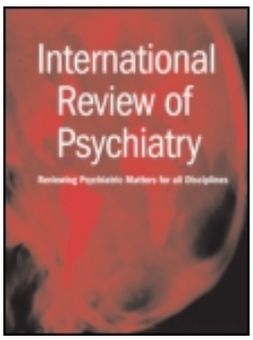

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Community healing for children traumatized by war

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Summary
This paper examines the interplay between the destructive and healing forces within human communities, as reflected in the life of children. This work stems from over 30 years of being involved as a participant/near-miss survivor/therapist, in a society exposed to intermittent wars and random terrorist attacks. An interventional model evolved to help children in the Israeli educational system. This model was expanded over time and utilized in other global settings, with a variety of national, ethnic and cultural groups in trouble. This paper attempts to scan an enormously complicated subject by looking separately at different layers before reintegrating them all into the 'larger picture' of a dynamic, pulsating whole. In trying to draw a global map of trauma and healing, one hopes not to lose sight of the individual, the unique and indispensable child.

Trauma—effects and healing

Psychological and sociological causes and implications of trauma reflect the interaction of multiple aspects: the physical, the intrapsychic (cognitive, emotional, imaginative, spiritual), the interpersonal (familial, social, communal, ethnic, cultural, religious), the educational (learning, socializing, occupational), material-economical, political, national and international. As all these aspects are involved in inflicting the trauma, so must they all be called forward for the cure. Healing of trauma cannot be accomplished by an individual alone, it must take place in all of life's relevant dimensions: family, peer group, community, society and culture (Reichenberg & Friedman, 1996). A model that treats symptoms rather than empowers the whole human being may be inadequate. Exclusive reliance on the PTSD (Post Traumatic Stress Disorder) approach, which has proven its effectiveness with individuals, may exclude large numbers of children from getting help who seem to be functioning well despite their invisible wounds (Jareg, 1995).

The conceptual frame of this work evolves from Lumsden's (1997) analysis of the three zones of the human experience, namely:

Zone 1. Situations in the outer world instigating and maintaining the cycle of violence, and the cultural systems that may be affected by war.

Zone 2. The individual's inner world, identity and sense of self, that are shattered by massive traumatization.

Zone 3. The transitional space where healing takes place. The 'third zone' in this context is an expansion of Winnicot's (1971) concept of the metaphorical or transitional space: the 'intermediate zone between the personal/psychological and the social structures, where children's play and creative activities are regarded as opportunities to take conflictual material, from the inner world, and reconstruct it outside of themselves.' In our work, Zone 3 is seen as a bridge between the situational and the psychological elements of the trauma of war in the lives of children. It is the arena of attending to children, listening to them, assessing their needs and using community facilities, community human resources and the language of creativity and play to involve war-affected children in the process of recuperation.

Situational elements of trauma—Zone 1

War encompasses all conceivable elements of trauma. It is also all-pervasive and persistent. More than 50 countries today are embroiled in armed conflicts. Human-made violence has been rampant in our century in many shapes and forms, resulting in an enormous escalation of its impact on non-combatant populations. Following are some harrowing statistics from UNICEF: in the First World War, civilians accounted for 14% of the victims; by the Second World War, it was close to 70%; and by 1990, almost 90% of those afflicted by war and its aftermath were civilians. Wars and armed conflicts are taking a terrible toll on children. In the past decade some two million children have been killed; almost five million disabled by bombing, land mines or torture; 12 million left homeless; more than one million orphaned or separated from their parents; and some ten million psychologically traumatized (Bellamy, 1986). Eighty per cent of the 53 million people uprooted by wars today are women and children. Most contemporary wars are not between states but within them. Today's conflicts are often bound up with ethnic differences, and in these circumstances warring groups target any member of the other group as a present or future enemy, leading to genocide and 'ethnic cleansing'. Another

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scourge of war is land mines, which maim and kill thousands of children every year. An estimated 110 million land mines await unwary footfall of an adult or child in 64 countries. Many combatants target civilians by damaging hospitals, schools, water supplies and food-production areas. As a result of this strategy, many more children die slowly from malnutrition and disease than from bombs and bullets (Miosso, 1996). While the scars of the Holocaust are still scorching, its memory has been fading. Hence, we can understand the following statement by Bellamy: 'Ex- Yugoslavia and Rwanda acquainted us with a reality of war for which the international community was unprepared, a reality which involved new instruments of war and new social categories of victims.'

