considerable number of teenagers had acute feelings of guilt. The reasons for this could be most varied – that they could not rescue someone from among their relatives or friends, surviving while they died, etc. In one case, a girl had an acute feeling of guilt for being late for school and not being among hostages, whereas some of her schoolmates died. She said that she was afraid that “now everybody will think that I was late for school on purpose.”

Aggression in some cases was expressed and obvious, and more often – suppressed and hidden (especially in girls). The suppressed aggression was shown in the form of high tension, auto-aggression (self-accusation, refusal of meals, etc.).

On the whole, the condition of the majority who applied for psychological aid could be estimated as an acute reaction to stress. In many cases, the condition fell under the criteria of post-traumatic stress disorder (PTSD). Hysterical and psychotic reactions were observed in some clients. Along with this symptomatology specific to the consequences of a mental trauma, aggravation of the children’s previous psychological problems was
observed. The children’s premorbid features (that is existing before the psychological trauma) were considerably amplified – such features as rigidity or, on the contrary, lability, sensitization, capriciousness, negativism, etc. Aggravations of existing mental illnesses were also observed.

The attitude towards school and study was acutely affected in children who were victims of the terrorist attack at school #1. An especially acute problem has arisen among first-graders, who came for the celebration of the first day of school with their relatives. As a result, many of these children lost one or both of their parents (in Beslan, there were more than a hundred such families; 17 children were orphaned).

The first-graders’ first contact with school turned out to be especially tragic. It has colored everything connected with school and study, causing them fear and revulsion. Many children refused to touch favorite items that were in any way associated with instruction – notebooks, books, etc., even though before, they were enthusiastically engaged in preparatory groups at school.

During the entire 2004/2005 school year, more than 30 first-graders did not attend any educational institutions. The majority of them exhibited borderline mental disorders to different degrees of expressiveness. Many children were registered in specific Beslan schools, but did not actually attend. Some children studied in-home, which deprived them of socialization with their peers and an opportunity for normal social adaptation.

The mental condition of children-hostages with whom psychologists at the Rehabilitation Center worked at the outpatient clinic considerably improved, but for a long time remained far from stable. International operational experience with children who have gone through post-traumatic stress specifies a rather long period of rehabilitation (not less than two to three years).

Let us cite the following examples.
According to medical records, asthenic-neurotic syndrome, an acute mental reaction, was observed in David\(^3\), 7 years old. The child was attending several classes at school, but subsequently flatly refused to go there. In the period when he was attending school, he could not study – he looked around at the slightest sounds, shuddered, started to cry over any trifle. Finally, he refused to attend school. His mom observed heightened nervousness, anxiety, and sleep disorders in him. In reply to the offer to continue studies at school, David told mom, “Be patient, I cannot forget everything all at once.” He forbade his parents to mention school, saying, “You led me into a war zone, instead of school.”

Amina, six and a half years old, lost her father and big brother. Her mother was heavily wounded, was in critical condition for long time, first hospitalized in Beslan, then in Moscow. According to her medical records, she was suffering from post-traumatic stress disorder and depression. Severe anxiety, panic reactions, blatant sleep disorders, refusals of meal were noted. Psychologists repeatedly visited Amina in-home and rendered various kinds of psychological aid\(^4\). Then she went to the rehabilitation center at the outpatient clinic. All year, Amina persistently refused to go to school and do anything at home associated with study. The girl’s condition subsequently improved greatly; however, sleep disorders still remained. Even after summer holiday at a resort, she refused to go to school in September 2005, but still continued to visit the rehabilitation center in the outpatient clinic.

Amina started attending school again in 2006. Now she successfully studies in the fourth grade. The psychological condition of the girl is normalized, and there are no outstanding concerns.

As a typical example of an unstable mental condition given positive general dynamics, we will cite the more detailed profile of Diana, 7 years old.

Her entire family was among the hostages. Her beloved grandmother died. Her daddy jumped out of a window as he was disposing of the bodies of

\(^3\) In order to preserve confidentiality, all names have been changed

\(^4\) The first stage of work with Amina is described in the section “Tasks And Techniques of Working with Psychological Trauma in Children and Teenagers.”
the shot men upon the order of terrorists, and was missing for a time. Mom and the younger daughter (one and a half years) were released on the second day, and Diana remained at school alone.

In September, she visited the rehabilitation center at the outpatient clinic together with her little sister rather regularly. During this period, Diana suffered from an acute neurotic reaction, sleep and socialization disorders. Panic attacks were observed at the slightest change of a situation, and communication with mom was symbiotic. Accordingly, for example, after two weeks of visiting the Center, after the girls gradually got used to the psychologists and felt comfortably enough with them, mom, with the permission of the two sisters left for a short while to deliver a care package to a relative and former hostage who was hospitalized in the same building. After mom left, the girls calmly played together for about five minutes, but then suddenly Diana seized her little sister in her arms in a tight embrace, loudly burst into tears and cried, “Mommy, mommy, where you?!?” None of the psychologist’s explanations that mom was nearby and just about to come back would calm her. Bewildered, the little sister looked at Diana, and with terror in her eyes, Diana continued to press her even more strongly to herself – a panic reaction had begun.

It became necessary to lead the girls into the corridor in search of mom who, fortunately, was already coming back. For next time, we and mom agreed that even having received consent from the children, she would not leave them on their own. In the year that Diana did not attend school, she visited a tutor together with mom and passed the first grade program. According to mom, the fear of school and impossibility of being in a large group of children were observed for more than two years, though already by the end of April 2005, Diana began to remain calm without mom in the familiar surroundings of the rehabilitation center, playing with a small number of children (3-4).

Now Diana successfully attends school, and anxiety is not observed. On the whole, the emotional state of the girl is favorable.
2.3. Regression as a result of psychological trauma

One of the most typical repercussions of psychological trauma in children is *regression*, i.e. a return to forms of behavior and interaction with peers typical for previous age groups. For example, teenagers striving to play “preschool” games, to sleep together with parents, etc. Regression testifies to presence of an identity crisis, recovery from which is a necessary condition of further personal development.

We have observed clear displays of regression in rendering psychological aid to the children and teenagers who were victims of the terrorist attack in Beslan. The most obvious display of regression in Beslan’s first-graders was refusal to attend school. Many rejected also home schooling, and tried to completely return to a preschool way of life. If one is to consider that in the last year before school they were to some extent trained in reading, arithmetic, etc. it is necessary to ascertain, that full refusal of schooling meant regression of more than a year.

Vygotsky (1983, v. 4) considered a *social situation of development* as a central characteristic of a particular age group, i.e. system of relations of the child of the given age with society. The social situation of development of the younger schoolboy is characterized, first of all, by him being a *schoolboy*. Accordingly, the termination of attending school becomes the most obvious display of age regression. Here is a specific example –

On September 1, seven-year-old Timur G.\(^5\) went to the first grade and ended up among the hostages together with four-year-old brother Zaur and their father. Terrorists shot his father, and his brothers sustained shrapnel wounds from the explosion but survived. During the next year, the boys’ mother was in deep depression caused by

---

\(^5\) In the interests of preserving confidentiality, the children’s names have been changed.
the death of her husband, and the children were being looked after by their grandmother and grandfather.

A year before school, Timur willingly attended a grammar preschool, and he learned to spell and write. According to his relatives, he studied with great enthusiasm. After the terrorist attack, he flatly refused to attend school and reacted extremely negatively to any attempts by his relatives to continue his education in reading and writing. At the same time, the psychologists working with him observed that other repercussions of the psychological trauma that he lived though were poorly pronounced. There were only moderate nightmares and an unsubstantial increase of level of anxiety (unlike many other children, whose condition was characterized by acute panic attacks and/or deep depression). Consequently, in this case regression was the basic psychological consequence of the psychological trauma.

In this and other cases, it turned out that the system of relations specific to a younger school age that had started to develop was destroyed. The majority of children, and not only first-graders, during the following year did not attend any educational institutions or attended them extremely irregularly. This was due, first of all, to the psychological state of the children, but also to the fact that the various organizations took the schoolchildren to sanatoria in Russia and abroad, taking them away from their studies for a long time (many trips did not coincide with school vacation). Similar complications are rather typical and widespread – “All too often, unhealthy competition between persons interested in providing aid is observed; thus, the victims of the disaster are at a loss.” (Yule, Williams, 2001, p. 303).

If the child ceases to attend school as a result of traumatic regression, there is a disintegration of the social situation of development corresponding to a given age. Beslan children associated the psychological trauma with school and consequently disintegration of a social situation of development has been especially clearly expressed. At the same time, theoretical analysis shows that
disintegration of a social situation of development lies at the heart of any traumatic regression.

By displaying infantile behavior, the child consciously or, more often, unconsciously tries to return to a previous system of relations with peers. For him or her, the former system of relations is safer than the present one, as it guarantees care and protection. Besides, the infantile position, assuring the aid of adults, gives to the child capability of the maximum economy of strength that becomes essential because of asthenic effect caused by the psychological trauma.

Nevertheless, peers are not ready to treat the child as “small.” They are guided, firstly, by his or her chronological age and, secondly, that earlier, he or she was already “big,” and time cannot move in reverse. As a result, surrounding adults regard the occurrence as either “bad behavior” or as an illness. Given pronounced regression, a “medical” interpretation is more typical. In due course, it usually is accepted also by the child him or herself.

Treating the child as a patient and his or her own relation to him or herself interferes with social rehabilitation. The child does not participate in forms of activity corresponding to his or her age and socialization with the milieu (adults and peers). It is the road to psychological handicapping, which can acutely disrupt all further mental development. The status of “patient” becomes an equivalent of the collapsed social situation of development; however, it does not bear in itself that intention which could restore the social situation corresponding to child’s age.

If the entire family is suffering through a psychological trauma, the situation becomes especially difficult (McFarlane, 1987). In this case, not only the child’s own condition, but also the inability of parents to build proper relations with him or her, interferes with the restoration of a social situation of development adequate to the child’s age. In particular, they quite often are afraid to let the child out of their sight even for a short while, supporting and
cultivating a symbiotic communication with him or her. At the same time, sometimes parents emotionally separate from the child, not knowing how to react to some or other behavioral displays or being afraid to infect with their own negative experiences.

As a result, household symbiosis is combined with emotional detachment. The child constantly is nearby parents, however emotional dialogue between them is distinctly weakened. It is possible to tell that they are nearby, but not together.

Traumatic regression manifests itself in disorders of both the child’s general system of relations with the social environment, with society, and in disintegration of individual activities that the child already mastered earlier. In order to understand the mechanism of disintegration of activities it is necessary to first consider the process of their formation.

According to the cultural-historical theory of development of the psyche, each new activity mastered by the child is originally done jointly. At this stage, it can only be carried out with the assistance of another person – most often, an adult (although in some cases – another child). At the next stage, thanks to the process of interiorization, the activity becomes the child’s individual asset. In joint activity, roles are in one way or another divided between its participants. For example, the adult carries out the planning and controlling role, and the child performs practical operations. Sometimes, on the contrary, the adult carries out practical operations, implementing the child’s plan. Other options for division of roles are also possible.

Activities which the child can carry out together with the adult, but cannot perform independently, make up the zone of the nearest development. As specified by L.S. Vygotsky, “That which lies in a zone of the nearest development in one stage of a given age is implemented and passes to the level of current development in the second stage. In other words, that which the child is able to do today in cooperation, he/she will manage to do tomorrow.
independently.” (1982, p. 250). Training, according to Vygotsky, should correspond to the zone of the nearest development of the child instead of an actual level of development.

Disintegration of an action is made in a direction opposite to its formation. At the partial, not especially expressed regress, an individual action breaks up, but the child remains capable of carrying out it together with the adult (regress to a zone of the nearest development). At deeper regress there is a full disintegration of action so its performance appears impossible even with the assistance of the adult.
3.1. Drawing as a method of diagnostics of a mental condition\textsuperscript{6}

Our experience has shown that in providing psychological aid to children who are in an acute condition, unlike other kinds of psychotherapy, it is not required to allocate diagnostics to an individual, independent stage of work. This is explained by the particular intensity and self-evidence of the symptomatology at which therapy is aimed, and also the lack of time in conjunction with the necessity of emergency aid. Assessment of the child’s condition is carried out on the basis of supervision, conversation, parents’ concerns, analysis of reactions to various influences, etc. Nevertheless, there is a group of diagnostic methods which can be very useful – these are drawing methods for express diagnostics.

In recent years, the psychotherapeutic value of drawing (as well as art in general) has been emphasized more and more. Consequently, thanks to application of drawing techniques, the boundary between psychological assessment and a psychotherapy session (Oster, Gould, 2000) has been erased.

In working with stress, drawing diagnostic methods often come to the fore thanks to their portability, high informative value, and simplicity in implementation. Nevertheless, the signs of drawings typical for a stressful state are not completely delineated by an impassable border from those signs that characterize the entire set of personal and emotional features, the specificity of cognitive processes, family and social relations, etc. On the contrary, the most valuable aspect in drawing diagnostics is specifically its systemic nature and the capability to recreate a complete psychological portrait of the person on its basis.

\textsuperscript{6} For a detailed description of drawing methods, see A.L. Venger (2007)
Application of drawing tests for revealing of personal and emotional features of the person is based on the projection principle, i.e. “bringing outside” one’s experiences, notions, aspirations, etc. By drawing a particular object, the person involuntarily (and sometimes consciously) communicates his or her relationship to it. It is unlikely that he or she will forget to draw what seems to be the most important and significant, but what that he or she considers minor will be given much less attention. If any theme particularly excites him or her, then its image will show signs of anxiety.

Drawing is always a message coded in images. The task of the psychologist consists in deciphering it and trying to understand what the client is saying. In order to use drawings for diagnostic use, it is very important that they reflect, first of all, not the conscious dispositions of the person, but his or her unconscious impulses and experiences. This is specifically why drawing tests are difficult to “forge,” in trying to present oneself not as being different than one is in reality.

As with other projective tests, drawing techniques are very informative, i.e. reveal a set of psychological attributes of a person. Nevertheless, they are simple to carry out, take little time and do not demand any special materials, other than a pencil and paper. An additional advantage of drawing methods is their “naturalness,” their similarity to usual kinds of human activity. Practically every person has experience drawing. This activity is most familiar to children; therefore, drawing methods are applied especially often when examining children. It is easy for a child to understand test instructions, and highly developed speech is not required for using the techniques. At the same time, drawings are a convenient way to strike up a clinical conversation.

Unlike the majority of other tests, drawing techniques can repeatedly be conducted as often as needed without losing their diagnostic value. They are applicable to clients of varying ages – from preschool to adults inclusive. This allows their use to control the dynamics of a condition and supervise a course of
mental development over a long period. All of this has also made drawing techniques the most widespread tool in work of the practical psychologist, which is proven, in particular, by surveys conducted by the American Psychological Association.

Certainly, drawing methods are not are not devoid of drawbacks. Their main drawback is the rather low reliability of results, which is associated with subjectivity of interpretation. Unlike more formalized tests – such as tests of intelligence or personal questionnaires – drawing tests, as a rule, do not allow measurement of estimated mental properties quantitatively. The terms which are used to interpret drawings usually lack the exactitude of formalized tests. Consequently, it is difficult to confirm the reliability and validity of drawing techniques using scientific methods. Nevertheless, practicing psychologists are hardly fazed by the insufficient “scientific character” of drawing methods. For them, the advantage that drawing methods bring in work with clients is more important.

Still, the special nature of drawing tests is not to be underestimated. Accordingly, it is not recommended to draw definitive conclusions about psychological features of a client solely on the basis of drawing tests. These tests give grounds for reasonable assumptions, but not for categorical judgments. A definitive conclusion can made only by comparison of the features of drawings to other data (for example, with results of observation, data from clinical conversation or additional, more exact tests).

Drawing. Sometimes one of them happens to be enough, and sometimes two to three or more drawing tests are required.

Drawing tests are sensitive to a large number of various personal and emotional features, such as:

- level of psychomotor activity, the heightened or lowered activity, asthenia
- insufficiency of self-control and planning of activities, impulsiveness
- heightened emotional lability or, on the contrary, rigidity
- uneasiness (as personality trait) and anxiety (as a condition at the time of examination)
- presence of fears
- depressive tendencies
- aggression (with the capability to differentiate its forms, such as physical and verbal aggression, protective aggression, neurotic aggression)
- extraversion or introversion
- demonstrativeness
- non-fulfillment of the need for socialization
- autization, avoidance of socialization
- negativism, antisocial tendencies
- the relation to family milieu as a whole and to individual family members
- level of general intellectual development

In addition, drawings allow to estimate the level of the general intellectual development. In certain cases they allow one to suspect that some features of the drawings present organic brain damage, learning disorders (retarded mental development), mental retardation, a neurotic condition, mental illness.
Instructions for drawing tests

Drawing tests are carried out on un-ruled white paper of format A4. For tests «Drawing of the person», «The House – a tree – the person», «The Nonexistent animal» (with additional tasks), «Family Drawing» a simple pencil with an eraser is provided. For tests «Beautiful drawing» and «Free drawing» – a set of color pencils (18 colors) and a simple pencil are given.

“Drawing a Person.” The test can be conducted from the age of three. Conclusions about the level of intellectual development are most reliable with reference to preschool and younger school age. As a personality test, the technique can successfully be interpreted, starting from senior preschool age and has no “top-end” age restrictions.

Instructions: “Draw a person – everything, in his or her entirety. Trying to draw as well as possible is better – as much as you are able” (the “children’s” version of the instructions is given here; naturally, in addressing an adult, the polite form would be used). For a small child, instructions can be slightly modified – “Draw your uncle. Try to draw better.” After the client has finished the drawing, it is useful to hold a discussion about it, having found out, what kind of a person was depicted – age, sex (if it is not obvious from the drawing), what kind of personality, occupation, what he or she loves and does not love, what he or she expects from the future, what he or she dreams of, etc.

According to the procedure developed by Machover (1949), at the close of the conversation, one more task is given. The client is given a new sheet of paper with the instruction – “And now draw a person of the other sex.” (if this is unclear, it is necessary to explain that this means a person whose sex is opposite to the one drawn earlier). The drawing of the person of the opposite sex is discussed the same as the first. It is useful to assign this task to adults and teenagers. Examination of preschool children and younger schoolchildren does not usually yield the essential additional information.
“House-Tree-Person.” This test is an expansion of the “Draw a Person” test and yields additional information on the child’s psychological attributes. House drawing reflects the child’s relation to “home life,” to family. The child’s notions concerning growth, development and communications with the environment are shown in the tree drawing. If the test “Drawing a Person” has already been conducted, it is necessary similarly to ask the child to draw on a separate sheet (placed horizontally in front of him or her) a house, and on a separate sheet (placed vertically) – a tree. The child provides additional information about who lives in the house. If the child draws a simple fir tree, he or she is asked to draw one more tree, this time – not a fir tree.

“Nonexistent Animal.” This methodology, developed by M.Z. Dukarevich, is very informative. We developed additional tasks – “Malicious Animal,” “Unfortunate Animal,” “Happy Animal,” increasing its information value even more. The “Malicious Animal” task reveals latent aggressive tendencies, and reactions to threats. The “Unfortunate Animal” task is good for identifying latent depressive tendencies, the nature of present fears and the client’s conscious and unconscious notions about his or her most acute problems. Besides it, tasks “Malicious Animal” and “Unfortunate Animal” are good at revealing the degree of the child’s tolerance to different stresses. The “Happy Animal” task is directed at revealing the values and aspirations of the client. All of these tasks can be conducted starting from senior preschool age (from the age of five to six).

Instructions to the initial task – “I want to look at how much your imagination and visualization are developed (a version for small children – how are you are able to think about and imagine something). Think up and draw an animal that does not actually exist, that never was and who nobody thought of but you – which is not from fairy tales, computer games or animated films.” When the child finishes drawing, he or she is asked to think up a name for the animal. This is written in the report. If inventing a name is too difficult, this part
of the task is dropped. If necessary, the child is asked what body parts (or organs) correspond to certain details in the image.

Having found out the name of the animal, the psychologist says, “Now tell me about it, its way of life. How does it live?” The story is recorded literally whenever possible. In evaluation of a teenager or the adult, one can ask him or her to independently write a story about the way of life of the made-up animal. If there is no appropriate data contained in the story, additional questions can be asked:

- What does it eat? Where does it live?
- What does it usually do? What does it like to do most of all? And what does it dislike most of all?
- Does it live alone or with somebody else? Does it have friends? Who? Does it have enemies? Who? Why are they its enemies?
- Is there something of which it is afraid, or is it afraid of nothing?
- What size is it?

Then the client is told to imagine that this animal has met a wizard who is ready to grant any of its three wishes, and the client is asked what these could be. All answers are recorded in the report.

Instructions to the task “Malicious Animal” – “Now think up and draw another nonexistent animal. This time, not just any animal, but the most malicious and terrible animal that you can think up.” Upon completion of the drawing, the client is asked – “In what way is this animal shown to be the most malicious and terrible?” Questions on its way of life can still be asked.

For the task “Unfortunate Animal,” the following instructions are given – “Now draw the most unfortunate nonexistent animal that you can think up,” and for the task “Happy Animal,” the instructions are “Draw the happiest nonexistent animal that you can think up.” Upon completion of the drawing, the
client is asked why the depicted animal is the most unfortunate (happy) what exactly makes it unfortunate (happy).

“Family Drawing.” Various authors offered this technique to reveal features of family interaction in the child’s perception. The technique can also be successfully applied to find out of the relation of the adult to his or her family milieu.

