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SCHOOL-BASED INTERVENTION IN ONGOING CRISIS: LESSONS FROM A PSYCHOSOCIAL AND TRAUMA-FOCUSED APPROACH IN GAZA SCHOOLS

Jon-Håkon Schultz, Laura Marshall, Helen Norheim, and Karam Al-Shanti

It is a complex challenge to design education in emergencies responses that meet local needs, are sensitive to local culture, build on international guidelines for best practice, and use research-based methods. This paper presents lessons learned from the implementation of the Better Learning Program, a school-based response in Gaza that combined psychosocial and trauma-focused approaches, and discusses how international guidelines were incorporated.The Better Learning Program intervention was designed as a partially manualized,[1] multi-level approach to help teachers, school counselors, and parents empower schoolchildren with strategies for calming and self-regulation. The stepwise approach first targeted all pupils, then pupils who reported having nightmares and sleep disturbances. The goal was to help these students regain lost learning capacity and strengthen resilience within the school community. The intervention was implemented in 40 schools over two and a half years, with a target group of 35,000 pupils. Teachers and school counselors reported that the combined psychosocial and trauma-focused approach was compatible with their educational perspectives. The approach appeared to enable teachers to be more proactive when teaching pupils affected by war. This paper concludes with reflections and lessons learned.

1 Manualized approaches use exact steps so that each person has relatively the same experience.

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BACKGROUND

Each year between January 2009 and November 2012, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) recorded an average of ten "limited escalations" between Israeli and Palestinian armed groups, each lasting nearly three days. Several reports have documented the negative psychosocial impact these hostilities have had on children in the Gaza Strip (e.g., UNICEF 2010; UNESCO 2012), where 101 civilians were killed and 1,046 wounded in an eight-day escalation in November 2012 (OCHA 2013).

Many communities in Gaza are in need of education in emergencies interventions, but the education sector suffers a shortage of almost two hundred school buildings, which forces schools to run double shifts (OCHA 2014). Efforts to track children in Gaza who are not in school led the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and the Norwegian Refugee Council (NRC) to identify schoolchildren in Beit Hanoon, a North Gaza district severely affected by the ongoing conflict, as likely to need considerable psychosocial support. Teachers and parents interviewed by UNRWA and NRC in 2011 expressed their concerns and asked for help in dealing with the large number of frightened children who were having problems concentrating at school. Standard practice was to refer pupils with severe stress symptoms to school counselors, but the school system could not accommodate the high number of pupils in need of counseling. Although several mental health projects have been implemented in Gaza, schools generally do not provide school-based mental health interventions, and despite the severity of the situation, teachers to date have not had systematic training to deal with mental health issues. Most schools in Gaza have at least one thousand pupils who are served by one school counselor, who usually has just a bachelor's degree in psychology; some have received supplementary training from UNRWA or the Ministry of Education and Higher Education.

The international guidelines discussed in the next section represent a comprehensive general framework for providing education in emergencies. However, practitioners must adapt to local conditions and needs, and fieldworkers often are left alone to make complex decisions in the midst of a chaotic emergency, with few practical materials at hand. Documented examples of how to operationalize established guidelines in specific school-based interventions are scarce, thus it is important for practitioners to document their experiences in order to bridge the gap between theory and practice in the field. This paper describes the Better Learning Program (BLP), a comprehensive

response for education in emergencies. We discuss its implementation in 40 schools in Gaza between January 2012 and July 2014, when 35,000 pupils were targeted, and demonstrate how BLP was informed by research-based methods and international guidelines for best practices for education in emergencies responses.

GUIDELINES ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The Inter-Agency Standing Committee (IASC) has issued a set of international guidelines on providing mental health and psychosocial support in emergency settings (IASC 2007; Patel et al. 2012). In 2008, the World Health Organization (WHO) launched the Mental Health Gap Action Programme (mhGAP) to address the lack of mental health care in low- and middle-income countries. In 2010, mhGAP also issued the "Intervention Guide Module" for mental health, which provided guidelines for non-specialist health-care providers on how to deal with conditions such as depression, psychosis, seizures, and suicide. In 2013, new guidelines were issued on how to assess, prevent, and treat conditions associated with traumatic stress. The aim of these guidelines is to scale-up mental health care to include non-specialized staff by providing manuals for clinical decision-making (WHO 2010; WHO and OCHA 2013). UNICEF has also developed a facilitators' guide for education in emergencies that offers recommendations for supporting schools in emergency situations and includes the WHO strategy for scaling-up mental health beyond the use of specialized staff (UNICEF 2010).