Children as direct targets

Mozambique's leader, Graca Machel, an advocate for children's rights, claims that the 'war on children' is a twentieth century invention. Children and their families are 'not just getting caught in the crossfire—many are being targeted. Children are considered the enemies of tomorrow! Therefore deliberately killed, mutilated, violated ...' (Machel, 1996). The UNICEF statistics are a chilling testimony, of the sanity of the world we live in. In the last decade more than 1.5 million children have been killed in wars. There were 333,000 child deaths registered in Angola, and 490,000 in Mozambique, between 1982–1986 (Bellamy, 1986). More than four million have been physically disabled through bombing, land mines and torture. Twelve million have lost their home, and five million are in refugee camps (UNICEF, 1993).

Children are also being used as instruments of violence: in over 30 countries very young children are deployed as soldiers (Cohn & Goodwin-Gill, 1994). Over 200,000 children under the age of 16 are fighting in wars in 25 countries every year, forced to take part in the torture and executions, sometimes of their own relatives. Most of them go through a process of indoctrination, of dehumanizing the enemy and preparing to die for the big cause. 'Thousands of children as young as eight years of age were recruited and trained as martyrs for Islam, given T-shirts inscribed 'To Heaven' and a plastic key to open Heaven's gate. They were compelled to walk in rows in front of the tanks to clear the mine-fields' (Boothby, 1986). Such 'war apprentices' were abundant in Sri Lanka, in the Iran–Iraq war, in the Palestinian–Israeli conflict, in Ireland, in Angola, and Zambia (Hundeide, 1994). Violence against women, especially rape, has added its own brand of shame to recent wars. Girls have been singled out for rape, imprisonment, torture and execution. Systematic rape is often used as a weapon of war in 'ethnic cleansing'. Teenage girls have been a particular target, and when impregnated, forced to bear 'the enemy's' child. In some raids in Rwanda, virtually every adolescent girl who survived an attack by the militia was subsequently raped. Many of those who became pregnant were ostracized by their families and communities. Some abandoned their babies; others committed suicide (UNICEF, 1996). The high risk of infection with sexually transmitted diseases, including HIV/AIDS, is part of sexual violence. Another form of ostracization is inflicted upon children conceived in rape, and born into and out of violence, branded for life.

Indirect exposure

In countries involved in prolonged military squabbles such as Israel (Ayalon, 1989), Lebanon (Bredy, 1983) or Northern Ireland (Fraser, 1983), even when children are relatively protected within a functioning community they are still aware of the looming danger and carnage. They are traumatized by vicarious exposure to war damages such as destruction of homes, schools and neighborhoods, living under the constant threat of terrorism and often involved in random evacuation from a community under threat, in addition to witnessing casualties directly or via mass media.

Responses to traumatic events differ from child to child, depending on individual factors such as age, gender, direct or indirect loss, and availability of family and community support systems. Outcome studies of the impact of war on children show some discrepancy, which reflects the different degrees of exposure to stressors, and even the manner in which stressors are perceived and defined (Kuterovac *et al.*, 1994). Some children can be sheltered and protected from the actual fighting, while the information about it is mediated by parents and peers or filtered through mass media. Some may be proud of fighting fathers and brothers, or mourn their death. Children may be randomly targeted by terrorists, taken hostage, or crowded in shelters to hide from air raids and rockets (Ayalon, 1988). Often, they are vicariously exposed as 'near-miss' victims to catastrophic events, eyewitness destruction and atrocities. Children may be abducted and coerced to be 'war apprentices', serve as child soldiers or as 'canon fodder'. Many are directly victimized—injured, tortured, orphaned and displaced. Children's diversified reactions reflect the manner in which they experience and interpret their situation. Their reactions are also dependent on the mediating factors, such as family and community, which can serve as protective and curative shields.

