Crisis Management of Children During Desert Storm

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Several groups have studied the impact of peacetime deployment on military dependents.[1] However, the wartime deployment of an overseas-based military to the Persian Gulf presented new challenges to dependent families. This paper outlines measures taken by military mental health providers to support dependent children and their families in Germany during Operations Desert Shield, Desert Storm and Provide Comfort. The authors discuss how mental health services in an overseas military community can be effectively provided in a changing, unpredictable, resource-limited environment to meet the unique demands of overseas dependent families during wartime deployment.

As Ursano et al noted, most military families live in relative isolation from the rest of society.[1] This is especially true in a foreign country such as Germany. Moreover, in an overseas military community, outside mental health facilities are often unavailable and mental health resources are at a premium because most military medical personnel are deployed with the troops. Consequently, mental health resources for overseas-based dependent families are severely limited during wartime deployments.

Pre-War Stresses

Never has a military deployment been so rapid and massive as during Operations Desert Shield and Desert Storm. In some cases, all active-duty members from entire military communities in Europe were deployed. A major stress on service members and their families during this pre-war phase was uncertainty about when a service member would leave. It was not uncommon for service members, spouses and children to experience relief when deployment actually happened, even though it occurred around the holiday season (Thanksgiving and Christmas).

During this pre-war phase, there was a flurry of activity in the medical community, the local military communities and the dependent schools. Virtually every aspect of family life was effected by media stories aimed at helping families cope with the impact of deployment, by the long convoys of military vehicles being driven to designated ports for shipment to Saudi Arabia, by increased numbers of military airlift flights and by the posting of armed guards at previously unguarded housing and military bases because of the increased threat of terrorism. As Amen et al stated, pre-deployment is a difficult time for many families because they want to be close physically, but at the same time, they need to distance themselves psychologically as a defense against the pain of separation.[2] Many military families found the pre-deployment interval difficult, especially when one member began the psychological separation earlier than others in the family.

A unique aspect of this deployment was the anticipation of war. It caused unusual stress on these military communities. Most military families are accustomed to frequent separations for field exercises, but this was often their first experience with military deployment to a life-threatening war zone. Mental health concerns during the pre-war phase focused on: assisting the family to handle the imminent separation; helping the family develop coping strategies; and community and school consultation to increase awareness of children's responses to separation and how to deal with their feelings and fears.

The following recommendations were helpful to parents:

(1) Spend time with each child before deployment to allow him/her to talk about feelings.

(2) Give the child pictures, etc, of the deploying parent.

(3) Make special nighttime story tapes in the deploying parent's voice.

(4) Make a contract between the child and deploying parent to write often.

(5) Discuss how the family will function once the service member leaves.

(6) Assure the child that the deployment is not his/her fault.

(7) Educate parents about the emotions children experience during separation.

Children showed many adjustment difficulties during the pre-war phase, including difficulty concentrating, fear of abandonment, depression, anger, guilt, difficulty sleeping, worry, increased demands for parental attention, somatic complaints, nightmares, self-criticism, clinging and academic problems. These symptoms occurred in both clinical and non-clinical populations. Ursano et al noted that the adequacy of family supports, the availability of surrogate parental models and the acknowledged degree of danger that a parent is likely to encounter directly effect how the child experiences separation.[1] Within each military community, family assistance centers and special counseling programs were organized. In spite of these efforts, many overseas military families noted a lack of extended family support because they were isolated overseas. In addition, surrogate parental models, such as scout leaders, church leaders and neighbors, were often deployed to the war zone as well.

As Amen et al noted, a number of family variables contribute to a child's reactions to his parent's deployment.[2] These include the child's pre-existing emotional development, the child's cognitive development, the emotional

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development of each parent and the stability of the parent's marriage. We found that the single best predictor of how well children (especially younger children) responded to the wartime stress was the emotional stability of the remaining parent. If the remaining parent adapted well, so did the child. On the other hand, if that parent adapted poorly, the child often had significant adjustment problems.

War Stresses

In dramatic contrast to our expectations, the initial reaction of many family members, once the war began, was a sense of relief. The anticipation of war had placed these families under severe stress. We discovered that the anticipation of a potentially devastating event, such as a war, can place people under more stress than the actual event does. Many children who exhibited signs of anxiety and stress during the pre-war period actually experienced relief once shooting began. The long anticipated and feared event had occurred, and reality could be dealt with in a more open and adaptive way compared with their fear of the unknown.

During the initial days of the war, many parents contacted us with questions about how they should handle the dramatic changes in their children's everyday life. For example, bomb threats became commonplace in the schools, long delays became routine at entries to all military bases as guards carefully searched for bombs inside every vehicle and the television media carried round-the-clock reports about the war. Routine medical services were disrupted as clinics moved out of hospitals to make room for a potential flood of wartime casualties. Most parents who called did not require a clinic visit. Rather, their concerns were addressed by telephone consultation. In addition, we found that mental health announcements over the local TV and radio stations were an effective means of helping large numbers of families deal with their stresses.

Even before the war, it became clear that individual and family based models of providing mental health care were inadequate. To maximize our limited resources, mental health professionals worked with the schools to meet the critical needs of children and their families. The schools did not have a pre-existing plan for responding to such an overwhelming crisis as a war. Virtually everyone in the school had a family member or close friend involved in Operation Desert Storm. This presented the macabre possibility of mass casualties involving many fathers and mothers from one community. At any moment up to 20 children in one classroom might lose their parent. It was a sobering reality. Moreover, their teacher could not always be a stabilizing force, since he or she was often emotionally connected to a deployed servicemember who was in danger.

