# CRISIS TEAM RESOURCE GUIDE:
**READINESS, RESPONSE, AND RECOVERY**

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>7</td>
</tr>
<tr>
<td>Chapter One: Readiness</td>
<td>9</td>
</tr>
<tr>
<td>Chapter Two: Response</td>
<td>11</td>
</tr>
<tr>
<td>Chapter Three: Student Reactions</td>
<td>17</td>
</tr>
<tr>
<td>Chapter Four: Cultural Issues</td>
<td>23</td>
</tr>
<tr>
<td>Chapter Five: Recovery</td>
<td>33</td>
</tr>
<tr>
<td>Chapter Six: Death by Violence</td>
<td>35</td>
</tr>
<tr>
<td>Chapter Seven: Suicide</td>
<td>41</td>
</tr>
<tr>
<td>Chapter Eight: Care for the Caregivers</td>
<td>43</td>
</tr>
<tr>
<td>Resources</td>
<td>47</td>
</tr>
<tr>
<td>Table of Contents for Handouts</td>
<td>59</td>
</tr>
<tr>
<td>Crisis Response Team Resource Guide References</td>
<td>173</td>
</tr>
</tbody>
</table>
Maryland School Psychologists’ Association (MSPA) has provided valuable professional development opportunities to school-based staff for years. The topics range from issues within special education, to mental health, to crisis/traumatic loss response.

In today’s school climate, the physical and mental well being of students and school staff come under siege from a variety of sources. Violence within the schools and surrounding communities co-exists with untimely accidents and losses (via death or serious illnesses/injuries) within school families. School-based professionals within districts across the nation continually search for resources to aid them in responding to the aforementioned emergencies.

MSPA recognized this need and as early as 2001, under the leadership of then president Robin Satchell, coordinated with the National Association of School Psychologists (NASP) to provide National Emergency Assistance Team (NEAT) training for participants of local school districts in Maryland, Delaware, and the District of Columbia. The response was overwhelming. According to feedback surveys collected after the training, the majority of participants acknowledged the workshops to be thorough, as well as relevant. Months after the completion of the workshops, some of the participants collectively inquired what MSPA could do to provide follow-up training on the topics of crisis and traumatic loss response.

In 2003, MSPA’s President Chandra McKnight-Dean led the Executive Board in moving forward with the crisis training project, which morphed into the development of a Crisis Response Committee (an ad-hoc committee).

This committee was charged with the initial task of developing a state-wide crisis response network that would be available for the local school systems. With this goal in mind, an emergency response needs assessment was distributed to each local district in January 2004. The recipients of these mailings included superintendents, directors of student services, safe schools coordinators, and school psychology coordinators/supervisors. The results of this needs assessment indicated that local school systems preferred a crisis resource rather than a crisis response network. It was determined that committee members needed to have a consistent model of training. Toward that goal, Robert Hull, Maryland State Department of Education’s School Psychology Representative at the time, facilitated contact with International Critical Incident Stress Foundation, (ICISF). ICISF agreed to provide free initial training to MSPA members selected from various school systems state-wide. With financial backing from the MSPA’s executive board, funding was secured for 10 MSPA members to receive additional training from ICISF.

The following districts had representation at the trainings: Anne Arundel; Baltimore; Carroll; Charles; Frederick; Howard; Montgomery; Talbot; Washington; and Baltimore City. The majority of those
trained formed the current MSPA Crisis Response Committee who initiated and completed this *Crisis Team Resource Guide: Readiness, Response, and Recovery*.

The following individuals developed this guide: Preston R. Bodison, Baltimore County; Claudia R. Bowen, Carroll County; Mary V. Cashdollar, Carroll County; Dana Deise, Baltimore City; Ann C. Hammond, Frederick County; Stephanie E. Livesay, Howard County; Robin M. Satchell, Anne Arundel County; Patricia C. Vaira, Charles County; Paul Wolverton, Washington County; and Steven Wrightson, Talbot County.

The committee would like to acknowledge the following: National Association of School Psychologists’ Crisis Prevention and Intervention Committee for its collaboration and contributions; local school systems for their crisis response materials and the time they allowed the committee members to work on this project; and Mary Schoenfeldt for the use of her materials on “Death by Violence.”
INTRODUCTION

The Maryland School Psychologists’ Association (MSPA) established a committee to examine the needs of, and provide support to, Maryland school psychologists serving as members of local, regional or state crisis response teams. This Crisis Team Resource Guide was developed in response to these identified needs. It has been organized as a hands-on resource guide for school psychologists seeking ways to communicate key information and intervention strategies to administrators, teachers, parents, and community members when responding to a crisis event. It reflects the continuing commitment of Maryland school psychologists to provide research-based, yet accessible information to those concerned with promoting positive coping behaviors in the aftermath of a crisis/traumatic event. The information contained in this guide has been compiled from multiple resources in an attempt to provide best practices in crisis readiness, response and recovery.

Suggestions for Using This Guide

Organized in a loose-leaf format, the content and resources in this guide are designed to provide information on the following crisis related issues: preparedness, response, student reactions, cultural considerations, recovery, death by violence, and care for the caregiver. References, handouts, and additional resources are an essential part of the guide as well.

As mental health practitioners, school psychologists have been called upon and are uniquely qualified to serve as team leaders or responders to crisis/traumatic events. The specific duties assigned to a team leader or responder may differ from site to site; therefore, flexibility will be needed in implementing the various components of this manual. For example, crisis responders will likely encounter a variety of building-level administrator styles. The Response section has been designed to support responders with suggestions on how to effectively interact with building administrators and school staff.

Finally, best practice recommends annual training at the beginning of each school year. This Crisis Team Resource Guide is a valuable source of information for readiness training. It is the committee’s intention that this guide will help review the typical roles and functions of school crisis response teams.
DEFINITION OF TERMS

CRISIS: A crisis is defined as an emotionally significant event or radical change of status in a person's life. It is an unstable or crucial time or state of affairs in which a decisive change is impending (Merriam-Webster Online). Crises create stress, which may be defined as the nonspecific arousal response of the body to any demand. Extreme stress reactions result when the individual’s capability to cope is overwhelmed by the demands of the situation (Johnson et al., 2002).

DEFUSING vs. DEBRIEFING: The International Critical Incident Stress Foundation (ICISF) has differentiated the defusing process from the debriefing process and advocates the use of the defusing process in initial responses to a school crisis (Johnson et al., 2002). A more detailed description of the defusing process is located in the Response Chapter. Debriefing requires rigorous training and was designed to reduce trauma and stress reaction among adults and emergency workers. Debriefing is not recommended for use within the school setting and should not be used without intense training.

GRIEF & MOURNING: Grief is a pure overwhelming sense of sadness and is a personal experience of loss. Mourning is “grief gone public.” It is the outward sharing and expression of pain. Sometimes it is helpful to make the distinction between the two in order to understand that there are some individuals in our society who have “permission” to grieve but cannot mourn.

PSYCHOLOGICAL TRIAGE: Psychological triage is “the process of evaluating and sorting victims by immediacy of treatment needed and directing them to immediate or delayed treatment. The goal of triage is to do the greatest good for the greatest number of victims.” (NIMH, 2001, p.27).

READINESS: Readiness is a planned approach or procedures for responding designed to minimize the short-term and long-term effects of crises experienced by victims.

RECOVERY: Recovery is providing the necessary follow-up interventions needed to support students and staff in the aftermath of a crisis.

RESPONSE: Response is the implementation of a set of pre-determined strategies in a crisis situation.

SCHOOL CRISIS RESPONSE TEAM: A school crisis response team consists of professionals who are prepared, trained, and ready to respond with a set of skills specific to a school situation. The goal of the crisis response team is to help the school return to a state of normalcy. For the purposes of this resource guide, the school crisis response team shall be referred to as crisis response team.
Trauma: Trauma is defined as a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury. It may also be an agent, force, or mechanism that causes an emotional upset.

Traumatic events overwhelm the person’s perceived ability to cope emotionally, cognitively, and physically. These events are unpredictable, unexpected, and usually result in feelings of intense fear, horror, and helplessness. Following a traumatic event, children and adults may experience some of the symptoms of Post Traumatic Stress Disorder (PTSD). The main symptoms are as follows: re-experiencing the trauma during play or dreams; avoiding reminders of the trauma and general numbness to all emotional topics; and increasing "arousal" symptoms (Handout 1).
CHAPTER ONE: READINESS

The goal of this chapter, and its accompanying handouts, is to introduce the reader to the actions that should be taken before a crisis occurs. Included in this chapter are the pre-planning/preparedness activities, recommendations for team membership, and role descriptions.

Being prepared for a crisis is essential for all school administrators and crisis response teams. A crisis can be frightening and potentially violent and leave us with a sense of helplessness and vulnerability. Crisis preparation or “readiness” can make a significant difference in such an emergency. It is not feasible to develop plans and intervention strategies during a crisis when individuals are stressed. It is vital to not only have a well-thought out plan in place, but also to know who will carry out this plan. This chapter will identify the components of preparing or creating such a plan.

PRE-PLANNING/PREPAREDNESS:

• Identify members of your school’s crisis team
• Schedule team meeting to review crisis response plan, including plans related to death/mental health issues
• Determine each team member’s individual role/responsibility (see administrative checklist in Handout 2 and crisis response team checklist in Handout 3)
• Ensure each team member has updated information (crisis plans, emergency information, phone trees, community referral information, etc.) that is readily accessible outside of the school building
• Develop a culturally and linguistically appropriate list of community resources for response/recovery including mental health support.
• Maintain a list of translators who speak the languages represented in the school community.

ROLE DESCRIPTIONS:

Best practices recommend assigning professionals to a specific role, and blending roles is not advised. Practicality will determine how well this can be carried out in the school.

Team Leader: Team leaders coordinate activities of the team and interact with the administration.

Administrator: With the support and guidance from the crisis team leader, the administrator coordinates the development and dissemination of information and resources to staff, parents, students, and the media.

Triage Crisis Responder: The triage crisis responder identifies and sorts children according to their exposure, identifies preexisting stressors, and the need for mental health support (Handouts 4 and 5).
Crisis Responders: Crisis responders provide immediate “Defusing” strategies to assigned groups of children/students and staff.
CHAPTER TWO: RESPONSE

The goal of this chapter is to introduce the reader to the actions that should be taken after a crisis has occurred. The chapter includes what to do when first entering the school, the responsibilities of both administrative staff and team members, and a brief explanation of what is considered best practices in responding.

RESPONDING TO CRISIS - IMMEDIATE ACTIONS

For purposes of this text, the Crisis Response Team (CRT) consists of crisis responders who are mental health professionals (or other individuals) who have been specifically trained in crisis intervention and defusing strategies. These people provide individual or group support to students and staff impacted by a crisis. It is recognized that various counties may have a network of school-based responders, regional responders, or county-wide responders based upon local factors.

The purpose of the CRT is to help the school return to a state of normalcy. In an ideal situation, the responding team will have knowledge of the need to respond the evening before and can begin to collect information at that point. The following tasks were predicated upon this situation. In a less than ideal situation, when information is not available prior to the start of the school day, the team will need to be more fluid in their response.

In general, a CRT supports and collaborates with the in-school team members, provides additional trained professionals to work with students and staff, and extends a level of expertise from professionals who are not directly influenced by the crisis event.

The CRT tasks include:

- Provide support in suggesting courses of action to the administration (e.g., staff meetings, letters to be sent home and announcements to the school body)
- Empower teachers in their efforts to talk with students
- Provide personnel in the classroom to assist staff members who may need emotional support
- Ensure consistency and a continuum of available responding techniques to fit various situations
- Obtain and disseminate accurate information that will help to dispel rumors
- Allow students and staff the opportunity to express their thoughts and feelings and to ask questions in a safe and controlled environment (see examples in Handouts 6 and 7)
- Provide support to staff and students during the recovery period

To accomplish these goals, responsibilities in a crisis situation can be divided among various personnel with the understanding that roles could possibly overlap.
Administrative Responsibilities:

- Verify information concerning the crisis, which may involve phone calls to police or the families involved
- Notify the school crisis coordinator (in districts where this position exists) and key support staff (including the assigned PPW, school psychologist and office personnel)
- Activate the CRT and school staff phone tree (Handout 8)
- Coordinate with the appropriate law enforcement officials assigned to your building (police or local Sheriff’s office) as appropriate per your district’s policies
- Notify the appropriate administrative offices for your school district (e.g., the Office of Student Services) and request additional personnel as necessary
- Set aside a room for incoming crisis team members to leave their personal belongings
- Make sure a floor plan of the school is available with key areas highlighted (e.g., bathrooms, front office, guidance, etc.)
- Work with the crisis team leader to help identify staff members who may need special assistance (e.g. breaks from class, support in reading the announcement, or leading follow-up discussions).
- Work with the crisis team leader to identify and utilize counselors, school psychologists, PPWs, and Employee Assistance Program personnel as appropriate
- Arrange for rooms (large and small) for team members to work with students
- Identify close friends and siblings of the victim/deceased who attend other schools and notify their schools of the crisis situation
- Stop any notifications that may be sent home (report cards, disciplinary letters, attendance letters etc.) for the deceased and others significantly impacted by the crisis
- Provide an approved written statement that includes the facts that you wish to disseminate to staff answering telephones
- Review the policies in place in your county concerning releasing information to the media
- Prepare an announcement to be read in all classes at a set time so that all students are given the same information concerning the crisis event.
- Provide staff with directions on reading the announcement and facilitating a brief discussion
- Provide staff with directions concerning the process to refer students for additional help
- Convene an after-school staff meeting that can include disseminating information, updating facts about the crisis event, obtaining information about the emotional functioning of staff and students, determining the need for follow-up support and the procedures used

Crisis Team Leader Responsibilities

- Report to the office to inform office personnel of who is expected to come to the building
- Meet with the administrator in charge prior to the start of the school day, if the situation lends itself
- Gather as much information as possible concerning the incident
- Notify appropriate team members and give them information about the crisis event
- Coordinate the incoming CRT members and other support staff to ensure everyone knows their role and responsibilities
- Work in conjunction with the building administrator to help identify staff members affected by the crisis and provide them with assistance (Tips for adults coping with cumulative stress in Handout 9)
• Appoint a “gatekeeper” to keep track of students and staff referred to the team to ensure that all are given assistance, and direct team members to their assigned locations
• Keep staff updated on events and circumstances
• Disseminate approved information and resources such as parent/teacher discussion guides about students’ reactions to death/grief, stress reactions, etc. (be sure resources are sensitive to students with special needs and English Language Learners Handouts 10, 11, and 12)
• Emphasize the need to provide established facts in reducing rumors
• If appropriate, separate close friends/relatives of deceased/affected students for small-group announcement of the crisis and follow-up discussion
• Assist in the writing of the student or staff announcements about the crisis event (examples in Handout 13)
• Suggest to the building administrator the possible need for rescheduling upcoming events, such as standardized testing programs, fire drills, etc.
• Ensure that team members have access to rooms to work with students and staff
• Assist the administrator in making phone calls to obtain updates from the family, hospital, or other organizations
• Help develop and disseminate a letter to go home at the end of the day that includes known facts concerning the crisis, possible reactions that might be observed in students, and referral information if further concerns are noted (examples in Handout 14)
• Help staff determine the appropriateness of class projects related to the crisis event
• Continually assess the efficiency in which students/staff are being seen and what assistance can be given to team members
• Request additional support if needed
• Assist in planning/coordinating class discussions as requested
• Coordinate with school counselors to discuss and intervene with students who are at-risk (e.g., students who have experienced recent loss, who may be at risk for suicide, or are emotionally vulnerable Handout 15)
• Monitor those students who are directly involved in or affected by the crisis
• Assign a team member to discuss the incident with support staff (cafeteria workers, custodians, bus drivers, volunteers, substitutes, and any other support staff)
• Arrange an after school meeting for the CRT to evaluate the intervention, and determine interventions needed for the following day(s)

The first CRT responder to arrive at the school may need to act as the team leader until that person arrives; therefore, initiate the above tasks.

**CRT Members’ Responsibilities**

**CRT members** are trained mental health professionals (or other individuals having been specifically trained in crisis intervention/defusing strategies) who provide individual or group support to students/staff who have been impacted by a crisis.

**CRT Activities**- Depending on the needs of the students and staff, the CRT may offer services such as:

• Defusing
• Classroom interventions
• Guided activities (e.g., memory books, cards, drawings, journals)
• Referrals to outside agencies
• Hall monitoring to ensure students go to classes
• Home visits in certain circumstances
• Help with reading announcements to classes
• Parent contact for immediate dismissal and/or monitoring of students
• Monitoring of classes to determine degree of impact
• Individual counseling
• Small group counseling
• Community meetings

Triage- The process of separating students into homogenous groups by using a short set of criteria:
• Students who are/were close friends with the victim(s)
• Students who were witnesses to the crisis
• Students who were associated with the victims (same class, same bus, same recess, etc.).
• Students affected vicariously by the crisis
• Students who are experiencing/reliving recent death events (death of parent/grandparent/relative, pet, or close friend)
• Students caught in the excitement of the crisis and/or seeking a way to get out of class (Do not be too quick to assign students to this group)

It is important to consider that not all individuals will be equally affected by the crisis. Some students in each group will need intensive intervention, while others will need little, if any. Recovery from crisis exposure is the norm, and crisis intervention should be offered only in response to need (Handouts 16, 17, 18, and 19).

Gatekeeper- Team members need to set up a system of keeping track of students referred to the team. An assigned gatekeeper/triage person is usually a good way to handle this system. Identify students who may be at-risk, discuss them with the school counselor, and decide which CRT member will work with those students. Students’ names should be given to the school-based counselor at the conclusion of the intervention for follow-up.

Defusing- The purpose of the defusing process is to achieve a rapid reduction in the intense reactions people often feel when a crisis occurs. The goals of this process are to:

• Gather information
• Normalize staff and students’ reactions to the crisis
• Educate staff and students about how to handle stress using good coping strategies
• Emphasize the use of peer supports
• Assess the need for further referrals of group members to outside resources

It is important to have a team member who is well versed in the use of stress management techniques participating in this process. The defusing process generally lasts about half an hour and should be implemented as soon as the students are available to you. The group size is recommended to be
approximately 5-15 students per session. Best practices recommend that this group should be closed once the session has begun.

It is recommended that homogeneous grouping be used, based upon students’ level of involvement in the crisis (see triage). Some situations may not allow this selection.

**Defusing is a 3-step process:**

1. **Introduction** - The purpose of the group and the process to be used are summarized. Members of the group are encouraged to participate. Issues of confidentiality should be discussed, as well as setting the tone for the process by reviewing rules and the outline of what to expect.

2. **Exploration** - Ask questions such as, “What did you see, feel, hear? How are you feeling now?” The purpose is to collect information and explore reactions and symptoms of the group. The individual value of each person is affirmed and people are given the opportunity to vent their feelings concerning the event.

3. **Information** - During this stage perceptions of the group are summarized, misperceptions clarified, and experiences and reactions are “normalized”. Appropriate information is provided, expectations are outlined, and stress management strategies are suggested (Handout 20). Point out the continued availability of mental health support within the school. Finally, determine the need for follow-up for students who are significantly distressed, and provide referral information.