Instructions – “Draw your entire family on this sheet.” Upon completion of drawing, it is necessary to find out, which family members are represented by each of the depicted characters. At the same time, the psychologist should not articulate his or her guesses. Accordingly, it follows from this that one should not point to one of the characters and ask, “Is this daddy?” The questions should sound neutral – “Who is this person? And this person?” It is also possible to ask additional questions of the type “Where is this taking place?” “What are you all doing?” (or “What is each one that you have drawn doing?”), etc. Such a conversation is conducted in free form.

R. Burns and S. Kaufman (2000) developed another version of using this technique – Kinetic Family Drawing. (The technique’s name is not precisely translated into Russian as “Kinetichesky risunok semyi”). Administering the test differs from the classical version in that additional instructions are given – “Each family member needs to be doing something, be occupied with something. The rest of the test coincides with the original version of “Family Drawing.”

“Free Drawing” and “Beautiful Drawing” Both versions of the test can be conducted with children from the age of three. The nature of the color scale the client uses characterizes his or her emotional state to a great degree, more so than a black-and-white drawing. The technique “Free drawing” does not involve any restrictions in the client’s choice of subject and graphic materials. Instructions – “Draw what you want.”
Instructions for the “Beautiful Drawing” technique – “Draw a beautiful color drawing of whatever you want.” During drawing, it is necessary to record in the report the sequence of different colors the client uses. Instructions to draw a “beautiful drawing” allow characterizing the client’s emotional state more unequivocally, than assessment of a completely free drawing. In the latter case, depiction of prior negative experiences, which do not reflect the present situation is sometimes possible. If negative experiences are reflected in a “beautiful” drawing where they contradict the instructions, it is possible to believe with high reliability, that they are important for the client at the present time.

Interpretation of drawing tests

In the most general terms, principles of interpreting drawing tests can be formulated as follows:

1. The conclusion should not at all be based on individual attributes of the drawing, taken separately, out of their context with each other. Interpretation can be relatively reliable only if it is based not on one individual attribute, but is supported by at least the two-three attributes found in the drawings.

2. Upon interpretation of the drawing, it is necessary to assess, first of all, the general impression that it makes (to try to “read the message” encoded in this drawing). Then it is useful to highlight the most unusual features of the drawings of the given child, which distinguishes him or her to the greatest degree from “average” drawings of children of the same age and sex. Only after some initial hypotheses are put forward on the basis of the non-standard features of drawings and the general impression from them, should one move on to analysis of other attributes of test drawings.

3. It is impossible to interpret everything. Interpretation is not amenable to the standard (typical for the given age and sex) way of performing tasks.

35
The attributes encountered in test drawings, are divided into two groups – formal and conceptual. *Formal indicators* are the general features of drawings not concerning the content of the images, such as pencil pressure, style of lines, the size of drawings, etc. *Conceptual indicators* are a presence/absence and features of the image of particular individual details (for example, the presence or absence of hands in the drawing of the person, their size, position, highlighting in this or that way, etc.).

Let us examine some of the *formal* indicators that are most essential to an assessment of a child’s emotional state.

**Pencil pressure**

Pencil pressure allows judgment of level of *psychomotor tone*, general activity. The force of the pressure is reflected in thickness of lines. In a favorable emotional state, a line is usually traced with moderate, uniform pressure. A decrease in the psychomotor tone is reflected in *weakened pressure*, a “high-strung,” hardly visible line corresponds to falling level of activity and is especially frequent given an *asthenic condition*. Weakened pressure can be a sign of insufficient self-confidence and is often encountered in passive, timid children.

*Strong pressure* testifies to *heightened psychomotor tone* or *emotional tension*. The strengthened pressure is also encountered given *hyperactivity*, a *hyperthymic type* or in a *hypomaniacal condition*. Uniform strong pressure is possible given *rigidity*, propensities to “hang ups” on particular experiences and activities. *Super-strong pressure* (the pencil tears the paper) quite often signals a high level of conflictedness, *aggression*. Sometimes it serves as a display of an *acute stressful reaction*.

Sometimes *pressure varies greatly* – some lines are traced with strong pressure, others with weak pressure (or in some drawings it is stronger, in others weaker). This is a sign of heightened *emotional lability*, i.e. frequent change of
moods in an insignificant occasion. Pressure changes reflect the degree of the importance for the child of depicted details or subjects, and consequently, and vital milieus, associated with these details or subjects. Pressure strengthening can be a sign of the psychological burden associated with a certain set of problems (for example, if it manifested itself only in the family drawing, it is an indicator of trouble in the family milieu).

The size of drawing and its placement on the sheet

The size of drawing is estimated in relation to the format of the sheet on which it is drawn. A drawing of average size occupies from 1/3 to 2/3 of the sheets. Increased size of drawings, up to not fitting on the sheet going off the edges, is characteristic of a condition of emotional arousal. Such drawings frequently indicate acute anxiety, a stress condition. They are also encountered given hyperactivity, a hyperthymic type of personality and hypomania.

Reduced size of drawings usually is a sign of lowering of mood and is often encountered given depressive and subdepressive states. It can also be a sign of general lethargy, passivity and low self-esteem.

If there is simultaneously anxiety (for which an increase in size is characteristic) and depression (leading to its reduction), the size of drawing can be variegated depending on which component prevails at present – disturbed or depressive.

Acute fluctuations in the size of drawings are a sign of emotional lability, frequent change of moods. They are characteristic for cycloids with alternation of the periods of the heightened and lowered mood.

Placement of drawings on the sheet can reveal the role of planning and some features of the emotional state. The arrangement of the drawing more or less in a center of the sheet is standard. The unsuccessful arrangement of drawing on the sheet so that there is no room for any significant part of a

7 Subdepression – lowering of mood that is not quite so pronounced as depression
Depicted subject is a sign of impulsiveness, lack of planning. Sometimes these disorders are caused by a condition of acute anxiety, stress.

**Placement of the drawing in a corner** so that most of the sheet remains empty, is characteristic of a lowering of mood, depressive and subdepressive states.

**Care, accuracy and attention to detail in drawings**

The degree of care, accuracy and detail in drawings reveals the relation to the task, motivation and level of self-control. Deviations in both one direction and the other (both lowered and heightened care) can reveal some other attributes of personality and the emotional state.

A **high number of various details** – the pattern on a dress, a bow, ornaments in the drawing of the person, a pattern on a skin of a nonexistent animal, etc. is encountered given high demonstrativeness (requirements for attention to oneself, aspiration to share one’s experiences with others). The richness of various details is characteristic of people with a creative (artistic) approach to the world and often signs of thoughtfulness, propensity for imagination.

**Heightened care** in rendering drawings, a high number of identical details (for example, scales on a nonexistent animal drawn in detail) testifies to a propensity for monotonous activity, about difficulties of switching from one activity to another. Such “viscosity,” propensity to hang-ups (rigidity) is encountered given epileptoid accentuation and also given some kinds of organic brain damage.

Sometimes, the habit of a negative assessment of the drawings by others (parents, teachers), insufficient self-esteem and anxiety is reflected in the heightened care. The combination of anxiety with rigidity, in turn, leads to perfectionism, i.e. to aspiration to perform all work on only the highest level. This personal feature associated with a heightened level of pretense, which as a
result often reduces achievement as a lot of time is unjustifiably spent on trifles so the person quite often has no time left to perform the main part of the work.

**Negligence** in performance of drawings is often encountered given low motivation. It can serve as an indicator of an uncooperative attitude to psychological examination or personally to the examining psychologist. Sometimes, it reflects general negativism (for example, that of teenagers). Negligence is characteristic also for hyperactivity. It is encountered given impulsiveness, a lowered level of self-control and at attention disorders (it is frequent these disorders are a consequence of a stressful condition). The impression of negligence can also be created by minor motor disorders.

**Low attention to detail** in drawings, their sketchiness is typical for a condition of lowered activity. It is encountered given asthenic conditions, depression or subdepression. Sometimes the poverty of detail is a sign of an excessively intellectual approach to the world and reduced emotionality. Low attention to detail can be a sign of an uncooperative attitude to the activity of drawing or to examination as a whole, about the aspiration to avoid intrusion into one’s private world. It is also encountered given negativism or antisocial tendencies. Extreme poverty of details can also sometimes be a sign of impulsiveness.

**Acute fluctuations in care and attention to detail** are often a consequence of instability of attention, impulsiveness. Quite often these fluctuations are encountered with children of heightened emotional lability, frequent change of moods. They can also point to the high importance of certain themes and vital milieus, about the concentration of the personality on these milieus. The positive attitude towards the character (vital milieu) is shown in an increase in the number of details, their increased variety, and the negative by poverty of details, sketchiness and deliberate neglect of the image. The occurrence of a large number of monotonous details is usually a sign of tense relations to the corresponding vital milieu.
Color scale

The nature of the color scale in a free drawing or in the test “Beautiful Drawing” can reveal much about a child’s emotional state. A favorable emotional state is reflected in the use of varied bright (but not excessively fluorescent) colors, including tones from the warm part of the spectrum (from red to yellow-green).

Prevalence of cold tones (from blue to violet) is a sign of some lowering of mood, usually not quite reaching the level of depression. Given more pronounced lowering of mood, cold tones are often joined by black or brown.

Use of dark tones is a much more serious sign of lowering of mood. It can be a sign of depression or a subdepression. Constant use of only dark tones often is encountered given clinical forms of depression. The combination of black with brown and dark blue (or violet) is especially indicative in this respect.

An impoverished color scale, lower density and brightness of color, preference for use of a simple pencil, despite the presence of some color is a sign of decrease in the general level of activity. It often is a sign of asthenia, weakness and exhaustion after having gone through stress. Sometimes the impoverished color scale is a sign of depressive tendencies, subdepressions. A poor color scale in the test “Beautiful Drawing” is especially indicative.

Contiguous soft tones, thin gradation of shades are a sign of high sensitization (sensitivity) and are characteristic of a heightened level of anxiety. They are often encountered with children with insufficient self-confidence and are more typical for girls than boys; in boys they can be a sign of an effeminate nature.

Heightened intensity of color, its excessive brightness, acute contrast of color combinations used, prevalence of bright red or dark red color are characteristic of a condition of high emotional tension. As a rule, it is a sign of a situationally caused increase in the level of anxiety. Sometimes excessive
brightness and contrast of drawings is encountered given heightened conflictedness, aggression.

3.2. Signs of a psychological trauma in children's drawing

Given especially strong anxiety and high emotional tension typical of a psychological trauma, there are often images that do not fit on the sheet or literally “squeezed” into space of sheet. Such is the drawing of 16-year-old Vladislav B, who recently went through the divorce of his parents (Fig. 1).

Fig. 1. «A nonexistent animal» of 16-year-old Vladislav V. who has recently endured divorce of parents.

In addition to the very large size of the animal, anxiety and emotional tension were revealed in the shading with strong pressure (the blackening of parts of the drawing). Vladislav’s story about the animal is extremely short – “This animal is called bumbuborusasu. It lives in the clouds. It eats nails.”
The illogical nature of the description of the way of life attracts the attention – where is animal that lives in the clouds going to get nails? In addition, the way of life is contradictory to the appearance of the animal. It has no wings and is obviously not adapted for life in the clouds. Lapses in logic in describing the way of life of the animal are frequent given both cognitive disorders and in acute condition (neurotic or psychotic). In this case, there are numerous additional signs of an acute condition whereas signs of cognitive disorders are not observed. In particular, both the kind and the name of an animal are original enough and, at the same time, it is quite accurately constructed based on real animals. Consequently, the assumption that Vladislav is in an acute condition, most likely neurotic, is the most plausible, (the disorders are not so blatant as to assume a psychotic condition).

Indications of the use of inedible things for food (nails, stones, glass, metal, etc.) are typical of blatant socialization disorders. In this case, it is plausible that there are socialization disorders caused by the boy’s acute condition. The drawing of a nonexistent animal, in aggregate with the data from other techniques, allows a diagnosis of post-traumatic stress disorder for Vladislav.

Materials of psychological examination of 13-year-old Irina D. show repercussions of the psychological trauma caused by the emigration of the family from Russia to Israel. Fig. 2 is her drawing of a person. He/she is a sad and very lonely person. His or her loneliness is emphasized by the horizontal arrangement of the sheet, which was initially place before Irina vertically. The angularity of the figure and its leanness and “elongation” are typical for the introverted type of person and for schizoid accentuation. The extended figure is frequent and in the sensitized type, given psychasthenic accentuation. It is rather probable that in this case, there is a combination of both schizoid and psychasthenic radicals. The image of hands pressed to a body is also a sign of introvertedness.
The most typical feature of Irina’s family drawing is a super-close arrangement of the characters, which partially cover each other (Fig. 3). It is a sign of symbiotic communication between family members. In drawing the person, Irina arranged it in the center of the sheet and left the most of the space empty, thereby having emphasized the loneliness of the character. Similarly, the family drawing occupies only the central part of the sheet, creating a sensation of disconnection and incapability of any external contacts. Family members are depicted in an introverted pose and most of them have no hands. This means that despite the closeness of family socialization, it is apparently, lacking in emotion. It is plausible that this explains Irina’s feeling of loneliness, which we noted in the analysis of her drawing a person.
In Irina’s family drawing, interest in sexuality natural to her age is shown. Owing to her isolation in the family, it is concentrated, first of all, on her own parents. Its signs are the breast of mother drawn with strong pressure and the emphasized hairiness of the hands and feet of the father.

In the drawing of a nonexistent animal there are expressive signs of high emotional lability – these are the considerable fluctuations in pencil pressure, degrees of detail and care in drawing (Fig. 4). Irina named the animal “koshilop.” It has a large ear, “to be able to hear in order to avoid enemies.” The animal lives in space, alone. It eats stars. It has neither friends nor enemies. Most of all, it would like to lie down somewhere, but is afraid of Earth most of all. As Irina explained, “It was never on Earth, but feels that it is necessary to be
afraid of it.” It has only one desire – “For everything to remain as it is.” Socialization problems are evident in the drawing of the nonexistent animal, as well as in the drawing of the person – the animal lives in space, alone, eats obviously inedible stars; its empty eyes, without irises and pupils, are a sign of possible autism. In the drawing of the nonexistent animal much more than in drawing of the person, anxiety, fear of changes (It has only one desire – “For everything to remain as it is.”), emotional lability, asthenization are present. The signs of asthenization are the incomplete lines and also the animal’s favorite activity – finding somewhere to lie down.

Fig. 4. “Nonexistent animal” of Irina D.

Fear of changes is a sign of a pessimistic position. Apparently, Irina does not expect anything good from the future and would consequently like for nothing to change.

Irina’s parents consulted the psychologist with the concern that she does not have friends and girlfriends. In conversation, Irina reports a feeling of
loneliness. The given examinations confirm the presence of pronounced introvertedness, nonconformism and originality in the girl’s thinking. Consequently, in this case, schizoid accentuation is possible. The low adaptability peculiar to schizoids in combination with asthenitization became the reasons why emigration caused a markedly pronounced stressful condition in the girl. Participation in collective activities was recommended to Irina for treatment of socialization problems – activities in a hobby group or studio, preferably with an artistic orientation. Attendance of group therapy would be useful.

The delayed repercussions of psychological trauma are reflected in the drawings of 14-year-old Vadim T. Vadim's parents were deprived of parental rights. The boy was raised in an orphanage, and was subsequently adopted. Having received the standard instructions – to draw a nonexistent animal – he depicted a “boxer” (Fig. 5), and wrote an extremely short story about it – “This is a boxer. He defeats everybody.” (This is also noted in an inscription in the drawing – “Hurrah – Victory”).

Fig. 5. “Nonexistent animal” of 14-year-old Vadim T.
The pronounced portrayal of muscles, fists and especially wide shoulders are a sign of the high importance of masculine (“man’s”) values. In combination with the being’s basic activity (boxing – an aggressive type of sport), it may be a sign of a heightened level of aggression. Nevertheless, the direct symbolism of aggression is rather scarcely depicted in drawing – these are the canines and the fists enhanced with boxing gloves and drawn with strong pressure.

The particular brevity of the narrative apparently serves as a means to avoid self-disclosure. Quite possibly, it is aggression that is specifically being hidden. An additional basis for such assumption is that in the drawing Vadim depicted a socially acceptable form of aggression (boxing). The acutely emphasized protection round the depicted figure (ring ropes) is a sign of a strongly pronounced tendency to control external forms of behavior.

Any doubts about Vadim’s true level of aggression disappear upon seeing his depiction of a “malicious and terrible” animal (Fig. 6). Since in this version of the test, the instructions legitimize aggression (i.e. allow it), this time the corresponding symbolism is presented in full. There are two acute horns on the head and one on the nose, long spurs on shoulders and on the knees, claws on the feet, a jagged dagger in one hand and a mace with large spikes – in another. All of these accessories are accentuated by a line with strong pressure, partially covered over.
The story about the malicious animal is a little more developed than about the plain animal – “It’s a vikongorigosaur. It lives in the mountains. It is malicious, defeats everyone. It lives alone. It eats people.”

It is interesting that except for the aggressive symbolism, the “vikongorigosaur” looks similar to the “boxer.” It is as though he is saying to the viewer, “This is how I try to look (“boxer”), and this is how I actually look (“vikongorigosaur”).” Accordingly, the main repercussion of psychological trauma in Vadim as is encountered quite often, is essentially heightened aggression. The major task of psychological correction work with him is reaction to and channeling the aggression.

Especially acute intrafamily conflict can be seen in the dynamic drawing of a family by eleven-year-old Konstantin K (Fig. 7). Usually in a dynamic drawing, at least one of the family members carries out a certain “family” role. Most often, it is mom making dinner. In Konstantin's drawing, the family
subjects are entirely absent. Each of characters is engaged in activities that are not in any way associated with the others.

Fig. 7. Dynamic drawing of a family by eleven-year-old Konstantin K

The most expressive element of drawing is a bathroom door behind which the boy has placed himself. Shortly before the visit to the psychologist, he had been locked by parents in the bathroom for three days as punishment for blatantly aggressive behavior at school. In the drawing, the situation is re-thought. A sign is hanging on the bathroom door – “Do not enter. I am occupied.” Thereby Konstantin shows that he has locked himself in, although in reality, he was locked in by his parents. The scene depicted in drawing may be interpreted as a counter-refusal of the boy to have any contact with his parents. It is emphasized in the additional strokes which are fencing off the door from the surrounding space. The strokes are sloppy and made with very strong pressure that is a sign of high emotional tension.

Parents are caricatured. The father has a huge belly and pimples are drawn on the face (as points on the forehead). Instead of feet, the mother has something akin to hooves. The lips are deliberately emphasized, the eyes are
empty, the pose ridiculous. This is the manifestation of Konstantin's negative attitude and his protest against applied “pedagogical” influences. An interesting detail on the door is a symbol which is normally used to mark a men's public restroom. In this case he is apparently saying that the relationship with the mother is more conflicted than with the father – for her, entry is barred definitively and irrevocably. The same goes for her remoteness and her directedness towards herself, while the father is facing the door behind which the boy is supposed to be.

In the given situation, urgent measures on adjustment of normal socialization with the child are necessary. If it is not restored, the most acute protest reactions are very probable. The form of their expression could turn out to be even more blatantly aggressive, than in the previous case, when he inflicted a serious injury on a schoolmate.

The huge wound is the center of the drawing of a nonexistent animal made 14-year-old Victor K. (Fig. 8). The comment written on it also concerns only this wound (though he was asked to write the name of the animal and to describe its way of life). The text is very short and emotionally unpleasant – “The stomach is ripped open, but it is alive, and blood flows out of it.” Consequently, the text indicates that the wound is the result of someone's hostile activities (“The stomach is ripped open”). The drawing is unfinished. Lines are “fragmentary,” with strong pressure in places, and place where they disappear. Drawing is poorly placed – it is as though it comes off the bottom edge of the sheet. This is a sign of high impulsiveness, high tension. Another adverse sign is the eyes, which are located outside the face.
About six months before, Victor had experienced the most acute mental trauma. His father murdered his mother with an axe. Victor was the first to find the body. During the examination period, his father was in prison, and the boy lived with his grandfather. The given examinations testify to the presence of strongly pronounced *post-traumatic stress disorder*. Consultation with a psychiatrist is recommended for Victor.

Having out the “Nonexistent Animal” test, 12-year-old *Igor I.* depicted a ghost soaring in front of a graveyard cross (Fig. 9). The symbolism used is a sign of *acuteness of a condition* and a high level of *anxiety*. The anatomic details testify to the same (the bones of the hands, a skull instead of a face) and the formal features of the drawing – the incompleteness of the image, its
unclosed contours, very pronounced fluctuations of pencil pressure, multiple lines, numerous deletions and corrections. Igor was brought up without his father, and about six months prior to the test, his mother had died. This served as the reason for the occurrence of the post-traumatic stress disorder reflected in its drawing.

Fig. 9. “Nonexistent Animal” made by 12-year-old Igor I

3.3. Drawings of Beslan children and teenagers

The drawings of suffering children and teenagers are indicative of the acuteness of their condition. Especially acute conditions were quite often shown in the “disappearance” of the subject drawing. Paints of different dark colors were blotted on the sheet, so a shapeless brown stain formed as a result.
Sometimes the sheet was filled with chaotic lines. An example of this was the free drawing of eight-year-old Inga A.