The term "mental health and psychosocial support" (MHPSS) is broadly defined by the IASC as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental illness (IASC 2007). The term "traumatic stress" describes a variety of emotionally overwhelming reactions to traumatic events, such as actual or threatened serious injury or death (American Psychological Asociation 2013).

Debates about how to deal with traumatic stress in emergency settings reflect a divide between advocates for general psychosocial interventions and those for specific trauma-focused approaches (e.g., Miller and Rasmussen 2009). Key questions include the cultural validity of the concept of traumatic stress (de Jong 2004) and the level of therapeutic exposure needed to desensitize trauma-related memories.

However, the past decade also has brought consensus on how best to prevent traumatic stress from becoming a mental health problem. A comprehensive review of intervention research on the treatment of those exposed to disasters and mass violence identified five widely accepted and empirically supported principles that are used to inform intervention and prevention efforts, both in the immediate aftermath of a critical event and up to three months thereafter (Hobfoll et al. 2007). These five principles are (1) to promote a sense of security, (2) to calm, (3) to foster a sense of self- and collective efficacy, (4) to promote connectedness, and (5) to instill hope. The same principles are included in such guidelines as Psychological First Aid (PFA; Brymer et al. 2013), "The European Network for Traumatic Stress Guidelines" (Bisson et al. 2010), and Skills for Psychological Recovery (SPR; Berkowitz et al. 2010). These guidelines present best practices for MHPSS after a critical event and show the concepts to be fairly easy to understand and deliver.

These various guidelines agree that prevention efforts can and often should be delivered by non-specialists, particularly those who are close to the affected individuals. This puts teachers in an ideal position to deliver preventive measures in ongoing crisis and postconflict contexts. This is reflected in the Inter-Agency Network for Education in Emergencies' (INEE) "Minimum Standards for Education" manual (2010), which encourages education in emergencies practitioners to address their pupils' psychological well-being. Many organizations have provided guidelines, such as clinical decision-making manuals, to help non-health-care specialists provide mental health and psychosocial support in emergency settings (IASC 2007; Patel et al. 2012; UNICEF 2010; WHO 2010; WHO and OCHA 2013). The UNICEF facilitator's guide includes advice specifically for non-health-care staff who are providing mental health support to schools in emergencies.

While psychological support is now often included in educational programs for pupils, several studies show that much of what is labeled a mental health intervention or psychosocial support in education in emergencies settings has not been properly evaluated or researched and fails to draw from the best available knowledge (Dybdahl, Kravic, and Shrestha 2010; WHO 2010). The INEE highlights this lack of research and the need to document field experiences in order to bolster the professionalization of the education in emergencies field (INEE 2016). It is important to understand more fully how different approaches to mental health and psychosocial support complement each other (IASC 2007), and to bridge the gap between general psychosocial approaches and specific

trauma-focused approaches in order to tailor interventions and target a broader spectrum of needs (for overview, see Miller and Rasmussen 2009; Ehlers et al. 2010; Gillies et al. 2013).

Finally, school-age children and young people are particularly vulnerable in the context of crises and disasters (Norris et al. 2002). They are more likely than adults to be affected negatively, and to be more severely so. Their level of cognitive ability and lack of life experience may impair their capacity to handle an acute sense of helplessness or to make sense of the world, and may cause them to lose their perceived sense of safety and social support (Norris et al. 2002). These findings point to the need for a psychosocial approach that targets all pupils and helps them make meaning of a situation, understand their reactions, and learn coping strategies.

DESIGNING THE INTERVENTION

Three rounds of the BLP intervention were implemented in Gaza from 2012 to 2014 at schools identified as having a high number of pupils with impaired mental health. In the first round, which occurred in January 2012, ten teachers and ten school counselors from ten UNRWA schools were trained. The second round was a direct response to the eight-day escalation in hostilities in November and December 2012, and included teachers and counselors from ten schools run by the Ministry of Education and Higher Education and ten UNRWA schools in the most affected areas. The third round began in February 2014 with another ten UNRWA schools. In the third round, to support the program's sustainability, eight counselors from previous cohorts received instruction to become master trainers who would support previously trained teachers and conduct new trainings.