We found that our most effective role was to assist the school administration and guidance personnel by making concrete recommandations for them to implement. Our task was to synthesize and condense existing mental health information into a useable package based upon sound psychological principles tailored to the unique setting of the US military familiy in Europe. School consultation involved helping the administration and teachers implement the following procedures:

(1) Recognize that children's reactions to stress depend on their maturity level.

(2) Recognize that most reactions to stress are normal. Only when an emotional reaction becomes so severe that it keeps the child from "getting on with life" is intervention needed.

(3) Maintain everyday routines. In the midst of uncertainty, it is important to keep routines constant. This is particularly important for younger children. School routines help a child feel secure, so when students are sent home because of a bomb scare, they should be given homework.

(4) Ensure that teachers have an adequate support system. Many teachers had family members who were deployed. Dealing with their own fears and meeting the needs of students taxed many teachers to the limit. Make sure teachers are not using the class to deal with their own fears; teachers' needs should be met by other adults, not by students. Teachers might consider establishing a "buddy system" or small group meeting for emotional support.

(5) Encourage teachers to let students talk about their feelings. They should validate students' feelings and let children know they are available to discuss feelings and fears. If teachers don't feel comfortable talking with students about these issues, the children should be referred to a counselor or another teacher.

(6) Develop a referral system within the school for all students. It is important that each school develop a system to recognize the emotional needs of their students and to meet these needs quickly. Emotional support can be provided in the homeroom class by giving students an opportunity to share their feelings. Students who are having more severe problems can be referred to a counselor who can see them individually or in groups. Students should be told how they can see counselors on their own initiative if they feel the need. It should be noted that some students may use this as a means of avoiding classes.

(7) Set up a comfortable support room where kids who are having difficulty can go to get away from stress. The room should be furnished with teddy bears, pillows, comfortable chairs, tissue, soothing music, peaceful posters, etc, and it should be staffed by a volunteer from the community, not school personnel.

(8) Establish an appropriate death notification system. Children should not be taken out of a class for notification.[3] This might unnecessarily traumatize the child and cause panic among the other students in the classroom. Rather, children should be notified at the end of the day or during normal

transition times, ie, lunch. It is further suggested that a person who is well known to the student make the notification. Also, avoid having the same person make all the death notifications —he will become a dreaded visitor. Dr. Embry suggests that teachers who have suffered a death in the family be notified as soon as possible to avoid finding out by accident.[3] All notifications should be made away from the classroom in a previously established support room.

(9) Be flexible about how students and parents separate from the school once they learn of a family member's death. Some students will want to continue school, others will not. Children who lose a parent will return to the States within one or two weeks. They face not only the loss of a parent, but the loss of friends and teachers as well. Letting them return to school to say goodbye can help them achieve closure. This should be allowed, even though it may increase the anxiety of school personnel and students.

(10) Get students involved in "active" projects, such as adopting a soldier, writing letters, sending cards, collecting items to send to soldiers, etc. This helps students channel their anxiety in positive ways. Students can also support one another. Have classmates of a distressed child stick "warm fuzzy" notes on his desk. Also, help students make lists of positive "helping behaviors" and encourage them to do one each day, eg, carry a friend's book, sharpen a pal's pencil, etc. Reward supportive students by writing their names on the board or by giving them "good supporter" badges or stickers.

(11) Employ the Gardner Story Telling technique as a way to teach children how to cope. It involves constructing a story with imaginary characters who handle a problem similar to the child's in a positive way. Pictures can also be useful in helping young children express their fears. Have the child draw how she felt when the war started and how she feels now. Students can also be asked to talk about their pictures. Encourage children to "name" and "claim" feelings of sadness, fear, etc. If they refuse, you might say, "If I were you, I would feel_____." Support groups can also be helpful (see Rubenstein and Embry, 1991 for excellent suggestions on how to set up children's support groups).[4]

(12) Don't overlook the needs of ordinary students who don't have a parent deploying in the war. They may also need support.

Post-War Planning

Once these basic principles were taught and implemented, the schools could deal with most problems themselves and required little additional psychological intervention. What seemed crucial was that the administration have a designated course of action so that school personnel didn't flounder in a vacuum. Several lessons emerged:

First: A community mental health needs assessment is critical when establishing priorities. We found that limited mental health reserves could not meet the emotional needs of the military families through traditional individual or group therapies. Other means had to be discovered. This required creative responses that often pulled us out of traditional settings. Employing traditional therapies would have overwhelmed our limited resources in a brief period. Our task was to anticipate the demand and provide primary intervention. We had to establish contacts with community agencies and schools to extend our resources and meet the rapidly expanding need for mental health services during the wartime crisis.

Second: Recognize the need to maximize limited resources and determine the most effective way to reach a large number of children in a short amount of time. School consultation became the most efficient strategy. We gave schools a blueprint to help them anticipate common emotional reactions, implement effective management techniques and maintain a healthy problem-solving perspective. It was particularly important to foster a sense of control and competence among school personnel. Loss of control could generate anxiety in the children, who look to their teachers and school administrators for support and guidance during crises.

Third: Establish specific professionals as the identified child and family mental health experts. As the disaster literature shows, established points of contact provide structure, control information and coordinate mental health decisions.[5] It is important for mental health professionals to establish a close working relationship and provide a consistent plan of action.

Fourth: Try to avoid responding to a crisis at the last minute—plan ahead. Although the literature has addressed the effect of crises and deployment on children, little attention has been given to wartime deployment. There is a need to establish effective standard operating procedures for helping children cope in a wartime scenario. As Aman et al clearly noted, a system that rotates its members on a regular basis but does not develop a standard operating procedure is dependent on individual interest and training.[2] In a wartime setting, an existing standard operating procedure is essential. The time to develop and implement these procedures is now, in the wake of lessons learned from the Gulf War, not during the next crisis.

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