Psychological elements of trauma—Zone 2

The experience of trauma is neither 'the event' nor 'the response', though all these elements are interconnected. Trauma is a systemic shock that unbal-

ances the individual's somatic, affective, cognitive and spiritual inner functions. Trauma breaches the psychic 'stimulus barrier', thus robbing the mental apparatus of its habitual defenses and modes of operations, with ensuing confusion and disorientation. According to Gordon and Wraith's (1993) capturing analysis, the main feature of trauma is 'rupture'—it ruptures continuity in time, in relations and attachments, in perception of self and others, in basic assumptions about the world, in expectations about the future, and above all it ruptures the fabric of meaning!

The distinction between traumatic stress reactions, that occur in the presence of the stressor of the catastrophe or immediately afterwards, and post-traumatic reactions occurring later, in response to the memories of these events, has been eloquently articulated by Figley (1985). Assessment of traumatic responses in children, both in the impact phase, which can sometimes be prolonged, lasting their childhood years (Ayalon, 1987); or in the aftermath (Yule & Williams, 1990), whether they had one major exposure, or endured repetitive and cumulative trauma (Type II: Terr, 1991), show an abundance and variety of symptoms across gender, age, type and duration of exposure. However, even in child populations that never came to psychological or psychiatric attention, there are remarkable changes in behavior and attitude. All these changes, whether they warrant the full diagnostic criteria of PTSD or not, denote an enormous amount of suffering (Ayalon, 1982; Desivilya *et al.*, 1996). Childhood, which is considered the 'foundation' for the whole development, is damaged, distorted or entirely lost.

Losses in childhood and loss of childhood

Loss of attachment comprises major trauma for young children, as observed by Freud and Burlingham (Dyregrov, 1991), and subsequently corroborated by ample observations. Separation from principal caregivers and family results in augmented anxiety and long-term mood and adjustment difficulties. In contemporary 'door-to-door' wars, such as Rwanda (Dyregrov & Raundalen, 1995), Angola (Hundeide, 1994) or Bosnia (Stuvland, 1994), the magnitude of loss, which is complicated by children witnessing family members slaughtered by neighbors, is unfathomable. There are no words, in any language, to describe the experience of 'violent loss', 'witnessed loss', 'participatory loss' but to call it 'the loss of childhood'. When childhood is lost—what replaces it? Rescue mission workers have observed that children who survive such atrocities have no sense of future, hateful fantasies to avenge the death of parents and relatives, admiration of power, uniform and guns, and lack of trust in human beings. Unfortunately, these children grow up often perpetuating the very same conflicts that victimized them. 'A pervasive sense of having lost the future, combined with a need to forget the past, can make life intolerable' as described by Dyregrov and Raundalen (1995) of traumatized children in Rwanda. The most common symptoms observed in these children are: persistent fears and anxiety, increased levels of aggression and hostility, tendency towards regression, withdrawal and avoidance, which stem from being exposed to situations which contradict the basic norms of society, namely the sanctity of life (Ayalon, 1993a).

The trauma of being an eye witness to violence

There are unique features that define traumatic witnessing and distinguish it from the trauma of direct victimization. The helplessness of a witness is determined by the imposed passivity of having to watch or listen to the sights and sounds of violent acts. Though physically uninjured, the child is unprotected from the full emotional impact of violence and may suffer all of the painful symptoms of post traumatic stress disorders. Research studies (Pynoos & Eth, 1985; Hendriks *et al.*, 1993) have shown that children who witness extreme acts of violence such as murder, rape or torture are at risk of developing anxiety, depressive, phobic and behavioral disorders. In addition, many develop PTSD characterized by the following symptoms (DSM-IV criteria for PTSD: APA, 1994):

1. Traumatic event so upsetting that it never leaves the mind.
2. The event is re-experienced in dreams and play through intrusive images or sounds.
3. Children may develop psychic numbing and constriction of affective responses.
4. Trauma-related psychophysical responses such as startle reactions, flooding memories, flashbacks, nightmares and free-floating anxiety may linger for years.
5. Rage and frustration directed inward may turn into suicidal behavior, and when directed outward may turn into homicidal aggression.

The needs of child witnesses are commonly neglected by the family, school, law enforcement agencies and mental health professionals.