Members of the intervention team formed by NRC were certified teachers and/or school counselors.[2] Although UNRWA representatives were not part of the team, they attended the training sessions and were given regular updates. Three educational advisors supported the participating schools full time for one year by holding parents' meetings and teacher trainings, and by facilitating routines, holding regular meetings with school principals, and monitoring the intervention for quality control.

2 Laura Marshall: team leader/teacher. Karam Al-Shanti: project coordinator/teacher. Ahmad Akram Herzallah and Machmod Al Fiqy: educational advisors/teachers. Amjad Joma: educational advisor/ PhD/ educational psychologist. Helen S. Norheim: educational psychologist. Jon-Håkon Schultz: PhD/educational psychologist/researcher. Safwat Diab: external advisor/PhD/educational psychologist/researcher, the Islamic University, Gaza.

The Framework of the Intervention

The Better Learning Program consists of two components: BLP-1 reaches out to all pupils and provides psychoeducation and coping skills, while BLP-2 is a specialized intervention for those with chronic symptoms of traumatic stress. Both components fall under the term "MHPSS," which combines a psychosocial and trauma-focused approach. A trauma-focused approach directly addresses the symptoms of traumatic stress and in some cases the actual traumatic event(s): BLP-1 does so by engaging students in conversations about being afraid of specific aspects of war and conflict, and BLP-2 does so by talking about and drawing images from traumatic nightmares in a systematic way. The framework of the two-pronged BLP intervention was built on the following:

- First, all pupils are targeted by a population-based, multi-layered approach (BLP-1); second, pupils reporting nightmares and sleep disturbances are targeted (BLP-2); and third, students are given an external referral for specialized treatment if necessary

- A multi-level approach targets teachers, school counselors, and parents to enable them to provide pupils with strategies for calming themselves and self-regulation

- School-based collaboration between teachers and school counselors

- A textbook that provides model language (BLP-1) and a manualized approach (BLP-2)

- An empowerment-oriented approach that emphasizes resilience in the school community using a combination of psychosocial and trauma-focused methods

Using the population-based approach of BLP-1, we targeted all pupils attending selected schools. The traditional intervention pyramid (IASC 2007) is geared to the general population, and it has different proportions of individuals in different layers when a specific population is targeted. Our expectations for the intervention pyramid for our target population were based on two primary assumptions: Because the sickest pupils would not be able to attend school, there would likely be fewer individuals in the top layer who needed specialized services not provided by the school counseling service. Moreover, some 20 percent of the pupils would volunteer when offered treatment, and would meet the criteria of

having repeated trauma-induced nightmares or other symptoms of traumatic stress that severely affected their ability to function in school. BLP-1, which targeted all pupils from six to sixteen years of age, was carried out by teachers (Schultz et al. 2013a). Because these teachers expressed uncertainty about how to deliver psychosocial support, we used a step-by-step procedure that applied research-informed principles, including practical explanations to help pupils understand stress-related symptoms. A two-hour teacher training was followed up with additional sessions for sharing experiences.

BLP-2 enrolled pupils ages nine to sixteen with persistent trauma-related nightmares (Schultz et al. 2013b). They were selected during a screening interview based on the following criteria: they were experiencing nightmares caused by a traumatic event three or more nights per week, the nightmares had lasted three months or more, and they were interfering with the pupils' daily functioning. Participation was voluntary, and enrollment required parental consent. The intervention consisted of four group sessions, followed by four individual sessions that specifically addressed the nightmares. The school counselor, who was in charge, worked with a teacher, and both had received formal training in all the steps of BLP-2. Basic training lasted for three days, including two days of case presentation and ongoing follow-up support. In the last round of implementation, the school counselor conducted individual sessions with pupils without the teacher, due to the therapeutic aspects of the work.

Educational Goals

Both BLP modules aimed to improve pupils' learning capacity by empowering the school community, integrating coping techniques into daily teaching and learning, and encouraging pupils' natural recovery. All psychosocial support was defined in terms of educational goals in order to be compatible with teachers' educational perspectives. These goals included (1) to establish a sense of stability and safety; (2) to promote calming and a capacity for self-regulation; (3) to increase community and self-efficacy, including where to find support and how to give and receive support; and (4) to promote mastery and hope. These goals were based on commonly accepted prevention efforts for dealing with traumatic stress (e.g., Hobfoll et al. 2007).

