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PSYCHOLOGICAL SUPPORT FOR CHILDREN AND TEENAGERS
AFTER THE BESLAN TRAGEDY

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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 “hairdressing 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.  

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).

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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.
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
initiative, Sabina drew a floating swan (Fig. 22.). She was very pleased that her picture was shown at the exhibition.

*Fig. 22. Drawing of Sabina “Swan”*

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.