Buffering strategies

When psychic trauma follows exposure to extremely dangerous events, it triggers intrapsychic responses that act as buffers against overwhelming anxiety and arousal. These defensive responses, if not attended to, may subsequently rebound and cause secondary psychological damage. A series of studies (Eth & Pynoos, 1985) identified five buffering strategies most commonly employed by children, limiting traumatic anxiety in the immediate weeks or months after the event:

- Using denial of facts and meanings.
- Reversing the outcome in fantasy.
- Inhibition of spontaneous thoughts to avoid reminders of the event.
- Continuous repetitions, to make the event more tolerable.
- Catastrophic expectations, to avoid confronting the actual trauma by replacing it with future imaginary fears.

As in the case of adults, post traumatic stress disorders are more severe and last longer whenever the stressor is caused by 'human-made violence'.

The intrusive imagery and associated affect may temporarily or chronically interfere with the child's capacity to learn. The child may be preoccupied with cognitive reappraisals of the event. Inner plans of action which replace activity, trigger fantasies of retaliation or identification with the aggressor that can seriously jeopardize the child's ability to control aggression. Reckless, aggressive and self-destructive behaviors or prominent inhibition may suddenly appear, affected by systematic stereotyping of the enemy as a monster, engendering hostility, fear and hate. When the enemy is portrayed as the symbol of evil, dangerous to the existence of society, all roads to peace, mutual understanding and the end of hostility are barred.

Elements of family and community as the potential space where healing can take place—Zone 3

Family's plight and might

The family—as a social system—is a crucial resource for recuperation. When disrupted by war, the family as a whole may be victimized directly or indirectly as 'near-miss'. Children of traumatized parents are left without adult support even within their own home. Holocaust studies on 'second generation syndrome' (Wardi, 1992), show that children carried the brunt of their parents' suffering, into their adult years. Parents' guilt over their own helplessness to protect their children from ordeals, also accounts for their inability to contain, listen and accept their child's pain.

Secondary stress factors emerge when parental distress triggers violence in the homes (Jareg & Jare.g., 1994). Death, upheaval and poverty increase the likelihood of violence against women and children, as men who feel that they failed to protect their women may compensate by exercising violent control over them at home. Many children separated, and treated for their trauma by social agencies, may eventually reunite with a precarious family shattered by war. Mothers may be the sole survivors, often brutalized and raped. Equally traumatized are siblings, far from being able to provide the necessary supportive environment.

The breakdown of traditional family and community structures by direct victimization, death, displacement and poverty results in role reversals and the shifting of adults' combatant role over to youngsters, as happened, for example, during the intifada and the struggle against apartheid. This resulted in parents' loss of control over their children, with radical implications for children's rehabilitation, and reintegration in the post-conflict era. Children who had engaged in military activities beyond their years, do not readily submit to the traditional demands of the educational system and may grow up to be truant and resentful. Radicalization of youth is also influenced by the fact that families and communities encourage children from an early age to incorporate beliefs and standards that protect their cultural and ethnic identity. Once the conflict ends, they may be reluctant to submit to the usual restraints upon their behavior (Bertt *et al.*, 1996).

Family as the 'optimal treatment unit'

The empowerment approach to helping traumatized families emphasizes the role of the family as a resource to reorganize, find its direction and purpose, nurture and heal the survivors, memorize the victims, continue reproduction as a message of hope for the future, continue the family legacy, and participate in rebuilding the community. The idea behind the 'empowerment' is to approach the family as a functional unit and to enhance its coping skills, such as communication, listening and containing the mental pain of its members, help develop new strategies for handling conflicts that result from the adjustment difficulties of the traumatized members, dealing with possible role reversals, loss of parental authority, and creating an atmosphere of support and healing (Ayalon, 1983). In consulting with post-war families, attention should be paid to possible marital problems which can plague the family dynamics. Such difficulties can lead to mental and physical domestic abuse (Ayalon & Zimrin, 1990). Families need to be empowered so that the adults can recapture their parental roles and learn new 'trauma oriented healing roles'.