Inga was the hostage at the Beslan school. She saw her older brother and sister die. At the time of referral, (12 days after hostages were freed) strongly pronounced signs of a depression were observed – deep general lethargy, Mask-like face and total mutism (full refusal to use speech). In reply to all of the psychologist's suggestions, Inga only shook her head.

The psychologist left her to sit in alone for a time so that the girl would get used to the surroundings. Then she was again offered paper and various drawing materials. This time, she silently agreed to draw and marked up the entire sheet with red and orange felt-tip pens (see Fig. 10).

Fig. 10. The free drawing of eight-year hostage Inga A, made in 12 days after liberation.

---

8 The first stage of work with Inga is described in the section “Tasks And Techniques of Working with Psychological Trauma in Children and Teenagers.”
Upon an improvement in her condition, there was a subject drawing done in a more harmonious color scale. In particular, the free drawing Inga made three months after the drawing described above. The breadth of shading and the color choice in the first drawing (red and orange) are evidence of extremely high anxiety, emotional intensity. All of this is characteristic of an especially acute stressful state. After three months of psychotherapy, Inga’s condition normalized for the most part. This was reflected in her subsequent “free drawing” tests. The drawing is plot-heavy. Various colors are used, and warm and cold tones are well balanced (Fig. 11).

Fig. 11. The free drawing of Inga A., made after three-monthly psychotherapy

The content of a psychological trauma quite often found direct reflection in drawings, especially if there were drawings on a free subject. Accordingly, in the free drawing of nine-year-old Madina C, her experiences during the stay with the hostages (Fig. 12) are reflected. The drawing was made two weeks
after the hostages were freed. It depicts a crossed-out bearded terrorist and crying “good girl.” The girl has huge eyes with blackened irises (fear symbolism).

Fig. 12. Free drawing of nine-year-old hostage Madina C., made in two-weeks after liberation

Fourteen-year-old **Georgy G.** made an even more expressive free drawing on the same subject, also in two weeks after hostages were freed (Fig. 13). It too has a crossed terrorist at the top of the sheet, and two other crossed out figures are depicted at the bottom. However, the drawing center is occupied with a huge figure of Death with a blood-stained scythe in its hands, surrounded with black
lightning. Active use of symbolism – especially such as the latter (Death with a scythe) – is typical for states of *acute stress*. The dominant black color suggests the presence of a *depressive reaction*. The blood-stained scythe is a sign of *aggression*, which is a frequent reaction to an acute psychological trauma.

*Fig. 13. Free drawing of 14-year-old hostage Georgy G., made in two-weeks after liberation*

![Free drawing of 14-year-old hostage Georgy G., made in two-weeks after liberation](image)

The parents of another former hostage, the six-year-old *Soslan T*, agreed to psychological aid for the first time only six months after the terrorist attack. The boy’s condition was characterized by disorder, high aggression. Soslan’s drawing suggests an *acuteness of condition*. Under the instruction to draw a beautiful drawing it has depicted the crossed bones against chaotic red and dark blue dabs (Fig. 14). He named the drawing “Terrible Death” and explained, “Here there was a dinosaur, he ate everybody and left. Here are blood stains, and here are its footprints.”
The color scale suggests a combination of anxiety, excitation (red) with a depressive background of mood (gloomy dark tone). Soslan is diagnosed with heavy post-traumatic stress disorder.

Fig. 14. “Beautiful drawing” of 6-year-old hostage Soslan T., made in half a year after liberation

Eleven-year-old Taimuraz M.’s post-traumatic stress disorder, though and not so heavy as Soslan’s, was also observed. Taimuraz was not a hostage, but two of his relatives (not close relatives) died during the terrorist attack. The “beautiful drawing” he made four months after the terrorist attack (shortly before New Year), represents snowball-terrorists (Fig. 15). The snowball located in the foreground, holds a child by the throat with one hand and a machine gun in the other hand. The snowball on a background is armed with a pistol and wears the “belt of a condemned man.” Under a fir tree, there is a box
with the inscription “dynamite” and a bag with the inscription “grenade.” Taimuraz explained, “Somebody will think that this box contains gifts, but will open – and BOOM!!!”

The drawing is extremely unfortunate not only in terms of content (reflecting, first of all, aggression and negativistic stance), but also in terms of color scale. Paucity of colors is a sign of an asthenic state and prevalence of black is a sign of reduction in mood and depressive tendencies.

Fig. 15. “Beautiful drawing” of 11-year-old hostage Taimuraz M., made in four-months after terrorist attack

Depression is expressed in the free drawing eight-year-old Anna K., made six months after the terrorist attack (Fig. 16). Prevalence of black suggests it. The paucity of colors suggests asthenic depression in this case.
In the free drawing of seven-year-old Milana G., made during the same period, a combination of large local stains of bright red and black colors (Fig. 17) attracts attention. Such combination is characteristic for disturbed depression (large stains of red color are typical for a state of anxiety, black – for a depression).
Chapter 4. TASKS OF PSYCHOLOGICAL SUPPORT AT DIFFERENT STAGES OF EXPERIENCING PSYCHOTRAUMA

4.1. Basic forms of psychological aid

Depending on time of rendering aid and tasks to be solved, it is possible to distinguish emergency, short-term and prolonged psychological aid.

Emergency aid is necessary directly after a traumatic event – in the first days or weeks (depending on the gravity of psychological trauma). It is also provided given a revival of acute symptomatology as a result of additional stresses. In particular, anniversaries of tragic events quite often become such stresses.

Short-term aid is provided within the first months after a psychological trauma. If the child has not received such aid in due course, quite often it is necessary to provide it at a later period. In this case, it becomes less effective and can occupy more time.

Prolonged aid is provided for several years after a psychological trauma.

The given categorization is conditional to a significant degree. In reality, these kinds of aid are quite often provided concurrently. Accordingly, emergency aid starts right after psychological traumas, at a crisis stage, but proceeds also at the stabilization stage. Short-term aid starts at a stage of stabilization and continues at the recovery stage. Prolonged aid starts at the stage of recovery and continues at the integration stage. It continues for two years or more.

The tasks of psychological rehabilitation of children and teenagers that have gone through deep mental trauma are essentially different from one another directly after the event and some months later. At the first stage, rehabilitation work as a whole can be characterized as medical and
psychological and as psychological and pedagogical at the second stage. This also defines the selection of specialists who are carrying out such work.

Countering acute reaction to stress requires not only specifically psychological or medical measures, but, first of all, providing comprehensive care –

1. Removal of victims from a dangerous zone, their accommodation in familiar, habitual, safe conditions. Provision of rest, warmth, drink and food.
2. Victims cannot be left in solitude and uncertainty. They need to be able to voice their concerns. It is necessary to listen to them without interrupting, hurrying, criticizing – with full sympathy.
3. Victims need information. It should be truthful, with an explanation of measures to be taken.

In order to avoid fixation on the tragedy, it is possible to divert the attention and imagination of victims to the near future with creation of a positive prospect, a reference to their personal resources.

Right after psychological traumas, the primary goal of emergency psychological aid to suffering children and teenagers is express correction of the most acute symptomatology interfering with the child’s normal behavior –

- recovery of a normal sleep and feeding patterns (that creates favorable conditions for recovery of the central nervous system)
- maintenance of a normal level of general activity
- treatment of acute phobias, depressions, acute anxiety, flashback effects

Removal of these symptoms promotes the further normalization of the psychological state and makes for active use by the child of his or her coping strategies. Such tasks are typical for short-term psychological intervention which, unlike long forms of psychotherapy, is directed not at maintaining deep
personal transformations, but at “disposal of negative experiences, discomfort or depression” (Garfield, 2002, p. 24). According to the available data, an essential increase of level of subjective well-being can already be reached in one to two psychotherapy sessions (Nardone, Waldwick, 2006 Howard et al., 1993).

Recovery from, or a decrease in, emotional discomfort is important not only in and of itself, but also as the preventive measure reducing risk of the subsequent development of post-traumatic stress disorder. It is established, that in the absence of special preventive work, this disorder is present in 70% or more percent of children and teenagers who have lived through deep psychological trauma (Nadir et al., 1990).

The specificity of work at the stage of emergency aid consists in the following:

- The initiative for referral often does not belong to the client, and the specialist’s energies and persistence are required
- There is no strict regularity of meetings, precise arrangements of relations.
- In some cases, care can be provided at the child’s home. Sources of information for house calls are calls on a “hot line,” data of local doctors, social services, information from neighbors, etc.

**Short-term psychological aid** is carried out, mainly, upon client’s demand.

Restoration of activity reached at the stage of emergency aid serves as an effective remedy for treatment of the child's depression. At the same time, it is quite often accompanied by the actualization of symptomatology which was not observed earlier, owing to the child’s general lethargy. Chaotic activities of little or no purpose, destructive and aggressive displays start to be observed. With most children whose level of activity initially has not been lowered, such
behavior is observed right away at the time of referral. As a rule, as a result of a psychological trauma, socialization with adults and peers is essentially disrupted, and these disorders in most cases are rather long-term.

Given all of the above-mentioned aspects, the primary goals of work at the stage of short-term psychological aid are:

- further normalization of the emotional state
- activity normalization
- catharsis of aggression
- treatment of blatant socialization disorders

Recovery of normal social and intrafamily behavior of children becomes the primary goal of prolonged aid (i.e. works with the delayed repercussions of a psychological trauma). It is very important to provide for regular school (kindergarten) attendance. One of the important problems of work at a stage of prolonged aid is also correction of those of the child’s adverse psychological features which existed already before the psychological trauma and the aggravation of which it has provoked.

As a result of a psychological trauma, socialization disorders with parents and siblings (brothers/sisters) arise. Special work to overcome these disorders is required. For restoration of children’s normal condition and behavior there is a need for psychological work with the child’s nearest environment – primarily with parents and teachers.

Prolonged psychological aid to children who have gone through a psychological trauma, both in terms of its tasks and forms, is close to other kinds of psychotherapy which have been not associated with treatment of stressful conditions. As shown above, emergency and short-term aid has mainly a symptomatic orientation. It is a kind of “psychological first aid.” Unlike it,
prolonged aid assumes much deeper study of the child’s personal problems. A high level of professionalism is required from the specialist to carry it out. This form of aid can be provided only in a limited form due to the lack of such specialists in Russia.

Diversified conceptual approaches and techniques can be used at all stages in providing psychological aid. Currently, one of the most developed vectors in work with children is play therapy (Schaefer and O’Connor, 1994 Webb, 1999). Nevertheless, other kinds of therapy also offer really great opportunities – art therapy, motor therapy, relaxation techniques.

4.2. Tasks for socially-psychological rehabilitation of victims

In cases of mass disasters, psychological trauma affects not only those who directly suffered as a result of the disaster, but also by many other people who are not direct victims. After the terrorist attack in Beslan, practically the entire city was traumatized. One of repercussions of this was that Beslan teenagers’ process of personality formation was disrupted, and they lost sight of vital prospects and plans. A passive lifestyle became customary for Beslan’s senior pupils, resigned dispositions are widespread. Similar problems also arise in cases of natural disasters, large-scale man-made accidents, etc.

Division of society into “victims” and “non-victims” is typical. Between these groups of the population, there is often considerable tension, up to and including open conflicts. One of the most serious sources of conflicts is the issue of the distribution of humanitarian aid. The vivid example of it is the statement by one of the female “non-victim” residents of Beslan approximately six months after the tragedy – “Now they (i.e. the victims) have everything. The next time they take hostages, I will come running first and take all of my relatives with me. Then we will have everything, too.” In addition, some humanitarian aid usually also ends up in the hands of “non-victims,” which causes indignation among the “victims” – “And why are they getting any?!!?”
One more psychological side effect of the humanitarian aid is a formation of a dependant position, a resigned disposition. Such a disposition leads to passivity, decreases in self-esteem and self-respect and finally to an essential decrease in level of emotional comfort, a deepening of an identity crisis.

The specified problems barely affect preschool children and younger schoolchildren a little, but start to affect them strongly in their teenage years. The following tasks for psychological work with teenagers stem from this:

- returning sensation of a normal life
- treatment of passivity and resigned disposition
- awakening of social activity
- treatment of the dissociation of teenagers, conflicts between “victims” and “non-victims”

Group work is most effective for resolving these tasks.

4.3. Tasks for psychological work with families

Corrective psychotherapy with the entire family (Yule, Williams, 2001) has great value for the restoration of a normal psychological state of a child after he or she has experienced psychological trauma. As a result of trauma, normal child-parent communications are disrupted and symbiotic or forcedly distanced relations arise between the child and parents. Given the occurrence of behavioral disorders in the child, parents feel a sense of incompetence and helplessness and involuntarily promote reinforcement of negative behavioral stereotypes – they indulge the child's whims, react in an excessively acute manner to hypochondriacal complaints and try to prevent encounters with the slightest difficulties in life.

If both the parents and the child have gone through psychological trauma (which is typical for mass disasters), the rates of recovery of their psychological state essentially differ. Usually children come back to a normal emotional level
faster thanks to greater mental flexibility and adaptive capabilities. The parents’ condition changes more slowly and interferes with the normalization of the mental development of their children. In spite of the fact that parents are anxious to render assistance to their children, insufficient scrutiny of their own psychological state quite often makes them avoid psychological aid. In conjunction with this, special attention should be given to making parents work on their own psychological problems and difficulties.

*Work with families is especially important when the family structure is disrupted due to the death of the father or mother.* Accordingly, communications break down and the roles of the dead parent do not pass on to the survivor. The most acute cases are widowers who are bringing up small children. Everyday care of a child is an unusual role for them. Their emotional state can remain very strained for a long time. It is aggravated by the widespread notion that seeking psychological aid is humiliating for a man and is a sign of inexcusable weakness. Grandparents often assume a great burden; however, they are not always ready to perform this role and also experience psychological trauma.
Chapter 5. CULTURAL APPROACH TO PSYCHOTHERAPY AND PSYCHOLOGICAL CORRECTION

5.1. The general principles of the Cultural approach

The notion that its central task is development of the personality of the client is characteristic for the various schools of non-medical psychotherapy. This notion is the most developed within the limits of the humanistic school (Rogers, 2001). Accordingly, the general theory of development of the personality serves as the most adequate theoretical basis for psychotherapy. One of the most developed similar theories is the cultural-historical theory.

This theory is usually considered as the basis of psychology of development and pedagogical psychology. The major schools of psychological practice which arose in the wake of clinical psychology, such as psychotherapy and psychological consultation, traditionally have other foundations – psychoanalysis, humanistic psychology, behaviorism, etc. Nevertheless, the cultural-historical theory equips the psychologist with concepts and methods that can essentially enrich the palette used by a psychotherapist. The contribution of this theory is especially significant for structuring work with children and teenagers.

The definition of “cultural-historical” is rather broad and indistinct. Apparently, it is necessary to search for sources of this approach in Emile Durkheim, Pierre Janet and other representatives of the French sociological school. Nevertheless, in the given context, cultural-historical psychology is taken to mean the version, the foundations of which were laid by L.S. Vygotsky and which has been developed further by his students and successors – A.R. Luriey, A.N. Leontiev, A.V. Zaporozhets, D.B. Elkonin, P.Y. Galperin, et al.

Can the conceptual and methodological device of this concept promote the substantial analysis of existing psychotherapeutic techniques and the design of new ones? For an answer to this question, let us summarize what in our
opinion are the major tenets of the cultural-historical concept, according to L.S. Vygotsky’s work “History of the development of the higher mental functions” (1983, v. 3), in which they it are outlined extremely accurately and in an elaborate manner.

1. According to the first tenet, the specificity of human mental processes is defined by their mediated structure. According to L.S. Vygotsky, “All of these processes are processes of mastering our own reactions using various means” (p. 273). As such means are the signs developed by mankind and symbols – the native language words, the standard gestures, graphic schemes, etc.

2. In later works of Vygotsky’s students and successors, the accent has been made on the ways in which psychological remedies are used. Mastering a method is a mastering the way it is used. Orientation in a situation plays a major role in the use of psychological remedies (Leontiev, 1983 Zaporozhets, 1986, v. 2 Galperin, 1966).

3. Psychological tools are developed by a society during its historical development. They are acquired by the individual thanks to a process of interiorization – “assignment” of some social attitude and its transformation into individual mental function – “Any higher mental function must pass through an external stage of development because the function is primarily social. It is the center of all problems of internal and external behavior. Many authors have already long since referred to the problem of interiorization, internalizing behavior.” (Vygotsky, 1983, v. 3, p. 144). So, for example, index gesture is originally used to direct attention of other person to a subject interesting me. Further it starts to serve also as a control facility of own attention: I really or mentally point myself to a subject to which I wish to concentrate the attention.
4. Applying an interiorized psychological remedy, a person gains the ability to operate his or her behavioral and the mental processes at will, to organize them according to his or her own intentions. Accordingly, Vygotsky contrasts the voluntary attention of a human to involuntary attention of an animal – “The attention of an animal, even a trained animal, is already involuntary since the human dominates this attention, and not the animal. Animals do not have transition from mastering by others to mastering by self, from submission to domination, the transition which makes up the most characteristic line in development of the attention of a human.” (p. 212).

These positions have received the most detailed experimental development as applied to development of cognitive processes. Nevertheless, they concern forms of specifically human development. In particular, they are completely applicable to the development of personality in the course of psychotherapy.

L.S. Vygotsky’s quoted work, in starting an analysis of the role of psychological remedies in mastering one’s own behavior, goes into detail on specifically human ways of decision-making. As the means to help resolve the “problem of Buridanov’s donkey,” he names the drawing of lots (citing Levi-Bryulya) and “dreaming on a set theme” used by the tribes of Southern Africa.

In one of the subsequent chapters, he cites his own experimental research into formation of voluntary action in a child. In this research, the child needed to make a choice between two courses of action. Both choices contained both pleasant and unpleasant outcomes and had approximately identical appeal to the child. As a way to overcome endless vacillation, the child was asked to draw lots – throwing a playing cube with black and white sides. The child decided in advance which option he or she would choose given a black or whiter side. This device allowed him or her to quickly and easily choose one of the options. As a
matter of fact, this is a direct way to create psychotherapeutic techniques for work with highly disturbed children for whom the problem of any choice is extremely acute.

D.B. Elkonin, in analyzing the origin of cultural-historical psychology, sees its source in Vygotsky’s early experiments devoted to art psychology – “L.S. Vygotsky… shows how by means of their art structures they (works of art – A.B.) having an influence on readers, organize and direct consciousness of the latter on quite certain affective-semantic formations.” (Elkonin, 1989, p. 477). A.V. Zaporozhets, also referring to Vygotsky’s book *The Psychology of Art*, puts forward the thesis that “in the formation of mental activity which is necessary… for emotional anticipation of repercussions of one’s own activities, figurative-expressive means have significant value… These expressive means and this *language of feelings* have a social origin. Its most perfect forms are presented in art.” (1986, v. 1, p. 270, the italics are the author’s). It is obvious that these views find direct expression in the psychotherapeutic process.

The general logic of cultural-historical psychology quite often leads researchers to a set of psychotherapeutic tasks even in cases when initial research problems were limited to the resolution of purely educational problems. This is most distinct in a number of the works produced in recent decades, when natural development of the basic method of cultural-historical psychology – the experimentally genetic – informed the transition from laboratory experiment to field study. Accordingly, psychotherapeutic aspects clearly figure in G.A. Tsukerman's research on inter-age cooperation (1993). We will also reproduce an excerpt from a student report from a participant of M. Cole’s project “The Fifth Dimension” – “I came to know everyone here well. We were almost like a small family here – after all, we helped each other and shared our thoughts about children with each other. Never in any way did I expect that I would form such an attachment.” (Cole, 1997, p. 338). The tone of
Accordingly, cultural-historical psychology gives a reliable substantiation of psychotherapeutic methods since it has access to the necessary theoretical toolkit and categorical device. It has so precisely defined the main development path of psychotherapy that psychotherapy has been following this path for a long time, not even addressing cultural-historical psychology at all. In particular, in recent decades, psychotherapeutic use of the expressive means of art is becoming more and more prevalent – art therapy, music therapy, drama therapy, bibliotherapy and story therapy.

Nevertheless, not being included in a serious theoretical context, these methods are frequently used “blindly.” Consequently, their application is usually limited to treating individual adverse symptoms. As distinct from the latter, the approach from positions of the cultural-historical concept allows resolving the much more essential task of normalization of the general course of the child’s mental development with the use of similar methods. A condition for this is inclusion of the methods of art therapy in a complete system of the child’s interaction with the social environment – parents, other adults, peers.

The art therapy methods for the cultural approach are the most organic, because the most powerful, universal and socially-developed means of processing experiences are presented in art. At the same time, quite often it is productive to use simpler psychological techniques. The psychological technique is understood as a means, the basic or even sole function that serves to influence a person’s mental processes. Owing to the latter, it differs from means with another primary function – such as, for example, from language (the primary function of which is socialization and communication), from expressive means of art, etc.

From the point of view of the cultural approach, the major problem of psychological correction is recovery of the child’s social situation of
development. It is reached thanks to the organization of some “interim,” substitute situations of development, consistently and gradually returning the child to the system of relations with society standard for his or her age (i.e. with adults, peers, social institutions – above all, school).

The cultural approach provides for the following main principles of structuring work –

1. The psychotherapist offers the child certain psychological remedies, the most effective for treatment of existing problems. Preference is given to common cultural means (instead of means specially invented for psychotherapy).

2. In the course of psychotherapy with the child, the way to use the administered treatments is revealed, i.e. the psychological mechanism of their action. This facilitates autonomy of their subsequent application and prevents the occurrence of dependence on the therapist.