**Faculty Responsibilities**

- Help identify students who may need to attend a group or individual meeting
- Identify students in distress throughout the day and follow the procedures to arrange for the students to be seen by the CRT
- Notify the CRT or guidance office if a class has a large number of distressed students in order to obtain support
- Assess the ability of the class to handle “work as usual,” and structure, shorten, or reschedule planned activities or tests if needed
- Involve students in a project related to the event, if needed
- Read the approved announcement concerning the event and allow time for student reactions and responses
- Request support from the CRT, if needed, in discussing the situation with students
- Rearrange tests/activities in the event the crisis involves a death and students and/or faculty wish to attend
- Consult with administration and CRT prior to removing personal items of a deceased student from lockers, desks, etc. (These items may need to be secured depending upon the event; however, a quick housecleaning can add to the discomfort of grieving students)
- Consult with school based mental health professionals prior to moving or removing the desk of a deceased student
ESSENTIAL ELEMENTS OF CRISIS RESPONSE

Before School Meeting- Whenever possible, a meeting should be held with all staff prior to the start of the school day. At this meeting, staff is generally given all the information that has been verified to date. Depending on family requests or the sensitive nature of some situations, this might be modified. The staff is informed of the presence of the CRT so they will understand why the team is there and what services are available to them. The morning announcement is shared, if ready, or at least the process is reviewed, including the process to refer students to the CRT.

Classroom Announcements- Teachers read a prepared announcement in all classes that presents the approved/verified facts, possible reactions, and how to seek counseling support if needed. Assistance should be provided to teachers who have difficulty with this task.

Letter Home- A short letter (approved by the school’s administrative team) should go home that day with each student. It may detail the following: the crisis event, the counseling support that was available to students and staff throughout the day, symptoms for parents to watch for that may signify a level of grief or discomfort requiring intervention, information regarding viewings and funeral arrangements if known and if approved by the parent, and information regarding who to contact with concerns (administrator, school psychologist, school counselor, etc.). This information may also be made available on the school system’s website (see Handout 14 for examples).

After School Meeting- A short meeting should be held with all staff at the end of the day. At this meeting the administrator should address updated information concerning the event. A member of the CRT should address the activities performed by the team, as well as basic stress responses and coping strategies. In addition, the CRT may refer staff for outside support such as the Employee Assistance Program, local counselors, support groups, etc. Any follow-up with staff members should be discreet.

Memorials- These should be addressed, if appropriate. Living memorials and memorials that are hard to replicate should be discouraged. Those considering memorials must remember that all students must be treated equally and visible displays may not be realistic to replicate in subsequent crises. If the death was due to a suicide, a public memorial is not advised (see section on suicide).

Family Contact- Affected families should be contacted and support should be offered. This designated contact person should obtain information regarding funeral visitation, home visitations, food/flowers, names of siblings/relatives, and schools. Once the information is obtained, it should be disseminated to appropriate school staff.

Communication with Media and the Community- The school administrator or designee should coordinate with the school system’s Media/Public Relations Department for the release of any information. No one should speak with the press without approval from the school system.

Post-Intervention Follow-up- A designated member of the CRT should continue to assess the needs of the school community and offer support through the school administrator. Such activities may include: checking in with vulnerable students seen by counseling staff; determining what follow-up is needed for designated students; assisting administrator with thank-you notes, follow up letters, condolence letters, family, hospital visits/funeral, etc.; planning for anniversaries and other events, which may trigger difficulty; reviewing handling of crisis and incorporating lessons learned into revised crisis plans; filing any needed reports with appropriate administrative staff; and rescheduling personal and professional activities cancelled.
CHAPTER THREE: STUDENT REACTIONS

The goal of this chapter is to introduce the reader to developmental expectations regarding students’ responses to crises and concepts of death. This chapter includes common and atypical characteristics of grief and suggestions for supporting students (Handout 21). This information should be used as a guideline. Given individual differences, not every student will experience every response or display every reaction.

GENERAL RESPONSES TO A CRISIS BY DEVELOPMENTAL LEVEL:

Preschoolers

Reactions from preschoolers are not always clearly connected to the crisis event. They tend to express their feelings nonverbally and sometimes through trauma-related play. Preschoolers may regress, temporarily losing recently achieved developmental milestones.

Elementary-age students

Reactions from elementary-age students are more directly connected to the crisis event, often resulting in a need for these students to give repetitive verbal descriptions of the event. They tend to express their feelings behaviorally, sometimes displaying event-specific fears (e.g., expressing fear to go on the bus after witnessing a bus accident). It is not uncommon for students to display attention difficulties or physical symptoms following a crisis event.

Middle and high school students

Reactions from middle and high school students are more adult-like compared to younger students. These students may display oppositional and aggressive behaviors to regain a sense of control. Other behaviors that may surface are school avoidance, self-injurious ideation or behavior, attention difficulties, or substance abuse.

WHEN A CRISIS INVOLVES A DEATH:

Children’s Understanding of Death

When a death takes place, students may experience a wide range of emotions and reactions. Adults should educate and support students on the impact resulting from a death. They may wish to convey that the students’ lives will not be the same, reactions differ among students, and it may take them longer to mourn than they may expect. Students may experience a number of feelings that may include (in no particular order):
• Abandonment - feeling left and no opportunity to say good-bye  
• Acceptance - final stage of grief  
• Anger - anger at the person for dying or increased irritability  
• Anxiety/Panic - something similar could happen to you or a loved one again  
• Confusion/Shock - inability to answer the “big” questions about life & death  
• Denial/Disbelief - denial of either the feelings about your loss or about the loss itself  
• Depression - feeling there is no purpose in life  
• Embarrassment - feeling uncomfortable with your & others’ display of grief  
• Estrangement/Isolation - feeling disconnected from others  
• Frustration - you couldn’t stop it from happening  
• Grief/Despair - a pure overwhelming sense of sadness  
• Hyper-vigilance - scanning the environment for possible danger  
• Numbness/Detachment - unable to feel anything  
• Remorse & guilt - guilt over feeling good (even momentarily) because you feel you are supposed to continually feel bad. Feelings of self-blame that one escaped the tragedy (survivor’s guilt)  
• Re-experiencing the traumatic event - Intrusive thoughts or image of the event, distressing dreams or nightmares, or flashbacks about the event

In addition to a variety of emotional reactions, students may experience both cognitive and physical reactions. Cognitively, students may have difficulty with sustained attention and display slower than normal thought processing. Physically, students may experience headaches, nausea or upset stomach, exaggerated startle response, and fatigue. The following are tips for managing these typical changes in performance:

• Forgetfulness - Help establish routines or develop a schedule. Give reminders to write down assignments and other important things.
• Disorganization - Provide structure, rubrics, and breakdown tasks into manageable units with timelines.
• Inability to concentrate - Provide redirection and consistent reinforcement and offer short breaks as needed.
• Inability to retain information - Encourage the use of study aids (e.g., outlining material, highlighting important facts, breaking study sessions into shorter segments).
• Lack of motivation - Provide counseling support, encouragement, and structure. Academic support may be necessary if the quality of work is seriously diminished for an extended period.
• Lowered tolerance level and increased impatience - Give reminders for monitoring reactions and regulating emotions. Provide strategies for problem-solving and conflict resolution.
REACTIONS TO DEATH BY AGE GROUP:

Preschool (age 2–6)

Generally around age 4 children have a limited and vague understanding of death. Children of this age generally do not think of death as permanent. They may believe it is reversible and talk of doing things with the person in the future. Preschoolers frequently engage in magical thought and play. They may believe if they pray or wish hard enough, they can bring the dead person to life. A teacher may overhear a child tell a friend, “My mommy is not dead. She is visiting Grandma.” Young children may connect events or things together that do not belong together. A child may tell his brother he hates him, and a short time later the brother is struck and killed by a car. The child may not only have guilt for what he said, but feel responsible for causing the death. As teachers and caregivers, we must disconnect these events in children’s thinking by reassuring them that the events are not in any way related.

Elementary Primary grade (age 6–9)

Children at this age have begun to grasp the finality of death, but very often they still engage in magical thinking and maintain the belief that their thoughts and wishes may have the power to undo death. This belief in their power may lead to the idea that they could have prevented the death or they should have been there to protect the person who died. This thinking also is likely to lead to feelings of guilt and responsibility for the person’s death.

Elementary Intermediate grade (age 9–12)

Developmentally, at this age, children are reading adventure books, telling ghost stories, and becoming preoccupied with super heroes. They often look on death as some supernatural being that comes and gets you. Even though they think of death as something that happens primarily to old people, they realize it can happen to the young, to their parents, to their loved ones. Children of this age may develop fears of their parents dying or have nightmares about the death of a friend or loved one. They may also think people die because of some wrongdoing of the dead person or someone around them; that is, death is punishment for bad behavior. Again, this type of thinking can lead to feelings of guilt and remorse.

Middle and high school (age 12–18)

By the time children reach middle school, they probably understand death as well as adults. They understand it is permanent and it happens to everyone eventually. They may spend time thinking, daydreaming, and philosophizing about death. They are often fascinated with death and fantasize about their own death to the dismay of their parents. They imagine their own funeral, for example: who will come, how badly people will feel, and how people will wish they had been nicer to them when they were alive. Even with this preoccupation with death, they can feel immune to it and engage in death-challenging behaviors such as reckless driving, drinking, or taking drugs.
REACTIONS TO SPECIFIC MAJOR LOSSES:

A student’s death

A student’s death arouses an overwhelming sense of injustice. Parents, staff, and other caretakers may feel responsibility for the student’s death, no matter how irrational that may seem.

A parent’s death

A parent’s death can be particularly difficult for young students, affecting their sense of security or survival. Often they are confused about the changes they see taking place around them, particularly if well-meaning adults try to protect them from the truth or from their surviving parent’s display of grief. Limited understanding and an inability to express feelings puts very young students at a special disadvantage. They may revert to earlier behaviors (bed-wetting), ask questions that seem insensitive, invent games about dying, or deny that the death ever happened.

A staff member’s death

A staff member’s death may impact the entire school community. This may necessitate changes in school routines, procedures, and functioning. Students and staff may have difficulty dealing with the changes.

A death due to suicide

A death due to suicide may be among the most difficult losses to understand. It may leave the survivors with a tremendous burden of guilt, anger, and shame. Survivors may feel responsible for the death.

PRACTICAL INTERVENTIONS FOLLOWING A CRISIS:

As outlined in the previous section, students respond to crises in a variety of ways. Staff members who have worked directly or indirectly with affected children are excellent sources for reporting behavioral information. Some reported symptoms are external and appear to be easily identifiable, while internalized symptoms present more subtly. Consequently, mental health interventions in the school setting must address the atypical behaviors exhibited from students within broad developmental stages. The following are practical interventions to be tried with students in the aftermath of experiencing a crisis event. These interventions may overlap age groups.

Preschool Students

Preschool students generally do not comprehend the event. Safety and security are the primary needs of this age group. Students oftentimes “pick up” their emotional cues from the adults around them. The following suggestions are provided for your consideration:

- Project a sense of stability and preserve routine events
- Provide and maintain nurturance, support, and comfort to affected students
- Reassure students that they are physically safe in the school building
• Encourage students to express thoughts and feelings via drawings, coloring, puppet play, or other play therapy modalities
• Correct (in simple terms) any misinterpretations of the event reported by students

**Elementary School Students**

Elementary students try to make sense of the event in concrete terms. Common cognitive distortions include “magical thinking” regarding the permanence of death, unrealistic expectations of their role in causing the event, and intense fears of dying or losing loved ones. The following suggestions are provided for your consideration:

• Emphasize their safety within the school environment
• Encourage students to verbally express their perceptions of the event, as well as express their reactions or fears
• Help them to sort out fact from fantasy or hearsay
• Validate their feelings by highlighting the normalcy of general feelings and actions
• Reassure students regarding self-adequacy, assist in realistically assigning responsibility for the origin of the crisis, and reassure and help students to anticipate what might happen in the future
• Allow students to draw, chronicle events in a personal journal, and read books
• Offer stress relief activities and physical outlets
• Utilize memory books, cards, and memorial drawings

**Middle School Students**

Middle school students are seeking peer acceptance, yet trying to maintain a measure of unique self-expression. The experience of a crisis event may compromise notions of self-adequacy, identity, and the meaning of life, resulting in intense emotions and major confusion. The following suggestions are provided for your consideration:

• Emphasize their safety within the school environment
• Assist students in differentiating facts from rumors or hearsay
• Validate the confusion that they are presently experiencing
• Normalize their feelings and actions and help them anticipate future experiences
• Help facilitate self-expression and memorializing (drawings, paintings, poems, journaling, and discussions)
• Assist in exploring the meaning of death
• Discuss previous experiences with similar crises
• Explore religious/spiritual beliefs and morals
• Review stress management techniques and coping skills

**High School Students**

High school students tend to think more abstractly about death/dying in the aftermath of a crisis. Some struggle with questioning their own mortality, whereas others consider themselves invulnerable to
injury or death. Others try to assign a moral connection to the suffering and death of certain individuals. The following suggestions are provided for your consideration:

- Emphasize their safety within the school environment
- Assist students in differentiating facts from rumors or hearsay
- Validate the confusion that they are presently experiencing
- Normalize their feelings and actions, and help to anticipate future experiences
- Help facilitate self-expression and memorializing (drawings, paintings, poems, journaling, and discussions)
- Discuss the topic of mortality
- Discuss previous encounters with loss and coping strategies used
- Discuss the commonality of shared experiences with crises
- Review coping strategies to use in this event
- Review steps in sound decision making

(NIMH, 2007; Mental Health America, 2009; & University of Michigan-Counseling and Psychological Services)
CHAPTER FOUR: CULTURAL ISSUES

The goal of this chapter is to introduce the reader to cultural considerations needed to understand expressions of grief and loss. Included in this chapter are several examples of culture specific grief observances and practices.

UNDERSTANDING CULTURAL ISSUES IN CRISIS AND LOSS:

Impact of Culture on Trauma

Cultural perspectives can shape peoples’ reactions to a traumatic experience. Specifically, culture:

- Influences what type of threat is perceived as traumatic
- Influences how individuals and communities interpret the meaning of a traumatic event and how they express their reactions to the event
- Forms a context through which traumatized individuals or communities view and judge their own response
- May help define healthy pathways to new lives after trauma

Cultural Considerations in Crisis/Traumatic Loss Response

When considering cultural influences on students’ and educators’ lives, responders should have a working knowledge of how a community or population’s beliefs, behavioral expectations, and patterns of thinking may be internalized by the individual (Young, 1994). As acknowledged by the U.S. Department of Health and Human Services, cultural competence is, “a recognition of cultural processes which is utilized to develop skills and policies for the effective delivery of services” (Sue & Sue, 1999).

A priority is placed upon honoring and respecting beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services (DHHS, 2003). Furthermore, effective responders have the ability to assess cross-cultural processes and pursue ongoing cultural awareness training.

Responder effectiveness is also enhanced by understanding the historical and socio-cultural dynamics impacting the cultural groups of the people served. Examples include: African Americans and slavery; Japanese Americans and internment; Native Americans and territorial displacement, among others. Pre-incident stressors on a community or individuals could intensify or complicate the experience of a crisis. For instance, consider a small community where an aging industrial giant has been the largest employer for years. Socio-economically, the majority of the town’s citizens could have been identified as solidly working middle-class. Eventually, the plant closes and its laid-off employees, who haven’t
been sufficiently trained to work outside of industry, are struggling. This change in events has implications for changes in the community’s economy, social structure, crime rates, and educational outlook, among others. In the event of a school crisis, the aforementioned community changes would likely influence the school’s (the students and their family’s) attempts to cope, receptiveness to mental health intervention, as well as the availability of outside follow-up services.

When devising a culturally competent response and recovery plan, responders would be wise to: be cognizant of the community’s composition (including primary languages and religions); assess culture-specific mental health needs for the community; and identify formal and informal community resources to address those needs (DHHS, 2003). Another consideration for responders is ascertaining the degree of control victims perceive having in the aftermath of a crisis. As adapted from Rotter’s (1966) work, it is surmised that individuals perceiving an external locus of control regarding crisis events and recovery tend to discount therapeutic interventions. Those who perceive a relatively strong internal locus of control are generally more receptive to therapeutic efforts.

American society is oftentimes accentuated by cross-cultural influences, enabling some people to subscribe to a variety of beliefs and practices. As early as 1976, Sanday pointed out that people could belong to one of the following four cultural categories: assimilation to mainstream values; possessing a bicultural commitment to the values of one’s origin, along with those of the dominant community; sole commitment to a cultural group which has little affiliation to the dominant one; and refusal to identify with any recognized cultural group (see Handout 22 for group training exercises).

The following section offers a snapshot of grief and funeral observances practiced among several cultures:

**OBSERVANCES AND PRACTICES OF VARIOUS CULTURES:**

**Practices of the Native American Culture:** Native American observances also vary considerably in their traditions, religions and rituals, but there is a strong commonality among many tribes that centers on the natural world - the earth, the animals, the trees, and the natural spirit. Even among those who have been converted to Christianity, there is an emphasis on the reunion with nature that occurs with death.

Common practices include:

The Medicine Man or spiritual leader usually moderates the funeral or death service. It may or may not follow a particular order since each individual is unique. In some tribes or clans, burial is not traditional. Some tribes call on their ancestors to come to join the deceased and, in effect, help in his or her transition. Most Native American cultures are not concerned about preserving the body so embalming is not common. However, dismemberment and mutilation outside the natural deterioration of the body is taboo. There is a belief that the spirit of the person never dies; therefore, sometimes sentimental items and gifts are buried with the deceased as a symbolic gesture that the person still lives. The spirit of the person may be associated with a particular facet of nature, such as animal, bird, plant, water, etc. Symbols of such spirits may be a part of the ritual in the death ceremony. It is important to ensure that the burial of the person takes place in their native homeland, so that they may join their ancestors and inhabit the land to which their loved ones will also return. Tribal cultures can vary in their burial traditions. The following are examples from various tribal cultures: pipes are
smoked at the gravesites, the deceased are buried with symbolic reference to a circle, or instead of burial the deceased are allowed to pass on to the other world in a natural way.

**Practices of the Asian-American Culture:** Asian-Americans may follow Buddhist, Confucian, or Taoist practices regarding death, with some elements of Christian traditions.

Common practices include:

Families gather at the funeral home to make arrangements with the family elders who assume ultimate responsibility for the ceremony. An open casket allows for respect to elders. There is also great respect for the body of the deceased, so warm clothes may be used for burial and watertight caskets are used to keep the elements out. Stoic attitudes are common among grievers, and depression may result from the internalization of their grief. Often poems in calligraphy are left for the deceased. Among Chinese Americans, a cooked chicken may be placed by the casket as a last meal for the deceased. Music is often used and a band may wait outside the funeral home and accompany the procession to the cemetery. The funeral route, burial location, and the choice of the monument are important. Incense may be burned at the grave. Among some populations, sacrifices may be made at the funeral. A gathering of family and friends for a meal after the funeral shows respect for the spirit of the deceased, and gives thanks to those who came to pay their respect. A picture or plaque is usually kept in the home and displayed with items that create a shrine.

**Practices of the African-American Culture:** African-Americans have traditions concerning death that draw from many cultures, ethnic, and religious backgrounds.