One recent example of a community approach to such empowerment is the 'Parent Advisory Program', attending to parents' needs to face, understand and heal their children's traumatic wounds. Framed within the psychosocial intervention in post-war Bosnia (Raundalen, 1996), it can become a blueprint for addressing parents in many post-war communities. Families' outreach is to be carried out by local trained advisors, and reinforced by booklets and videotapes addressing the main issues of traumatic experiences of children, re-entry of traumatized children into mainstream society, modeling ways of listening to the child with empathy, and effective ways of dealing with pent up anger and violent behaviors. Thus the family becomes a major

agent in guiding children in pro-social conflict resolution, and directing them to adapt to the ethics of peace and tolerance in society. Similar programs, promoted by the Israeli Community Stress Prevention Center, during and in the wake of war and terrorist hostilities in the last few decades, have been offered to parents by specially trained school counselors, with remarkable results on the wellbeing of children (Ayalon & Lahad, 1990; 1992).

Community approaches to trauma and healing

Loss and rehabilitation of the 'sense of community'

The term 'community' has multiple connotations, but basically it holds a shared denotation of togetherness, united by common history or goal, sharing and participation in activities, culture and ideology (Webster, 1996). Embedded in the concept lies the lifeline of community, namely 'communication'. Though loosely organized, a community as a social system has its own boundaries (visible or invisible), rules, roles, leadership and interactions. One of its main functions is to contain and support both family systems and the individual members. A community social support system shields the individual by creating psychological continuity and stability, which enhance a 'sense of community' for each single member (Lumsden, 1997). This is especially important for children, who rely on the continuity of routines and on the familiarity of their surroundings to develop their 'sense of self'. The trauma of war simultaneously impacts community members and agencies such as family, school, health and recreation. Caregivers and receivers alike are shaken off balance, limiting vital interactions and transactions. If the community boundaries, roles and interactions are extensively damaged, either by natural or by human-made disasters, it symbolizes the destruction of life's continuity for the children.

Destroying the infrastructures of water and food supply, health and education, is often a deliberate systematic destabilization used as a weapon of war. During the decade-long war in Afghanistan, three million school-aged children were deprived of schooling. In Mozambique, 3,000 primary schools were destroyed in 11 years of bloodshed. The destruction of schools goes far beyond the loss of formal learning. It shreds a child's connection and continuity with its community and culture, further perpetuating and exacerbating the already existing cycle of illiteracy, poverty, despair and violence. Some communities become toxic, when is waged by neighbors against neighbors and tears families apart, as in dozens of countries where war does not provide community solidarity against a common outside enemy. Children are betrayed by trusted relatives and former friends, while the 'community' becomes a lethal trap (Reichenberg & Friedman, 1996).

In such cases, not only is the community incapable of aiding the victims, but it is itself in danger of breaking down, needing rehabilitation so it can once again shield and heal the individual. To rehabilitate the 'sense of community', belonging, coherence and continuity, it is necessary to merge the efforts for healing the individual child with a broader investment in a wide range of community-oriented activities. Such integrated interventions take place in the 'transitional space' between the individual's need for remedy and the community's need for rehabilitation. The 'transitional space' between the outer and the inner world, as coined by Winnicot (1971), is the area of 'play' that provides a metaphoric space, for expressing emotions and resolving conflicts for rehearsing roles and acquiring social skills. The overlap between 'play' and 'work' in rebuilding the community creates an opportunity for recapturing the 'sense of self' and the 'sense of community' at the same time. This is very appropriate for many traumatized societies. The following examples highlight the effects of the transitional space of reality 'work-play' healing. In devastated rural Guatemala, 12,000 children were involved in community rebuilding, helped by 375 youngsters aged 12–17 years, who were trained as peer counselors, healers and social change agents! Drawing on resources that emerged from their own pain and loss as well as from their own survival skills, they promoted work, study and play opportunities for other children (Reichenberg & Friedman, 1994). Adolescents hunger for a meaningful role. Two thousand youngsters in South Africa changed their attitudes from despair and fear to ingenuity and hope when given the opportunity for participation and leadership in their rural communities. In Angola, thousands of homeless war-victimized children were gathered in makeshift camps on the beach. The Methodist church supplied materials and supervision for the older children to build small group-homes for themselves and playgrounds for the younger children. This was a major step in combating despair and destitution among the children and promoting 'survivor mentality' within the indigenous cultural norms and expectations (Ayalon, 1995).