3. The process of interiorization, “appropriation” by the child of psychological remedies and the ways of their use is purposefully organized.

4. In choosing psychological remedies and building a system of therapeutic relations, special attention is paid to the specifics of the culture to which the child belongs.

5. In correctional work, substitute situations of development are created that allow restoring the child’s social situation of development standard for his or her age.

Practical application of these principles will be illustrated in subsequent sections of the book.

Let us separately address the issue of psychotherapeutic relations. Within the framework of the cultural approach, the psychologist does not assume a parental position, as in psychoanalysis. It is also not “friendship for money” as
the system of relations in personality-focused psychotherapy is sometimes ironically called. When working in a cultural-historical paradigm, the psychologist acts as a teacher, who controls the way psychological remedies are used, which the client-pupil still has to master. Nevertheless, it is not at all a position of Teacher with a capital T, the teacher of life. This is its essential distinction from cognitive psychotherapy, where the therapist represents him or herself as the carrier of “correct” life dispositions, unlike the client, whose dispositions are “wrong.” (see Beck, 1979).

The analysis psychotherapeutic techniques from the standpoint of the cultural-historical approach should answer the following questions –

- What basic psychological remedies are offered in the given system of psychotherapy to the child and what ways to use these treatments does the child form?
- How is the social relation between the child and the therapist built, and how effectively is interiorization of remedies and their “appropriation” by the child reached?
- What measure of autonomy and independence is provided to the child in management of his or her own mental conditions and activity?

Some of these questions are covered by the founders of particular schools of psychotherapy. For example, in art therapy, already the name of the method specifies that it is based on the use of the expressive means of art. At the same time, adherents of art therapy, as a rule, do not address the issue of the specifics of relations between the client and the therapist. On the contrary, in personality-focused psychotherapy building therapeutic relations becomes central (C. Rogers, 2001), and the issue of psychological remedies is not addressed. On the basis of the analysis of applied techniques, it is possible to assume that as the basic means within the limits of this school, client-therapist relations serve as
the structure itself. As a result of its interiorization, new notions of the client about him or herself are formed, his or her level of self-esteem rises and a feeling of self-worth appears.

Consequently, the cultural approach allows for the creation of new psychotherapeutic methods as well as more complex analysis and subsequent improvement of techniques developed within the framework of other approaches.

The techniques based on the cultural approach have proven to be highly effective in practice. We applied them successfully in work with the repercussions of acute psychological trauma in the hostages of Moscow’s Theater on Dubrovka and the school in Beslan, and also in psychological correction work with children and the teenagers who were the victims of local accidents.

The individual techniques useful in working with psychological trauma are presented in subsequent chapters. It is not our goal to offer any complete system for psychotherapeutic work. Such a system is always built individually, applicable to the age, a condition and specific features of a specific child. Nevertheless, in order for it to be built, it needs material – a set of methods, techniques, approaches. Such techniques and approaches will be described subsequently. Some of them are applicable only to children of a certain age (for example, to teenage years or early childhood), while others are more universal. But, of course, absolutely universal methods do not exist. Therefore, only experience and professional intuition can guide the psychologist in which of the approaches described by us is useful for applying in each specific case.

5.2. Restoration of previously mastered activities

Psychological correction, as well as “ordinary” instruction, is built up taking into account the level of regression. Given full disintegration of activity, the first task is its restoration in the joint form (i.e., its return to the zone of
nearest development). This variation is naturally defined as the primary correction. If activity remains in a zone of the nearest development, psychological correction is directed at its restoration to a zone of current development, acquiring a rehabilitatory task. Restoration of the ability to independently carry out the activities mastered earlier serves as an important component of the child’s normal social skills.

As with any instruction, psychological correction is based on use of psychological remedies (signs) acting as “regulators” of the child’s activities. A typical example of such a remedy is the word in its regulatory functions (Vygotsky, 1982). At first, the adult directs the child’s behavior by using words (For example, the adult asks, “Where’s the lamp?” and the child points to a lamp). Then the child starts to use words to direct the behavior of the adult (for example, asks, “Give it to me,” and the adult gives him or her the desired object). And, at last, the child learns to direct his or her own behavior using words (gives himself or herself self-orders).

Along with a word – the most universal of psychological remedies – Vygotsky named also other kinds of similar means for providing for the organization of behavior. These are, for example, demonstrative gestures, small knots “for memory,” drawing lots, helping make a decision when the person is at a loss to choose from two available alternatives, etc. (Vygotsky, 1983, v. 3). A person does not invent psychological remedies independently. They are developed by a society in the course of its historical development and remain in human culture. The child masters them in the course of socialization and joint activity with adults.

Reflecting on how a child masters psychological remedies (or signs as Vygotsky called them), D.B. Elkonin (1989) wrote in the scientific diaries – “The significance of a sign is in the function of the other person which is entered into the organization of behavior. These can be diverse (the deciding factor, the controller in general aiding, reminding about someone). A sign is
something like a gift. After all a gift is a reminder of the one who has made it. For this reason, a sign is social and this is specifically why it organizes behavior.” (p. 514). Continuing D.B. Elkonin's analogy, it is possible to tell that the “shop” in which the adult gets his or her “gift” (a sign) is human culture.

This mechanism can be illustrated in the example of working with seven-year-old Amina E.

In mid-September 2004 employees of a telephone hotline transferred a request for house call to us in order to assist a girl who as a result of deep psychological trauma lost the capability to independently fall asleep. Amina was taken hostage together with her parents and older brother. The father and the brother died, the mother was hospitalized for several months with serious injuries, first in Beslan, then in Moscow. Amina herself was injured with burns and some light shrapnel wounds. According to her medical records, she was suffering from post-traumatic stress disorder and depression. Severe anxiety and panic reactions were noted.

While visiting Amina at home, her grandmother said that the girl refuses to eat, sleep, shouts loudly for long periods, especially when evening comes and it is time to go to bed. At times when it is possible to put Amina to bed, she is afraid to close her eyes and she screams and cries in fear. As a result, the girl sleeps no more than 3-4 hours a day. During our visit, after a short getting-to-know-you session, Amina, as a hospitable lady of the house from the Caucasus, invited us to the set table. Then she agreed to “feed” a toy doggie and gradually began to eat “for it.” After dinner, Amina listened to a fairy tale together with the doggie and agreed to put it to bed.

A relaxation session was conducted with the girl. The doggie remained on a pillow near her to protect her and keep the nightmares away. Amina was at once informed that the doggie is someone else's and it is necessary to return it to Moscow. Subsequently, the girl began
to go in the afternoon to a play room at a medical clinic. In the evening on two more occasions, Amina herself phoned and said, “Please send a psychologist to put me to bed.” Later, she began to fall asleep herself, without psychologist’s visits, but with the doggie. Every day in the play room, Amina informed psychologists, that the doggie did not feel that it had visited enough and it asked to stay on little longer.” Right before our departure, which she had been warned about, on her own initiative Amina returned the doggie which she had grown fond of, and in exchange got another “protector” a large plush dog.

In this example, it is easy to see that even such a simple activity as independently going to sleep is well visible, can break up completely as a result of psychological trauma. At the first stage of correctional work, the activity comes back into the zone of the nearest development – the girl, earlier not capable of being put to bed, could perform this activity together with an adult (the psychologist). In this case, her skill consisted of showing initiative (the phone calls). The rest – the relaxation exercises, putting her to bed, etc. – was provided by an adult. At the next stage, the activity became independently performed. The girl started to take herself to be with the aid of the toy doggie, which acted as a psychological remedy. In full conformity with D.B. Elkonin's reasons, this remedy was been presented to Amina as the “gift” of an adult. In and of itself, it is developed historically – use of a stuffed toy as the means to calm a child and protect his or her sleep has been ingrained in culture for a long time.

Amina’s high degree of attachment to the toy is indicative. For a long time the girl could not part with it, even though she understood that it was necessary. Finally she managed to do it – it was a result of the next stage of interiorization of an activity when it became accessible and given the lack of the original external remedy.
5.3. Correction of acute anxiety: work with a talisman

In the following paragraph, implementation of the cultural approach with the example of work with one of traditional psychological techniques – a talisman – will be shown. Traditionally talismans were used, primarily by people whose activity has been associated with heightened danger – in particular, soldiers. A great number of people of dangerous trades – test pilots, stuntmen, seamen-submariners, etc. – widely use various talismans to this day.

The psychological role of a talisman consists of creation of feeling of security, confidence that a dangerous undertaking will reach a happy end – i.e., in language of science, a decrease in the level of anxiety. This allows use of a talisman in psychotherapy working with highly disturbed people. Consequently, a cultural resource called upon to aid in coping with oneself in a dangerous profession, is transferred to another milieu. It starts to be used as aid for the neurotic, who equates everyday work or school as a fight fraught with destruction.

In its full form, work with a talisman can be done starting in the younger teenage years. It is this form of work that will be described below. Nevertheless, in simplified and a little modified form, it can also be successfully applied in work with children of younger school and preschool age.

According to the general principles of the cultural approach, work starts with discussion of the psychological role of a talisman. Its possible magic role is put “outside the parentheses” in advance as not being within the competency of the psychotherapist. As a result of discussion, the teenager comes to conclusion that the talisman helps a person to cope with worry and unrest (household synonyms of the term “anxiety”). Since disturbed people are quite familiar with the destructive influence of anxiety on productivity, they immediately understand that in reducing anxiety, the talisman really helps lower the risk of death or other extremely undesirable outcomes. Accordingly, it is widely
enough known that panic is one of the most widespread causes of death in mass disasters (for example, a fire in a public building).

Next comes finding out what objects were traditionally used as talismans. It is important to bring the teenager to understanding that it is completely unnecessary that they be symbols of a religious cult (a cross, an Agnus Dei, a saint’s remains) or objects presumably possessing magic force. It could very well be a medallion with a lock of hair of a child or a beloved woman. Accordingly, the psychological role of a talisman is emphasized. It is decisive that the talisman reminds the person about something very significant and dear to him or her. These memories also serve as the basic calming factor, that remarkably illustrate the words of one of songs from World War II –

You wait for me and do not sleep by the cot,
And therefore I trust that nothing will happen to me.

Additional positive associations are defined by memories of the person who gifted the person with the talisman. As a rule, it was mother, wife or beloved woman. But even this it is not enough. The talisman gathers genuine psychological strength gradually as dangerous situations are safely resolved over and over again (or, at least, it is rather safe). It is already reminiscent of all these successfully resolved situations. Discussion with the teenager of all of these subjects is, as a matter of fact, the organization of his or her orientation in the ways to use talisman.

The following step is a discussion of possible complications. The teenager himself thinks out those complexities which can arise in using talisman, and the psychologist helps him or her to recollect the culturally-defined ways to cope with these complexities. If the teenager is too passive, the psychologist names additional possible complications.

The most obvious complication is loss of the talisman. In culture at least two possible meanings of this event are defined. One version is that talisman
loss means that it is not necessary any more, that the person already is more-or-less calm without it. The other version (if the person nevertheless feels uncomfortable without the talisman) is that the person was threatened with some serious trouble and, having prevented it, the talisman spent all of its force. In this case, it is necessary to introduce a new talisman. The same happens in cases when the talisman is broken. If it is stolen, it is only the same type of loss – after all, it is impossible to steal the memories associated with it!

Sometimes the teenager formulates a particular negative version, for example – “Maybe loss of the talisman means that I am threatened with some trouble!” The therapist vigorously rejects such ideas, emphasizing that the teenager can independently establish a symbolic meaning for him or herself of any events, that he or she is free to choose the interpretation which suits him or her more. It may be said, “Probably, one of your enemies would try to inspire to just such a thought in you. But you yourself probably prefer something about which we spoke about earlier. But only you can make the choice.”

A more serious problem is – “I was carrying the talisman, but there was serious trouble anyway.” If this happens several times, no positive interpretations (of the type “without it, things could be even worse”) will help. After all, the main psychological force of a talisman is in the positive associations with it, and now negative associations are connected with it. Even in these cases, culture has provided ritual activities directed at “renewing” a talisman, i.e. revival of positive associations and suppression of the negative. Accordingly, the cross or Agnus Dei should be re-anointed. Stones often used as talismans in Asian cultures for days (and in recent decades, by us), are recommended to be put the in flowing water in order to return strength. It should be explained to the teenager that he or she will feel him or herself whether such rituals “have worked” or whether the talisman has definitively lost its effect. In the latter case, it should be replaced.
The psychologist shows the teenager that the given technique is based on original “games with oneself,” but this at all does not belittle its seriousness. If I want to encourage myself, and I start to sing a cheerful song, then this too is a game with oneself; however, my mood really does improve. Similar “games with oneself” are the basis of any psychological technique. Discovery of the psychological mechanism of self-control with external means is an important step in the direction of interiorization of this method and the teenager’s “mastery” of it.

Some clients see danger in possible dependence on a talisman. This is absolutely true. But that is the way human culture rolls – each new achievement leads to the occurrence of a new dependence. When my computer breaks, I am not at all in a condition to work, even though fifteen years ago, I did perfectly well without it. If electrical power goes out, then it is generally almost a catastrophe.

And one more apprehension is extremely useful. It is possible to forget a talisman at home. It even needs to be forgotten periodically at home, since it is the next step to internalization, reducing dependence on a talisman. It is important to learn to remember it while not having it in one’s possession – then all those calming associations which are associated with it will automatically emerge (probably not quite consciously) in the memory. At first, it should not be done in the most responsible situations – physical presence of a talisman makes associations more vivid and consequently more effectively reduces anxiety, than mere memories of it. Nevertheless, in the future, it will be possible to stop carrying a talisman on one’s person.

The question arises – Why do we even need a talisman at all? Why not directly recollect those benevolent relations and favorable events, which it is associated with? The answer is simple – when the person is worried, disturbed, anxiety-ridden, he or she is not in a condition to independently call forth positive memories in him or herself. On the contrary, he or she will

81
involuntarily start to remember his or her troubles and failures. And one touch of a talisman or only memories of it, fully accessible even in a condition of acute anxiety, calls upon a sum of all the positive associations connected with it.

Consequently, in an intense situation fraught with increased anxiety, a psychological tool prepared in advance by the teenager together with the psychologist is used. It corresponds to the figurative description of strong-willed action, cited by L.S. Vygotsky – “The struggle, thus, is transferred forward, it plays out and is resolved before the battle itself and makes for a strategic plan of battle as though it was anticipated by the commander.” (1983, v. 3, p. 286).

In the described version, work with a talisman does not allude at all to its magic essence and does not assume use of corresponding suggestion – neither direct, nor indirect. Nevertheless, if the teenager believes in its magic force, there is no basis to undermine this belief, especially if it is the believer and the talisman is associated with a religious cult. Therefore it is not necessary to convince the teenager of the absence of magic force in a talisman. It is necessary to only explain that this issue is outside of the psychologist’s competence.

As a rule, someone from among the child’s relatives should be the one to give the talisman to the child, and not the psychologist. An exception can be made in cases where work started a long time ago and the psychologist has had time to become a highly significant person for the child. For example, upon our departure from Beslan (a month after the tragedy) many children were given small toys, buttons, etc. The children were told that these subjects will remind them about “how we played with you, engaged with you and how you learned to overcome your fears.” During our subsequent visits to Beslan, it was revealed that children took the talismans very seriously, stored them and often carried them on their person. Our experience has shown that talisman use helps children and teenagers who have gone through a deep psychological trauma cope with anxiety and fears.
5.4. Substitute situation of development for Beslan first-graders

The description of the Rehabilitation center for children and teenagers at Beslan polyclinic has been given above. In this center we have tried to recreate a normal children's life as much as possible, despite the tragic atmosphere that overtook the city. It was a necessary condition of restoration of both, the social situation of development corresponding to the age of the children, and the situation of life in general.

Talking to the children and teenagers, we named the two rooms in which the Center settled down, “game area”, without advertising their therapeutic assignment. At the same time for the parents we underlined the medical character of our work so that the children's laughter and fun were not perceived by them as disturbance of the tradition of mourning, “feast during plague”. It sympathetically was accepted by parents as they understood well enough that the condition of children was far beyond normal mourning and required psychological help.

For preschool children we considered the Rehabilitation center ("game area") as complete enough embodiment of a replacing situation of development returning children from the world of grief to the world of children's game normal for this age. However, for younger pupils the Center could serve only as the first step on the way to returning into the world of school corresponding to this age period. Therefore we have tried to organize for them one more replacing situation on the basis of school-kindergarten "Rainbow", which was closer to usual school conditions.

In April, 2005 in parallel with game area at the polyclinic there began the work on the second site where we assumed to realize the following type of replacing situation. If game are at the polyclinic was focused, mainly, on medical and psychological work, the new center was meant to be focused on psychological and pedagogical work. The rehabilitation platform was created at school-kindergarten "Rainbow". The center in "Rainbow" was meant for a
narrower group, than the game area at the polyclinic. It was intended mainly for the first-graders who were not attending school. At this group of victims the breaches of social functioning were especially acute.

Two basic zones were organized at "Rainbow" center: Game and Art-educative. The game zone, unlike a game room at the polyclinic, has been to a greater degree focused on didactic (educational) games. In an Art educative zone, also unlike game at the polyclinic, the organized group trainings of graphic activity prevailed over its free forms.

Unfortunately, owing to a number of organizational reasons the scheme of systematic carrying out of the children through two consecutive replacing situations has not been realized in all completeness. However the results adequate to the tasks initially put have in certain cases been achieved. It well illustrates the process of social and psychological rehabilitation of Timur G, whose initial condition was described in section 2.3.

Timur started to go into "game area" at the polyclinic in September, 2004 and visited it for about two months. Then the condition of the boy in general was normalized, and he stopped going to the “game area”. However he still refused to both attend school, and to study at home. In August, 2005, upon the recommendation of the psychologist, he again started to visit game area at the polyclinic and almost at once – the center in "Rainbow". Since the middle of September, Timur began to visit a common first class at "Rainbow" as well (continuing to go several times per week to the rehabilitation center). Now he regularly attends school and studies with pleasure. His psychological condition is stable enough.

Other dynamics of development of a poststress condition is demonstrated by the following example.
Seven-year-old Alan C, his four-year sister Madina and their mother were hostages. The mother of the children died. According to the record in medical cards, both with Alan, and with his sister stressful reaction was observed. During the following year the father was in a heavy psychological condition, but his attitude towards children was careful and attentive. Since November, 2004 Alan started to visit a usual first class at school-kindergarten "Rainbow", however, his emotional condition remained extremely unstable. According to his teacher, he sometimes cried all the day without any visible reason. The slightest change of a habitual situation caused in him a particularly acute reaction. So, almost half a year after the tragedy (in February, 2005) Alan saw an open emergency door which was usually closed at school, and began to explain that, open door meant that the terrorists would soon come. He shouted that it was necessary to escape right away, tried to hide under a school desk. Loudly cried, and wouldn’t succumb to any persuasion. After that case some for several days the boy refused to go to school, and further on visited it irregularly.

Since January, 2005 Alan together with his sister and the father started to visit "Game area" at the polyclinic, and since April – the Center "Rainbow". In May, having heard peals of thunder during a lesson, he gave a sharp panic reaction: cried, shouted, could not calm down by any means. The teacher took him to the psychologist, and after some time Alan calmed down. In the beginning of next academic year he started to go to the new school built instead of school № 1 (in which act of terrorism took place). Now Alan is studying successfully, his psychological condition remains stable.

Analyzing the given example, we see that the child who had endured psychotrauma though attended school, "was not kept" within the social situation of development corresponding to his age. Search of the replacing situation corresponding to his psychological condition was required.
Quite often there simultaneous realization of two replacing situations is used. Possibility of such combination essentially distinguishes the process of psychological rehabilitation from the process of "normal" development of the child, in the course of which each following social situation develops upon the child’s completion of the previous one.
Chapter 6. ART THERAPY IN WORK WITH STRESS

6.1. General characteristics of art therapy techniques

Art therapy, in the broad sense of the term, is use of art media in the therapeutic purposes. In narrower sense, art therapy is understood to be use of graphic media – drawing, molding, cut-outs – for therapeutic purposes. Within the limits of the magic consciousness typical for the child (but in any rudimentary forms remaining in the adult), drawing is perceived as a lever of influence on the depicted subject. Psychologically, it is a powerful means of influencing the experience associated with the subject.

Art therapy represents one of the most effective methods of working with repercussions of psychological trauma in children and teenagers. Various art therapy techniques allow successful resolution of a wide range of psychological correction problems, such as:

- restoration of activity
- decreasing emotional pressure, treatment of anxiety, fears and other adverse experiences and emotional states
- increasing self-esteem and self-confidence
- activity normalization, restoration of the disrupted roles of planning, self-control
- processing of notions about the future
- treatment of communication problems
- restoration of disrupted family relations

Many art therapy techniques have great potential not only for individual work, but also for the organization of group interaction. These features are defined, first of all, by the ways defining tasks. The given theme of drawing has essential value also. Accordingly, in starting to work with a group (on the first
or second activity), it is useful to assign the task of a “group self-portrait.” Subsequently, the same task is repeated at the last therapy session. Comparison of the first and second drawings visually shows the changes which have occurred as a result of activity and promotes group reflection. The drawing can be done on a sheet of A2-format Watman paper or on the back of wallpaper.