Common practices include:

There is often a high involvement of a funeral director in preparations for mourning and burial. Friends and family gather at the home of the deceased to offer support and share in the common grief. Wakes where music, songs, and hymns are played or sung are common. Some African-Americans hold a service known as a "Home-Going" service. It usually reflects the personality of the deceased and celebrates the conviction of going home to Jesus and being reunited with past friends and relatives. Church observances frequently reinforce a deep religious faith. Memorial services and commemorative gifts may be included. The funeral service is commonly followed by a burial. There may be a shared meal among grieving loved ones after the wake and funeral. Cremation is less accepted in the African-American community. Many individuals in African-American communities mourn by dressing in white as a sign of resurrection and celebrate with music and hope. However, Native Africans often wear red or black. African-Americans often express grief at death with the physical manifestation of great emotion. Some may believe in the concept of the "living dead". This concept refers to people who have died but whose spirits live in the memories and thoughts of those still living. These people are the ones who will help others who die move to the next world.

**Practices of the Haitian-American Culture:** Although there is diversity in religious practices among the Haitian-American population, they tend to share the following common patterns in the aftermath of death:

Close family members and relatives make arrangements for the funeral and church services. Family members and close friends gather at the home of the deceased to pray and to offer support. A wake is held at the home of the deceased every night from the time of the death to the time of the burial. At the
wake, they chat, eat, drink, and share jokes. A viewing is followed by the funeral service and burial. Close family members mourn by dressing in black or white. The wearing of bright colors such as red is not considered an expression of mourning. It is preferable to wear dark colors such as blue, purple, and brown to attend a funeral. Many Haitians express grief with the physical manifestation of great emotion. After the burial, family members and friends usually gather at the home of the deceased for a reception, where flaky pastries, black coffee, tea, and other foods are served.

**Practices of the Hispanic-American Culture:** Hispanic-American populations also have diverse cultural backgrounds including individuals from the islands of Cuba, Puerto Rico, and the Dominican Republic, and those who come from Spain, Mexico, and Central and South America. Most Hispanic populations practice the Roman Catholic faith, but not all.

Common practices include:

There is usually a high involvement of the priest in the funeral plans. Family and friends are encouraged to be part of the commemoration. The rosary is said by surviving loved ones, often at the home of the deceased. Among some Hispanic groups the rosary is said each night for nine nights after the death. Some families say the rosary every month for a year following the death and then repeat it on each anniversary. Funeral services often include a Mass. Loved ones are encouraged to express grief and many are involved in the procession to the grave. Many Hispanic survivors commemorate the loss of their loved ones with promises or commitments. These promises are taken very seriously and those who fail to honor them are considered sinners. Money gifts to help cover the expense of the funeral and burial are not unusual.

**Russian Observances:** Traditions are related to the religion of the Russian Orthodox Church (Christianity) or to Judaism. However, after the Revolution in 1917 several generations were raised as atheists and people didn’t follow religious traditions. After “Perestroika” in 1986 more Russians started joining the Church (churches). Therefore, many older citizens, especially those having had affiliations with the Communist Party, are atheists while middle age and young people tend to be affiliated with churches. Currently, many Russian atheists follow the same observances as religious people.

Common practices include:

When a person has a terminal illness, he or she is not informed about it and, until death, continues to believe that he or she might recover. Relatives are informed by the doctor about the true picture but they continue providing emotional support by “lying” to the patient that he or she will get better. A similar approach is being used with young children. They are not informed that their relative “is dying” but that the person will get better. So death is always “sudden” for young children.

When somebody dies in the family, all family members start wearing black or dark clothes until the day after the funeral. Very close relatives might continue wearing dark clothes after that. At the home of the person who passed away all mirrors are covered. Relatives and friends call on the phone and come to the home to provide emotional support to the family and help with daily activities (e.g., cooking or cleaning) and arranging the funeral.

In Russia people express their feelings very openly. They cry bitterly and loudly together and talk a lot about the person who passed away.
Relatives and friends often bring money to the family to help with the funeral expenses. They also frequently take young children to their homes so that children would be less traumatized by the death and funeral. Children continue attending school and live their daily routine. Until the age of 12-14 children rarely attend funerals.

A “viewing” is not popular in Russia and is used only for very prominent political leaders or famous people (actors, etc.). Children are not taken to the viewing. Before the funeral, caskets are often brought to a church to “pray for the soul” of the person who passed away. There is a special procedure in Russian Orthodox Church called “OTPEVANIYE” (SINGING) which is performed by a priest.

Everyone comes to the funeral with flowers or wreaths. There should be an even number of flowers in a funeral bouquet (on all other occasions the number of flowers should be odd.) Music can be played during funerals but it’s not necessary. Family members, relatives, and friends accompany the casket to the grave and throw a handful of soil on the casket. At the funeral it’s OK to cry and scream loudly. Eulogies are given by family members and friends.

After the funeral everyone goes to the home of the person who passed away to “remember” him or her. The procedure is called “POMINKI.” People sit at the table with a lot of food and alcohol and they eat, drink, and cry together. A special plate with a piece of rye bread and a small glass of vodka are placed on the table for the person who passed away. It is presumed that his or her soul remains at home for nine more days. At the beginning of the dinner everybody stands up with a glass of alcohol and quietly drinks “to the memory” of the deceased person.

Afterwards, participants have a long dinner at the table. The meal is usually prepared by the relatives and friends and after the dinner they stay to clean and wash the dishes. Young children rarely participate in “POMINKI” and often spend time in another home of relatives or friends.

Another “POMINKI” dinner is arranged on the ninth and again on the fortieth days after the death of the person. It is considered that on the fortieth day the soul finally leaves the Earth. The small glass of vodka and a plate with a piece of rye bread are kept at the deceased’s home for 40 days.

Every year “POMINKI” is arranged at the home of the person who passed away on the day of his or her death. Relatives and close friends attend. Children usually participate in this procedure.

The family and children visit the grave several times a year especially on the days of the person’s birth and death and on Easter. They always bring flowers and clean the grave and the territory around it. In Russia each grave is usually surrounded by a fence and has a small bench to sit near the grave. There is a cross or tombstone on the grave with the picture of the deceased person. On Easter people often bring special food (colored eggs and Easter cake) and leave it on the grave “for the soul of the deceased.” Men often bring vodka and drink it near the grave (Suslova-Lloyd, 2006).

Practices of the European-American Culture: European-Americans follow various cultural, ethnic, and religious traditions regarding post-death ceremonial and bereavement practices.

Common practices include:

Friends and family gather at the home of the deceased or family member to support and share in the common grief. This practice usually occurs following the announcement of the death. The funeral
director and/or person of the clergy usually advises and directs the family in preparing for mourning and burial. A visitation and/or viewing at a funeral home is typically followed by a religious or graveside/crypt side service. Funeral services tend to rather subdued. Traditionally, dark clothing tends to be worn during ceremonial services; although this trend has shifted in recent years to a more color-based wardrobe focused on creating an atmosphere of celebration and hope. Interment is followed by a gathering of friends and relatives where food and refreshments are provided.

**RELIGIOUS OBSERVANCES OF DEATH:**

The role of religion is important for most victims/survivors because their answers to religious questions form their view of life, death, and meaning.

Many people do not know their position on religion until disaster strikes, and then their religious faith and beliefs are formed. Some religions give individuals more power over life than others. Other religions give collections of individuals power over life. Some religions give spirits more power over life than the living. Some religions espouse free will; others, fatalism. All have defined ways of dealing with death. The following is a sampling of some religious practices:

**Jewish observances**

All customs are designed to treat the body with respect; therefore, autopsies and embalming are generally prohibited. Viewing the corpse is also considered disrespectful. The emotional needs of the survivors are very important.

There is variance among Reform, Conservative, and Orthodox Jewish practices. No funeral is allowed on Saturday (the Sabbath) or on major religious holidays. Music and flowers are not encouraged. Eulogies are given by rabbis, family and friends. When the deceased person is held in high regard, there are usually several eulogies. Family members and others accompany the casket to the grave and are encouraged to place a shovel of earth on the casket, as a sign of the finality of death. The period of mourning lasts for one year. The mourner's "Kaddish" or declaration of faith is said at the gravesite. "Sitting shiva" refers to the seven-day mourning period immediately following burial. The family cooks no food and a candle or lamp is kept burning in the memory of the deceased. The Kaddish is said every day during this time. Some people observe a period of three days following the burial during which visitors are not received and the time is devoted to lamentation. After the first seven days, survivors are encouraged to rejoin society but still maintain mourning by reciting the Kaddish twice daily for thirty days. Many mourners may wear a black pin with a torn ribbon, or a torn garment during the funeral and for the next week as a symbol of grief. Newborn babies may be named after the deceased. The first anniversary is marked by the unveiling of a tombstone at a special ceremony.

**Roman Catholic observances**

The Sacrament of the Sick is a ritual of prayers and sacraments that is performed as a person is dying, and involves receiving the sacraments of Reconciliation and Eucharist. If a person dies before the sacraments are given, the priest will anoint the deceased within three hours of the time of death. There is often a wake before the Mass of Christian Burial and, if so, the priest will conduct the service or say the rosary. Cremation is now an accepted option.
There are distinct phases to "The Mass of Christian Burial":

- Prayers at the funeral home.
- Welcoming the body to the church.
- Covering the casket with a white cloth.
- Sprinkling the casket with holy water.
- The Eucharist is celebrated.
- Prayers are said after the Mass.
- Casket is escorted to back of church.
- At the cemetery, the grave is blessed.

Consecration is a reaffirmation that the person will rise again. Prayers address not only the dead but the survivors - their faith in eternal life is encouraged. The one-month anniversary of the death is often celebrated by a Mass, as are other anniversaries.

**Protestant observances**

There are a wide range of Protestant observances. Often there is a family gathering at the family home or funeral home. Caskets, open or closed, are part of the passage ritual. Memorial items may be placed in the casket. Cremation is an accepted option for some. Black dress is a part of mourning. Funeral services include music and testimonials. Music may include traditional hymns and/or songs of praise celebrating the Christian experience and the hope of everlasting life. Gravesite visits may be made. Memorial services are common, and sometimes replace funerals and other immediate observances of death. Flowers and donations are preferred ways to express condolences. Church members and friends will usually assist in providing the food needs of the family. The period of time will vary according to the needs of the family. There is no formal structure to observe the death, month after month or year after year.

**Islamic Traditions**

Traditions differ in every country and the Turkish interpretation of Islam is in some ways different than those in other Arabic countries. The following practices are relevant for Turkish culture.

Death is considered an act of God and is not questioned. Faithful followers believe that all the events in the life-course of an individual, including the time and type of death, are pre-written by God. People in grief are encouraged to show their feelings openly. They are encouraged to cry loudly as it is believed that crying cleanses the soul. Any expression of rebellion against God's decision to take a person away from his or her loved ones is considered a sin. Friends visit the house of the deceased and talk with the family members, encouraging them to describe how the death occurred, what they were doing at the time of death, etc. For seven days, the family members are never left alone. Friends and neighbors bring food, as no cooking is supposed to be done in a funeral home during those seven days. Traditionally, no television, radio or any musical devices would be allowed for 40 days, but this practice has waned in recent years. There is a religious prayer at the 40th and another at the 52nd day after the death. Muslims are very sensitive to where their beloved ones are buried and will seek out a cemetery for Muslims. They also want the funeral prayers to be led by a Muslim. A special ceremony and prayers accompany the funeral. The body is buried without the coffin and wrapped in white clothes,
as it is believed that the body should touch the earth. The body must be bathed along with certain rituals before the funeral ceremony begins. This usually takes place at either a special section of the mosque or in the morgue of the hospital. It is very upsetting when a body is buried without being washed. When meeting with someone who has lost a relative, conversations start by saying: "May you be alive and may God's blessings be on him/her - the deceased." *(NASP, 2003)*

**DEVELOPING CULTURALLY COMPETENT CRISIS RESPONSE/RECOVERY PLANS**

When devising a culturally competent response and recovery plan, responders would be wise to *(Young, 1997)*:

- Be cognizant of the school district/community’s composition relative to:
  - Race, ethnicity
  - Languages/dialects
  - Age
  - Gender
  - Religions
  - Refugee/immigration
  - Socioeconomic status
  - Rural/suburban/urban
  - History of trauma
  - History of community relationships within the district
- Assess culture-specific mental health needs for the community.
- Identify formal and informal community resources to address those needs.
- Ascertain the degree of personal control that victims perceive having in the aftermath of a crisis.
- Differentiate between cultural group norms and the victim’s unique perspective.
- Identify the meaning of suffering, pain, and death relevant to the norms of the community’s cultural groups.

**PROVIDING CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES**

When providing culturally and linguistically competent services responders would be wise to *(Young, 1997; Athney and Moody-Williams, 2003)*:

- Be accessible, appropriate, and equitable
- Convey respect and good will
- Dress appropriately
- Participate in access ritual
- Say, “please” and “thank you”
- Be aware that cultural conventions vary
- Refer parents to culturally appropriate post-crisis resources
- Use effective interventions including: group work, relaxation techniques, meditation, education about crisis in culturally relevant terms, and development of individual empowerment
- Acknowledge your limitations and differences, such as your inability to speak or understand the language
- Access resources for support with identified limitations
• Seek clarification of customs, rituals, or spiritual understandings
• Convey your sincere desire to learn
CHAPTER FIVE: RECOVERY

The goal of this chapter is to introduce the reader to the recovery phase of the crisis. Included in this chapter are the characteristics of resiliency, as well as recommendations to support the development of resilience in children.

AFTER THE CRISIS: HELPING CHILDREN HEAL AND FOSTERING RESILIENCE

It is not unusual for children to continue to show signs of stress in the first few weeks after a crisis has been resolved. Reactions and recovery may vary in accordance with a child’s direct exposure to the crisis, age, past experience with trauma, coping skills, and networks of caring adults. An evaluation of the CRT’s school crisis intervention would be useful in gauging the overall school climate (Handout 23). Most children, however, will return to their usual state of physical and emotional health within four to six weeks. These children are demonstrating resiliency, the process of adapting well in the face of adversity, trauma, tragedy, threats, or other significant sources of stress. In short, resiliency is the ability to “bounce back” from difficult experiences. Resilient children and adults have certain skills in common, traits that can be taught and strengthened.

People who are resilient demonstrate:

- **Sociability** - Form healthy relationships
- **Optimism** - View self and the future positively
- **Flexibility** - Accept change as a part of living
- **Self-confidence** - Base decisions/choices on instincts and confidence in abilities, while moving towards goals
- **Competence** - Are “good” at something, and are aware of their skills
- **Insightfulness** - Understand people and situations
- **Perseverance** - Continue despite difficulty, don’t give up
- **Perspective** - View crises as challenges to be faced, rather than insurmountable obstacles
- **Self-control** - Manage strong feelings and impulses

**Fostering Resilience**

Research has shown that despite exposure to community crises, children can emerge from challenging life events with a positive outlook on life.

Adults can foster positive outcomes in children after alarming events in the following ways:

- Help build and maintain a close relationship with a supportive, accepting adult
- Support positive, healthy relationships with other children
- Discuss safe and healthy ways children and teens can calm themselves
- Remind adolescents to avoid smoking, alcohol, drugs, and use of irresponsible behavior for stress reduction
• Help relieve children from constant worry by enabling them to recognize that future crisis events are unlikely to happen to them or to members of their family
• Teach and model healthy ways of communicating feelings, wants, and needs, as well as regulating the behavioral expression of emotions
• Build problem-solving skills
• Empower children to consider life’s challenges as problems to be solved in an organized manner
• Emphasize empathy, caring, and reaching out to others
• Encourage a positive outlook for the future
• Remind children that negative events are typically temporary and may be managed through planning and coping strategies

If a child’s reactions to a community crisis are prolonged or interfere with everyday activities in the home, school, and community, school psychologists should consult with the parents about seeking appropriate mental health services. Parents may also wish to consult with the family physician.
CHAPTER SIX: DEATH BY VIOLENCE

The goal of this chapter is to introduce the reader to the nature of violent death and the impact of violence on students, staff, and the school community. This chapter includes specific considerations regarding death by murder, suicide, and traffic accidents. Guidelines for responding to immediate and long-term effects of violent death and the associated needs of students, staff, and school community were developed by Mary Schoenfeldt (Schoenfeldt & Associates, 1999).

MURDER/HOMICIDE OF A STUDENT: THE NATURE OF VIOLENT DEATH

The death of a student is always a sad event causing various personal emotional crises. The death of a student by violent means is even more traumatic. As crisis responders we must be compassionate first, keeping the unique needs of all concerned in mind as we plan our response.

If the death occurred as a violent attack or murder, others in the school may know the alleged perpetrator. He or she may be a student or former student, or the sibling of a student. If the death occurred as the result of family violence, children, especially young children, may wonder if the same thing could happen in their family. If the death was the result of a random act, anxiety and fears about personal safety will be raised. However the death occurred, adults and students will speculate about the facts. Do not rely on rumors for information, and take immediate steps to instruct others not to rely on rumors or speculation. If a friend or family member of one of your students is the alleged perpetrator, then your student will need much extra support. Sometimes people "blame" the friend or family of the perpetrator and scapegoat them even though they had no knowledge about, or control over the actions of the perpetrator.

If a violent death occurs on your school grounds, the response issues become very complex. Your school will now be a crime scene, and it will come under the jurisdiction of local law enforcement. Areas may be sealed off within a law enforcement perimeter. Students and staff may be questioned. Your school will become home to a number of emergency services personnel as they perform their duties. People may not be able to leave the school for quite some time because the police will have set up inner and outer perimeters for the investigation. While public safety personnel are on campus, they will be in charge. The best you can do in this kind of situation is cooperate with the police as they conduct their investigation.

Things to think about:

The Media:

- The school district’s Public Information Officer should coordinate activities with the spokesperson for the local police department.
- Set up a Media Information Center and channel all communication through your Public Information Officer.
- Prepare statements and update them frequently.
- Do not to be tricked into giving more of a statement than you've prepared.
• Respond to only those questions you can answer honestly; “I’ll get back to you on that” is an honest approach to uncertainty, but be sure to have a response later.
• Do not give out any names.
• Do not allow access to the scene to take pictures of the injured or distraught.
• Advise the parents and families of both the victims and perpetrators of the media presence, and tell them that they do not have to talk to reporters.
• Discourage students from talking to the media.

The Scene:
• Check with the local law enforcement representative to see if your community has a business that specializes in crime scene and "hazardous waste" clean up.
• Normalize the area; clean, paint, rearrange, replace. Caution: do not inadvertently create a memorial by making a very obvious change to a small portion of the area. If you paint, paint the whole wall. If you lay new carpet, re-carpet the entire hallway. A very obviously patched carpet, a repainted, different colored section of a wall, or a dented file cabinet left in its original place may serve as visual reminders of the event and make it more difficult for people to recover.
• Have the asphalt on the parking lot washed and repainted.
• Remove the yellow "Police Line - Do Not Cross" tape as soon as possible.