Community-based programs

Community-based programs represent a major departure from accepted theories and methods of therapy in general, and 'trauma therapy' in particular. The paradigm shift is embedded in the notion of 'empowerment of the client', as opposed to the models of handling traumatized people in the clinic with preconceived diagnostic and therapeutic procedures. It emphasizes resilience, coping and the salutary effects of intervention in the natural life space. This rather innovative approach to healing traumatic effects by 'community-based programs' in-

volves turning to communities, families and children themselves as proactive participants in assessing their needs, finding their own resources and working out solutions, as opposed to the more accepted traditional interventions. Indigenous communities develop their own ways of working through the impact of the trauma and mourn their loss of rites and rituals as a means of coping with the future. Recovery and reintegration processes are undertaken at the community level, using local religious and cultural methods meaningful to the people themselves. Community events, such as a mass memorial or a ritual, affect the course of the traumatic response and recovery. For example, after a street theater group played 'the killing of a fire dragon' in the wake of a bush fire in Australia, children's traumatic symptoms subsided significantly (Gordon & Wraith, 1993). A community approach endorses resourcefulness and encourages a sense of self-worth, creativity and management skills in local caregivers. It recognizes the family and community as the best setting for the recovery of children who have endured trauma, maintaining a dialogue, partnership and advocacy with affected community agencies (Pozzardi, 1995).

Schools—the preferred community agencies for trauma intervention

Schools are the preferred community agencies and appropriate system within the community for addressing children's misery and implementing relief programs. Schools are easily accessible to children, and are a reservoir of educational knowledge for adults who can be trained. Training teachers to function as emergency counselors can enable them to unburden their own pain, while they facilitate group discussions and group activities where children share and try to make sense of their experiences (Lahad, 1988; Pynoos & Nader, 1988). This approach, though initially rejected by the educational system, has finally been accepted in Israel and many other countries. For example, schools and library projects developed rapidly to deal with the massive traumatization of youth in Croatia and Bosnia (Ayalon, 1996) and in Northern Ireland (Fraser, 1973). In Rwanda, UNICEF & UNESCO developed the 'school in a box', an educational 'first-aid kit' which contained basic tools to establish a classroom-like environment (Dyregrov & Raundalen, 1995). The fact that many schools are still reluctant to shoulder this responsibility (Ayalon, 1979), points to the efforts that should be invested in changing attitudes toward community involvement in children in disasters (Capewell, 1992).

Modern (western) communities that have lost most of their traditional healing potential can take advantage of procedures and programs offered by professionals, gleaned from a vast knowledge-base of trauma and its repercussions. A key issue is to distinguish between what is culture specific and what is universal when it comes to psychological healing: 'Traumatized communities may not be able to do this alone. Like traumatized individuals, they need direction, resources and support' (Capewell, 1993). A bridge has to be built between experts and people in need.

COPE project—bridging the gap

'Community Oriented Preventive Education' (COPE) was a pioneering project (Ayalon, 1977; 1979), developed over 1974–1977, when the Israeli community was badly shaken by the eruption of an unpredicted war (known as the 'Day of Atonement War'). These were the early days of 'trauma research', with little expert knowledge or awareness of the plight of children in dangerous environments and of the role of the community in providing large-scale trauma relief. Thus the COPE model became a breakthrough in disaster response and management, to be implemented first in the Israeli educational system, and later in other societies caught up in the throngs of human-made or natural disasters with special focus on children (Ayalon, 1978; 1992).

The COPE model is based on the following principles:

1. Realizing children's traumatic sequelae, their need for help and the responsibility of the community (especially the educational community) to respond to these needs.
2. Preparing community personnel, mental health and education professionals as well as paraprofessionals and volunteers to deal with traumatic events and their consequences.
3. Focusing on three intervention strategies: anticipatory, buffering and recuperation, roughly corresponding to the three stages of a crisis. These classifications help in planning preventive stress inoculation (before), crisis intervention (during) and rehabilitative treatment (in the aftermath).
4. Presenting an open-ended trauma-recovery curriculum for group activities based on creative means for therapeutic ends; using the child's language of imagination and play. The model package includes a variety of methods:
   - Expressive techniques for debriefing and ventilation by verbal communication such as writing or enactments and narrative-metaphoric methods.
   - Non-verbal methods such as imaginative drawing, playing and using relaxation and body language.
   - Cognitive and social restructuring methods such as affirmations, attitude change activities, problem solving and conflict resolution.