**Forms of work** in art therapy differ in terms of many parameters that make it a flexible tool in the hands of the psychotherapist. Some of these parameters are:

- art materials offered to the child
- techniques of creating an image
- the child’s position
- form of organizational work
- proposed theme

**Materials for art therapy and art techniques**

In art therapy, *gouache* is used more often than anything else. It allows making bright dense spots of color, dries quickly and is easily washed off. It is also convenient that it is a covering paint; therefore, the image is easily amenable to correction – it is possible to “draw over” it by putting on a new coat of paint. Gouache allows use of different techniques. Drawing on dry surfaces provides for accurate borders of color spots. Drawing on wet surfaces promotes soft interactions between different areas of the drawing. For work on wet paper, the paper is first generously moistened with a sponge. The same sponge, used instead of a brush, can be used to applied liquid paint. Pastose drawing (that is creation of a thick layer of a dense paint) generates high-density color spots and subsequently allows creating an original effect by scratching the paint with a stick or nail.

Gouache also allows the use of simplified *monotype* techniques. For this purpose, a dense layer of paint is applied on a ceramic tile, piece of glass or
sheet of dense paper. Then a blank sheet of paper is strongly pressed onto it, and the source image is mirror printed. Usually the print differs strongly enough from the initial image, which creates various unexpected effects always causing a spontaneous reaction to the drawing. The resulting print can also be completed with drawing.

Almost the same technique is used to make partially symmetric images occasionally reminiscent of Rorschach tests. For this purpose, the paint is put on one half of a sheet, which is then folded in half. Consequently, a mirror image of the painted half of the sheet is formed on the clean half. Having seen a similarity of the resulting image to some object (just like in Rorschach tests), it is possible to finish it by strengthening the similarity.

**Pastel** is also a convenient medium for art therapy. Similarly to gouache, it allows creating bright color spots, but also thin gradations of shades. Pastel is easier to use than gouache and does not need added water (and, hence, consistent available of pure water). Its relative disadvantage is the incapability to cover one layer with another and thereby make considerable changes to drawing. Color pencils are less convenient, as they do not allow creating bright, saturated color spots.

**Finger paints** liven up the proceedings considerably. These paints are safe, even if the child licks a soiled hand. Using ordinary inks for drawing with pens is impossible since some of them are poisonous. But it is possible to make the necessary mix independently. Starch or flour paste is boiled and then colored with food dyes for this purpose.

In order to make **cut-outs** or **collages**, individual elements of the image are cut out from color paper and then pasted on the sheet serving as a base. If a glossy magazine is used instead of ordinary color paper, it is possible to find ready-made drawings and photos of people, cars, houses, animal, etc. in it. Thanks to it, even if the child is hardly able to draw, he or she can still make a complex and expressive composition.
Such materials as **plasticine** and **clay** offer great opportunities for art therapy. They allow creating voluminous images and bas-reliefs, which additionally enriches the spectrum of expressive media used by the child. Besides, molding provides great opportunities for transformation, modifications of created images, changing one molded object into another. Monotonous small movements typical for molding (kneading plasticine, rolling a ball or “sausages”) have a calming, relaxing action.

**The child’s position, and forms of activity organization**

We hold that the position the child occupies in the course of art therapy is a major characteristic of the particular techniques used by the therapist. On the basis of the analysis of various techniques, we have identified the following basic positions:

- free position
- art position
- performing position
- educational position
- communicative position

The **free position** implies self-expression not addressed to any individual person. The child taking a free position represents what he or she desires and what it would be like. Thereafter, he or she controls the results of the activity (the drawing, the collage or the molded figure) at his or her own discretion.

The free position is favorable for the initial stage of psychotherapy, especially in cases of lethargy, acute shyness or isolation. It is convenient for establishment of initial therapeutic contact. This position helps create a feeling of safety, security and trust in the psychologist. It also provides great opportunities for reaction to actual experiences and expression of the child’s emotional state.
This position is especially natural to preschool children, since at this age, drawing is usually habitual and a favorite activity among children. Compare this with adult clients who quite often refuse to accept a free position, since they do not love or are shy about drawing.

In order to create a free position, it is important to give the child a wider choice of graphic media, not to limit its independence in a choice of subject matter and graphic medium. It is useful to warn him or her in advance that he or she can do what he or she wants with the drawing. He or she can choose to show it to the psychologist or – in group work – to other participants of the group, or not show it to anybody. He or she can give it as a gift to the psychologist or take it away with him or her, if he or she wants.

In order to maintain a free position, the psychologist should not look over the child’s shoulder or openly observe the drawing process in any way. If the psychologist considers it necessary to ask questions about the drawing, it is no longer unforced and becomes obligatory. Upon completion of the drawing, the psychologist asks (but does not demand!) to see it. In our experience, there were practically no cases where the client (adult or child) refused to satisfy this request.

Taking up an art position means that the child acts in a role of the artist making a picture, creating a work of art. This position is most characteristic of graphic activity (V.V. Brofman, in designating this the “auteur” position, considers it to be very specific even for art therapy; however, this statement seems to us insufficiently justified). The art position promotes increased self-esteem and self-confidence, and provides the child sensation with a feeling of worth and importance. It is useful also for overcoming the feeling of the inability to cope with oneself, with one’s experiences and emotional states. If the free position is required, as a rule, given reaction to experiences, art is more appropriate to the following stage, when figurative processing of experiences
becomes the primary goal. This position is appropriate for work with clients of varying ages – from 5 – 6 years old to adults.

The art position is assigned as both the organization of the process of activity and relation to the result – to completed drawing or a picture. Its acceptance is promoted by the “professional” organization of graphic activity – drawing with an easel, with the use of a palette, a set of different-sized brushes, etc.

In answering the child’s questions, the psychologist tries to emphasize his or her “status” – “You are the artist – that means, you can decide how it will be.” In assessing the artwork, the psychologist emphasizes the expressive means and artistic discoveries used by the child (for example, “Drawing the grass lighter here and darker there was very well thought out”). The art position implies absence of rigid management, and the therapist assumes a spectator position.

In order to create the art position, it is necessary to emphasize the importance of the product of the activity – the drawing, collage, plasticine sculpture, etc. It is possible to discuss in advance where the completed work will be displayed. Irrespective of whether this has been discussed, the completed drawing should be displayed in a visible place. It is beneficial to frame it, to present it in an exhibition, etc.

This position is also secured by the child putting his or her signature on the drawing.

Taking up a performing position assumes that the child is conscious of the therapeutic orientation of the procedures being carried out. For him or her, making art acts as a form of work on his or her psychological problems. This position is most appropriate for correction of individual symptoms such as phobias, flashback-effects, heightened impulsiveness, acute anxiety, etc.

The performing position is assigned by means of a detailed explanation to the child of the purposes of the lesson being conducted (certainly, taking into
account the child’s age). If the child is a teenager, it is useful to describe the psychological effects of the given tasks in expressions that are understandable to him or her. Work in a performing position combines well with application of additional psychotherapeutic techniques outside of art therapy – verbal, motor, relaxation, meditative, etc.

Adults accept the performing position easily, as do teenagers who actively seek psychological aid. It is appropriate for younger schoolchildren, and sometimes for older preschool children as well. Children of younger and average preschool age, as a rule, do not accept this position because of insufficiently developed reflection.

The educational position is close to the performing position, but in this case, the emphasis is not on therapeutic influence, but on training the child in certain skills. In particular, it is convenient for formation of skills of self-control, for training to plan one’s activities and abilities to effectively organize work.

The educational position is most natural for younger schoolchildren; however, senior preschool children, teenagers, and adult clients can accept it. In order to create this position, the psychologist, acting as a teacher, explains the goal of the training to the client and gives accurate instructions for performance of tasks.

The communicative position develops when other people guide the child in the activities. It allows using art therapy for empathy development, decenation, ability to understand another person and to express oneself so that one is understood by others. This position can promote treatment of various socialization problems – isolation, shyness, heightened conflictedness, negativism, etc.

The communicative position naturally arises in group work, but can also be established in individual art therapy. In this case, the psychologist represents him or herself as a partner in socialization, emphasizing the aspiration to “read”
the drawing to understand the experiences expressed in it. The communicative position is accessible to clients of any age – both adults and children.

Further in the text, some examples of techniques from the art therapy arsenal will be presented. *We have not tasked ourselves with compiling a comprehensive list of art therapy techniques* (the number of which is extremely large), and we have limited ourselves to only a few illustrations. Accordingly, we want to especially draw the reader’s attention to the fact that each of techniques does not come down to an individual approach, but is presented as the sum of a set of consecutive stages.

**6.2. Art therapy at the initial stage of psychological correction of stress**

Maximum freedom of self-expression is provided by a combination of a *free position*, free choice of theme and absence of any restrictions on the choice of art media and expressive means. Such a combination is useful for work at the initial stage in the treatment of acute conditions.

As it was specified above, the major problem of psychological correction at the first stage of work with stressful conditions is restoration of the child’s activity. Given an especially deep decrease in activity, activity in a free position is most appropriate. Nevertheless, the one-time suggestion to draw something is very often insufficient – either the child says that he or she does not want to draw, or says that he or she is not able, and quite often does not say anything, but also does not start drawing. In these cases, it is possible to suggest for him or her to choose a piece of chalk or a pencil of his or her favorite color. The following step is to ask for him or her to “try” this color on paper. Then one may ask what the resulting color spot looks like. After the child names some association, he or she is asked to finish the image by making it more recognizable.

Sometimes at the initial stage, the child more readily agrees to draw with a sponge moistened with paint (the “dabbing” approach). For this purpose, it is
better to use color paper – for example, it is thus possible to draw yellow stars on dark blue – “the night sky.” Quite often, finger painting turns out to be the most appealing to the child. Nevertheless, sometimes he or she would not like to soil his or her hands. In this case it is not necessary to persuade him or her – it is better to offer other activities.

6.3. The “Fear Destruction” technique

*Applying the technique* – the reduction of fears, the prevention and treatment of phobophobia (i.e. fear of occurrence of fear, – a typical consequence of acute stress in many children that have gone through extreme situations, who have trouble falling asleep from fear of nightmares) will come. The technique is effective in work with children from the age of five to six.

The reduction of fears is reached thanks to the action of the several interconnected factors:

- switching of attention away from the fears and onto drawing
- experience activity (according to F.E. Vasiljuka's terminology, 1984), carried out by means of a symbolic procedure of objectifying the fear in a drawing with its subsequent destruction (reaction acts as one of components of this process)
- the child’s realization that he or she can master the techniques of overcoming of his or her own fears.

The last factor is most important for treatment and the prevention of phobophobia.

*Form of implementation* – individual or group. In working with a group, the effect is amplified thanks to mutual emotional inoculation. It is important that the children making up group are of a similar age and psychological profile.
If the group is too large (more than five or six children) implementing the technique becomes complicated due to difficulties in maintaining close enough emotional contact between the psychologist and each of the children.

**Implementing the technique** is done in five stages – preliminary conversation, image creation, image destruction, rational explanation to the child of the technique and subsequent relaxation (this last stage raises the effectiveness of a technique, but is not obligatory). Implementing each of the stages should vary according to age and the psychological profile of the children, their condition, attitude towards the task, etc.

**Stage I** is conversation with the child about whether he or she is afraid, and if he or she is – what exactly he or she is afraid of and whether this prevents him or her from sleeping, etc. The psychologist should refrain from pressuring the child in order to avoid the occurrence of induced fears; the conversation is conducted in a free and easy tone.

If the child admits the presence of fears (regardless of whether he or she specifically names them or not), the psychologist offers to teach him or her how to cope with the fear. It is enough for preschool children to explain that the fear needs to be drawn. For older children, it is desirable to give motivation such as, “If you wish to banish fear, it is necessary to make it so that it is not in you, but outside – here on this sheet. To do this, you have to draw it.”

If the child does not admit the presence of fears within him or herself, but they come to light from the accounts of relatives or from psychological examinations, in assigning the task, it is possible to use a game (in work with preschool children) or literary preamble (with schoolchildren). In the first case, the psychologist says to the child that the doll (or the person depicted by the child) is very much afraid and it is necessary to help it to banish the fear. In the second case, the hero of the history composed by the child under the guidance of the psychologist becomes such a character.
Stage II – discussion of how it is possible to represent fear, and the subsequent creation of the image. At this stage, there can be following difficulties.

1. The child refuses to draw, asserting, that he will not manage to draw what is necessary. In this case it is necessary to explain that the drawing should not be good at all – on the contrary, fears are better drawn badly as they are bad and there is no need to decorate them.

2. The child does not name specific fears so the image subject is not clear. In this case, one of two approaches is recommended – a.) personification of fear in the form of any very unpleasant, terrible animal, line, etc. (This technique is expedient in work with rationalistic children) b.) the drawing directly expressing the emotional state (at work with emotional children). Discussion of the following type can precede it – “What do you think? What color should fear be? What color is most suitable for it?”, etc. If there are further difficulties, a sample drawing can be made – “I would probably draw fear like this,” – with these words the psychologist draws some rough black strokes, or puts a blot of black ink or some other shapeless black stain on the sheet.

If the child’s acutely pronounced condition of fear activates during the drawing, work should be interrupted for a few minutes to conduct a short relaxation session. Nevertheless, some not too strongly pronounced emotional tension is admissible and even desirable. If it is completely absent, while the child draws, the psychologist tries to support his or her concentration, serious attitude to the activity, using nonverbal means of socialization and individual words of encouragement (“Yes… that’s, like that…”), which provoke partial activation of the feelings of fear.

If the drawing turns out to be emotionally inexpressive, it is possible to take advantage of the example technique described above (“Let me help you a little so that we can see that we are drawing fear. Well, is it as it should be now?”).
**Stage III** – drawing destruction. First of all, it is necessary to obtain recognition from the child that the drawing really depicts its fear (fear of a game character) and consequently, now the fear is not inside (in the head, the heart, or the chest), and is really outside. And since it is there, outside, it is easy to chase it away, to destroy it – it is enough to tear up the drawing for this purpose. The child should be asked to do it.

While child is ripping up the drawing, the psychologist, adopting a high level of emotionality, introduces an indirect suggestion – “Like that, tear it up into small pieces so that nothing remains! May the fear be gone and never come back. Tear it into even smaller pieces, so that all fears will be frightened of you and will run away. Yes, like that! So that absolutely no more fear is left!”

Then scraps are thrown out.

If the child is highly emotionally sensitive or sensitized, to avoid excessive emotional arousal, it is better to suggest that he or she crumple the drawing and throw it out. In this case, the suggestion should not be introduced with undue emotion.

In a case if the child is inhibited, the psychologist may take part in the ripping (or crumpling) – “I’ll help you to chase away the fear so that it’ll never return.”

After drawing is ripped up by the child (probably, with the assistance of the adult), the psychologist collects the scraps, especially emphasizing that he or she is collecting them all and none will remain. Having crumpled the scraps, the psychologist energetically throws them out (“There! Absolutely nothing remains!”). All is done extremely emotionally, seriously and with concentration. Throwing out the drawing is done in the same way if the drawing is not ripped, but crumpled.

Sometimes the drawing made by the child does not reflect the feeling of fear he or she feels. This can be noticed both in the child’s behavior during drawing, and on the impression made by the drawing itself. In these cases, it is
better not to tear or crumple the drawing, but simply put it aside and turn it over, with no emphasized suggestions. The subsequent stages in this case are conducted the same as and in other cases.

**Stage IV** – a rational explanation to the child of the meaning of the technique. The child is told that now he or she knows how to banish fear. This means that if he or she suddenly becomes afraid again, he or she will stay afraid, but will simply draw the fear and chase it away just like he or she just did. It is not even necessary to actually draw a picture; it is enough to only imagine doing it.

Schoolchildren are to be given a more detailed explanation with a reminder on how first the fear is transformed from the real into a drawing, and then it is easy to destroy. For rationalistic children given to reflection (especially teenagers), it is useful to present the procedure technique as a psychological means, emphasizing that it is the procedure that helps person to control his or her mental state on his or her own.

**Stage V** – relaxation accompanied by suggestion (conducted in an awake or drowsy condition, depending on the child’s specific attributes and its attitude towards the situation). The suggestion includes two basic themes –

1) The fear is overcome and will not return any more now the child will sleep easy and not be afraid of anything

2) the child knows what to do if he or she suddenly becomes afraid again – he or she can easily banish fear, having drawn it and ripped up the drawing or only having imagined doing so.

Both themes are repeated several times in different variations. It is no problem if they contradict one another. Children do not notice this contradiction. It is necessary to specify that fear may return; otherwise, the first occurrence of this feeling will remove the effect of the correctional work.
The first theme (disappearance of fear) will be supported by feeling of well-being experienced by the child during relaxation (especially in contrast to the emotional tension during drawing).

The following is an example of work with the Fear Destruction technique.

Edgar M., 9 years old, was brought to the psychologist regarding concerns with sleep disorders and fears. He could not fall asleep for a long time and often woke up with a shout at night. In conversation with the psychologist, Edgar explained that he could not fall asleep, as he was afraid of “ghosts or something even more terrible which comes in a dream.”

The boy was asked to draw the fear such as he feels it. First Edgar refused to draw, saying that he does not know to do it. Then the psychologist began to ask him – “Is your fear beautiful or not? What does it seem to be to you? What color it would need to be drawn in?” After a number of similar questions, which the child has quite adequately answered (“Fear is ugly, black...”), the psychologist said, “Now there, you see that you have already told me all about the fear. Now it will be absolutely easy for you to draw it and then chase it away.” This time, Edgar willingly began to draw. He depicted a black humanoid figure with a wavy trunk and shapeless outgrowths instead of hands and feet.

The psychologist explained that then the fear was easy to chase away – to do it, it was necessary to rip up and throw out the drawing. After Edgar did this, the psychologist told him that he could independently use the technique he had been shown if some time he suddenly had fears again. It was also explained that it was not necessary to actually draw and tear drawing – it is enough to visualize it. Afterwards, Edgar was conducted through a relaxation session and a suggestion was made to him, the essence of which was that he was able to chase away his fear and consequently would not be afraid of anything.
The next day parents informed the psychologist that the night before, Edgar fell asleep easily, there were no fears, but at night he sometimes still woke up – only to quickly fall asleep again. Edgar’s statement completely corresponded to that of his parents.

In conversation with the boy, the psychologist emphasized the importance of the achieved result – Edgar’s acquired ability to control himself, banish his fears and fall asleep quickly. The purpose of the day’s activity was formulated – to learn to fall asleep so as not to wake up at night. As means for achieving this purpose, the technique of consecutive concentration of attention on parts of his own body was assigned. During this activity, Edgar relaxed well and quickly fell asleep. After a five-minute sleep, he felt vigorous and well-rested. The boy was asked to subsequently use this technique independently upon going to bed.

The boy slept well the next few nights. The fears came one evening after acquaintances frightened him with stories about ghosts. But, according to Edgar, he “chased away the fear” just like he had learned to, and was not afraid any more. Consequently, the psychotherapeutic effect turned out to be stable.

**Variation of the technique of using molding**

The “Fear Destruction” technique can also be implemented using a molding material. It is especially appropriate when the child is afraid of specific objects which are easy for molding – for example, dogs. The technique is implemented in approximately the same manner as with drawing. The difference is that after destruction of the object of fear, the plasticine from which it has been molded is not thrown out, but is used to create something the child considers pleasant (a flower, a tree, etc.).

So, for example, parents of four-year girl Lusine, who had the distinct fears interrupting her sleep and causing emotional discomfort, applied to us. Tanks, though they did not represent direct threat, became an object of fear.
During correctional work the girl with the help of the psychologist moulded a tank from plasticine. Upon the psychologist’s suggestion she began to carry this tank hither and yon, imitating the sound of engine growling. «Here is how our tank loudly growls!» – the psychologist commented. Having put on the tank way a small doll, he warned: «be careful, there is a person. Be cautious, going around it».

This preliminary stage of work already had correctional value as it promoted returning of the feeling of control over the situation. To formulate the idea embodied in game actions (that, certainly, did not happen) something like the following reasoning would come up: «These are not THEIR tanks that can knock us down, but OUR tanks which go cautiously and will not knock down anyone».

At the following stage of work the psychologist suggested that the girl made something else out of this tank– «something very-very beautiful». As the tank had been moulded from green plasticine, Lusine said right away that she would make a tree out of it. The psychologist approved the idea and helped the girl to mould a tree on which afterwards multi-colored "flowers" and red "apples" were stuck.

The catamnesis data testified that the work conductet resulted in a stable effect. Subsequently no fears of tanks occured.

6.4. The “Harmonization of a Drawing” technique

Purpose of the technique – to increase the level of emotional comfort, to treat apathetic, depressive and disturbed conditions in children. It makes treatment of late repercussions of experienced stress possible and is effective for children from the age of four. Indications that the technique (or the “Beautiful Drawing” technique) may be applied are such features of spontaneous children’s drawing as:
- paucity of color, use of only one or two colors
- prevalence of dark tones
- decrease in a psychomotor tone (very weak pencil pressure)
- heightened density and intensity of color, especially high contrast of color scale used
- particularly large spots of local bright red or red-orange color.

The psychologically corrective effect of the technique is based on actualization of a wide spectrum of emotional representations, associated with a particular color or a combination of colors.

**Form of implementation** – individual or group (with group of up to five to six children).

**Implementation of the technique.** Children are asked to draw with color pencils or paints that they want. During drawing, they are asked questions that induce children to develop a subject. The task can consist of possibly even more detailed development of a subject. If questions do not aid in achieving this result, then direct instructions are given (“Next to the house, draw a boy who left the house to take a walk,” “Let’s draw flowers on the field,” etc.).