The Response:
• If the incident happened on your campus and/or the reaction to the event is extreme, an informational meeting for parents may be necessary to restore the parents' belief that their children are safe. Local law enforcement and mental health professionals should play a large role in that meeting.
• If the event is the result of family or domestic violence, contact your local domestic violence agency and get information for your students, including a hotline or crisis phone number where they can get help if they need it for their own situations.
• Arrange with neighboring schools to mobilize counseling staff in the event of a crisis as another way to have extra resources available.
• Beyond the local level, most states have networks of Critical Incident Stress Management Teams who can be mobilized quickly to come and assist. The International Critical Incident Stress Foundation maintains a list of Critical Incident Stress Management Teams throughout the world. (Website: http://www.icisf.org)

Before School

If the incident took place after school or over the weekend, a staff meeting before the next school day is essential to share information and reactions. This meeting should be attended by all staff members: teachers, custodians, bus drivers, cafeteria workers, instructional assistants, etc. It should be organized by the school and regional crisis team leaders who would have had a prior brief meeting, at least by phone. Given the circumstances of a violent death, keep in mind that local law enforcement or others may attend the staff meeting. Notification of the meeting should be done in whatever manner is most convenient for your school and district.
**Things to think about:**

Don't expect the staff to function in a "business as usual" manner following a violent death. School personnel will be shaken because their illusions of being able to keep kids safe will be shattered. “Violence has now touched their lives in a very personal way and they will be forever changed.” Staff members may need extra support during this time so they can deal with their own reactions and still be a healthy support for students. If a staff member is experiencing extreme distress, make arrangements to provide whatever assistance he or she might need—maybe an additional classroom aide, a break from extra duties or responsibilities, or even a few days off.

**First Period**

The beginning of the day is the crucial time to begin rumor control. If we don't give students accurate information, they will create their own stories, details and theories. Their fiction is often much more extreme and frightening than reality.

**Things to think about:**

- Do not give graphic details, but do give facts.
- The classroom is the ideal setting for discussion.
- Focus the discussion on reactions of the students and what they may experience as the result of the grief and trauma of the incident.
- Adolescents need to know that they may have trouble concentrating, be accident-prone or be withdrawn. Start determining which students may be more vulnerable and refer them to a counselor.
- Provide community crisis numbers for those students who prefer privacy.

A **Student Safe Room** is a designated place where students can go if they are having difficulty maintaining their composure in a regular supportive classroom environment. It should be staffed by at least two knowledgeable and trained people:

- Equip the room with tissues, drawing and writing materials, stuffed animals, books about loss and information on typical reactions.
- Provide refreshments such as cookies and juice.
- Set an attendance procedure in place to manage the tendency of students to leave classrooms and wander around the school building or campus. It is recommended that students sign out of their regular classroom and then sign in to the Safe Room within a certain time limit.
- Contact parents or guardians of students having a particularly difficult time.
- Establish a mechanism for staff to be relieved of their duties periodically.

**Rest of the Day**

Children who are emotionally impacted by an event sometimes isolate themselves from others.
Things to think about:

• Check bathrooms, back closets, little-used hallways, and cars in the student parking lot every 15 minutes.
• Prepare a letter to go home for parents or guardians explaining what has happened and expressing condolences for the victim’s family, while being sensitive to the alleged perpetrator’s family.

After School

A staff meeting after school serves several purposes. First, it enables you to update the staff on the current status of events. Second, it lays the groundwork for the next day's response. Last, it lets staff members decompress after a very intense day.

Things to think about:

• Allow for time to ventilate by organizing into small groups (no more than 10 people each) and give staff members a chance to talk about what the worst part of the day was for them. Allow 20 minutes or so for this.
• Bring everyone back into the large group to share information.
• Begin to identify those people that may need some additional help dealing with the tragedy.
• Educate the staff on typical reactions from such a trauma.
• Share the latest information you have about the investigation, funeral services, charitable donations, etc.
• Conclude the meeting by going over the schedule for the next day.

PARENT/COMMUNITY INFORMATIONAL MEETING CONSIDERATIONS

When violence hits a school community, it is suggested that a parent/community informational meeting be held. This allows parents and other citizens to express their concerns and get information on the complex issues of school safety and violence. The meeting can be held from as soon as a few days after the event to anytime within a couple of weeks.

Things to think about:

• Coordinate the agenda with all speakers ahead of time so everyone knows expectations.
• Arrange for translators, transportation and childcare, if appropriate.
• Invite public safety officials to attend.
• Invite mental health experts who specialize in school safety, violence and its aftermath to encourage parents to talk with their children about their reactions.
• Anticipate that the media will come to this meeting, invited or not.
• Manage the media by setting up interviews with key people and giving them information ahead of time .
• Provide information on any and all steps the school community had taken that emphasized safety and crisis planning before this event.
Memorials

Things to think about:

Remember that the family's grief will be intense. Be careful not to get caught up in it and overreact with a school memorial or other act that somehow glamorizes the event or person. Help students create an appropriate way to say goodbye to the victim.

- Buy a scrapbook or journal and encourage everyone to write poems, stories, create artwork, add photographs or put any other contribution to it. Make this available at school for two weeks.
- Make sure someone reads the book before it's given to the family to make sure there isn't anything hurtful or inappropriate in it.
- Present it to the family as a gift.

Summary:

The critical Things to Remember when dealing with a violent death are:

- The illusion of "it never would happen here" has been shattered. Staff and students will be afraid that it could happen again.
- Be sensitive to the fact that the alleged perpetrator may be a student, former student or the family member of a student.
- There will be an on going police investigation.
- If anyone is feeling vulnerable, get help.
- Help students create an appropriate way to say goodbye to the victim.
- The school staff members may be "secondary" victims. They need support too.
- Give accurate information to reduce rumors.

Things to Avoid:

- Avoid any activity that glamorizes the student or his/her death. Don't do large memorials or assemblies.
- Don't be afraid to talk about death with students. They need to talk about it to reduce their own risk.
- Avoid ignoring the warning signs of other students or staff.
- Do not clean out the victim's locker or reassign his/her desk or take down his/her artwork for a day or two.

First Month

During the first week or so, students and staff will talk a lot about the event. After a couple of weeks it will start to seem as though everyone has forgotten about it. The reality is that people are still thinking about it and each may believe he or she is the only one.

Things to think about:

- Remind staff and students that getting over a tragedy takes time.
• Remind everyone that if they are having trouble sleeping, making decisions or eating, then they are experiencing normal reactions.
• Reassure all students and staff that they are not alone in their feelings and reactions.
• Convey the message that it's still OK to talk about the incident.
• Encourage teachers to bring up the subject with their students every now and then; for example, a teacher might say something like, "I've been thinking about Dwayne a lot the last couple of days and missing him. I'll bet some of you are missing him, too." This provides a forum to continue to talk about the trauma and accompanying feelings.

Beyond First Month

Things to think about:

• Be aware of anniversaries or any other "trigger" events that might happen.
• The end of the school year will almost certainly cause a reaction of some sort.
• Allow students to do something; it encourages closure.
• If someone is arrested and goes to trial, the tragedy becomes fresh again. Those people closest to the event probably will have to testify. The media attention may be intense. In many ways, this can become a second victimization. Expect to continue dealing with reactions for some time to come.
CHAPTER SEVEN: SUICIDE

The goal of this chapter is to review the actions that should be taken when a suicide occurs, as well as to provide recommendations for responding to the immediate and long-term effects of suicide and the associated needs of students, staff, and school community.

The accompanying handouts provide an overview to the reader as to the nature, scope, and impact of suicide on students, staff, and the school community. (Handouts 24-32)

EMOTIONAL REACTIONS: A QUICK REFERENCE

- Shock
- Anger
  - Surprising emotion, directed at the deceased
  - Response to feelings of hurt, complicated by feelings of pain caused by suicide
- Blame
  - Focused on why.
  - Attempting to answer the question “Who caused this suicide?”
- Stigma
  - Some may feel shame to be connected with a person who has completed suicide
- Guilt
  - They may have tried to help but failed
  - They second-guess themselves (if only, what if…)
  - They must remember suicidal person made a choice
- Relief
  - Some may be troubled that they are glad to be rid of emotional pain caused by a needy person

WHAT TO DO IN A COMPLETED SUICIDE POSTVENTION PLAN

CONFIRM THE SUICIDE

- Obtain family cooperation to discuss the death as a suicide
- If family consent is not provided, the school must honor the family’s wishes
- Develop a clear, honest statement about death (rumors make it worse)
- Prepare a letter to send home containing:
  - Statement of the student’s death
  - Steps taken to implement a Postvention plan
o Assistance provided to students
o How parent can continue discussion at home
  • Identify at-risk students
  • Have teachers read an announcement in their first-period class and lead discussion
  • Provide counseling – individual, group, class
  • Return to regular class schedule when appropriate
  • Visit classes of the deceased
  • Discuss and address “empty chair” issue with teachers/students

WHAT NOT TO DO IN A COMPLETED SUICIDE

POSTVENTION PLAN

• Close school
• Lower flag
• Hold a memorial
• Use PA to announce death
• Authorize a large group assembly
• Permit a large yearbook picture of the deceased
• Sweep the nature of the death under the rug
• Give detailed, graphic particulars of death

HOW TO HANDLE THE AFTERMATH OF A SUICIDE

• Provide follow-up with affected staff members as needed
• Evaluate the effectiveness of the postvention plan
• Assure that follow-up counseling is provided to those seen who need further help
• Help develop some appropriate school response to the loss (i.e., purchasing books on suicide prevention for library, loss support group, training peer helpers)
• Have student support staff work and follow attempters
CHAPTER EIGHT: CARE FOR THE CAREGIVERS

The goal of this chapter is to introduce the reader to the needs of responders before, during, and after the occurrence of school crises. The chapter includes recommendations for creating a crisis team network.

Critical incidents in schools appear to be increasing in frequency, intensity, and complexity. As a result, school psychologists and other mental health practitioners are called upon more and more throughout the year to intervene in situations that are often complex and emotionally demanding. Providing emotional support to those who are grieving or who have been traumatized can be painful for the helper and can leave lasting symptoms. In addition, we all have life experiences that may be triggered due to the sights, sounds, and stories involved in a crisis. School crisis response team members, who continually work with traumatized, grieving, depressed, or suicidal students and school staff, often become traumatized themselves. This is called vicarious trauma. Some symptoms of vicarious trauma include feeling:

- burned out
- anxious
- cynical
- depressed
- distrustful
- suicidal
- alienated
- despairing
- numb
- suspicious
- irritable
- pessimistic
- fearful
- ineffective

Fortunately, there are numerous interventions that can reduce the effects of vicarious trauma for school psychologists or other professionals serving on the crisis response team. The following are some suggestions:

Before a crisis:

- Build your professional and interpersonal skills. Take advantage of crisis training and get experience working on a crisis response team with knowledgeable members who can give you supervision and feedback and provide an opportunity for reflection.
- Become aware of your own vulnerabilities that may become bruised during crisis work.
- Be aware of personal needs and stress level. We are not helpful to others when we are emotionally distraught ourselves. We must give ourselves permission to say no if we are not available to help others.
- Keep up to date on school and community resources that are available to you and your team.
During a Crisis:

- Be aware of and monitor your own emotional, cognitive, behavioral, and physiological reactions and your capacity to continue to be helpful to others.
- Take a break if you find you are becoming stressed or if a team member suggests you need a break. Try to find a quiet place and use self-calming techniques before resuming your role on the crisis team. Request help from other team members, if necessary. Remember, you can’t help others when you need help yourself.
- Acknowledge and talk with team members about how the event is impacting you, but avoid disclosing specific, personal information. It’s OK to say, “This is really sad/hard for all of us,” but avoid saying, “I remember when my father died…”

After the Crisis:

- Reflect on the incident with team members to celebrate successes, to give and receive supportive feedback, and review team functioning
- Obtain a psychological debriefing when necessary from another mental health provider (see crisis response team support network below)
- Talk with others. Talking about your feelings, issues, and events is healing
- Eat well and get plenty of exercise and rest
- Avoid caffeine and alcohol
- Structure your time, focusing on maintaining as normal a schedule as possible
- Reassure yourself that you are normal and having normal reactions to an abnormal situation. Avoid admonishing yourself as weak or ineffective
- Give yourself permission to experience a range of emotions
- Do things that support positive mental health

Crisis Response Team Support Network:

An important intervention is to provide the school crisis response team with support from their colleagues or other mental health professionals who were not involved with the crisis (Help for the helpers, so to speak). We are not helpful to others when we are emotionally distraught ourselves. Below is a model for a Crisis Response Team Support Network.

1. Create a team of school psychologists/mental health practitioners on your staff who will NOT be a part of the crisis team. If your staff is small, contact community mental health agencies or private practitioners, who are willing to serve in this role. These people will serve as your Crisis Response Team Support Network. Appoint a chairperson of the team.

2. When a crisis occurs in a school, the Chairperson of the Crisis Response Team Support Network is notified and given details of the crisis (name of the school, information about the event, name of the person who was killed, committed suicide, and other pertinent information) and names of those who are serving on the crisis team.

3. The chairperson notifies the members of the Crisis Response Team Support Network and assigns them a responding crisis team member to contact at the end of the day for debriefing.

4. Debriefing can occur over the phone or in person with a supportive colleague who was not involved in the crisis contacting the crisis team member. The debriefing process can
involve asking the responding crisis team member to share thoughts and feelings about the actual crisis, how the intervention went, how he or she felt during the intervention, how he or she feels now, what is going to be done for self-care, what coping strategies will be used, and if any additional assistance is needed.
RESOURCES

(As with all materials, individuals are encouraged to preview and choose those materials that are appropriate for the audience intended. This list is not all-inclusive and is just a beginning for obtaining reference materials.)

Some Introductory Materials (Videos and Articles)

Grief in America (video)
Fanlight Productions
Media Library                   800-937-4113 www.fanlight.com
Post Office Box 1084
Harriman, NY 10926

This video takes an honest and comprehensive look at how our culture deals with loss in all its forms. Interviews with a number of nationally recognized authorities on the grieving process examine, among other things, some common myths about grieving, the importance of social supports, the impact of ethnic traditions regarding grief, and the social costs of unresolved grieving.

The documentary also includes the moving stories of seven individuals who have experienced losses both from anticipated causes such as progressive disease, and from unexpected causes including heart attack, murder, and suicide. 57 minutes© 1997

Inner Views of Grief (video) Fanlight Productions

When young people experience the death of a loved one, the adults in their lives sometimes fail to understand what an overwhelming experience this can be. In this compelling video, five young adults, from ages 14 to 26, discuss their reactions to the sudden, sometimes violent death of a parent, sibling or friend. These eloquent, insightful young women and men talk about what helped them at the time of death, how family relationships changed, how they have coped with their feelings, and the ways they have commemorated the deceased. This is an excellent teaching tool for mental health professionals, teachers, school crisis teams, hospice workers, clergy, funeral directors, parents, and bereaved individuals of all ages. 30 minutes© 1995

Stand Tall (video) Fanlight Productions

I wished I had a black sheet that I could just throw over the window, so that I could never, ever see that again." Student

When an airliner crashed into the second World Trade Center tower, on September 11, 2001, Rachel Croyle's 4th and 5th grade students were watching from their classroom window at
Manhattan's PS-3. It was her fourth day as a teacher. Looking for ways to help the children deal with their feelings about what they had seen and experienced, she drew upon the expertise of a drama therapist and a group of theater professionals from City Lights, a youth theater organization. Following a series of theater workshops, an original play was developed, based on the role plays created by the children.

Told from the point of view of their classroom teacher, this video documents the transformation of the young students' stories into a theatrical performance. It explores the ways that drama can help children learn how to transform a frightening, chaotic experience into one of clarity and hope - how to express the inexpressible in a safe and symbolic form and, in so doing, to feel more balanced and in control. For the audience of parents and friends, their play offered an intergenerational community an opportunity to participate in a ritual through which to share a common history.

This innovative program will help parents, teachers, school psychologists, social workers, arts therapists, and others who work with children to understand the role that story-making and dramatic performance can play in helping children cope with traumatic experiences. It offers a compelling portrait of the sometimes amazing coping strengths that children can display when they are able to work through such experiences with the help of skilled, supportive adults. 

24 minutes © 2003

Strong at the Broken Places: Turning Trauma into Recovery (video)

P.O. Box 390385
Cambridge, MA 02139-0004  (617)-484-3993

Strong at the Broken Places is a 38 minute educational video about people, devastated by trauma and loss, who find common ground for their journeys to recovery.

A new film from the producers of "Defending Our Lives," "Strong at the Broken Places" is the story of vastly different lives; but the death camps of Cambodia, the violent streets of South Boston, the amputee ward of a V.A. hospital and the cell of an alcohol and drug addicted inmate yield remarkable survivors, all of whom heal themselves by helping others.

Web-based Hand Outs and Other Resources (also could be used for introductory materials)

Please view these for yourself and decide if you want them; then download, save, print, and make copies in case you ever need to use them.

Association of Traumatic Specialists (ATSS)  (800)991-2877
home page http://www.atss.info/

Tips for Times of Crisis COVA (Colorado Organization for Victim Assistance)
www.coloradocrimevictims.org/Crisis%20Trauma%20Tips.htm

1. Trauma Recovery Tips (Handout for Victims)
2. New COVA Trauma Tip Sheets (This document includes: Victim & Witness Reactions to Trauma; Helping Children & Teens Cope With Trauma: Tips for Teachers, Staff, & Mentors: Tips for Parents & Family Members; and Tips for Students
3. Spanish Version

*International Society of Traumatic Stress Studies (ISTSS)* (847)480-9028

home page [www.istss.org](http://www.istss.org) articles

[http://www.istss.org/terrorism/what_is_traumatic_stress.htm](http://www.istss.org/terrorism/what_is_traumatic_stress.htm) and


**National Mental Health Information Center (Disaster/Trauma Links)**

[www.mentalhealth.samhsa.gov/topics/links.aspx?topic=Disaster%2fTrauma](http://www.mentalhealth.samhsa.gov/topics/links.aspx?topic=Disaster%2fTrauma)

Examples include:

1. Helping Children Cope with Fear & Anxiety
2. After Disaster: What Teens Can Do
3. After a Disaster: A Guide for Parents and Teachers (Covers Preschool, 1-5, Early Childhood, 5-11, Adolescence)
4. After a Disaster: Self-Care Tips for Dealing with Stress
5. How to Deal with Grief (at the end of this page is a list of other organizations and web sites that provides information and support for coping with grief)
6. Self-Care Tips for Emergency and Disaster Response Workers

*National Office for Victim Assistance (NOVA) (800)TRY-NOVA*


**Materials for Pre-Planning/Preparedness**

*Administrator’s Checklist for Responding to a School Crisis.* Charles County Public Schools, Dept. of Student Services, P.O. Box 2770, 5890 Radio Station Road, La Plata, MD 20646.


*Picking Up the Pieces: Responding to School Crises.* Schoenfeldt & Associates (1999). Totem Beach Loop Road, Marysville, WA 98271 (360) 659-2271 yoursafeplace@msn.com


**Some Article Sources for School-Based Staff or for Parent Groups**


Helping Children Cope with the Loss of a Loved One. Dr. William Koren, 1996. Free Spirit Press, MN. Available from A Place to Remember (800) 631-0973. What can we say to a child who has lost a sibling, parent, or other loved one? How can we be sure to say and do the right things without adding to the child’s confusion and grief? In clear, concise language, the author offers comfort, compassion, and sound advice. He explains how children from infancy through age 18 perceive and react to death, and offers suggestions on how we can respond to children at the different ages and stages.


My Always Sister. Available from A Place to Remember, (800) 631-0973. In this 16-pg. coloring book, My Always Sister, Callie remembers back to when her baby sister, Laura was born and died. Through her story, other children experiencing the death of an infant sibling will be able to relate to the feelings of fear, anger, sadness, and eventually acceptance that Callie tells about. The large, easy to color pictures provide another outlet for children to express their own emotions as they process their grief.