The BLP program taught students to identify possible reactions to living in a crisis situation and to understand that these are normal reactions to an abnormal situation. The pupils learned that the body and mind are connected and that a relaxed body cannot be attached to a frightened brain, so that by relaxing the

body the mind also becomes more relaxed. They practiced a range of calming techniques and found their own combination of relaxation exercises to regulate their reactions.

In addition to the goals described above, BLP-2 has a specific approach for pupils with persistent nightmares and sleeping problems. Two evidence-based programs inspired the design: Trauma-Focused Cognitive Behavior Therapy (TF-CBT; Cohen, Mannarino, and Deblinger 2012) and Narrative Exposure Therapy (NET; Schauer, Neuner, and Elbert 2011). The focus of the eight sessions in BLP-2 was as follows:

1. Identify reactions to stress. Recognize and describe one's own reactions in detail in order to become more familiar with them.

2. Connect memories to words. Reduce the body's automatic alarm response, which is connected to traumatic memories, by drawing pictures of the worst nightmare during the group session and talking about it in the individual sessions. We aimed to connect fragmented memories to words by working through the worst nightmare(s). This helped frightening life experiences become understandable events that belonged to the past.

3. Collaborate with parents and teachers. Practice, reinforce, and adapt personal relaxation exercise routines. Dialogue between parents and teachers was established to help reduce children's symptoms and improve their learning capacity at school.

Several studies have shown that highly structured protocols can be effective in changing professional behavior in a desired direction (e.g., Lamb et al. 2000). Our Gaza intervention included written models for how to provide explanations and communicate in the classroom. The example below from BLP-2 models language to explain why pupils should talk about their nightmares:

> We can reduce the intensity and the power of the nightmares by talking about them during the daytime when we feel safe. Bringing the nightmare out of the dark into the daylight to talk openly about it reduces its power. During the daytime it is easier to see that the horrific things you dream about cannot hurt you now because you are safe. The terrifying event happened a long time ago, and you are safe in the present moment. (Schultz et al. 2013b).

EXPERIENCES FROM THE FIELD

For quality control, NRC conducted a series of focus group interviews with 20 teachers and school counselors, 13 parents of pupils participating in nightmare groups, and 17 teachers—all who had experienced BLP-1. In addition, an external evaluator (Shah 2014) carried out qualitative interviews with pupils, teachers, school counselors, headmasters, and parents who had participated in BLP-1 and BLP-2. These data provide participants' impressions of the implementation process, described below. We also present descriptive data on nightmares from selected samples.

Adaptability

Some teachers found it inappropriate to demonstrate the calming exercises with teachers of the opposite sex and were left to decide which exercises to use. Pupils, teachers, and school counselors found explanations written out in appropriate language, but they frequently supplemented them with explanations from local traditions and from the Quran. During training we encouraged using a combination of these perspectives to supplement each other without claiming that any one was superior. Some of the school counselors advised parents to seek religious advice from a local sheikh, which we encouraged when doing so was part of a school counselor's repertoire and of a parent's religious belief. When teachers and counselors brought up aspects of martyrdom during training, we argued that this type of explanation might promote hatred and conflict with the healing process, and that such explanations were not a part of BLP.

The majority of pupils interviewed reported that the various exercises were "fun and helpful" and the information "good to have." After all teachers had received the mandatory introduction to BLP-1, 60 percent returned to receive short follow-up sessions. They reported a high degree of satisfaction with the training and with using the methods in their classes, and said that the methods helped improve pupils' ability to concentrate. Some teachers chose to implement the whole procedure described in BLP-1, while the majority saw it as a toolkit and selected what they needed from the various exercises and lessons. The structured approach empowered teachers to be more proactive with pupils affected by the conflict and promoted greater collaboration between the school counselor and teachers. Teachers who were trained in BLP-2 reported that the combined approach of psychosocial and trauma-focused frameworks was compatible with their own educational perspectives and an extended role for teachers, the exception being the more clinical work in individual sessions. School counselors

frequently reported the positive effects of having a clear structure, using groups, and sharing the workload by collaborating with teachers—all of which resulted in a more efficient way to reach the most possible pupils in need.