At the following stage of work, the psychologist induces the children to alter the drawing, making it more harmonious. Accordingly, if color is lacking, he or she suggests enriching the palette of color tones used (“Let’s paint some clothes on the boy,” “Let’s make the clothes bright and multicolored,” etc.). In this case, the task consists of increasing density and brightness of color, strengthening contrast and expressiveness of color combinations.

If, on the contrary, initial drawing has turned out to be excessively bright the psychologist suggests softening the color using whiteout (“Let there be fog.”). The same method can be used, if dark, gloomy tones prevail in the initial drawing.
In work with schoolchildren (and senior preschool children at high level of mental development) – it is expedient to combine this technique with composing a story (fairy tale) which makes its start from the first drawing, and is illustrated by subsequent, more harmonized drawings. Duration of one activity should not be too long in order to avoid exhaustion. Usually one to three drawings are done in a session. The technique can successfully be repeated during regular correctional activity. Its efficiency can be heightened using prior relaxation, which creates a favorable initial emotional background. In turn, “Harmonization of a Drawing” promotes stabilization of this background.
CHAPTER 7. WORK IN THE REHABILITATION CENTER

This chapter is devoted to the concrete description of practical work at the Rehabilitation center at Beslan polyclinic (fig. 18 see). Taking part in preparation of the chapter have been L.M.Kallagova and M.T.Kanukova – the Beslan psychologists who worked at the Center since the first days of its creation (at first – as volunteers, then – as regular employees of the polyclinic). The experience of their work with several children is offered in section 7.5.

Fig. 18. The General view of the Rehabilitation center (September, 2004).

7.1. The general issues of the organization of work in the Center

In equipping the game rooms, we tried to create separate zones, each of which would be furnished with the equipment and materials necessary for a certain kind of activity. These zones were provisionally divided into three groups –
“Therapeutic” zones

- a *relaxation* zone (an aquarium; stereo equipment; mattresses, rugs, pillows; small "magic" accessories – little elephants, hand bells, dream catchers, etc.)
- a zone for *catharsis of aggression* (a punching bag and gloves; inflatable swords, hammers and cudgels)
- a zone for *water games* (a basin with water, floating toys, scoops, a water-mill, etc.)

“Preschool” zones

- a zone for *role-playing games* (“doll house” with dolls, toy furniture and dishware; “garage” with various cars and equipment; sets for a “hairstyling salon,” “shop,” “hospital,” stuffed toys)
- a zone for *constructive activity* (sets of homemade products, building materials and “building blocks” of different types)

“Pre-Preschool” zones –

- a zone for *sports activities* (exercise machines; indoor wall ladder; mattresses used as floor-mats; dry pool; balls, hula hoops; spring mattresses used as trampolines)
- a zone for *art activities* (paint, brushes, water, pencils, pastels, clay, white and color paper for collages, etc.).

Consequently, tasks for psychotherapy and social rehabilitation were actually combined in work with children. Division of zones into “therapeutic,” “preschool” and “pre-preschool” was appreciably provisional. Accordingly, psychotherapy was not limited to the “therapeutic” zones, but was also conducted in “preschool” zone (for example, in forms of play therapy), and in “pre-preschool” zone (in particular, in forms of art therapy). Staging of a doll performance in the game zone more likely pertained to the “school” forms of the organization of activity, rather than “preschool.”
For the sake of the children and teenagers, we named these rooms “game rooms,” and did not advertise their therapeutic purpose. At the same time, we emphasized the medical character of our work for parents so that they did not perceive the children's laughter and fun as a disruption of the tradition of grieving, “a feast during plaguetime.” The parents accepted it sympathetically since they understood well enough that the condition of the children is far beyond normal grieving and needs psychological aid.

Anywhere from 20 to 40 children visited the game rooms daily. At any given time, there were usually eight to 20 children of different ages (from toddlers to teenagers). During September 2004, the game room was open daily from 9 a.m. to 8 p.m. The time of stay per child averaged about two hours per day. Some parents, upon the recommendation of the psychologist and also at the insistence of the children themselves, brought them to the game room for practically the whole day, and sometimes twice a day (taking them away for a short while to have dinner). Some children visited the game room daily, while others came only once or twice a week. Certainly, the psychological aid provided was of a higher quality for those children who visited the game room regularly.

After the rehabilitation center closed for the evening, we made house calls to children who were in an especially acute psychological state – according to the information received from local doctors and requests made over the telephone “hotline.” The Beslan psychologists who worked on the hotline were in the office next to us at the outpatient clinic. It allowed them to be in constant close contact with us and ask us for professional help and supervision.

Having organized the Center, we had an opportunity to render psychological aid to a considerable number of children and teenagers given a significant lack of personnel. It also allowed to us to conduct effective monitoring of the condition of children and parents, tracing dynamics during the
day as well as from day to day. Professional observation of the condition of adult victims was especially important given their lowered criticality to their own condition and the condition of their children.

The extent of disorders in many children was such that purely psychological means turned out to be insufficient. Therefore, it was important that our work was conducted in the outpatient clinic, *in close contact with the children's psychiatrists*. In some cases, on the basis of observation, conversations with parents and express diagnostics, we concluded that medical aid was needed. In these cases, we invited a child psychiatrist to the game room so that he or she could observe children, estimate the extent of disorders and if needed, offer parents treatment. In some cases, we discussed the condition of the child with doctors in advance and this resulted in intake of a family. It provided a flexible combination of psychologically corrective and medical influences.

If informing the child of the death of one of their parents was necessary, we asked the doctor to medicate beforehand. Sedatives were prescribed and administered to the child before the message was delivered, and also several days afterward.

We were aided in the work by *local psychologist-volunteers*; however, their support was initially irregular and insufficiently effective. They required constant support and recommendations, were afraid to work independently and did not have sufficient qualifications for this work. For the most part, it was the two of us working together.

Parallel to the psychologically corrective work, lectures were conducted within the limits of the “Psychological and psychiatric aid in extreme situations” cycle of professional development for psychologists, doctors, conventional medical personnel, as well as additional study seminars for the local psychologists assisting us. This allowed them to continue work the Center under our supervision after our departure from Beslan in October 2004. Additional
short-term courses for improving their qualifications were subsequently organized. At present, supervision of the local psychologists working at the Center is carried out from a distance (by phone and Internet) and in-person during our trips to Beslan (once every one and a half months the first year, once a quarter thereafter).

Psychologically corrective work with younger children was conducted mainly with use of methods of *game* and *motor therapy*. We used *art therapy* and *rational therapy* with the older children. The psychologist subtly joined in the free play and free art activity of the children. Psychotherapy was conducted both individually and with small groups. Such groups were usually of various ages. During the same session, different roles were offered to children, which allowed a high degree of individualization of the psychologically corrective work. The role of “assistant to the chief” was quite often offered to older children (teenagers).

Each session was structured according to a “wave” principle – at first there was gradual inclusion of children in an activity, its intensity increased, reached some maximum defined by the psychological state of children, and then decreased. The session would come to an end with relaxation or quiet activity (drawing, games with water, watching small fish in an aquarium or clouds floating in the sky, etc.).

We practically did not apply verbal methods in work with younger children. In work with teenagers, we used verbal methods, but to a small degree. We constantly showed readiness to listen to the story of the child (teenager) about his or her time as a hostage, but never provoked memories on tragic events, *did not stimulate actualization of damaging experiences* if the child did not want to talk about them. We were afraid to disrupt mental defense mechanisms and in so doing, strengthen the pathogenic influence of the psychological trauma. *Involving parents* and restoring their normal interaction with the child was an important component in our work. Psychotherapy was
also conducted with them individually. We provided for their interaction with each other and mutual support of each other. Parents’ observation of the improvement of the condition of their children also had a great psychotherapeutic effect.

7.2. Initial stage of work

A child who came to the Center for the first time was first familiarized with the premises. Putting an arm around the child’s shoulders, the psychologist brings him or her over to the aquarium (in the relaxation zone) and shows how the small fish swim – “You see, beautiful small fish swim all together, in one school…” Having stood at an aquarium, the psychologist brings the child to the following zone – “Here is a garage. There are many different cars … And here there are dolls and everything needed in order to play with them – dishware, furniture. You can also play hairdressing salon, shop, or hospital.”

Having brought the child to a sports zone, the psychologist explains – “Here children jump from a short flight of stairs into the dry pool. It is very fun. And here is an exercise machine. Those who use it, become the strongest and bravest. They were no longer afraid of anything or anybody and even could jump into the pool from the highest step.”

If the child was afraid to part with mom, we asked her (or another relative who brought the child to the Center) to join us. The psychologist communicated with especially repressed and lethargic small children using a hand puppet. He or she addressed the child as the doll, which facilitated making contact. Having acquainted the child with the premises, the psychologist offered him or her to choose any activity and left the child alone for a time, giving him or her a chance to get accustomed to the new surroundings.

Some of the most apathetic children would not explore the Center. Such a child would sit down on the carpet at the entrance to the game room and sit for a long time, doing nothing. In such a case, the psychologist would sit down by the
child and offered him or her various activities, bringing a paper and paints, giving the child a balloon, etc. All of this was done very slowly and unobtrusively.

Already this preliminary stage had considerable psychotherapeutic value. Adaptation in the new premises filled with children and adults, promoted overcoming socialization problems and phobias resulting from a psychological trauma. In particular, the wall ladder, which reminded children of the gym where they were held hostages, was good for desensitization. To make this reminder not too frightening, we decorated the wall ladder with balloons and toys that emphasized its safety and appeal. As a result, the children used the sports equipment with enthusiasm, gradually overcoming their fear of height, picked up the balls, jumped off into the dry pool with stuffed toys.

7.3. Restoration of Activity

At the first stage, the primary goal was restoration of physiological functions and activity. The number of rules and restrictions was kept to a minimum – it was forbidden to fight, pick on other children or throw toys and other objects at each other and out the window. Mostly free play, motor and artistic activity were organized.

Art therapy played a major role in the restoration of general activity. Children drew gouache on sheets of wallpaper spread out on the floor. Sometimes at the initial stage, the child more readily agreed to draw with a sponge moistened with paint (the “dabbing” approach). Finger paints were also used. At first, drawing, as well as other kinds of activity, was organized according to the principle of “playing in a row” – each of children drew something on their area of the wall-paper. Having seen that children were ready for more substantial interaction, the psychologist started to assign some general subject, and children distributed work on it among themselves. The children subsequently started to collectively assign themselves subjects.
At the first stage of work with psychological trauma, it was necessary to pay special attention to treatment of sleep disorders in order to provide favorable conditions for recovery of the nervous system. Restoration of sleep was promoted by various forms of relaxation and control over breathing rhythm. One of the options for such control was the task to fine tune breathing to a rhythm directly set by the psychologist (the psychologist counts slowly, and the child takes a breath at each number counted). It is possible to set a rhythm, taking the child’s hands in one’s own and slowly, in regular intervals, lifting them (inhale) and lowering them (exhale), similar to an artificial breathing apparatus. One more option for control was concentration of the child’s attention on breath (“Listen to how you breathe, but do not try to do anything with your breath, do not try to direct it”). Thanks to this instruction, breath becomes deeper and more even.

The aforementioned exercises not only promote restoration of normal sleep, but also decrease the general tension. They aid in treating the condition of acute anxiety typical for the first stage of experience of a psychological trauma.

One more major problem of the first stage of work is restoration of the general level of activity. The forms in which it is conducted depends on the degree of initial lethargy in the child. Accordingly, given especially acute passivity, the psychologist offers a choice of various simple tasks – drawing, assembling jigsaw puzzles or the elementary models from building blocks, playing with dolls, etc. He or she encourages the slightest displays of the children's initiative and actively participates in the activity, but so that the activity does not suppress or substitute for the budding sprouts of activity of the child. In case the child refuses all these kinds of activity, the psychologist starts to play or draw the child in front of the child, periodically calling upon the child to participate. Sometimes at the initial stage, in order to involve the child in the activity, it is possible to use joint activity. For example, taking his or her hand.
and starting to draw the sky or the sea together with broad uniform movements. This both calms and makes the child active.

An example of the initial stage of work was our work with 8-year-old Inga, another Beslan hostage who witnessed the deaths of relatives – her older brother and sister were lost (the general characteristics of Inga’s condition are given in section “Organization of the center for psychological aid to the children and teenagers of Beslan”). At the first stage of work, Inga’s total mutism was observed. The first drawing she made was of chaotic red and orange strokes covering the entire sheet (Fig. 1).

After Inga finished drawing, the psychologist gave her a balloon and told her to draw something on it. Inga drew a face on the balloon; then, on her own initiative, took some more balloons and drew faces on them as well. The psychologist told her to do whatever she wanted with the balloons. Inga took one of balloons on which she had drawn a face and pierced it with the sharp end of a pencil. Then she pierced the other balloons except for the last. She gave it together with the pencil, motioning with a gesture for the psychologist to pierce this ball as well.

When the psychologist satisfied her silent request, Inga said, “It’s good that you killed him.” After that, she periodically started to use speech in socialization and agreed to draw one more drawing. Unlike the first, it turned out to have a subject – using paint on a large sheet of paper, Inga drew a tree, grass and the sun. She subsequently took active part in decorating the play room – she helped hang drawings and balloons on the walls, to place toys on the carpet and on the window sills, etc.

If a child’s lethargy is not so pronounced, it is possible to stimulate his or her motor activity, by inducing him or her to use an exercise machine, climb a wall ladder, to jump into dry pool filled with stuffed toys. Art therapy plays a major role in restoration of general activity. Children whose baseline level of
activity was deeply lowered, but already started to be restored during corrective work it, are offered the same activities. It is useful to organize any joint activity for children, at least at the level called “number games.” Even though such socialization is typical for an early age (two years old), given the pronounced psychological trauma, it is also quite often the only accessible form of communications for much older (up to teenage) children.

7.4. Normalization of activity and release of aggression

At the stage of restoration of activity, no restrictions were imposed; on the contrary, any displays of activity by the child were encouraged. In the following stage of work, normalization of activity figures prominently. This is accomplished by gradual introduction of rules and restrictions (for example, “You’ve finished playing, now clean up the toys after yourself; only then can you move on to another activity”).

The considerable weight is given to the release of aggression, children are offered such activities as fencing with inflatable swords, boxing with a punching bag or cardboard box, piercing balloons, marching, stomping feet, ripping paper or cardboard, etc. In doing so, it is necessary to make sure that the aggression is not directed at another person. Accordingly, even in fencing it is only authorized to use a sword to strike the other sword, and not the other person. Release of aggression is facilitated by drawings by children with aggressive content. Release of aggression can be conducted both in individual and in game form in an isolated room (so that the accompanying noise does not frighten other children).

Many activities promoting release of aggression also help overcome ligyrophobia (fear of loud sounds) which is one of typical repercussions of mass disasters almost always accompanied by loud noise, explosions, etc. Accordingly, puncturing balloons is a good way to treat ligyrophobia. The fear is overcome thanks to two factors. First, the child is ready in advance for an
“explosion” – as soon as the balloon will burst. Secondly, he or she controls the situation, intentionally causing this “explosion.” A noise orchestra (in our practice, instead of drums we used cardboard boxes, and instead of drum-type sticks, a hollow plastic club) can serve the same purpose. It is useful to additionally secure the effect, having discussed with the child why he or she was afraid of loud sounds before (they reminded him or her of the disaster) and now will not be afraid (as now they will remind him or her of a cheerful noise orchestra). The described techniques implement a strategy typical of the cultural approach of artificial establishment of new, positive associative connections replacing former negative ones.

For overcoming of fears games with the toys representing aggressive characters (a wolf, a crocodile, a baba-yaga) had great value. Depending on desire of the child, he could or "win" these characters, or to speak on behalf their name. In both cases fear overcoming was promoted by sensation of the control over an aggressor. In the latter case the protective mechanism of identification with an aggressor (Freud, 2003) was included also. (Freud, 1946).

In constructing psychologically corrective activities, the “wave principle” is maintained – the child’s activity level rises, reaches culmination and then decreases. Before the session is over, there should be quiet games or drawing (molding clay, building with building blocks). At the end of each session, it is recommended to conduct a relaxation session (tired hikers or soldiers lay down to rest).

At this stage of work, structuring and ordering of the child’s activity takes center stage. The number of rules and restrictions increased, gradually bringing the situation close to that of “school.” At this stage of work, as well as in the previous one, various forms of art therapy were widely applied. Preference was given to tasks demanding observance of certain rules. For example, group drawing with passing a brush around a circle – each group participant dabbed
the brush with paint and drew until the paint on the brush was used up, then washed the brush and passed it on to the next participant.⁹

Some children already made the transition to this stage in the middle of the first session; others did so at the second, third or fourth session. Rules and restrictions were set already from the very beginning of psychologically corrective work for children whose baseline condition was initially characterized by high activity.

Leaving home, each child received as a gift a toy which served as a reminder of the activity in the game room, thereby cementing the results of the psychologically corrective work. Children also received materials for artistic activity. As the first step to restoration normal social situation of development for younger school-age children, we assigned them “homework” (on which performance we, however, did not insist at all) – to draw and bring the drawing to the sessions, to make and bring any hand-made article. Many of them willingly brought the drawings and hand-made articles, which were hung out on walls of the game room and in the outpatient clinic corridor along with drawings done during psychologically corrective sessions. This improvised exhibition promoted improvement of the emotional state of children, parents, other patients and medical staff.

Passage through different stages of psychologically corrective work can be seen in the example of work with seven-year-old Damir.

Concurrently with sessions at the Center, Damir was undergoing treatment at the outpatient clinic for a shrapnel wound to the abdomen. This strengthened the suppressed mood and the deep passivity, the principal cause of which was, apparently, the stress of being a hostage. In addition, he knew that his mother was in extremely grave condition in a Moscow hospital (she was discharged from the hospital only six months later).

---

⁹ The assignment was developed by Y.A. Poluyanov.
During his first visit, Damir refused to socialize with the other children and the psychologist. The most typical features of his actions were stereotypy and striving to put his surroundings in order. When he was in the game room, boxes with the multi-colored stuffed rabbits sent to Beslan children as humanitarian aid were brought in. Different colored rabbits lay in a mixed pile. On his own initiative, Damir began to sort them— he would take each rabbit out of the box and slowly carry it in the opposite end of the game room. In half an hour, he grouped all of the rabbits of the same color— rows of green, violet, blue rabbits… The psychologist used this occasion to set up Damir’s first, for the moment, superficial contacts with children. When the group of other children played the improvised doll performance, the rabbits were arranged to represent spectators. Upon the suggestion of the psychologist, Damir arranged them so that it was more convenient for them to “see the performance.”

In subsequent sessions, Damir was already more active. He decorated the game room together with the other children and some times joined collective games for a short while. Nevertheless, on the whole, his activity became chaotic and erratic, which strikingly differed from his behavior during his first visit. He reached a new level of activity at the third session when the psychologist organized a “noise orchestra” — three children, including Damir, knocked hollow plastic maces on empty boxes, making extreme noise (it promoted catharsis of aggression and overcoming the fear of loud sounds — ligyrophobia). As the result of the vividly shown aggressive impulses, the boy was offered other kinds of activities for catharsis of aggression. Several times, he asked to be taken to the room intended for it. During this period, an interesting internal conflict was observed in Damir between his aesthetic feelings and neurotic aggression. His aggressive impulses induced him to pierce balloons, and his aesthetic feelings to use them for decorating the premises. As a result, upon taking the next balloon in his hands, only after long vacillations did he dare do something with it (sometimes to pierce it, sometimes to hang it up on the wall).

Later, Damir’s activity became more ordered. Some rigidity was still characteristic for him, but that strongly pronounced stereotype exhibited in the first session disappeared. Damir began to communicate substantially with
other children. Under his own initiative, he began to be involved in the joint activity of children coming to the Center for the first time, explaining the rules for behavior in the game room to them (no fights and no throwing toys out the window). Damir prepared sets of gifts (toys, albums, paints) for each child leaving for home.

This example illustrates high effectiveness of sessions at the Rehabilitation Center. Nevertheless, overcoming the most acute symptoms is only the first step to restoration of a normal psychological condition. In particular, Damir’s difficulties in socialization and study persisted for the next three years.

7.5. Examples of work with children at the Rehabilitation Center

Work with Sabina

Age at the time of referral – 10 years, five months

Anamnesis (according to the father) – daughter from second pregnancy, second birth. Grew and developed without abnormalities. Was sociable, obedient, well-intentioned. Went to school at seven years of age, studied well, managed to follow the school program.

From September 1-3, 2004 was among the hostages of Beslan’s School No. 1. When the hostages were freed, suffered a shrapnel wound to the cervical spine. When the hostages were freed, her older sister died and her mother was wounded and subsequently died in hospital. Sabina was transferred from hospital of Vladikavkaz to Moscow’s N.N. Priorov Central Research Institute of Traumatology and Orthopedics (TsITO) where the girl was treated for one month. Then she was sent to a sanatorium. Accordingly, psychological work with her started three and a half months after the tragedy.

Reasons for referral to the Rehabilitation Center (RC) at the outpatient clinic of Beslan – fear of solitude, loud sounds, unshaven men. Afraid to attend
school, not very sociable, aggressive towards peers. Sleep disorders, nightmares are observed.

Behavior characteristics – Sabina entered into social contact, but for the first few minutes she is a little tense, repressed, anxiety-ridden. She came to the RC very reluctantly, with a gloomy look. She gradually calmed down, became accustomed and began to feel more relaxed. Her posture remained undifferentiated, but free. Often had a sad facial expression. A quiet voice. Did not want to talk about the terrorist attack and her time as a hostage in the school.