These orientations were adopted and further developed by the Israeli Community Stress Prevention

Center (CSPC), established in 1981 following prolonged exposure of civilian populations to massive bombardments and terrorist attacks on homes and schools. Community-oriented trauma intervention included modules for primary preventive stress inoculation, secondary crisis management and tertiary restorative-therapeutic interventions (Caplan, 1974).

'BASIC-Ph' as a multi-channel model for coping resources

The salutary approach assumes the existence of coping resources, either active or dormant, in every individual and in every system. These interdependent resources, identified through observation and research of traumatized populations (Lahad, 1997), were grouped into an integrative cluster called: BASIC-Ph, namely: Belief, Affect, Social interaction, Imagination, Cognition and Physiology. The BASIC-Ph multi-dimensional approach, inspired by the ideas of multi-modal therapy (Lazarus, 1981), relates to six dimensions of coping. It suggests that each individual's coping style comprises an idiosyncratic combination of these six dimensions, which act as input and output channels in the person–world interaction. Everyone has the potential to use all six channels for coping. Children, like adults, respond to traumatic stress in more than one of these channels. The cognitive channel (C) transmits strategies including information gathering, problem solving and positive thinking. The affective channel (A) processes the wide range of emotions triggered by the trauma and their verbal or non-verbal expression. The social channel (S) contains group belonging, role fulfilment and the mutual function of receiving and giving support. The imaginative channel (I) enables the amelioration of stress by denial and fantasy, but is also responsible for creative solutions to the problems by imagery, dreams and intuitions. The spiritual channel (B) sustains religious beliefs and value systems and the search for meaning. The physical channel (Ph) is broadly responsible for the Negro-chemical and motor responses to stress, as well as behavioral ways of handling stress that may range from relaxation to excessive physical activity. This holistic channel approach became the major denominator for assessing resilience and enhancing coping resources of individuals and large population groups (Lahad *et al.*, 1997).

BASIC-Ph components as coping resources

The following examples from cross-cultural research bring some of the vast evidence accumulated about the function of the 'multi-dimensional model of coping resources' as a generic container for specific situational and cultural modes of coping.

Ph—sensory and motor coping resources. Most traumatic situations involve extreme sensory exposure. Specific sensory stimuli such as smell, sight, noise or touch may later become triggers for emerging intrusive memories. Body awareness, body-work, active relaxation and planned activity help to channel or extinguish the shock and the intrusive memories stored in the body (Rothchild, 1993). Relaxation training has proven very beneficial in abating anxiety when employed with Israeli children who had to spend prolonged periods of time in air-raid shelters. It was also effective in reducing hyperventilation when children had to wear gas-asks in sealed rooms against Iraqi missile attacks in the Gulf war (Ayalon, 1993b; Solomon, 1996).

A—affect: ventilation and expressing emotions as a coping resource. Children have a great need to tell their story, express their horror, guilt or rage and ask unanswerable questions. Shutting up the trauma story becomes a secondary victimization, and hinders recuperation. As children's natural language is play, the debriefing program should promote free play, projective play and role-play, as well as other verbal and non-verbal expressive methods such as drawing, dancing, singing and story-telling (Ayalon & Flasher, 1993).

Therapeutic responsibility and ethics are often breached when severely traumatized children are offered a brief opportunity to ventilate, but all expectations for compassion and dependency are curtailed by the end of the brief one-time encounter. This can also happen when the number of victims outnumbers and overwhelms the therapeutic resources which are limited. In other instances, children are pressured into telling and retelling their 'horror stories' to journalists and researchers. The retelling is not always in the best interest of the child. It may compromise a child's rehabilitation and reintegration, as he sees his or her value only in regard to his or her identity as a victim, soldier, or worse—as a 'killer'.

When surviving is at stake, it is more responsible to encourage the coping and challenging aspects and refrain from compromising the children by opening the raw emotional wounds. In situations of imposed passivity, for example when children hide in shelters during air-raids, distraction of their minds by humor and games is preferred to ventilation of fears (Ayalon & Lahad, 1990). Only in relative safety is it recommended to encourage ventilation. For most victimized children, it is important to create a context of hope and future meaning.