Reduction of Nightmares

Pupils participating in BLP-2 reported having trauma-induced nightmares an average of five nights a week. Raw data from one of the samples (N=101) indicated that, prior to the intervention, 29 percent had persistent nightmares for three to twelve months, and 71 percent for more than one year. The same nightmare was repeated for 84 percent, and 68 percent reported their dream to be related to an event they considered one of their worst real-life experiences. More than 70 percent could not go back to sleep after waking up from the nightmare, and 64 percent saw "pictures" from the nightmare during the daytime. As many as 79 percent of the pupils between the ages of nine and thirteen had not told their teachers about the nightmare before the intervention. Measured eight weeks after the intervention ended, the nightmares were eliminated or reduced to one night a week for about 70 percent of participants. The remaining 30 percent experienced a reduction but continued to have more than one weekly nightmare. This pattern was generally repeated in the subsequent intervention rounds. A small group had symptoms that did not respond to BLP-2 or were so strong that it was deemed best not to admit them to the group. These pupils were given individual counseling or referred to other external services.

Parents' Experiences

Few parents (an average of 10% from each school) attended parent-teacher meetings. Those who did attend reported a high degree of satisfaction and noted the need for more information on dealing with conflict-related stress. All parents of pupils who attended nightmare groups came for special meetings and/or received home visits, and they also reported a high degree of satisfaction with the program.

Collaboration with Local School Governance Authority

Close collaboration with UNRWA was vital for the continuation and improvement of the program. Important issues were debated and negotiated, included defining the teacher's role, agreeing to terms for collaboration between teachers and school counselors, and assessing the quality of parents' and pupils' informed consent. Most important was finding theoretical and practical ways to fit the intervention

as a package into the mental health structure and to the school system. It was crucial that administrative and operational UNRWA representatives take part in all formal training sessions in order to be part of the ongoing discussions.

CHALLENGES AND SUGGESTIONS

The most frequent challenges were logistical obstacles, like finding time in a busy school schedule to implement the program and finding space to practice calming exercises, which dedicated teachers, school counselors, and headmasters always found ways to deal with. A more substantial challenge was to redefine the role of teachers in an ongoing crisis. While teachers agreed that many of their pupils were not achieving their full learning potential due to the conflict, they disagreed considerably over how long stress reactions would influence learning capacity and what measures would be most effective in class. For example, some teachers enforced a strict regime of disciplinary actions, while others preferred to just wait and see whether the stress reaction passed. From an educational-psychological perspective, we would argue that neither of these strategies is effective and that schoolchildren benefit most from a proactive teacher who communicates about the current learning situation from a mental health and psychosocial perspective. Pupils should be invited to speak individually with the teacher about how they can reduce their level of fear together so the pupil can concentrate and learn more effectively. Taking such an educational-psychological approach would require that teachers be empowered by having a proper toolkit and that their role be somewhat extended in emergency settings.

Based on the overall experience with the BLP intervention, we consider both BLP components applicable to the roles of school counselors and teachers. The program also was adaptable to the local school system and to the administrative level of the educational authority. We did not successfully engage a large number of parents at traditional parent-teacher meetings for BLP-1, thus the question of how to harness the potential of parental support needs further consideration. A possible solution might be to engage parents by providing information more proactively using local media and smartphones.

Continuation of BLP after the Intervention Period

As a MHPSS response to the 50 days of military conflict starting on July 7, 2014, UNRWA decided to scale-up the BLP intervention to reach more pupils. In November 2014, eight local BLP master trainers were assigned to implement

both components of BLP in 135 additional schools. This was completed by December 2015, and the scalability was found to be satisfactory. UNRWA has set a further goal of integrating BLP into the mental health and psychosocial support system in all 245 schools in Gaza by the end of 2016. UNRWA established a six-month project position in the community mental health program to develop and coordinate local procedures and routines for BLP supervision. The BLP material was also adjusted to better reflect Palestinian culture and the mental health and psychosocial support framework of UNRWA.[3]

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CONFLICT OF INTEREST

The Better Learning Program underpinning this intervention is distributed free of charge and is not available for commercial use. The authors declare no conflict of interest with the present study.

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3 The contextualized version of BLP-2 is labeled "Better Sleep: Solving Sleeping Problems for Pupils Living in Ongoing Crisis." Gaza, Palestine: UNRWA Community mental health program, 2016.

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