Was not very sociable to peers. Obvious display of both physical and verbal aggression in relation to peers was observed. One of example of a display of aggressive behavior –

Sabina is close with her cousin Sarmat (they were in the Beslan school gym together). During a group drawing activity, Sarmat, took a brush without asking. For this, she punched and kicked him, having cried – “WELL, SARMAT!” She would immediately destroy a drawing or hand-made article out of clay she didn't like.

She did not want to study at school, even though she never had difficulties with study before; she used to particularly like mathematics.

Sabina regularly visited the RC for four months. Within the first month, her visits were daily. She subsequently attended sessions with a frequency of three times a week, with rare absences. She felt comfortable at the RC, did not want to go home, found various reasons to stay longer (explained that it was boring and lonely at home).

As a talisman, we gave Sabina a toy bear (she named it Kuzya). It became her favorite toy, and she slept with it. It could serve as a reminder of activity in the Center and thereby promote fastening of results of psychologically corrective work. She was also given homework (making cut outs, coloring, making mosaics, etc.) in order for her to be occupied by activity. She would
complete all assignments, bring in the artwork, emotionally explain how it was made, and was sad if she did not manage to do something.

At first, she was afraid to come to the RC, even though she lives near the outpatient clinic. When she had nobody to take her there, she skipped sessions. Having come the next day, she said that she was anxiously waiting for the next meeting with us. One and a half months after starting therapy, she began to come alone.

At the start of sessions at the RC, Sabina participated in joint activities with other children reluctantly (except those in which her cousin was participating). If one of the children addressed her with some request, she could answer with an insult. If somebody unintentionally brushed up against her, she could even throw a punch. Gradually, her participation in collective activity became more active and well-intentioned. She had an appreciable lapse during preparation for New Year’s celebrations.

In connection with mourning, the usual city celebrations of the New Year in Beslan’s Palace of Culture were cancelled. Therefore, we organized a small celebration in the RC. New Year is Sabina’s favorite holiday. She actively took part in preparations – together with the other children, she decorated a fir tree, cut out snowflakes, helped draw the New Year’s poster. Such activity in interaction with other children was not previously observed.

Despite her active preparation, during the holiday, her demeanor was most often sad. Though periodically Sabina smiled, laughed at jokes, her eyes remained sad during this time.

We conducted play therapy with Sabina directed at catharsis of aggression and overcoming of fear of loud sounds. For example, using soft materials as “axes,” we depicted woodcutters chopping fire wood. These sessions were accompanied by loud sounds (the knock of “axes,” shouts of “woodcutters” such as “Oogh! Ah!”). Each active session came to an end with drawing or
relaxation. Sabina liked to lie in the dry pool filled with stuffed toys, with quiet music playing.

The “fear destruction” technique with the use of molding clay was also applied in the work.

Sabina said that she was afraid of men in camouflage. She was instructed to try to mold her fear in the clay, and Sabina molded a person. When the psychologist asked what she wanted to do with that person, Sabina tore off its head and limbs and then crumpled it. The psychologist then asked her to mold something pleasant and beautiful from this clay, and Sabina molded a small flower.

Art therapy methods were widely used in work with Sabina. Seven sessions of free composition were conducted with her, since Sabina found it difficult to verbalize her experiences.

Her first picture was free form. Sabina started to draw very carefully and accurately in a dark blue color. While drawing, she did not talk, she drew silently. At first, she used a brush, then, at the suggestion of the psychologist, she began to draw with sponge in a standing position. Her hand movements became freer and their scope amplified. She also drew with her fingers enthusiastically. Then she took a brush again, and began to dip it in red color and splash it on the picture. Consequently, the paint got on her, but Sabina did not notice. She finished the work with the words – “That's it, I'm done.” (Fig. 19.) An attempt to discuss the resulting picture failed outright – the girl did not want to talk about it.
At the next session, Sabina drew a picture on the set subject – “Butterflies in a Meadow” (V.V. Brofman and T.A. Selivanova's technique). She drew it willingly. While drawing, the jumpy movement of her hand that held the brush was observed (Fig. 20.). The girl agreed to discuss the resulting picture and was happy with the result.

Fig. 20. Drawing of Sabina “Butterflies in a meadow”
At the third and fourth session, such subjects as “winter night and summer morning” (Fig. 21.), “sad and cheerful day” were offered. During discussion of the latter picture, on her own initiative, she began to talk about the events associated with the capture of school (she did not want to talk about it before).

*Fig. 21. Drawing of Sabina “Winter night and summer morning”.*

During work, along with other techniques, we used the technique of art collage to help the child convey her feelings, emotions and private world. These sessions became Sabina’s favorites. Gradually, Sabina began to feel more confident and free in the RC. She started to communicate and play with the other children. According to her father and Sabina herself, her sleep became calm, without nightmares. Her mood has also improved.

In April, the RC’s employees organized an exhibition in Beslan’s Palace of Culture of the works of children made during art therapy. The exhibition was called “Spring in Beslan.” The artists, parents and all interested persons came (there were many visitors). On her own
As shown by observations of Sabina’s behavior, her drawings and feedback from relatives, after four months of sessions, the girl’s condition improved considerably. Her activity increased and became more ordered, and displays of aggression were fewer. Sabina began to attend school. Within the next one and a half years, her condition remained stable, and her progress good. In 2007, Sabina moved with her family to another city, which made it impossible for us to further monitor her condition.

**Work with David**

Age at the time of referral – five years, two months From September 1-3, 2004 was among the hostages of Beslan’s School No. 1.

**Reasons for referral** to the RC – David’s mother said that after hostages were freed, the boy was severely frightened, disoriented, and cried frequently. Since then, he practically cannot be apart from his mother for even a minute, he cries, is afraid to be alone, has nightmares, shouts in his sleep and his the mood
is reduced. He displays physical aggression. He often fought with his sister if she did not let him have his way.

**Behavior characteristics** – Entered into social contact, but only if his mother was nearby. If mother was not present, he started to run and look for her, to cry and call out for her. He almost never parted with his mother and constantly stayed by her. He could leave alone or with his sister for a short time to look at and take toys. For the first few minutes of conversation, he was a little tense; then he calmed down, but would continue to nestle up to his mother and hold her a hand. His facial and eye expression were sad, but sometimes he could both smile and laugh (adequately to the subject of conversation). He refused to participate in activities, as he would quickly get tired.

His voice was quiet and he did not pronounce all sounds. He would answer questions, but not show any interest in the conversation. For a short time, he was interested in toys and played with them for a little bit. He complained of headaches. He did not want to talk about the terrorist attack, and would start to act up. He said that he was afraid “to be without mom” and that he was having nightmares. He would switch to other subjects and toys with a feeling of relief.

Sessions with David were conducted three times a week for three months. The first sessions were individual, but David soon began to join in the group sessions. He grew fond of games with water, joint themed games with toys with the other children.

The boy became accustomed to the Rehabilitation Center rather quickly. Gradually, he began to spend a lot of time without mother and among the children. In playing with them, he stopped “clinging” to his mother. His mood improved, his sleep became calm, without nightmares, shouts and crying. He became more active, lively, joyful and participated in collective games with enthusiasm. He was sometimes temperamental. He did not voice concerns. After three months, his condition was deemed to be sufficiently stable.
Chapter 8. PSYCHOLOGICAL REHABILITATION OF THE FAMILY

Parents of the victimized children were in deep depression or apathy, and remained in this condition for a rather long time. Accordingly, even a year later after the terrorist attack, many parents of the children-hostages remained in a depressive state. In conversations among themselves and with psychologists, they would constantly return to memories of the tragedy. External displays of depression were observed in many of them – amimic mask-like face, insufficiently intonated, monotone speech. The parents’ disorders interfered considerably with the restoration of the psychological condition of the children. Accordingly, we considered it necessary to not only work with children, but with the family as a whole, including parents.

Originally (right after the terrorist attack), correctional work was conducted with children in the presence of parents. Already at this stage, it was possible to note some positive dynamics of change in their condition, development of motivation to receive psychological aid. Seeing improvements in the condition of the children stimulated the parents’ desire to continue sessions and formed their inner need for further consultations concerning their children’s problems. It promoted changes in their own inner state. They started to show their first positive emotions at the sight of playing and rejoicing children. This influenced them positively and made them active in the educational and social sense.

Nine months after the terrorist attack, the two-week field trip program for family rehabilitation “Vacation for the Children of Beslan” was organized. The program was carried out in the Bavarian Alps with financial support from E.ON Energie and E.ON Ruhrgas (Germany), in cooperation with the Heksherov Clinic. Rehabilitation work was conducted under the supervision of E.I. Morozova and E.G. Dozortseva.
In developing the program, the experience of a number of previous measures implemented by various Russian and foreign organizations was considered. It should be noted that besides positive effects international aid to the victims of the terrorist attack in Beslan sometimes also had negative impact. Passive lifestyle and dependent position were generated in many victims. This resulted in passivity and a fixation of pathological symptoms in terms of their mechanism of “provisional benefit.” In addition, in 2004/2005, many organizations took the schoolchildren to various Russian sanatoria and abroad, tearing them away from study for a long time. These trips were often insufficiently well-prepared – no parents and psychologists accompanied the children and special rehabilitation programs were not developed in advance. Many trips were untimely – too early and not timed during a school holiday. It interfered with the restoration of a normal schedule for the schoolchildren. As a result of all these circumstances, many children and teenagers suffered additional amplified disadaptation caused by mental trauma.

The program we implemented took place during summer school vacation, with extensive prior preparation. Program tasks consisted in improvement of the emotional state and sense of self of the participants, overcoming dysfunctional relations between children and adults, restoration of intrafamily relations. Children visiting the Center at the outpatient clinic and their families were included in the program. The following participated in implementing the program –

- Moscow psychologists working in Beslan since September 2004
- Beslan psychologists, employees of the Center of psychological rehabilitation
- ten older student volunteers, students at Beslan schools, who studied preliminary preparation as part of the “New Tomorrow” program (some of these teenagers were hostages)
Beslan specialists and older students not only participated in psychological rehabilitation of families of hostages, but also underwent psychological rehabilitation they needed themselves. It included elements of group studies, game techniques, group and individual consultations. The Discovery Program (by Jean Berube), adapted to the needs of the therapy, formed the basis of the training program. The main emphasis in this program was unlocking the potential of a person. It is reached by means of overcoming a series of obstacles, physical and psychological difficulties with the aid and support of others (the leader and group as a whole).

The older students worked with children, encouraged them, promoted a feeling of security, support and emotional warmth. They involved them in sports, games and creative activities. During the program, teenagers saw much, formed positive and bright impressions, communicated with new people, tried to see themselves in new form of activity and in a new light. They formulated a somewhat different perception of the world and the children-hostages. Some observed new sense of their own capabilities – “It was important to me that I did not lose it and protected Irishka in a difficult situation, in a difficult descent from the mountain on a sledge.” One of teenagers admitted that in Beslan he was afraid to approach children-hostages and communicate with them since it seemed to him that the children’s souls “had died at school.” After successful work he understood that “they are the same children and it appears that they are capable of laughing and rejoicing…”

For several months, families of hostages underwent preliminary preparation in both individual and group psychotherapy. The need for such preparation was because of the high level of families’ mental traumatization. Unfortunately, despite the long preparation for participation in the program, we were unable to involve any family in which one of the parents died. The psychological condition of the widow/widower parents was so heavy, that they were not able leave for rehabilitation outside of the Beslan city limits. Some of
them, having already agreed to participate in the program, nevertheless had not overcome their fears and anxiety, and at the last minute, refused to make the trip.

Before the start of the rehabilitation program, meetings with parents were held in which we explained its purposes. A contract defining need and rules of their participation in group work was then concluded because of the importance of such work for their children, and also for them. There were often cases where parents cried at the mention of the events they had gone through, refused to actively participate in the therapeutic process, explaining their unwillingness as being the result of morbidity of returning to the memories or perceived lack of necessity for such work. The conclusion of the contract with parents was an important condition which established the objective need to participate in the psychotherapeutic group.

Although symptoms of psychological disorders in the parents subsided a little by the time of the beginning of the trip, their condition was rather unstable and many signs of depression were observed. They themselves, nevertheless, could not always critically assess the degree of expressiveness of their psychological problems. By the time the program started, the children were in much better emotional shape than their parents. The condition of the parents impeded the activity and the further recovery of the children.

At the start of the program, parents had serious problems communicating with the children. Parents thought that they could infect the children with negative experiences and were afraid of contact with them. The heightened uneasiness and concerns of parents extended to the children, which interfered with them freeing themselves from their own anxiety. Many parents had a pronounced feeling of guilt (especially mothers who lost other children). In addition, the parents’ behavior and condition were in many respects defined by the standard expectations of their peers and traditions of mourning.
The dynamics of the parents’ condition began with passive observation over how the children were working with psychologists and the teenager-volunteers. At the same time, parents communicated poorly with the children, did not pay enough attention to them and were glad that others took it upon themselves to care for them. In group work, especially during the initial period, parents were passive or even showed resistance to the lead therapists. However, they did not refuse to participate in activities and walks.

As the parents’ condition improved and their activity level increased, they inquired about satisfaction of the individual needs not directly connected with the rehabilitation program. For example, in the middle of a cycle, the desire of parents to go shopping or receive unplanned medical services began to represent a big organizational problem. Satisfying all the new inquiries proved to be impossible. Assessing program experience, it is possible to recommend allowances for such issues in future contracts with participants and to adhere to strict observance of the established rules.

During the program, group structuring took place. One parent participated in almost no group work, which sometimes represented a serious problem. The most socially active members of the group began to help the lead therapists in drafting the organizational plan and to represent themselves as graders (“the conscience of the group”). Some parents constantly and enthusiastically helped with organization of the children’s activities and prepared celebrations and meetings with them.

Gradually, the parents became more active, emotional, lively, and they participated in the activities and sessions more and more. Group sessions usually came to an end with each group sharing their impressions and experiences for the day with the other groups. Specifically these times fostered an awakening of the parents’ creative activity. At the start, they carried out the tasks only for the sake of the children, but subsequently started to enjoy this activity and derive pleasure from it. When adults showed the children sketches,
pantomimes, drawings, they livened up, rejoiced and together with children, relived the events of day anew.

During the second half of the program, parents were able to join more actively in joint creative activity with children (“message to the children,” construction of a general “family house”). Interaction with children, their support, joint experience of new impressions and program events changed the parents’ self-perception, and they lived parental roles more positively, and their relations with their children became warmer and closer. Joint creative activity, the experience of interaction with the nature, perceptions of another culture, another nation – all of this facilitated parents forming a new life perspective. They started to consult psychologists more for advice, more eagerly assumed parental roles, and requested the organization of a seminar devoted to raising children who had experienced tragic events.

The extension of the field trip program was the organization of periodic family visits to Algus Center (Vladikavkaz), a program financed by Keystone Foundation for Children and Families. Four to five families participate in each such trips – at least one parent from each family (frequently both parents) and the children. They are accompanied by two-three psychologists, employees of the Center of Psychological Rehabilitation of Children and Teenagers of Beslan.
Chapter 9. GROUP WORK WITH TEENAGERS

9.1. The Discovery Program

“Discovery” is skills and knowledge attained in a very interesting way – if you are a bystander, “Discovery” can seem like only a game or simple entertainment. But all that we do are actually metaphors that correspond to real life. For us, “Discovery” is a place where we start to think and also a safe, reliable place where we learn skills.

(Jean Berube)

One of the recommended productive approaches to group work with teenagers was developed by J. Berube. Her Discovery Program is focused on personal development. The principles of this program have been applied in work with teenagers in a number of general education schools in Russia, with teenagers who have gone through an acute psychological trauma (who suffered as a result of the terrorist attack in Beslan in September, 2004) and experienced a number of psychological traumas in the past (ranging from students of special educational establishments to minor offenders).

The Discovery Program Concept

In developing this original program, Jean Berube start with the philosophical ideas and pedagogical approaches of K. Hahn, ideas of the humanistic school of psychology, A. Maslow and C. Rogers's psychotherapy and L.S. Vygotsky’s theory of development.

The main emphasis in the Discovery Program is on unlocking a person’s potential, him or her discovering new abilities, in knowledge of oneself. This is achieved by means of collective treatment of some problems and difficulties thanks to the aid and support of others – the leader and group as a whole. The program’s author starts from the position that the person is capable of much more than he or she thinks. He or she can become successful, if he or she really tries to do something. Only by overcoming physical and psychological
difficulties, fear and uncertainty, does the person really actualize and “discover
him or herself.”

The special **structure and dynamics of activity** serve participants’
reception of new and unique experiences of intense joint efforts – failures,
defeats, disappointments, and in the end – **certainly** treatment and victorious
success shared with other members of their group. Afterward, an opportunity is
provided to discuss and reflect on the experience, its correlation with the
contribution of each participant to the general achievement, as well as
definitions of its connection with real world events.

An important characteristic of the program is its accurate humanistic
ethical orientation expressed in a non-directive way, but penetrating the entire
event fabric of activity – from necessity of strict observance of rules and caring
relations with peers to listening to allegoric parables and discussion of the right
of each participant to be mistaken or not to cope first time, as well as discussion
of the issues of human relations and values.

Even in the most difficult social conditions, the child can become a whole
person. For this purpose, it is only necessary to see the huge reserves of a child's
soul, to learn to trust in the most difficult and problem child, to open the
reserves of the child's “I.” It is necessary to understand, that the child always
acts (or aspires to act) according to notions about him or herself. Nevertheless,
the child is not always what he or she perceives him or herself to be.

Any change in a person starts with change of his or her perception of the
possibilities, capabilities and consciousness as a whole. Therefore, if a goal is
set to change the behavior of a teenager, it is necessary to not influence directly
his or her behavior, but his or her view about him or herself. For developing and
strengthening the teenager’s sense of his or her own effectiveness and self-
confidence, a positive emotional attitude and basic trust of peers and adults is
extremely important.
Recognizing the teenager’s right to make his or her own independent choice – shows participants that they are trusted as adults. The Discovery Program is built on a foundation of *freedom in choosing*, moreover – on CHALLENGE BY CHOICE. This has key value – the decision on degree of participation in each exercise or discussion is made by the participant. He or she defines the purposes and that level to which to move ahead in each specific exercise. No teenager is forced to participate; he or she chooses whether or not to carry out a task.

The teenager is given an opportunity to engage in independent, as opposed to forced activity, so that he or she bears responsibility for his or her actions. Forcing or coercing him or her is absolutely impossible. The child defines boundaries of the possible independently. It is extremely important to learn to respect the child such as he or she is for today, and it is obligatory to give him or her a chance to feel goodwill and respect for him or her.

Not necessarily each participant of group should carry out all tasks. If the person has decided not to participate in the task, he or she can become an observer, an objective judge, can provide emotional support to others, as well as be a commentator or coordinator. There are many roles in which the person who is not participating in the task may be involved and still share in the general experience. For example, at any time, he or she can simply observe how others carry out the exercise (“helping the leader”), and become convinced that, in general, it can be done and it poses no apprehensions for the others. In another case, shyness can be overcome by touching another person, and the fear is as if “squeezed out” by touch. In addition, the necessary emotional support can be given to the uncertain, timid participant. Accordingly, by benevolently smiling and sharing the teenager’s doubts and anxiety, it is possible to express confidence that he or she will manage and, of course, everything will turn out alright. Besides, it is possible to propose joint performance of the task (for example, to form a trust circle in embrace with the psychologist and to carry out
exercise together with him or her or to jump a jump-rope together with him or her). Besides, rendering all-round group support is possible to even the most irresolute participant.

This is the special uniqueness of Discovery – here people are never forced to do to what they are not ready to do. One can only encourage the person to change an exercise so that it becomes more convenient for him or her. None of us can have experiences identical to another person’s. We do not know another person's experience nor fears. The only thing that we can do is to stay together, and if someone wants to try to do something, then we need to help him or her do it.

**The motivation** for subsequent achievements in the activities develops through comprehension of the experience of one’s own success. Its formation is promoted by *enthusiasm, curiosity and aspiration to risk* which are characteristic of the teenage years and can be stimulated with experiences of surrounding people.

The program can be carried out in groups of up to 50-60 persons, divided into subgroups of 10-12 persons in which the basic work is conducted. The *general leader* supervises the program. Each subgroup has a specially prepared *trainer* and his or her *assistant*, who directly organizes the team’s activity.

**Work periods** can vary. In some cases they can be long, running for six months, as weekly activities for two-three hours per day. In others, fulfilling the program go on for several days with intensive activities for four to six hours or in the form of “marathon” sessions for 8-10 hours within three days.

**The basic components** of the program are specially developed tasks, exercises, or “events” in the terminology of J. Berube. “Exercises-events” throw down a challenge to the individual capabilities of participants, inducing them to reach the boundaries accessible to them – the goals which they set for themselves, and to expand these boundaries with group and leader support. Feeling the faith and support of peers, a person at times overcomes restrictions
and does the impossible. Besides, the person will more readily share his or her abilities with surrounding people more, by being responsible for others, he or she will achieve more than acting on his or her own behalf.

*Exercises-events* are characterized by certain rules and a clear goal, achievement of which demands joint discussion of arising problems, acceptance of group decisions and development of general tactics for the behavior of all participants of the group. Performance of these tasks is possible only with coordinated activities of all of the participants and their special care of each other’s safety.