Saying Goodbye Activity Book, Jim Boulden, 1989. PO Box 9358, Santa Rosa, CA 95405. A children’s activity book that will help them work through their feelings of grief.


Some Introductory Parent Resources


Helping Children Cope with the Loss of a Loved One, Dr. William Koren, 1996. Free Spirit Press, MN. Available from A Place to Remember, (800) 631-0973. What can we say to a child who has lost a sibling, parent, or other loved one? How can we be sure to say and do the right things without adding to the child's confusion and grief? In clear, concise language, the author offers comfort, compassion, and sound advice. He explains how children from infancy through age 18 perceive and react to death, and offers suggestions on how we can respond to children at the different ages and stages.

Self- Help Resources for Children

Am I Still A Sister? Alicia Sims, 1986. Big A and Company, Albuqerque, NM. This book was written by an 11 year old girl to express her feelings and questions following the death of her younger brother.

Am I Still A Big Sister? Audrey Bernheimer Weir, illustrared by Susannah Hart Thomer, 1992. Fallen Leaf Press, PO Box 942, Newton, PA 18940-0845. Elisabeth Kubler-Ross calls this a “wonderful book for siblings who have lost a brother or sister.”


When Death Walks In, Mark Scrivari, 1991. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE. 68104-5064, (402) 553-1200. This book deals with the different aspects of the grieving process specific to teenagers.

Helping Children Grieve (Underlined/highlighted books are available from the A Place To Remember www bookstore.)


About Dying: An Open Book for Parents and Children Together, S.B. Stein, 1974. Walker and Co. This is one of an outstanding series of "open family books" for parents and children to read together. It offers suggestions for parents in helping children understand and cope with death. The story tells of a bird that dies, then about a grandfather who dies, and concludes with a discussion of how parents can help children to cope with such events.

Butterflies, Grandpa, and Me, Bruce Conley, Thum Printing, 116 W. Pierce St., Elburn, IL 60119 (312) 365-6415.

Children Are Not Paper Dolls, Erin Linn Levy, 1982. Human Services Press, PO Box 2423, Springfield, IL 62705. "This book deals relevantly with the most profound of human experiences - the death of a child. No one could express such a mature subject better than a sibling. They do it with disarming frankness and honesty. Adults will be helped as much by this book as children" (Human Services Press Fall/Winter 1985).

Dancing on the Moon, Janice Roper, illustrated by Lauren Grimm, 2001. SIDS Educational Resources, Cheverly MD. Ages 3-8. The journey of a young girl to find her infant brother who has died. She dreams she flies to the moon, where she finds him. In the end, she realizes, he will be with her always, in her heart.


Helping Children Cope with Death, Robert Dodd, 1984. Herald Press, Kitchener, Ontario. This booklet was written to assist parents in helping their children deal with their thoughts and feelings concerning the death of a friend or relative, or in facing their own death.

Helping Children Cope with Grief: Facing A Death In the Family, Rosemary Wells.

Helping Children Cope with Grief, Alan Wolfelt, Ph.D., 1983. Accelerated Development Inc., 3808 W. Kilgore Ave., Muncie, IN 47304-4896, (317) 284-7511. Written for parents, teachers and counselors who have both a desire and a commitment to help children when they experience a death.


Helping Families with Miscarriage and Newborn Loss: How to start and Maintain a Community Support System, Karis Crawford and Mary Schuman, 1988. Lamaze, Ann Arbor, MI.

Herman and Friends, Sandy Priebe, 1986. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE 68104-5064, (402) 553-1200. This book is for all children who are very ill, for all parents who love them, and for all nurses and doctors and other people who care.


It's OK, Thomas G. Crouthamel Sr., 1986. Keystone Press, PO Box 166, Langeloth, PA 15054. This book is a help, aid and assistance survival kit for bereaved brothers and sisters. Written by a bereaved father to help his son and other children who must deal with the death of a sibling.


Loss. How children and teenagers can cope with death and other kinds of loss, Patricia L. Paenbrock and Robert Voss, 1990. Medic Publishing Company, PO Box 89, Redmond, WA 98073. A small booklet intended to help parents, and others, give children the understanding and support that they need to come through the grieving process in a healthy manner.


Molly's Rosebush, Janice Cohn, illustrated by Gail Owens, 1995. Albert Whitman & Company, Morton Grove, IL. Available from A Place to Remember, (800) 631-0973. Certainly one of the nicest children's book available on the topic of miscarriage. The story is told in a straight-forward manner and openly confronts the fears that might confront siblings after a miscarriage. It is fully illustrated with four-color illustrations by Gail Owens, whose pastels bring the story and the characters alive. For children aged pre-school to grade 2.

My Always Sister. Available from A Place to Remember, (800) 631-0973. In this 16-pg coloring book, My Always Sister, Callie remembers back to when her baby sister, Laura, was born and died. Through her story, other children experiencing the death of an infant sibling will be able to relate to the feelings of fear, anger, sadness and eventually acceptance that Callie tells about. The large, easy to color pictures provide another outlet for children to express their own emotions as they process their grief.

No Bigger Than My Teddy Bear, Valerie Pankow. A book for siblings of a healthy preemie about the NICU experience. Talks about machines and what actually happens in NICU.

No New Baby, Marilyn Bryte, 1988. Centering Corp., Omaha, NE. Available from A Place to Remember, (800) 631-0973. For boys and girls whose expected new baby brother or sister
dies through miscarriage. Grandma explains how they are not to blame, and how there are not always answers for tough questions. Also affirms the normalcy of play during grief.

150 Facts about Grieving Children, Erin Linn, 1990. The Publisher's Mark, PO Box 6939, Incline Village, NV 89450. Facts about grieving children that help parents understand their feelings surrounding the death of a loved one.

Our Baby Died, Why?, Jake Erling, ed. by Susan Erling Martinez, Revised in 1994. A Place to Remember, 1885 University Ave., Suite 110, St. Paul MN 55104, (800) 631-0973. Seven-year-old Jake Erling tells the story of his dreams for a new brother and devastation when Jesse is stillborn. He shares his grief experience from a child's perspective, and relates an accounting of the subsequent pregnancy and birth of his twin siblings. The booklet is a place for children who have had a baby brother or sister die, to journal their thoughts and feelings. Questions are posed throughout the book and space is provided for children to write or draw their response.

Saturday Night Mulberries, Dorothy Ferguson, 1988. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE 68104-5064, (402) 553-1200. A children's book that addresses the death of a pet and the death of a parent by a child who was raised on a farm.

Saying Goodbye Activity Book, Jim Boulden, 1989. PO Box 9358, Santa Rosa, CA 95405. A children's activity book that will help them work through their feelings of grief.

Should the Children Know? Encounters with Death in the Lives of Children, Marguerita Rudolph, 1978. Schocken Books. The book "shows how the very young can and should be taught about death at school and at home-through books, the care of plants and animals, and direct experience with human death. It is sensitive and sensible, good for teachers and parents."

Sibling Grief, Marcia G. Scherago. Medic Publishing Company, PO Box 89, Redmond, WA 98073. A small, well put together pamphlet written by a clinical social worker who is also a bereaved parent that provides excellent information to help children following the death of a sibling.

So Much To think About: When Someone You Care About Has Died, Fred Rogers, 1991. Family Communications Inc., 4802 Fifth Ave., Pittsburgh, PA 15213. An activity book for children to help them deal with their feelings after the death of someone they cared about.

Stacy Had A Little Sister, Wendie C. Old, Illustrated by Judith Friedman, 1995. Albert Whitman & Company, Morton Grove, IL. Available from A Place to Remember, (800) 631-0973. One of the nicest children's books that we have seen. Beautifully illustrated with 15 4-color watercolors, the book speaks to the issues and concerns of many siblings who have lost a baby brother or sister. For preschoolers through the third grade.

Talking About Death: A Dialogue Between Parent and Child, Earl A. Grollman, 1976. Beacon Press, Boston, MA. Death is explained in a clear, easily understandable format. It gives examples of what fears and questions children have and how parents can respond honestly and directly; a resource bibliography is included.
Talking with Young Children About Death, Mr. Rogers Neighborhood, Pittsburgh Family Communications, 4802 Fifth Ave., Pittsburgh, PA 15213. A general guide to a healthy approach to explaining death and dying to children.

Tell Me About Death, Mommy, Janette Klopfenstein, 1977. Herold Press, Kitchener, Ontario, Canada. A young widow shares her experiences in helping her two young sons understand and cope with the death of their father.

Tell Me, Papa, Joy and Marvin Johnson. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE 68104-5064, (402) 553-1200. This is a family book for answering children's questions about death and funerals.

The Angel with the Golden Glow: A Family's Journey Through Loss and Healing, Elissa Al-Chokhachy, Ulrike A. Graf, 2001. Penny Bear Publishing. Based on a true story about a family whose first child was born with a rare genetic disorder. His family showered him with love, not knowing how long he would survive. They celebrated his life and savored every moment they shared. A book for children (4-8) and adults.

The Butterfly Tree, Joan Lowery Nixon, 1979. Our Sunday Visitor, Huntington, IN. A storybook that revolves around the pending death of Great Grandma. Told in a Catholic perspective, it acquaints the reader with those special customs. The pictures are beautiful but the story is evasive regarding death.

The Fall of Freddie the Leaf, Leo Buscaglia, 1982. Charles B. Slack Inc., Thorofare, NJ. A touching story describing the cycle of life. The portrayal of Daniel as the wise old leaf that explains life and death to Freddie is very well done. The photographs add a special warmth to the book.

The Grieving Child, Helen Fitzgerald, 1992. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE 68104-5064, (402) 553-1200. The author tells how children react to death, how parents can explain it, and how to cope with the child's emotional responses.


Thumpy's Story: The Story of Grief and Loss Shared by Thumpy the Bunny, Nancy Dodge, 1984. Prairie Lark Press, PO Box 699-N, Springfield, Ill 62705. Thumpy's sister has died because she is not strong enough to go on living. A story for ages 5-10.
Thumpy's Story. Sharing With Thumpy Workbook. Thumpy's Story Coloring Book. 1985. Prairie Lark Press, PO Box 699-B, Springfield, Ill 62705. To add color to Thumpy's life is to add color to one's own. Loss of someone we love is painful, and we are able to allow the return of colors from other lives, especially of those we love. For the child - and for adults too - the coloring task is therapeutic far beyond what words alone permit. "Thumpy's Story is a life-affirming book that conveys a child's pleasure and curiosity for exploring God's world." Ages 3 and up.


Timothy Duck, Lynn Bennett Blackburn, 1987. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE 68104-5064, (402) 553-1200. About a duck that loses his people-friend through death. His thoughts, feelings and recovery are clear cut, easy to understand, and an excellent resource for children who lose a friend or loved one.


What Will I tell the Children?, Jacque Bell and Linda Esterling. American Cancer Society, Omaha, NE. A guide for parents to help their children understand death.

When Death Walks In, Mark Scrivari, 1991. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE 68104-5064, (402) 553-1200. This book deals with the different aspects of the grieving process specific to teenagers.


Where's Jess?, Ray and Jody Goldstein. Centering Corp., 1531 N. Saddle Creek Rd., Omaha, NE 68104-5064, (402) 553-1200. A booklet for siblings whose baby brother or sister dies through miscarriage, stillbirth, or newborn death. Softly introduces the changes that come in a family. Gently presented for children, 2-5 years of age.
Self-Help Resources for Crisis Response Caregivers

When Helping Hurts: Sustaining Trauma Workers (video) (Gift from Within, RR 1, Box 5108, Camden, ME; #V416-50 min., $95.00  http://www.giftfromwithin.org/html/video.html

Resources for Adults

The Grieving Guidebook Series 6 booklets - each approx. 50 pp. This series shows you how to effectively handle death in the school community, recognize student reactions to loss and develop a school intervention plan. The series includes: When Death Impacts Your School: A Guide for School Administrators - This book provides practical and immediate information about how to work sensitively and effectively with your staff and students after a death.

Helping Teens Cope with Death Adult This book explains common grief reactions of teenagers and offers advice from parents on supporting teens in grief. You’ll find helpful hints on navigating anger, guilt, and frustration as well as suggestions for coping with holidays and anniversaries. This is an invaluable resource for anyone with a grieving teen in their life.

Helping the Grieving Student: A Guide for Teachers Adult This guidebook has been developed by the Dougy Center, The National Center for Grieving Children & Families. Since 1983, the Center has worked with thousands of children, teens and their adult family members who have experienced the death of a parent, adult caregiver, sibling, or teen friend. It is written for you, the teachers and school personnel who come in direct daily contact with grieving students.

Helping Children Cope with Death Adult An in-depth look at grieving children which addresses specific developmental issues and answers the most frequently asked questions about children and grief.

35 Ways to Help A Grieving Child Adult The information on these pages is simple and practical and is drawn from the stories of children and teenagers who have been on the front lines of grief.

What About the Kids? Understanding Their Needs in Funeral Planning & Services Adult This guidebook has been developed to help parents and caregivers support their children before, during and after a funeral or memorial service. By adulthood, most of us have known someone who died and have attended a funeral. But what is a funeral like for a child or teenager who unexpectedly loses a parent, sibling, grandparent or friend? And how do you say goodbye?


http://www.parentbooks.ca/Grief & Loss.html
CRISIS TEAM RESOURCE GUIDE
HANDBOUTS
TABLE OF CONTENTS

1. Posttraumatic Stress Disorder (PTSD): A Primer for School Administrators
2. Administrators Checklist for Responding to a Crisis
4. Levels of School Crisis Interventions
5. Checklist for Determining Levels of Risk for Psychological Trauma
6. A Sample Individual Psychological First Aid Dialogue
7. Professional Behavior, Delivery Guidelines, and Things to Avoid When Conducting Psychological First Aid
8. Using A Crisis Telephone Tree
9. Tips for Adults: Coping with Cumulative Stress
10. What to Say/Not to Say
11. Teacher Tips Regarding Loss
12. Parent Tips For Helping Children Handle Tragic Events
13. Sample Student and Staff Announcements Regarding Crisis Events
14. Sample Letters for Parents/Guardians Regarding Crisis Events
15. Individual Vulnerability to Psychological Trauma Subsequent to Crisis Event Exposure
16. Possible Questions to Ask When Identifying and Prioritizing Crisis Problems
17. The Relationships Between Psychological Triage and Crisis Interventions
18. Matching Psychological Trauma Risk to the Appropriate Crisis Intervention
19. Possible Questions to Ask When Assessing Problem-Solving Resources
20. Stress Reduction Techniques for Adults and Children
21. Crisis Reactions
22. Cultural Considerations in Crisis and Loss: Group Training Exercises
23. Evaluating the School Crisis Intervention
24. Suicide Incidence Rates
25. Facts about Suicide and Depression
26. General Warning Signs of Youth Suicide
27. Protocol for Intervening with a Potentially Suicidal Student
28. Preventing Suicide in Troubled Children and Youth
29. Tips for School Personnel or Crisis Team Members
30. Preventing Youth Suicide: Tips for Parents and Educators
31. Tips for Teens to Prevent Suicide
32. Survivors of Suicide Fact Sheet
As was clearly demonstrated following the events of September 11, 2001, we are all vulnerable to the consequences of events that cause feelings of fear, helplessness, and/or horror. Given the right set of circumstances, just about anyone (regardless of how "psychologically strong" they are) will be affected to some degree by exposure to a traumatic event. [See Table 1 for a list of common effects.] However, with time most people will be able to integrate the traumatic experience into their lives and return to their typical levels of functioning. In fact, according to the National Institute of Mental Health (2002), a "sensible working principle" in the immediate aftermath of a traumatic event "is to expect normal recovery" (p. 6).

Table 1  
Common Effects of Traumatic Event Exposure

<table>
<thead>
<tr>
<th>Emotional Effects</th>
<th>Cognitive Effects</th>
<th>Interpersonal/Behavioral Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Shock</td>
<td>• Impaired</td>
<td>• Avoiding reminders</td>
</tr>
<tr>
<td>• Anger</td>
<td>• concentration,</td>
<td>• Crying easily</td>
</tr>
<tr>
<td>• Despair</td>
<td>• decision-making</td>
<td>• Change in eating patterns</td>
</tr>
<tr>
<td>• Terror/Fear</td>
<td>• ability, and memory</td>
<td>• Tantrums</td>
</tr>
<tr>
<td>• Guilt</td>
<td>• Disbelief</td>
<td>• Regression in behavior</td>
</tr>
<tr>
<td>• Phobias</td>
<td>• Confusion</td>
<td>• Risk taking</td>
</tr>
<tr>
<td>• Sadness</td>
<td>• and distortion</td>
<td>• Aggression</td>
</tr>
<tr>
<td></td>
<td>• Self-Blame</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dissociation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fatigue</td>
<td>• Headaches</td>
<td></td>
</tr>
<tr>
<td>• Insomnia</td>
<td>• Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>• Sleep difficulty</td>
<td>• problems</td>
<td></td>
</tr>
<tr>
<td>• Overly alert</td>
<td>• Decreased appetite</td>
<td></td>
</tr>
<tr>
<td>• Startle response</td>
<td>• Decreased libido</td>
<td></td>
</tr>
<tr>
<td>• Become sick easily</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes.  
Adapted from Brock and Jimerson (in press).  
Sources include Young, Ford, Ruzek, Friedman, & Gusman, (1998); and Speier, (2000).  
Examples include perceptual experience like seems “dreamlike,” “tunnel vision,” “spacey,” or on “automatic pilot.”

A minority of people will develop long-term difficulties that can significantly impair their daily functioning. The exact size of this minority will depend upon the type and severity of the traumatic event, as some events (especially acts of human violence) are more traumatic than others. Psychopathological outcomes associated with exposure to traumatic events include anxiety, substance-related, dissociative, mood, sleep, and adjustment disorders (Brock & Jimerson, in press). Among one of the more common and devastating anxiety disorders is Posttraumatic Stress Disorder (PTSD).
What is PTSD?
The diagnostic criteria for PTSD are found in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM) published by the American Psychiatric Association (2000). According to DSM, PTSD is a characteristic set of symptoms that is the consequence of “exposure” to a “traumatic stressor.” The kinds of traumatic stressors that are suggested to result in PTSD include death, threatened death, serious injury/harm, and other threats to physical integrity. Exposure is defined as directly experiencing or witnessing a traumatic event, or learning about such an event being experienced by a significant other (e.g., close friend or family member).

The general symptom classifications characteristic of PTSD are a) persistent re-experiencing of the traumatic stressor, b) persistent avoidance of reminders of the traumatic event, c) emotional numbing, and d) persistent symptoms of increased arousal. [See Table 2 for specific examples of each symptom classification.] While the symptoms of high-school-aged students may closely resemble those of adults, some middle-school students and many younger children may display a relatively unique pattern of PTSD symptoms. Specifically, their anxieties may be more generalized than those of adolescents and adults (whose symptoms are much more clearly linked to the traumatic event). For example, among younger children PTSD may manifest as a generalized fear of strangers, separation anxiety, and sleeping difficulties (including frightening dreams that are not necessarily identified as reflecting the stressor). Their re-experiencing symptoms may include repetitive play that expresses elements of, and/or specifically reenacts, the stressor. Children may also express the belief that they will not live into adulthood, believe that certain “omens” foretell traumatic event occurrence, and are likely to exhibit physical symptoms such as head- and stomachaches.