C—cognitive coping resources. Children are helped by learning about normal reactions to trauma and loss. Telling the truth about injuries and death and about the destruction of homes or schools helps to anchor them in reality and start the process of grief and recuperation. Stress inoculation skills

(Meichenbaum, 1985), positive affirmation, assertiveness and self-regulation are all important cognitive tools for coping with adversity.

B—belief systems. In all cultures, religious prayers are used to obtain help or guidance in threatening situations. In Rwanda, for example, this common principle has been used to prompt parents and religious leaders to encourage children to tell or draw their traumatic stories to God, as a form of 'communication from the powerless to the almighty' (Dyregrov & Raundalen, 1995). Rituals like memorials for the dead, traditional mourning ceremonies such as the Jewish 'Shiva' or even therapeutic 'metaphoric burial' (Van der Hart, 1986) can help children to process feelings of loss. Our longitudinal study of children hostages (Ayalon & Soskis, 1986; Soskis & Ayalon, 1985) unfolds the major role of religious faith, political ideology and value system as coping strategies. This area of belief systems, overlooked for a long time by psychologists, needs to be better understood and used in certain post-trauma interventions.

I—imagination and creativity as coping resources. Creative imagination is the most prominent resource in the formation of the 'potential space'—the 'sea of possibilities'. Spontaneous 'flight' into fantasy is reported by survivors of prison camps or torture and kidnapped hostages as their salvation in maintaining their sanity (Terr, 1987). The power of imagination to expand our existence beyond limiting realities has been repeatedly confirmed by prisoners of war and hostages (Ayalon, 1983), by abused children (Ayalon & Zimrin, 1990), by torture victims, dying patients and other survivors of adversities. Imagination is the core of spontaneous play and play-therapy, of drama therapy and enactment. It nurtures the creative process of drawing and sculpting, of poetry and prose writing, of dancing and of making music. This triggers the imaginative power to conduct metaphoric 'parting ceremonies' for bereaved children (Lahad & Ayalon, 1994). Healing imagery and laughter have been known to strengthen the individual's immune system, and the community's *esprit de corp*.

S—social belonging and support as coping resources. Peer support groups promote children's integration of the trauma by providing age-appropriate communication of the shared experience, continuity and stability, a relief from conflict with the adult world, and opportunities for fun activities. Youth leaders help the younger children reintegrate their pre-traumatic life experiences with the new life-style and opportunities. This model was developed in Israel as a response to the urgent need to absorb the numerous child survivors of the Holocaust since 1945, and found useful even now in helping refugee/immigrant children separated from their parents. Refugee camps in south east Asia, the former Yugoslavia, South African townships, and children's camps in Angola have also adopted this model (Ayalon, 1995).

It is important to note that the BASIC-Ph holistic model is not a clinical tool. It is used to identify strengths, and in indicating which coping modalities should be enhanced. It is sensitive to cultural norms and expectations, enabling the promotion of indigenous activities that contain the therapeutic elements as natural ingredients in everyday life, such as social and religious rituals and collective challenges that confirm each person's place in the community.

Children's empowerment—the fight for children's rights

Studies of children in war zones around the world found that a great many of them maintain an active and positive attitude in the face of adversity (Garbarino, 1993). Furman (1997) insists that people can be taught to identify their resilient elements that sustain them through life's hardships. The movement toward empowering children is controversial, as it fundamentally questions adults' authority, and the social structure that depends on exercising power and control (Dubrow, 1997). UNICEF (1993) declared that being caught up in violent conflict is a reality for millions of children in the world, a reality that consistently robs them of justice and human rights and constitutes a violation of the Geneva Convention on the rights of children, which are often violated. Graca Machel's Project (Machel, 1996) promotes active involvement of children in breaking the cycle of violence and traumatization, looking at children as a 'zone of peace'.

Children should never be allowed to play an active role in warfare, and they must be offered immediate protection and assistance when conflicts erupt. Out of these intensive activities a new hope is rising, that different community interventions that focus on 'detraumatizing' adults will benefit children as adults become more attentive to their children's needs.

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