Work is organized according to a *wave principle* – it starts with simple, engaging tasks painted by joyful emotions which gradually become complicated. In the end, simple exercises are again carried out, causing positive experiences and creating motivation for continuation of work in the future.

**Program structure**

In terms of structure, the program can be divided into three basic stages.

The goal of the *preparatory stage* is to create participants’s motivation and emotional tuning for joint activity. With that goal in view, the general leader can tell a true story, a parable or a fairy tale, setting the meaningful content of the subsequent activity.

At a preparatory stage, warm-up is conducted, in which there is a process of liberating teenagers, charging them with joyful emotions, galvanizing them by performing simple game activities. At the end of the warm-up, participants break into groups, lining up at their own will.

The goal of the *basic stage* is organizing group interaction directed at overcoming difficulties and resolving arising conflict situations, on the basis of an establishment of trusting relations, development of constructive behaviors, acceptance of one’s own responsibility and the subsequent reflection of one’s own experiences.
The leader creates simple, and then more and more difficult game problem situations (for example, one task given to the entire group is to jump over a cord stretched at level of the waist of the smallest in the group without touching to this cord).

Typical teenagers’ worries of uncertainty, fear of the unknown, and shyness in the first stages of group work are gradually replaced by sensation of warmth, attention and inclusiveness from other participants of group that generates a feeling of trust in the group, as well as motivation for subsequent joint activities.

Thanks to group interaction, the ability to listen and understand others develops, as do respect for their thought and feelings, patience in the face of emotional and behavioral displays of other people, trust in oneself and one another, sometimes gaining one’s own leadership experience.

Gradually the level of complexity and risk elements in tasks surge up. In the process of searching for ways to resolve conflicts, refusals from work are possible. It should be noted that participation in tasks can only be voluntary. In situations when the teenager leaves a group, his or her internal psychological problems should be solved individually, and then he or she can rejoin the activity.

The group leader, by stimulating the search for independent decisions in a non-directive manner, provides necessary emotional support to everyone, instills belief in the general success and demands tolerance of every person to one another. At the same time, he or she does not allow negative-destructive displays in relations between participants, destruction of a situation or leaving it.

If the individual person or the entire group has not been able to cope with difficulties for a long time and start to lose interest in completing the task, the leader can replace the task with another. Nevertheless, if participants, in wanting to attain success, do not come back to the outstanding exercise, with time, the leader necessarily offers it again. All of the exercises lead sooner or
later to the goal set by the entire group. At the same time, it should be considered that disappointment at failure is a very strong feeling; therefore, it is important to introduce it gradually and at certain stages. But the success after disappointment appears as fantastic experience and is also a very strong feeling, both for the specific child and for the group as a whole.

The special attention is paid to work safety rules. Rules of performance of tasks, in particular, defining their successful end, are strictly observed – up to discharge of group from a dangerous task if the level of interaction and responsibility in the group, in the leader’s view, is insufficient for work on a task of such level of complexity. Breaking rules leads to starting the task over from the very beginning for all participants of group, irrespective of their stage.

J. Berube considers feelings of disappointment arising and disappointment as an important emotional component of such group work which, however, should be introduced cautiously and gradually. Nevertheless, it is necessary, as achievement of success after a number of failures yields a powerful emotional and energetic effect, pointing to the basic capability of overcoming difficulties.

In the course of work, how many and what exercises the group carries out is not as essential as the problems it solves. This also concerns arising conflict situations, the resolution of which the leader can aid by showing constructive ways of interaction.

The important part of this stage is discussion of one’s own experiences and sensations after completion of tasks. The experience of success reinforced by the reactions of other group members leads to positive change of one’s relationship to one’s own capabilities, an increase in self-confidence and self-esteem that is fixed at conscious level in the course of reflection. The leader can activate a reflection by participants, analyzing conflicts together with them, establishing the reasons for these conflicts and assessing the behavior of group members. It is desirable to accentuate the positive aspects of joint activities, to
draw an analogy between the event just experienced with real life to establish a valuable sense of joint activity and discovery of one’s own capabilities.

The goal of the final stage is emotional catharsis to the arisen emotions, issues and conflicts; creation of motivation to continue activities and maintenance of mutual trust in the group.

Leadership style and role of the leader

According to the general principles of the Discovery Program, the basic orientation of the psychologist’s activity consists in giving participants a new life experience and realization of each one’s “I” and an understanding of other people. The fabric of this activity are exercises-events in which participants live excerpts of such experience, in due course assembling into a new bright picture of oneself and peers. In the exercises, participants reach the boundaries of their capabilities and expand them, leaning on the support of the leader and the group. This process demands special conditions which are created by the leaders, who perform three basic functions:

- organization of work
- maintenance of motivation and a positive emotional state of group
- supervision over the processes occurring in the group, and reflection on them

Different positions of the leader correspond to these roles – organizer, emotional leader and observer. Nevertheless, in reality they are closely intertwined; therefore, one of the basic attributes of the psychologist working in the program should be flexibility and ability to carry out all these roles at various stages of work.

As organizer, the psychologist:

- plans the entire process
- sets a theme and goal for the work
defines rules and enforces them, does not allow destructive and aggressive displays
provides physical and psychological safety
shows and supports a positive style of relations between participants
establishes achievement of result or necessity of repeated performance of the task

As the emotional leader, the psychologist:
creates initial motivation for performance of tasks, involves and motivates his or her group
shows emotional involvement in the process, empathizes with the group participants
gives timely emotional support and necessary aid
supports an optimistic atmosphere, using encouragement and humor.

As an observer, the leader:
follows the condition of the group and its individual participants
keeps track of the general dynamics of group process

The overall performance under the described program essentially depends on personal features and the skill of the leader, who should possess such qualities and abilities as:
respect for oneself and other people
ability to understand and describe feelings
ability to listen to other people, to feel their presence, to understand their needs
sincere care for each member of group
ability to show that he or she can be trusted and that he or she can trust another
• readiness and ability to support other people and group as a whole
• ability to rally the group and to be included in the group
• ability to reveal problem areas
• ability to doubt and explain what the source of doubts is
• consideration for the opinions of others
• ability to accurately and intelligibly transfer ideas
• ability to share ideas, not imposing them on another
• ability to convince others, but without aggression
• ability to inform group and include everyone in the work
• ability to delegate responsibility
• concentration on the given task taking into account the capabilities of participants in the group
• ability to work within the limits of the rules and requirements of the given situation
• ability to keep the group focused on carrying out the task
• ability to lead the group to completion of the task
• ability to support the following notion in the group – “All of us will achieve success together or we will lose together.”

The leader should preliminarily plan the entire work process and its individual stages. The principle of building activities is wave-like – from simple to more and more difficult, and then back to simple again. At the initial stage of group work, the leader also acts as emotional leader. By means of simple emotional tasks, the psychologist warms up the group, demonstrating important principles – participants’ freedom to self-express and display feelings.

More structured tasks, in which the leader will accurately organize work process, are introduced later – he or she defines the theme and purpose of the task, formulates clear rules and makes sure they are strictly observed. Nevertheless, his or her emotional inclusiveness in the activity and creation of atmosphere of emotional comfort and safety in the group are also important.
The leader shows genuine interest in and care for participants and gives emotional support. He or she accepts them as individuals and does not allow any negative statements or aggression. The model and style of relations in the group are set accordingly. Gradually, an atmosphere of mutual aid and trust between participants forms, supported with success of collectively completed tasks in which the creative potential of teenagers can be revealed.

Leaders should show genuine interest and care. Thanks to the latter, the participants of the group can gradually reach a sense of psychological safety and an emotional involvement in the process. The establishment of emotional communication of the psychologist with the group and between participants is done with special trust and support exercises meant to promote understanding of emotional states, both those of one’s own and those of other members of the group. After a certain time, warm relations develop in the group, which give rise to responsiveness and sensitivity to each other’s needs, desires and moods.

Supporting a style of interested cooperation, flexibility, with no imperative orders or interdictions, and suppression of all attempts of excessive pressure by members of group against each other are necessary for this purpose. The participants are given freedom of expression of their own feelings and desires and a high volume of activity, especially of the creative types. If necessary, leaders promote displays of flexibility, tolerance and acceptance of one another.

The supportive style of management assumes equal responsibility of each member of the group for everything that happens during the sessions. The leader offers the theme, sets the style of interaction and discussion, then is gradually discharged of direct management of group, relying on participants’ capability to independently build interaction.

If there is such an opportunity, it is convenient when both a man and a woman supervise the group. This facilitates a projection to teenagers of
representations associated with fatherly and motherly figures, promoting effective group dynamics. In our work, there was a classical cast of two leaders – one acted as the emotional leader, establishing close contacts to teenagers and young people, while other kept more of a distance, giving necessary explanations, conducted interpretations and organized discussion.

It should be noted that young people are inclined to search for adults who could become role models. This imposes special obligations on the leaders of the group. They cannot act only as the instructors-professionals honestly implementing the certain work program. Teenagers always assess leaders in a personal way as well, applying – sometimes rather high – criteria and striving to establish informal personal contacts. Readiness for such contacts is one of necessary conditions of successful work with older teenage students. Certainly, this does not mean, that the head of teenage group should be an ideal person free of faults. It means only that he or she should be perceived as an integral and sincere enough person, and simply as a person implementing a set of psychological techniques and approaches.

Owing to teenagers’ characteristic versatility of interests, it is desirable that the leader has a broad enough education, to where he or she could participate substantially in conversation, answer questions and express reasoned opinions concerning different cultural milieux. In particular, rather good familiarity with teenage subculture is necessary – informal teenage groups and the movements, popular music among teenagers, literature, etc.

9.2. Group work with Beslan senior pupils

Six months after the tragedy the program of social-psychological rehabilitation of teenagers «New Tomorrow» begun under the direction of A.A.Tagiev and V.A.Morozov. In February – March, 2005 its first stage, organised in the form of group training, was conducted simultaneously for all secondary educational institutions of Beslan at rehabilitation and diagnostic
therapeutic facility "Tamisk". It was aimed at overcoming communication frustrations (first of all, between teenage-hostages and not-hostages), restoration of life prospects and social activity.

The target group of the program were not only the victims of the act of terrorism, but all senior students of the city.

At the preliminary stage of work the team of trainers – leaders of the program was prepared. It consisted of six Moscow and four Beslan experts (including – employees of the Rehabilitation center at Beslan polyclinic). Preparation was carried out in the form of trainings and discussions on the basis of the Rehabilitation center.

In February – March, 2005 the first stage of the program was realized: in the mountains, 40 km from Beslan, a series of training marathons was spent. It was aimed at creation of setting promoting social self-realization of teenagers and youth. During the first stage in total four three-day streams passed, with 60-70 participants in each. In total more than 260 students of senior classes from all average educational institutions of Beslan (seven schools and professional school № 8) took part in the trainings.

In the course of work the stream was divided into four subgroups so that in everyone students from different educational establishments were presented. Thanks to it mutual relations in interschool groups were established during the training. Trainings were conducted by two trainers from Moscow and two from North Ossetia, under the direction of the leading trainer A.Tagiev.

"Interaction" was the key word of the first day of the program: children learnt the ability to work together. The result of this group interaction was the following step of the training: teenagers prepared «news of Beslan of 2015», planning their own life, the future of their city.

As a result of the three-day work senior students – participants of the program offered a number of social projects directed at resolution of the problems that the youth of the city was concerned about. For example, projects
of carrying out a marathon of health, planting of greenery in the city park by their own forces, etc. For each project a concrete plan of action was developed.

With the most active participants special additional seminar-training directed at their preparation for work with preschool children and younger students as volunteers was conducted.

To estimate the results of trainings the following methods were used: the involved supervision; written responses of participants of the program; conversations with parents; teachers and school psychologists. In addition to this, the degree of participants’ involvement (in comparison with other students) in the subsequent projects of the program as well as in other social-psychological projects conducted in Beslan was indicative.

In written responses the participants were asked to describe their feelings and condition before, during, and after the training. The majority of participants, describing the condition "before", marked boredom, emotional emptiness and complexities in dialogue. Feelings during the marathon were characterized as "fascinating", "cheery, "meaningful", "useful", "friendly"; in many responses occurrence of new possibilities of communication, abilities to cope with emotional conditions and difficulties, self-trust increase were marked.

After carrying out the first stage of the program one of the social projects developed by schoolboys during the training was selected. It called for conducting in the central city park of a mass holiday devoted to the Day of protection of children. Realization of this project became the second stage of the program. The holiday was held in the Children's park of Beslan. During the holiday the park was visited by about 1000 adults and children who were greeted by the teenage volunteers, participants of the program «New Tomorrow». The authorship, development, planning and preparation of the holiday (design, sticking posters, invitation of people to participate) belonged to the teenagers themselves. They also lead the holiday: games, competitions,
sessions with children. About 50 graduates of the first stage of the program took active part in the preparation of this action and in conducting it more than 100.

That is how action «The Flowers of Life» was carried out for the first time, in 2005. But an "amateur" city holiday on which music from children's films sounded, where children were allowed to bathe in the fountains, where children wrote messages with their wishes, attached them to the root of the flower and planted on the lawns so that the wishes could come true, was so pleasant to the inhabitants of Beslan that they conducted it the second time in 2007. And a year later an initiative group of graduates of the program «New Tomorrow» and child psychologists working in Beslan, independently repeated the action which has already become a tradition in the city. Thus, the social initiative and the activity of teenagers, stimulated by the training, have found theirs practical realization.

Now the majority of participants of the program «New tomorrow» study in various higher educational institutions. However, some of them still actively and successfully work as volunteers with preschool children and junior schoolchildren at the Center of psychological rehabilitation of children and teenagers and participate in other projects.
Chapter 10. ISSUES OF ORGANIZATION OF PSYCHOLOGICAL SUPPORT TO VICTIMS OF CATASTROPHES

Psychological rehabilitation of the children and teenagers who have experienced heavy psychological trauma takes a long time – measured in years instead of weeks or months. Consequently, the major condition for success in this work is stable activity of the local structures providing psychological support to the community. Creation and professional maintenance of the activity of such structures is a necessary component of the work of professionals from other regions with a more developed system of psychological aid.

The operational experience with children and the teenagers traumatized by acts of terrorism in Beslan (September 2004) and earlier – at Moscow theatre performance on Dubrovka (Nord-Ost, October 2002) – has shown that existing psychological services and the state structures are inadequate to successfully cope with this activity. As a result, we have developed recommendations for creation and perfection of a service for administering emergency psychological aid to children and teenagers.

1. Creation of a uniform psychotherapeutic staff is necessary. Possibly, the staff should be formed at the Emergency Situations Ministry. The staff structure should be constant and staff should be appointed by special order. The psychotherapeutic staff should work in close and constant contact with medical staff (and if possible, be a component of medical staff). For optimization of work the following positions should be created:

- **Head of staff** – a highly skilled specialist (the psychologist or the psychotherapist), occupying a leading post and having personal contacts with heads of different levels and different departments.
- **Assistant/Coordinator** who should gather information, coordinate the activity of specialists, supply necessary phone numbers, etc.
A rapid-reaction team should exist in a “dormant” form, in case of the need to be instantly “developed” into a high-grade working structure. In an extreme situation, a substructure of the central staff should be developed for working with children, teenagers, and their families.

2. A database should be compiled of organizations, psychologists, psychotherapists, social workers and volunteer non-specialists capable and ready to assist in extreme situations. Besides voluntary offers of the services, some system of expert evaluation of qualifications of experts with a specialization (type of possible aid, adults/children, available experience, etc.) is necessary. In order to render psychological and psychotherapeutic aid, it is necessary to involve only professionals having experience in clinical work.

3. In cases when work has to be conducted in hospital, the chief of staff or his or her assistant (operating on his or her behalf) should conduct initial communication with the hospital management or doctors on duty, but not the secretary and not the specialists themselves. The successful initial arrangement with doctors serves one of the major conditions for the timely start of provision of psychological help. After the initial connection with the medical institution is established, the specialists directed to this establishment should always coordinate their actions with hospital management or directly with the attending physician. The following should be coordinated:

- Visiting hours
- Dress code (hospital gown, hospital footwear, etc.)
- Duration of work with each of patients (depending on their somatic condition)
- Tasks and forms of work
- Desirability or undesirability of a relaying information about the condition of the family, considering the acuteness of the patient’s condition
During the work process, it is important to discuss dynamics of each patient’s somatic and psychological condition with the doctor after each patient’s visit, to coordinate joint strategy and to identify outstanding issues.

4. In addition to work of psychologists, the aid of social workers and social services is necessary for families of victims. The function of the social worker should include maintenance of communication with relatives of the victims, relaying information on their condition and the requirements of patients, informing patients of the situation at their home. Specialists would preferably be supplied with mobile phones, especially at the first stage, when most victims are acutely interested in the condition of their families.

5. In order to identify children and teenagers who have suffered directly and indirectly in mass disasters and require psychological (and possibly psychiatric) aid, survey of teachers and parents is recommended. It is necessary to involve social workers, the regular medical personnel of outpatient clinics, and the staff of schools and kindergartens in the questioning. The recommended questionnaires, developed by us while rendering aid to Beslan children and teenagers, are given in Appendices 1, 2.

6. Establishing a national center for training and restraining specialists to work with children and teenagers who have suffered in extreme situations is needed. For this purpose, it is necessary to conduct preliminary selection of the specialists willing and able to work with children and teenagers in extreme situations. Such a center should also render advisory aid to specialists working with children and teenagers in an extreme situation in the conditions of a medical institution.

7. It is desirable to create a constantly operating advisory center advising on providing psychological and psychotherapeutic aid to families requiring support during the extreme situation and in its aftermath.
8. It is important to provide system of psychological rehabilitation for the specialists working with children – teachers, educators of kindergartens, physicians. The condition of children also appreciably depends on their psychological condition. It is also necessary to conduct psychological education with them, to acquaint them with displays of acute stress and PTSD in children and teenagers, to train them in the specifics of work with children traumatized in an extreme situation.

Principles of building a system for providing emergency psychological aid to children and teenagers, which were widely discussed at the International Forum “Children in Extreme Situations”, which took place in Moscow in October 2003, have been approved by many specialists and representatives of interested departments. At the same time, they have not been implemented. As a result, when a need arose in Beslan for emergency psychological aid to children, neither local nor federal organizations could provide it in the necessary volume. This gap was partly filled by the active aid of foreign charities; however, even their efforts turned out to be obviously insufficient to cope with the scale of psychological trauma.

In summarizing the stages of work on the psychological rehabilitation of the children and teenagers traumatized by the terrorist attack in Beslan, it is necessary to state that our society is currently absolutely unprepared for the resolution of similar problems. Aid to suffering children is irregular. Professionals participating in this work are isolated from one another and have no uniform concept or strategy. State structures are not able to react flexibly to a quickly changing situation and to adapt to the needs of the community of suffering children. Creation of a stably operating service of emergency psychological aid to children and teenagers remains a major issue demanding the urgent resolution.
Let us try to summarize some results. What do we have and what do we need?

There is a conviction uniting us that people who have gone through local and mass psychologically traumatic situations need psychological, and sometimes even psychiatric, aid. It should be rendered systemically, covering children, teenagers and adults. The basic unit to which it should be directed is, as a rule, not an individual, but a family, or in case of mass disasters, a certain cohort of the community.

The materials presented above suggest that such aid is very effective. The majority of children visiting the Rehabilitation Center successfully adapted to school, study well (several examples of successful cases are given in Chapters Two, Three, Seven – the cases of Amina, Diana, Inga, Sabina, David). As distinct from our observations, the stories of parents and teachers, the mental state of the first-grader hostages who did not receive psychological aid remained stably acute for a year or more (some examples are given in Chapter 3 – the cases of Soslan, Taimuraz, Anna, Milana).

There is a wide spectrum of the methods allowing work with people of varying ages (from babies to old men) and conditions (from normal to psychotic reactions to stress). It is important that work be carried out by teams which include a range of specialities – psychologists, doctors, social workers and teachers. The tragic events of recent years have compelled us to amass extensive experience of such cooperation and prove its effectiveness.

And what we still do not have is any system for the organization of psychological aid to the community. Each new extreme situation strikes us unawares. Each time it is rediscovered that there are no state or professional structures which provide for the possibility of such situations. Work begins from scratch, hastily, without necessary materials, premises and equipment. Consequently, aid is late in coming and is not provided to all who require it. A
lot of time and energy is spent on coordination of actions with interested ministries and departments.

The problems of overcoming of such social and psychological consequences of mass disasters as conflicts between victims and non-victims, occurrence of a passive lifestyle (a dependant position), falling social activity of teenagers and youth have barely been studied. Interaction with mass media is insufficiently calibrated. As a result, instead of the big help they could be in the medical and psychological education of the community, they are quite often damaging in their distribution of secondary traumatization.

There is no system for training specialists who are able and willing to render emergency psychological aid. There are far fewer qualified professionals working with children and teenagers than is necessary. There is also no literature devoted to these age groups. Psychologists and doctors who are general practitioners are poorly acquainted with the issues surrounding psychological trauma. Their learning happens in emergency mode, only when “the thunder has already struck.” It is obvious, that this reduces the quality of training and does not allow full use of the potential of professionals providing it.

It is necessary to state that today our society is absolutely not ready to solve the psychological problems resulting from mass accidents. Help to children victims of tragedies appears unsystematically. Professionals participating in this work are isolated, have neither common concept nor strategy. The state structures are not able to react flexibly to quickly changing situation and to adapt to the needs of the children victims. Creation of a stably operating service of emergency psychological help to children and teenagers remains the major task that requires an urgent resolution.
REFERENCES