One of the key features that differentiate PTSD from the more “typical” traumatic event response (i.e., makes it a mental disorder vs. simply being a normal response to abnormal circumstances) is the duration of the symptoms. For this disorder to be diagnosed, the symptoms must be long lasting. Specifically, they must have lasted for at least one month. In addition, before this diagnosis is made DSM also requires that there be evidence of “clinically significant distress” or impairment in the individual’s daily functioning. In other words, the symptoms must cause significant disruption or difficulty in the individual’s day-to-day life. Following a school-related traumatic event, symptoms may, for example, result in a student being unable to attend school or a teacher being unable to return to work.

How Common is PTSD?
Among adults, the lifetime prevalence of PTSD is just under 8%, with women being two times more likely than men to develop the disorder. Among children and adolescents, it appears that more than 10% can be diagnosed with PTSD, with girls more than twice as likely as boys to have the disorder. As these data suggest, it appears that PTSD is more common among females and youth.

Table 2
Specific Examples of PTSD Symptoms Classifications

<table>
<thead>
<tr>
<th>Symptoms of Re-Experiencing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reoccurring intrusive and distressing thoughts, images, or feelings associated with the event.</td>
</tr>
<tr>
<td>2. Reoccurring and upsetting dreams about the trauma.</td>
</tr>
<tr>
<td>3. Behaving and/or feeling as if the trauma was happening again.</td>
</tr>
<tr>
<td>4. Intense distress (both psychological and physiological) when presented with reminders (e.g., locations, sensations, symbols, etc.) of the trauma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms of Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Deliberate efforts to avoid thoughts, feelings, discussions, activities, places, or people that are associated with and/or bring back memories of the traumatic event.</td>
</tr>
<tr>
<td>2. Inability to remember elements of the event.</td>
</tr>
</tbody>
</table>

Continued
Table 2
Specific Examples of PTSD Symptoms Classifications, continued

<table>
<thead>
<tr>
<th>Symptoms of Emotional Numbing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reduced interest in important and previously enjoyed activities.</td>
</tr>
<tr>
<td>2 Feeling all alone or detached from others and unable to react emotionally.</td>
</tr>
<tr>
<td>3 Feeling as if there is not a future.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms of Increased Arousal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Difficulty falling and/or staying asleep (sometimes a result of the re-experiencing symptom of disturbing dreams).</td>
</tr>
<tr>
<td>2 Unusually alert and easily startled.</td>
</tr>
<tr>
<td>3 Concentration difficulties.</td>
</tr>
<tr>
<td>4 Increased irritability and anger</td>
</tr>
</tbody>
</table>

Note: Adapted from the American Psychiatric Association (2000).

Following specific traumatic events, the rates of PTSD vary greatly depending upon event type and severity. For example, one review of PTSD among children and adolescents found PTSD rate estimates following a broad array of traumatic events to range from 0 to 95 percent (Saigh, Yaskik, Sack, & Koplewicz, 1999)! Clearly, some traumatic events are more stressful than others. Specifically, it appears that sudden, man-made disasters involving assaultive injury and/or threat, and/or fatalities have the potential to be highly traumatic. In addition, it appears that if the perpetrator of a violent act is a trusted adult (vs. a stranger), PTSD is more likely to develop. However, it is important to acknowledge that each crisis event is unique and, given the right set of circumstances, virtually any traumatic event has the potential to cause PTSD among a percentage of trauma victims. In particular, any event that is unusually intense and long lasting has the potential to be highly traumatic. For people who develop PTSD, this initial response must involve “intense fear,” “helplessness,” and/or “horror.” Among children this response may be manifest as “disorganized or agitated behavior.” Simply put, the more severe the fear, helplessness, or horror, the greater the risk. Not only does a severe immediate response (e.g., those who dissociate or panic) act as a powerful warning sign for PTSD, but it also influences the ability to independently, adaptively cope with the traumatic stressor. Thus, the severity of the initial reactions to the traumatic event should be an important factor used in determining who will receive crisis intervention assistance and support.

Although the diagnosis of PTSD requires symptoms to be present for at least one month, the presence of any PTSD symptom in the immediate aftermath of a traumatic stressor is reason for concern. The diagnostic category of Acute Stress Disorder (ASD) was added to the DSM (in 1994) to classify those individuals who display the symptoms of PTSD for more than 2 days but less than one month. While for many these acute symptoms will disappear with time, the diagnosis of ASD is highly correlated with PTSD and should be considered a significant warning sign. Its presence should trigger careful monitoring of affected individuals. Among those symptoms that appear to be of the greatest concerns are those that reflect an unusually high level of alertness (e.g., being easily startled) (McFarlane & Yehuda, 1996).

How Can School Principals Help?
PTSD is a very serious mental disturbance that cannot be taken lightly. Effective treatment typically requires the assistance of a clinical psychologist or psychiatrist who has specific training dealing with trauma victims. Thus, the most important role that school principals can play is to make sure that their school staffs are able to recognize risk factors and warning signs of PTSD, and know how to make appropriate referrals. While most school-based mental health professionals (e.g., school counselors and school psychologists) do not have the training needed to treat PTSD, they are typically able to assist principals in providing the staff development needed to ensure school staff members can recognize it and make appropriate referrals. Other related recommendations for school principals include the following:

1 Facilitate the development and training of crisis intervention teams. These teams are designed to assist students and staffs cope with psychologically traumatic events and to identify those who need professional mental health assistance (e.g., those with PTSD).

2 Ensure the development of a protocol for the school crisis intervention response. Such a protocol should identify specific individuals to fill specific crisis intervention roles. Among these roles is the mental health officer. This is the individual responsible for establishing referral mechanisms and monitoring student and staff crisis reactions.

63
3. **Ensure** that a range of school and community-based interventions is available for students and staff who have experienced a psychologically traumatic event. As has been previously mentioned, most individuals should be expected to recover from such exposure. However, for that minority who need professional mental health assistance, it is critical that the school has previously identified who in the local mental health community has expertise in working with trauma victims. In particular, it will be important to know who has training in a form of psychotherapy known as **cognitive-behavioral treatment**. This form of therapy has documented effectiveness in helping individuals to recover from PTSD.

References and Resources:


The Posttraumatic Stress Disorder (PTSD) Alliance. A group of professional and advocacy organizations that have joined forces to provide educational resources to individuals diagnosed with PTSD and their loved ones; those at risk for developing PTSD; and medical, healthcare, and other frontline professionals. Retrieved July 25, 2003, from http://www.ptsdalliance.org/home3.html


CRISIS TEAM RESOURCE GUIDE: READINESS, RESPONSE, AND RECOVERY

Handout 2: Administrator's Checklist For Responding To A Crisis

IMMEDIATE ACTIONS TO BE TAKEN

______ Verify information regarding crisis.
______ Notify the Office of the Deputy Superintendent of Schools, who will notify Student Services.
______ Contact crisis team leader and key support staff. Determine times for a crisis team meeting and a full staff meeting.
______ Activate the phone tree to notify staff (if after hours).
______ Cancel non-emergency appointments and meetings.

WITH CRISIS TEAM

Review team role and assign the following responsibilities:

______ Identify a family contact person.
______ Arrange for substitute teachers.
______ Identify staff members to assist substitutes and teachers who need help with reading the student announcement.
______ Write student announcement to distribute to teachers.
______ Determine triage center; arrange small and large group meeting rooms; assign staff to cover these areas.
______ Gather resource materials for students and staff.
______ Decide who will follow the student's [or teacher's] schedule for the day.
______ Establish procedure for tracking students who are counseled, as well as those in need of follow-up.
______ Establish procedure for students in need of early release.
______ Contact Student Services for a list of siblings and students living within close proximity to the persons involved in the crisis and check on these students. Ask Student Services to notify affected schools.
______ Determine the need for, and request, additional assistance from Student Services.
______ Involve students and staff, especially those who were close to the deceased, in planning a memorial. Provide guidelines for keeping plans in line with past memorials. Create a timeline, preferably within a week, for carrying out activity.

AT STAFF MEETING

______ Provide an update on the events and circumstances.
______ Distribute the student announcement and review the teacher handouts.
______ Establish the time and place the announcement is to be made.
Handout 2: Administrator's Checklist For Responding To A Crisis

_____ Emphasize the need to stick with the facts in order to reduce rumors.

_____ Identify staff in need of support and identify appropriate personnel to assist. (Utilize counselors, psychologists, PPWs, central office, etc.)

_____ Explain the protocol for requesting services, sending students to the triage site, etc. Ask staff for the names of close friends and other students most likely to be impacted.

_____ Notify staff of any activities that will be rescheduled or cancelled. Establish a post-intervention/follow-up meeting time.

THROUGHOUT THE DAY

_____ Write letter to parents; have public information officer review before sending home.

_____ Obtain memorial arrangements and submit this information to the Deputy Superintendent of Schools. If appropriate, prepare a handout with the information for students and staff.

_____ Be highly visible to show presence, support and control of the situation.

_____ Coordinate with the public information officer to determine who will respond to media contacts.

FOLLOW-UP ACTIVITIES

_____ Hold staff meeting at the end of the day, providing informational updates.

_____ Ensure follow-up of students in distress, including phone calls to parents.

_____ Provide a defusing session for staff, as needed.

_____ Make arrangements for excused absences for students [and coverage for staff] wishing to attend services.

_____ Share plans for moving forward with staff, including the rearranging of the student's desk, emptying the locker, etc.

_____ Stop any school and system notifications that might be sent home, including report cards, newsletters, etc.

_____ Continue to monitor impacted students and staff.

_____ Emphasize the need to stick with the facts in order to reduce rumors.

_____ Identify staff in need of support and identify appropriate personnel to assist. (Utilize counselors, psychologists, PPWs, central office, etc.)

_____ Explain the protocol for requesting services, sending students to the triage site, etc. Ask staff for the names of close friends and other students most likely to be impacted.

_____ Notify staff of any activities that will be rescheduled or cancelled. Establish a post-intervention/follow-up meeting time.
THROUGHOUT THE DAY

_______ Write letter to parents; have public information officer review before sending home.
_______ Obtain memorial arrangements and submit this information to the Deputy Superintendent of Schools. If appropriate, prepare a handout with the information for students and staff.
_______ Be highly visible to show presence, support and control of the situation.
_______ Coordinate with the public information officer to determine who will respond to media contacts.

FOLLOW-UP ACTIVITIES

_______ Hold staff meeting at the end of the day, providing informational updates.
_______ Ensure follow-up of students in distress, including phone calls to parents.
_______ Provide a defusing session for staff, as needed.
_______ Make arrangements for excused absences for students [and coverage for staff] wishing to attend services.
_______ Share plans for moving forward with staff, including the rearranging of the student's desk, emptying the locker, etc.
_______ Stop any school and system notifications that might be sent home, including report cards, newsletters, etc.
_______ Continue to monitor impacted students and staff.
## Handout 3: Student Services Crisis Preparedness Checklist—
A Guide for Counselors, Psychologists, Social Workers, and Pupil Personnel Workers

### Preplanning

<table>
<thead>
<tr>
<th>Activity</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review your school's crisis response plans, especially plans related to</td>
<td></td>
</tr>
<tr>
<td>mental health issues.</td>
<td></td>
</tr>
<tr>
<td>Be aware of the crisis roles and responsibilities you are expected to</td>
<td></td>
</tr>
<tr>
<td>assume</td>
<td></td>
</tr>
<tr>
<td>Discuss prevention/intervention issues specific to your school(s) with</td>
<td></td>
</tr>
<tr>
<td>administration and other school-based crisis team staff members</td>
<td></td>
</tr>
<tr>
<td>Assemble personal crisis packet that includes:</td>
<td></td>
</tr>
<tr>
<td>• The MSPA Crisis Team Resources Guide</td>
<td></td>
</tr>
<tr>
<td>• Crisis plans/materials for potential scenarios not already covered</td>
<td></td>
</tr>
<tr>
<td>within existing school crisis plans</td>
<td></td>
</tr>
<tr>
<td>• Such scenarios could include faculty/student death, terrorist acts,</td>
<td></td>
</tr>
<tr>
<td>violent student/parent, accidents, etc.</td>
<td></td>
</tr>
<tr>
<td>• Updated staff telephone tree as well as key Student Service staff</td>
<td></td>
</tr>
<tr>
<td>numbers</td>
<td></td>
</tr>
<tr>
<td>• Student, parent, staff handouts/letters for possible crisis</td>
<td></td>
</tr>
<tr>
<td>• Note accompanying disk resources for specific tragedies</td>
<td></td>
</tr>
<tr>
<td>• Defusing/Debriefing guides/checklists</td>
<td></td>
</tr>
<tr>
<td>• Referral information (Crisis Center, Employee Assistance, community</td>
<td></td>
</tr>
<tr>
<td>resources)</td>
<td></td>
</tr>
<tr>
<td>Help revise crisis plans and disseminate relevant materials as needed.</td>
<td></td>
</tr>
<tr>
<td>Maintain and locate updated crisis packets outside of school (car, home,</td>
<td></td>
</tr>
<tr>
<td>etc.)</td>
<td></td>
</tr>
<tr>
<td>Be aware of students and staff members who may be vulnerable in a</td>
<td></td>
</tr>
<tr>
<td>crisis because of past loss experiences or unique needs; prepare a list</td>
<td></td>
</tr>
<tr>
<td>of individuals who may need special support during and after a crisis</td>
<td></td>
</tr>
</tbody>
</table>

### Day 1 Planning/Response

<table>
<thead>
<tr>
<th>Activity</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support principal in activating crisis team and planning immediate</td>
<td></td>
</tr>
<tr>
<td>response. Assist with on-scene support as needed.</td>
<td></td>
</tr>
<tr>
<td>Help advise principal as to additional resources needed (Additional</td>
<td></td>
</tr>
<tr>
<td>mental health responders, Employee Assistance, community volunteers,</td>
<td></td>
</tr>
<tr>
<td>substitutes, cell phones, comfort center).</td>
<td></td>
</tr>
<tr>
<td>Identify closest friends of deceased/injured, vulnerable students who</td>
<td></td>
</tr>
<tr>
<td>might be most affected, and others who may require intervention.</td>
<td></td>
</tr>
</tbody>
</table>
Notify counselors of nearby schools and those attended by victims' siblings, children, friends.

Help prepare a student announcement that presents crisis facts, possible reactions, as well as how and where to go for school counseling support. Announcement should:
- Be factual, clear, concise, culturally and developmentally appropriate
- Respect the wishes of affected family while providing information about arrangements, etc.
- Normalize reactions and instill hope
- Urge students to support themselves, families of victims, and each other during this difficult time

Assist in assessing the need for staff handouts/written classroom discussion guides about children's reactions to death, tragedy, etc.

Help identify staff members affected by the tragedy and assistance they may need (e.g. breaks from class, support in reading the classroom announcement or leading follow-up discussion)

Separate closest friends of deceased/affected student for small-group announcement of the crisis and discussion
- Decide if individual or small-group support is needed for vulnerable students

Help develop any home letter and relevant handouts for parents that include facts, possible reactions, who to contact with problems or questions.

Help assess need for faculty debriefing, EAP involvement, extra substitutes to give breaks to affected teachers, etc., and encourage staff discussion of events and experiences

Plan logistics of the intervention

### COUNSELING SUPPORT/DEFUSING, DEBRIEFINGS

<table>
<thead>
<tr>
<th>Activity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinate activities and documentation of outside counseling support</td>
<td></td>
</tr>
<tr>
<td>Assist in class discussions of tragedy as requested, appropriate, and feasible</td>
<td></td>
</tr>
<tr>
<td>Activate resources as necessary for supporting students with special needs or for whom English is not the primary language</td>
<td></td>
</tr>
<tr>
<td>As needed, allocate counseling staff to follow the schedule of deceased or seriously injured students and close friends to support affected students</td>
<td></td>
</tr>
<tr>
<td>Meet individually or in small groups for defusing or debriefing with the deceased's closest friends and other students who would like the opportunity for such a meeting</td>
<td></td>
</tr>
<tr>
<td>Identify students in distress and develop a follow-up counseling plan for them</td>
<td></td>
</tr>
<tr>
<td>Check-in with students who have experienced recent losses, have special needs, are at risk for suicide or are emotionally vulnerable</td>
<td></td>
</tr>
<tr>
<td>Maintain an ongoing list of counseled students, vulnerable students, and follow-up plans</td>
<td></td>
</tr>
<tr>
<td>Contact parents of students in distress and suggest ongoing support/referrals as needed. Document all parent contacts</td>
<td></td>
</tr>
<tr>
<td>Encourage the activation of healthy coping strategies and the development of support networks in school (as classes, clubs, or teams)</td>
<td></td>
</tr>
<tr>
<td>Assist with faculty follow-up meetings to review events, debrief, thank staff, plan for subsequent crisis response activities, etc.</td>
<td></td>
</tr>
</tbody>
</table>
# STUDENT SERVICES FOLLOW-UP

<table>
<thead>
<tr>
<th>Activity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue counseling support and referrals of students in ongoing distress</td>
<td></td>
</tr>
<tr>
<td>Check-in with vulnerable students seen by outside counseling staff</td>
<td></td>
</tr>
<tr>
<td>Determine what follow-up should be considered for individuals needing additional support</td>
<td></td>
</tr>
<tr>
<td>Assist principal with thank you notes, condolence letters, family, hospital/funeral follow-up, etc.</td>
<td></td>
</tr>
<tr>
<td>Anticipate and plan for anniversaries and other events, which may trigger difficulty</td>
<td></td>
</tr>
<tr>
<td>Incorporate lessons learned into revised crisis plans</td>
<td></td>
</tr>
<tr>
<td>• Assess ongoing crisis preparedness of Student Services staff</td>
<td></td>
</tr>
<tr>
<td>File appropriate reports and documentation of crisis response activities</td>
<td></td>
</tr>
<tr>
<td>Re-schedule personal and professional activities you cancelled</td>
<td></td>
</tr>
<tr>
<td>Help review overall crisis response with school crisis team members:</td>
<td></td>
</tr>
<tr>
<td>• Which response was used?</td>
<td></td>
</tr>
<tr>
<td>• Who received mental health support?</td>
<td></td>
</tr>
<tr>
<td>• What worked? Didn't work? How could you tell?</td>
<td></td>
</tr>
<tr>
<td>• What must happen 12, 24, 36 hours from now?</td>
<td></td>
</tr>
<tr>
<td>• Who requires follow-up support?</td>
<td></td>
</tr>
<tr>
<td>• What resources are needed?</td>
<td></td>
</tr>
<tr>
<td>• What resources are available?</td>
<td></td>
</tr>
<tr>
<td>• What are our specific next steps? What? When? Where? By whom?</td>
<td></td>
</tr>
</tbody>
</table>

# CARE FOR THE CAREGIVER

<table>
<thead>
<tr>
<th>Activity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remember that you have been exposed to trauma and stress</td>
<td></td>
</tr>
<tr>
<td>Be aware of the impact of your past experiences and unique situation on your current functioning</td>
<td></td>
</tr>
<tr>
<td>• Excuse yourself from crisis response if past experiences or personal situations are affecting your ability to provide support</td>
<td></td>
</tr>
<tr>
<td>Be alert to signs of your own stress</td>
<td></td>
</tr>
<tr>
<td>Activate healthy coping strategies</td>
<td></td>
</tr>
<tr>
<td>Eat healthy foods, drink plenty of fluids, exercise</td>
<td></td>
</tr>
<tr>
<td>Ask for support from team members, colleagues, friends, and family as needed</td>
<td></td>
</tr>
<tr>
<td>Contact Employee Assistance or the local Crisis Center as necessary</td>
<td></td>
</tr>
</tbody>
</table>
**Indicated Crisis Interventions**
Provided to those who were severely traumatized
Typically a minority of crisis survivors
Depending upon the nature of the crisis can include a significant percentage

**Selected Crisis Interventions**
Provided to those who were moderately to severely traumatized
Following highly traumatic crisis can include an entire school

**Universal Crisis Interventions**
Provided to all students who were judged to have some risk of psychological traumatization
Depending upon the nature of the crisis can include an entire school

*Indicated Crisis Interventions* Provided to those who were severely traumatized Typically a minority of crisis survivors Depending upon the nature of the crisis can include a significant percentage *Selected Crisis Interventions* Provided to those who were moderately to severely traumatized Following highly traumatic crises can include an entire school *Universal Crisis Interventions* Provided to all students who were judged to have some risk of psychological traumatization Depending upon the nature of the crisis can include an entire school

From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
# Handout 5: Checklist for Determining Levels of Risk for Psychological Trauma

## CRISIS TEAM RESOURCE GUIDE: READINESS, RESPONSE, AND RECOVERY

## Checklist for Determining Levels of Risk for Psychological Trauma

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Proximity</strong></td>
<td><strong>Physical Proximity</strong></td>
<td><strong>Physical Proximity</strong></td>
</tr>
<tr>
<td>Out of vicinity of crisis site</td>
<td>Present on crisis site</td>
<td>Crisis victim or eyewitness</td>
</tr>
<tr>
<td><strong>Emotional Proximity</strong></td>
<td><strong>Emotional Proximity</strong></td>
<td><strong>Emotional Proximity</strong></td>
</tr>
<tr>
<td>Did not know victims(s)</td>
<td>Friend of victims(s)</td>
<td>Relative of victim(s)</td>
</tr>
<tr>
<td></td>
<td>Acquaintance of victims(s)</td>
<td></td>
</tr>
<tr>
<td><strong>Internal Vulnerabilities</strong></td>
<td><strong>Internal Vulnerabilities</strong></td>
<td><strong>Internal Vulnerabilities</strong></td>
</tr>
<tr>
<td>Active coping style</td>
<td>No clear coping style</td>
<td>Avoidance coping style</td>
</tr>
<tr>
<td>Mentally healthy</td>
<td>Questions exist about pre-crisis mental health</td>
<td>Pre-existing mental illness</td>
</tr>
<tr>
<td>Good self-regulation of emotion</td>
<td>Some difficulties with self-regulation of emotion</td>
<td>Poor self-regulation of emotion</td>
</tr>
<tr>
<td>High developmental level</td>
<td>At times appears immature</td>
<td>Low developmental level</td>
</tr>
<tr>
<td>No prior trauma history</td>
<td></td>
<td>Significant prior trauma history</td>
</tr>
<tr>
<td><strong>External Vulnerabilities</strong></td>
<td><strong>External Vulnerabilities</strong></td>
<td><strong>External Vulnerabilities</strong></td>
</tr>
<tr>
<td>Living with intact nuclear family members</td>
<td>Living with some nuclear members</td>
<td>Not living with any nuclear family members</td>
</tr>
<tr>
<td>Good parent/child relationship</td>
<td>Parent/child relationship at times stressed</td>
<td>Poor parent/child relationship</td>
</tr>
<tr>
<td>Good family functioning</td>
<td>Family functioning at times challenged</td>
<td>Poor family functioning</td>
</tr>
<tr>
<td>No parental traumatic stress</td>
<td>Some parental traumatic stress</td>
<td>Significant parental traumatic stress</td>
</tr>
<tr>
<td>Adequate financial resources</td>
<td>Financial resources at times challenged</td>
<td>Inadequate financial resources</td>
</tr>
<tr>
<td>Good social resources</td>
<td>Social resources/relations at times challenged</td>
<td></td>
</tr>
<tr>
<td><strong>Threat Perceptions</strong></td>
<td><strong>Threat Perceptions</strong></td>
<td><strong>Threat Perceptions</strong></td>
</tr>
<tr>
<td>Crisis not viewed as threatening</td>
<td>Crisis viewed as dangerous, but not a life threat</td>
<td>Crisis viewed as life threatening</td>
</tr>
<tr>
<td><strong>Crisis Reactions</strong></td>
<td><strong>Crisis Reactions</strong></td>
<td><strong>Crisis Reactions</strong></td>
</tr>
<tr>
<td>Only a few common crisis reactions displayed</td>
<td>Many common crisis reactions displayed</td>
<td>Mental health referral indicators displayed</td>
</tr>
<tr>
<td>Coping is adaptive</td>
<td>Coping is tentative</td>
<td></td>
</tr>
</tbody>
</table>

## Comments:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
CRISIS TEAM RESOURCE GUIDE:
READINESS, RESPONSE, AND RECOVERY

Handout 6: A Sample Individual Psychological First Aid Dialogue

This crisis situation begins with an intermediate grade student, Chris, crying in a corner of a schoolyard, just out of view of the playground. Two days earlier, Chris had witnessed a schoolyard shooting.

Establish Rapport

Counselor: Hi. I'm Mr./Ms. Sanchez. What's your name?
Chris: Chris.
Counselor: Are you cold, Chris? Can I get you a jacket?
Chris: No, I'm okay.
Counselor: Chris, I'm here to try and help the kids at your school deal with the shooting. You look sad. Can you tell me what's wrong?
Chris: (Through tears Chris says) I'm scared. I think I know why, but could you tell me why you're scared?
Counselor: I'm afraid of being shot.
Chris: I'm afraid of being shot. (The counselor places an arm around Chris' shoulder.) I understand why you are crying. Would it be okay if we talked? I would like to help.
Chris: Okay.
Counselor: Chris, before we talk about the shooting is there anything you need right now? Are you sure you don't need your jacket? (It is a cold January day.) Are you thirsty or hungry?
Chris: Yes, I guess I would like to get my jacket.
Counselor: (As Chris and Mr./Ms. Sanchez go to get the jacket it becomes clear that Chris is able to begin the problem-solving process. Chris is responsive to questioning and while very scared, appears to have his/her emotions under control.)

Identify and Prioritize Crisis Problem

Counselor: Do you think you could tell me about what happened to you the other day?
Chris: Yes. I was standing right over there (Chris looks around the corner and points to the kickball field). I was waiting my turn when the shooting started. At first I didn't know what was happening. Then I saw all the kids screaming and falling to the ground. My friend Sam was bleeding from the foot. (Chris begins to cry again.) That sounds really scary. So the reason you are not going on the playground is that you are afraid, right?
Counselor: Yes.
Chris: You know you're not alone. A lot of kids feel the same way you do.
Counselor: Before now, have you told anyone about being afraid to go out to play?
Chris: No.
Counselor: Are there people who you can talk to?
Chris: Yes. I would like to talk to Sam.
Counselor: Sam was bleeding from the foot, right?
Chris: Yes, and I really need to see Sam. Is Sam okay? Can I talk to her?
Counselor: So you are also worried about your friend, right?
Chris: Yes.
Counselor: I don't know Sam, but I can find out how she is doing right after recess. For now, however, we need to decide what we are going to do about recess. We need to 'make sure you are safe and we can't do that if you hide during recess. Is there anyone else who might be able to help you not be scared of the playground?
Chris: My mom, my teacher, my other friends (pause), and you. (Chris looks up at the counselor as the crying begins to subside again.)

**Address Crisis Problems**

Counselor: We can look into talking to Sam after recess. But for now what can we do about your recess time? What have you done so far about being scared to play?
Chris: I've hid in here or in the restroom. Once I stayed in class with my teacher.
Counselor: Look out on the playground and tell me what you see. Chris: (Chris looks around the corner and at the playground.)
Chris: Kids are playing.
Counselor: Are they having fun?
Chris: Yes. (A tentative smile briefly flashes across Chris' face.)
Counselor: Who are those people over there and there? (The counselor points in the direction of the two police officers that have been temporarily assigned to the school after the shooting.)
Chris: Police.
Counselor: I think that it is safe to go out on the playground today. And your friends look like they can still have fun playing kickball. Do you think that anyone will hurt you on the playground today?
Chris: No.
Counselor: So if it's safe and still fun, why not try going out and playing again?
Chris: Yes. But I'm still scared. (Chris' eyes become teary.)
Counselor: Okay. Let's see what we can do to help you not be scared. What if your friends helped you? What if I stayed on the playground and watched you?
Chris: That might help. (Chris' tears subside.)
Counselor: I'll go talk to your friends and see what I can do about getting them to include you in their kickball game. (The counselor approaches Chris' friends and explains the problem to them. They readily agree to invite Chris to play. One member of the group walks over to Chris and says ...)  
Friend: Chris, kickball is still fun. Will you please come and play with us?  
Chris: Okay. (The friend puts an arm on Chris' shoulder and begins to walk toward the playground.)

**Review Progress**

Counselor: Before you go, Chris, can you give me your last name and your classroom? I'd like to be able to check up on you to make sure you are okay.  
Chris: Sure. My last name is Smith, and I'm in Mrs. Wong's classroom.  
Counselor: I'll be standing right over there. (The counselor points to an area just off the playground within view of the kickball field.) I'll be there during the rest of today's recess. When the bell rings in a few minutes come over and see me and we can look into how Sam is doing.  
Chris: Okay. (Chris has stopped crying and is smiling as s/he walks with the group of friends out onto the playground.)

*Note. Compilation of several playground conversations following the Stockton schoolyard shooting in January 1989.*

From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
Handout 7: Professional Behavior, Delivery Guidelines, and Things to Avoid When Conducting Psychological First Aid
(Source: The National Center for Child Traumatic Stress, 2005, pp. 5-7)

Professional Behavior
• Operate only within the framework of an authorized disaster response system.
• Model sound responses; be calm, courteous, organized, and helpful.
• Be visible and available.
• Maintain confidentiality as appropriate.
• Remain within the scope of your expertise and your designated role.
• Make appropriate referrals when additional expertise is needed.
• Be knowledgeable and sensitive to issues of culture and diversity.
• Pay attention to your own emotional and physical reactions, and actively manage these reactions.

Guidelines for Delivering Psychological First-Aid
• Politely observe first; don't intrude. Then ask simple, respectful questions, so you can determine how you may help.
• Initiate contact only after you have observed the situation, and the student or family has determined that contact is not likely to be an intrusion or disruptive.
• Be prepared to be either avoided or flooded with contact by affected students, and make brief but respectful contact with each student who approaches you.
• Speak calmly. Be patient, responsive, and sensitive.
• Speak in simple, concrete terms; don't use acronyms. If necessary, speak slowly.
• If students want to talk, be prepared to listen. When you listen, focus on learning what they want to tell you and how you can help.
• Acknowledge the positive features of what the student has done to keep safe.
• Adapt the information you provide to directly address the student's immediate goals. Clarify answers repeatedly as needed.
• Give information that is accurate and age-appropriate, and correct inaccurate beliefs. If you don't know, tell them this and offer to find out.
• When communicating through a translator, look at and talk to the student you are addressing, not at the translator.
• Remember that the goal of psychological first-aid is to reduce distress, assist with current needs, and promote adaptive coping, not to elicit details of traumatic experiences and losses.

Things to Avoid
• Do not make assumptions about what the student is experiencing or what he/she has been through.
• Do not assume that everyone exposed to a disaster will be traumatized.
Handout 7: Professional Behavior, Delivery Guidelines, and Things to Avoid When Conducting Psychological First Aid

• Do not pathologize. Most acute reactions are understandable and expectable given what students exposed to the disaster have personally experienced. Do not label reactions as "symptoms," or speak in terms of "diagnoses," "conditions," "pathologies," or "disorders."

• Do not suggest fad interventions or present uninformed opinions as facts.
• Do not speculate or offer erroneous or unsubstantiated information. If you don't know something that you are asked, do your best to learn the facts.
• Do not talk down to or patronize students, or focus on their helplessness, weaknesses, mistakes, or disability. Focus instead on what the student has done that is effective or may have contributed to help others in need, both during the disaster and now.
• Do not assume that all students want to talk or need to talk to you. Often, being physically present in a supportive and calm way helps affected people feel safer and more able to cope.
• Do not "debrief by asking for details of what happened.

From the National Association of School Psychologists' School Prevention and Intervention Training Curriculum. Used with permission.
Handout 8: Using A Crisis Telephone Tree

The phone tree must be reviewed with all staff each year. Remember to include all staff - school psychologists, PPWs, bus drivers, cafeteria workers, building maintenance workers, and other support staff-in communication and in as many meetings as possible.

Handouts should go to all staff.

When you receive a call about a school crisis, it is critically important that you relay the information to the next person on your list. If a person on your list does not answer, call the next person assigned to that person so that the information tree is not broken. Continue calling anyone who does not answer until connection is made.

Suggestions For Making The Call:

• Begin with a statement such as, "I'm sorry to have to call with bad news."
• Ask the person to get paper and pencil to write specifics if they will be calling another person.
• Give the specifics of the event, as you know them.
• Give the details of the before-school meeting: where, when, that it is required, that further details will be made available.
• Remind them not to speculate - just pass on essential information.
As the community continues to cope with the current crisis, many people may begin to show signs of the cumulative effects of stress. Stress from one incident may not be fully resolved before another incident occurs and triggers stress once again. Considering the prolonged effects of major crisis events such as Columbine, September 11, and Virginia Tech., the continued random violence affects people, young and old, with special intensity.

It is very important that all of us are aware of our own stress levels and work to lower them when necessary, especially when we are charged with supporting children. As parents, teachers, counselors, administrators, crisis responders, or other educators, caring for ourselves is an essential first step to taking care of our children. There are warning signs that individual can identify as a result of repeated exposure to stress.

**SIGNS OF CUMULATIVE STRESS**

*Early warning signs*
- Boredom
- Fatigue
- Anxiety
- Depression
- Poor concentration

*Mild signs*
- Memory problems
- Increased illness

*Extended signs*
- Relationship problems
- Increased alcohol/drug use
- Performance changes
- Fear of leaving home

*Severe signs*
- Relationship changes
- Health changes
- Personality changes
- Becoming housebound

It is critical to address signs of cumulative stress as soon as they begin. Contact the local/county crisis center if you have concerns about how you are reacting. The Employee Assistance Program at your workplace is another source of support, as is your family physician.

**What helps?**
- Activating some healthy coping strategies can ease the cumulative effects of stress.
Handout 9: Tips For Adults: Coping With Cumulative Stress

• Create a daily routine to help regain a sense of control
• Eat balanced, healthy meals
• Get extra rest to let your body relax and recover
• Exercise
• Let frustration and anger out through safe, exhausting physical activity
• Ask for support from friends, colleagues, and loved ones
• Avoid alcohol, drugs, and tobacco
• Limit caffeine
• Don't dwell on news of the crisis. Gather the information you need, then turn off the TV or radio
• Be aware of the impact of your own past experiences on your current functioning
• Seek mental health assistance when you are concerned about your reactions

Remember:
• Some behavior change following a crisis is a typical response to an extraordinary situation
• Behavior changes following a crisis are generally temporary
• Each person responds to crisis in different ways and moves through the crisis at his or her own pace
• You are not alone. Many in our community are sharing these reactions and feelings
• It is a sign of strength - not weakness - to ask for help when it is needed
Handout 10: What To Say/Not To Say

Adapted from: *What To Do When Someone Dies*
Buz Overbeck - Joanie Overbeck TLC Group -
Dallas, Texas 1995

Although many people want to comfort and help the bereaved, the stress and anxiety of the encounter sometimes makes it difficult to know what is actually helpful. Often, the phrase that is meant to help actually produces more pain and distress. What follows is a partial list of phrases that have been found to be helpful (or hurtful) in comforting the grieving person.

**WHAT TO SAY**
I'm sorry.
I'm sad for you.
How are you doing with all this?
I don't know why it happened.
What can I do for you?
I'm here, and I want to listen.
Please tell me what you are feeling.
This must be hard for you.
What's the hardest part for you?
I'll call you tomorrow.
You must really be hurting.
It isn't fair, is it?
You must really feel angry.
Take all the time you need.
Thank you for sharing your feelings.

**WHAT NOT TO SAY**
I understand how you feel.
Death was a blessing.
It was God's will.
It all happened for the best.
You're still young.
You have your whole life ahead of you.
You'll feel worse before you feel better.
You can have other children.
You can always remarry.
Call me when I can help.
Something good will come out of this.
At least you have another child.
He (She) led a full life.
It's time to put it behind you now.
Be strong.

TLC Group grants anyone the right to use this information without compensation so long as the copy is not used for profit or as training materials in a profit-making activity such as workshops, lectures, and seminars, and so long as this paragraph is retained in its entirety.
Handout 11: Teacher Tips Regarding Loss

**Elementary Aged Students**

Situations of loss and grief are uncomfortable for all of us. As a teacher, you can create a supportive environment where students can express their feelings and learn to cope. Students already know and trust you. They will appreciate the opportunity to talk about the situation in a secure environment. They can learn by observing your manner in dealing with this painful situation.

1. Provide children with the facts in a calm, caring manner.
2. Define "death," "separation," and/or "loss."
   - Assess students' knowledge and eliminate misconceptions.
   - Limit your discussion to physical aspects rather than religious.
   - Discuss students' past experiences with loss (relatives, pets, etc.).
3. Encourage students to recognize, express, and accept related feelings of anger, sadness, confusion, and denial.
4. Accept behaviors of children that may be expressions of grief.
   - Look for obvious behaviors like crying, sulking, withdrawing.
   - Be aware that behaviors like fighting, laughing, silliness, paradoxical behavior for a particular child (hyperactivity, disorganization, disorientation) may also be expressions of grief and are very common among children.
5. Remember, most children do not understand that death is permanent until they are approximately **9 years old**.
6. Help children understand that although they may have been angry with the person who has died, their anger did not cause the death. **This is quite important!**
7. Talk about your own feelings regarding loss if you are able.
8. Remember that handling grief is a process that takes place over time and may include identifying, labeling, expressing, and resolving feelings

**Tips For Secondary Level Teachers Handling Crisis**

As hurtful as it is, tragedy can bring people together and can provide opportunities for growth and new understanding. The following are some thoughts for consideration as you speak with students today:

1. Provide students with the facts in a calm, caring manner.
2. The students know and trust you. They will appreciate the opportunity to talk about the situation in a secure environment. They can learn from the manner in which you deal with this difficult topic.
3. If you are comfortable with a discussion, allow students to talk about what they have heard about what has happened, but remind them that the facts may be different from rumors. Tell them that you will keep them informed.

4. Some students may not know the student/staff member in crisis. Others won't have much personal reaction to the situation. Still other reactions may be inappropriate and appear to be inconsiderate. This is because students may not be comfortable talking about this situation because of memories of their own life. Do not force anyone’s involvement, and move back into your normal curriculum as soon as it is comfortable. Normalcy is a comfort, and providing it with compassion is our mission.

5. Allow yourself some time as well. Ask for support and assistance as needed. None of us can tend to the needs of our students unless we also tend to our own.

6. If you need assistance, please contact main or guidance offices.

**In The Event Of An Attempted Or Completed Suicide, Special Consideration Is Needed:**

1. Students often have either friends who have thought about suicide or have entertained those thoughts themselves. Help students, if appropriate, brainstorm alternative courses of action, school, and community resources.

2. Many of the students will feel guilty for either not having tried to help or being unable to help avoid this tragedy. Guilt has only limited value and needs to be worked through as quickly as possible.

3. Remind students of what they can do to help prevent tragedies by:
   - listening;
   - taking someone else's concerns seriously; and
   - contacting an adult who can help.

**Teaching Classes Following A Death**

The days and weeks that follow a student's death can have a profound effect upon the classroom environment. Educators have suggested several strategies to assist teachers in making these days complimentary to the grief process.. These suggestions will be useful in regaining a sense of normalcy:

- Don't be impassive about a student's death. Talk about it and share your own reactions as appropriate.
- Let students have time to talk or write about their reactions as the subject arises. Don't be concerned that this will take an inordinate amount of time, as it will diminish if allowed to occur after the loss.
- Work with your building Crisis Response Team to have factual information in the event of questions from students.
- Try to balance a "regular day" with opportunities for students to grieve. Too much or too little structure will not be productive for you or your students.
- Talk about ways to express grief to each other or how to respond to another's grief.
• Talk about what to do with the empty desk. Students may have intense reactions if it is removed too quickly. Let them be part of the decision-making process, as it will help them with their own grieving.
• Remember that your class has looked to you as a model in many situations and will continue to do so following a death. Your responses and comfort can provide much needed security.
• Expect unusual behavior. Daydreaming, lack of concentration, withdrawal, misbehavior, absenteeism, somatic complaints and fears may be some of the behaviors you observe or hear students discuss.
• Refer students for help when necessary.
• Be aware of literature and stories that may be helpful for your class.

Remember — Death Is A Natural Part Of Life And, As Such, A Natural Topic In The Classroom.
Write a eulogy
Design a yearbook page commemorating the deceased
Write stories about the victim or the accident
Draw pictures of the incident
Debate controversial issues
Investigate laws governing similar incidents
Create a sculpture
Create a class banner *in memoriam*
Build a fitness course, a sign for the school or a bulletin board in memory
Discuss ways to cope with traumatic situations
Discuss the stages of grief
Conduct a mock trial if laws were broken
Start a new school activity such as a SADD unit if a child was killed by a drunk driver.
Encourage students to keep a journal of events and of their reactions, especially in an on-going situation
Place a collection box in the class for notes to the family
Urge students to write the things they wish they could have said to the deceased
Practice and compose a song in memory of the deceased
Discuss alternatives for coping with depression if suicide was involved
Encourage mutual support
Discuss and prepare children for funeral (what to expect, people's reactions, what to do, what to say)
Direct energy to creative pursuits, physical exercise or verbal expression when anger arises
Create a class story relevant to the issue
Children sense the anxiety and tension in adults around them.

Each child responds differently to tragic events, depending on his or her experiences, understanding and maturity.

Children will interpret the tragic event as a personal danger to themselves and those they care about.

Your child needs to talk about his or her feelings.

**Signs of Stress**

Parents should be alert to these changes in a child's behavior now or in the future:

- Persistent fears related to the incidents (such as fears about being hurt or being permanently separated from parents)
- Sleep disturbances such as nightmares, screaming during sleep, and/or bedwetting which persist more than several days after the event
- Loss of concentration and irritability
- Change in activity level
- Behavior problems, such as, misbehaving in school or at home in ways that are not typical of the child
- Physical complaints (stomachaches, headaches, dizziness) for which a physical cause cannot be found
- Withdrawal from family and friends, sadness, listlessness
- Preoccupation with the events of the incident

**Age Appropriate Suggestions for How Parents Can Talk to Their Children at Home**

- Children need comforting and frequent reassurance that they're safe. Make sure they get it.
- Be honest and open about the tragic event, but keep information age-appropriate.
- Encourage children to express their feelings through talking, drawing, or playing.
- Try to maintain your daily routines as much as possible.

**Pre-School Age Children**

- Reassure young children that they're safe.
- Provide extra comfort and contact by discussing the child's fears at night, by telephoning during the day and with extra physical comforting.
- Get a better understanding of a child's feelings about the tragic event.
• Discuss the tragic event with them, and find out each child's particular fears and concerns.
• Answer all questions they may ask and provide them with loving comfort and care.

*Grade-School Age Children*

• Provide realistic assurance.
• Avoid saying tragic events will never affect your family again; children will know this isn't true.
• Instead say, "You're safe now, and I will always try to protect you," or "Adults are working very hard to make things safe."
• Monitor children's media viewing.
• Images of the tragic event are extremely frightening to children, so consider limiting the amount of media coverage they see. A good way to do this without calling attention to your own concern is to regularly schedule an activity - story reading, drawing, movies, or letter writing, for example - during news shows.
• Allow them to express themselves through play or drawing.
• As with younger children, school-age children sometimes find comfort in expressing themselves through playing games or drawing scenes of the tragic event. Allowing them to do so, and then talking about it, gives you the chance to "retell" the ending of the game or the story they have expressed in pictures with emphasis on personal safety.
• Don't be afraid to say "I don't know."
• Part of keeping discussion of the tragic event open and honest is not being afraid to say you don't know how to answer a child's question. When such an occasion arises, explain to your child that tragic events are extremely rare and may cause feelings with which even adults have trouble dealing. Temper this by explaining that, even so, you will always work very hard to keep your child(ren) safe and secure.

*Adolescents — Special Concerns*

• Children with existing emotional problems such as depression may require careful supervision and additional support.
• Monitor their media exposure and information they receive on the Internet.
• Adolescents may turn to their friends for support. Encourage friends and families to get together and discuss the event to allay fears.
• Be aware that some adolescents may express their feelings through risky behaviors.

*Reassure Your Children of Their Safety at School*

• Reassure your child that adults and school are keeping them as safe as possible.
• Remind your child that if they need to talk while at school, that school staff (teachers, counselors and others) are available to talk with them.
• Encourage your child to go about their daily routine at school, just as you will at home.
TIPS FOR HELPING TRAUMATIZED CHILDREN

These suggestions are offered as essential guidelines to use during times of crisis in the lives of children and teenagers. (Healing Magazine, Therapist's Corner, Spring 2002)

Children should be encouraged to:

- Talk. Talking to trusted adults is strongly encouraged, not only to express concerns and fears, but also to get answers that were accurate from those they trust.
- Express their feelings. Helping children verbalize and understand their safety concerns should normalize what are often powerful and frightening reactions to traumatic events.
- Limit television. Children and even young teens are advised to limit repeated exposure to graphic media images of the events. Continued exposure increases the likelihood of adverse reactions both short- and long-term.
- Get involved. Offer children ways of helping or getting involved in the efforts of their community. Give children the message that being young does not prevent them from helping others.
- Get back to things they like. Children are encouraged to continue doing things that are fun, enjoyable, and routine as soon as possible. Routine activities are powerful in helping to reduce anxiety and fear.
- Be on the lookout for warning signs. Children are encouraged to be aware of headaches, stomachaches, nightmares, feeling sad, trouble sleeping or eating, increased arguing with family or friends, school refusal, trouble concentrating, or not wanting to be alone (for younger children). Behavioral and somatic complaints are characteristic of excessive worry, anxiety, and depression.

Parents should be encouraged to:

- Listen carefully to what children are saying. Giving children answers to their questions while letting them know their parents care about them is essential, especially during times of crisis.
- Provide their children with answers that are age-appropriate and easily understood.
- Reassure their children of their safety. While not telling children it can never happen to them, parents should let them know it is very unlikely and that there are people to protect them. It is likely that children will need to be assured of this many times over the weeks or months following the trauma.
- Limit continued viewing of graphic violence associated with the event.
- Remember that teens get scared too. Parents should not forget that even teens need to be reassured that they are safe.
- Take care of themselves. Parents were encouraged to watch themselves for the same behavioral and somatic complaints listed above.
- Be open to professional consultation, if necessary. Parents are urged to seek professional advice from their family physician or mental health professional if symptoms appear and remain for more than two weeks.
WHAT CAN I DO AS A PARENT?

As a surviving parent, there are several things that can be done to support the grieving child.

- Explain the death in a clear and direct manner. If the remaining parent cannot do this, then the child should be informed by another adult who is close to the child.
- The child should be told the dead person will never return and that the body will be buried in the ground or burned to ashes.
- The remaining parent should not deny the child an opportunity to share in the expression of pain.
- Adults should avoid using children as confidants for their own comfort and understanding.
- The single most important message to relay to the child is, "You are not alone; I am with you."
- Touching and holding a child can do more than any words to relay a parent's message.
- Children should be allowed to attend the funeral, if it is their wish.
- Prior to the funeral someone should explain to the children what is likely to take place, who will be there, and how people are likely to react.
- The choice of whether to view or touch the deceased should be left up to the child.
- It is important to establish continuity in the daily routines of children.
- Changing to a new school or moving to a new neighborhood should be postponed.
- If it is determined that a child is experiencing pathological grief, rather than grief reactions, counseling may be necessary in order to help facilitate the grieving process.

Children Need the Structure of Family Support

When someone dies, parents may forget that this may be the first death their child has ever experienced. There are many new issues, adjustments, and events for which children need firm structure. Consider the following very partial list of what children may encounter for the first time:

- Understanding the concept of death
  - Experiencing family members' grief reactions
  - Sensing the inability to bring a loved one back
  - Seeing their first dead person
  - Seeing a dead relative for the last time
  - Experiencing hopelessness
  - Wondering why people are put in the ground or crypt or cremated
  - Recalling, as time proceeds, all the automatic reactions of the dead loved one
  - Feeling a strong sense of emptiness
Today we received tragic news. We were informed that one of our students, ____, died from (Give any details which are known and relevant here).

When events such as this happen, people react in many different ways. Today you may see people acting sad, upset, angry or shocked. We all need to practice patience and respect for each other. Some of us will want to have quiet time or time to talk with an adult. Some of us will be ready to return to academics sooner than others.

We can take some time to talk about this now. When most of the students are ready to return to our regular schedule, we will do so.

If you need to talk to an adult, there will be counselors available for you today in the "Safe Room" (identify location in building). You will need to take a pass and sign-in in the Safe Room when you arrive.

The school day will remain on schedule. Students are expected to stay at school and be in rooms with adults present.

, Principal
**ACCIDENT INVOLVING STUDENT**

Staff Memo (from Principal):

Last night, ________________________________, a fourth grader in Room 204, was hit by a car while she was out trick-or-treating with two other girls, students in middle school. She is at __________ Hospital in very critical condition. Officer _____________________________ of the police department came to school this morning to report the accident. He suggested that we have an assembly for all students. We will meet at 9:30 a.m. in the Multi-Purpose Room for approximately 20 minutes. At that time, we will tell the children about the accident and then discuss basic safety. Our school psychologist, ____________________________, will be available after the assembly to assist any individual children and/or classrooms who are having difficulty understanding or dealing with this situation. Our school counselor, ____________________________, will spend the morning in Room 204 to provide some extra support to the children and their teacher.

I have written a letter to parents that will be ready to go home with all students this afternoon. It has been suggested that students might want to draw pictures or make cards to send to __________ or her family. This will provide the children with an opportunity to release their feelings and will bring some closure to the tragedy.

Sincerely,

Principal

**DEATH OF A TEACHER**

**STATEMENT TO TEACHERS AND STAFF MEMBERS**

It is with great sadness that I share with you that today we were informed of the death of our colleague, Gwen Smith, our kindergarten teacher. A statement was delivered to our school in a sealed envelope by one of Gwen's family members. At this time, I would like to share the letter with you. (share the letter)

We will all share in the family's sorrow and will miss ________'s presence in our building.

I would like each teacher to make an announcement to their students on Monday. A statement will be prepared for you to read. We will have members of our school system's crisis team available to assist any students who you feel may need assistance.

(please feel free to modify)
ELEMENTARY SCHOOL

Teachers,

The following statement is to be made to your students regarding the sad news that has touched our school:

Last night, Joe Student, a first grade student at our school died suddenly. At the time we are unsure of the cause of his death. We extend our deepest sympathies to his family.

If you feel that one of your students may need some help in dealing with this news, please contact Ms. School Counselor (or Ms. Secretary). She will notify the Traumatic Loss Counselors who are standing by to lend any assistance needed.

______________________________

ANNOUNCEMENT TO _____________ ELEMENTARY SCHOOL STUDENTS

TEACHERS, PLEASE READ THE FOLLOWING STATEMENT DURING THE AM HOMEROOM PERIOD:

We were saddened to learn that one of our pre-kindergarten teachers, Ms.____________ passed away during the weekend. Neither specific details regarding her death, nor viewing/funeral service arrangements are known at this time. That information will be provided as soon as it becomes available. Our thoughts are with Ms. 's family and friends as we extend our condolences.

TEACHERS:

After the above statement is read, it may be helpful to allow students some time to express their thoughts and feelings. Try, however, to continue with normal class routines for all students. Should you have students in your classes who are obviously not coping well with the news, please refer them to the (Guidance Suite, Library, Cafeteria, etc.). We will have Crisis Team members available to work with students today. Thanks for your support in this matter.
ANNOUNCEMENT TO ______________ ELEMENTARY SCHOOL STUDENTS

TEACHERS, PLEASE READ THE FOLLOWING STATEMENT DURING THE A.M. HOMEROOM PERIOD:

Yesterday, several students and faculty members saw a family emergency take place in our school. It was a hectic day for the students and staff involved which left some people scared. ______________ Elementary school staff, however, worked really hard as a team to help. Fortunately, no one was hurt. No more details are known at this time. That information will be provided as soon as it becomes available. Our thoughts are with the _____ family during this difficult time.

TEACHERS
After the above statement is read, it may be helpful to allow students some time to express their thoughts and feelings. Try, however, to continue with normal class routines for all students. Should you have students in your classes who are obviously not coping well with the news, please refer them to the (Guidance Suite, Library, Cafeteria, etc.). We will have Crisis Team members available to work with students today. Thanks for your support in this matter.

TEACHERS, PLEASE READ THE FOLLOWING TO YOUR FIRST PERIOD STUDENTS AT 7:55 THIS MORNING:

We were saddened to learn of the death of Joe Student, member of the Class of 199- Joe died in a car accident on Friday evening. At this time, nothing more is known concerning the accident.

The family has not finalized plans for the viewing or the funeral services. When the arrangements have been made, this information will be shared with faculty and students. We will miss Joe and extend our condolences to the family.

TEACHERS
After reading the above statement, it may be helpful to allow students some time to express their thoughts and feelings. Try, however to continue with normal class routines for all students. If you have students in your classes who are obviously not coping well because of the news, please refer them to the Guidance Office. We will have Crisis Team members available to work with students today. Thanks for your support in this matter.
ANNOUCMENT TO ____________ HIGH SCHOOL STUDENTS

TEACHERS, PLEASE READ THE FOLLOWING STATEMENT DURING THE A.M. HOMEROOM PERIOD:

We were saddened to learn that one of our students, __________, unexpectedly passed away during the weekend. She was reportedly struck by an automobile and died from her injuries. Specific details regarding viewing/ funeral service arrangements are not known at this time. That information will be provided as soon as it becomes available. Our thoughts are with ________________________________’s family and friends as we extend our condolences.

TEACHERS:
After the above statement is read, it may be helpful to allow students some time to express their thoughts and feelings. Try, however, to continue with normal class routines for all students. Should you have students in your classes who are obviously not coping well with the news, please refer them to the (Guidance Suite, Library, Cafeteria, etc.). We will have Crisis Team members available to work with students today. Thanks for your support in this matter.

READ TO STUDENTS FOLLOWING THE MORNING ANNOUNCEMENTS ON THE P.A. AND DAILY BULLETIN

It is with great sadness that I inform you that on Saturday, September 8, Jamie A., an eleventh grade student at _____ High School, died early in the morning from injuries sustained in an accident at a family residence.

Reactions to this incident may vary for each of you. As well as sadness, there may be feelings of anger, frustration, helplessness or even guilt. A Crisis Intervention Team has been formed. Our school counselors, Mr. H., Mr. C., and Ms. W., along with other counselors from the school system will be available throughout the next few days. Students who feel they would like to talk to someone may get a pass signed from their teacher at any time.

A letter with further information will be sent home with you at the end of the day. Thank you.

• Read tips on dealing with grief. Allow students time to talk as your comfort level and theirs allow.
• If a student is seriously in distress, have a trusted person accompany him/her to guidance and then ask the escort to return to class.
• Maintain regular routines as much as possible. Students need "normalcy" during a difficult time such as this.
• Ask for assistance if you are having trouble coping individually or with a class.
• Be on the lookout for students in unauthorized areas and assist appropriately.
• We will not be dismissing students on Monday "en masse" from school. We will encourage them to use support groups and finish the day.
• Be on heightened alert for any reports/rumors/conversations you may hear about other students interested in harming themselves or others. Report all cases to the Crisis Team
CRISIS TEAM RESOURCE GUIDE: 
READINESS, RESPONSE, AND RECOVERY

Handout 14: Sample Letters

Sample Letter to Parents/Guardians

Dear Parents:

Yesterday, several students and faculty members saw a family emergency take place in our school. It was a hectic day for the students and staff involved which left some people scared. _________ Elementary school staff, however, worked really hard as a team to help. Fortunately, no one was hurt. No more details are known at this time. That information will be provided as soon as it becomes available. Our thoughts are with the _________ family during this difficult time.

To assist our students and staff in coping with the anxiety created from this crisis, I requested the support and resources of the school system's Crisis Response Team. Today, this specially trained team will join in working with our students and staff. We will continue to have resources available to us through this most difficult time. Should you find that you are in need of these resources or have questions about how to approach your children regarding this unusual incident, please do not hesitate to call us at (xxx) xxx- school telephone number). When a crisis touches a school, it affects us all.

Sincerely,

Principal
**ELEMENTARY SCHOOL**

Dear Parents,

We were sorry to learn today about the sudden death of one of our first grade students, Joe Student. At this time we do not know the cause of death, but we felt it important that you know about this tragic loss.

Teachers were asked to share the following statement with their students. "Last night, Joe Student, a first grade student at our school died suddenly. At the time we are unsure of the cause of his death. We extend our deepest sympathies to his family."

Counselors and support staff interacted with the boys and girls in Miss Teacher's class, assisting them in dealing with the situation. In addition, counselors have been in the school today to work with children and staff members who may be experiencing difficulty with this news.

To assist you in further dialogue with your child, we have attached strategies that you might find helpful. Please realize that these are merely suggestions that you might find helpful as a resource to your family.

We are certain that you share in our sorrow for the family.

Sincerely, Ms. Principal, Principal

Mr. Assistant Principal, Assistant Principal
Sample Letter Announcing The Death Of A Faculty Member

Dear Parent/Guardian,

It is with deep regret that I inform you of the death of Mrs. Smith, the special education teacher. She died as a result of injuries sustained in an automobile accident yesterday afternoon while returning home from work. Mrs. Smith worked with students in the first, second, and third grade in the resource room and also provided support in Mrs. Jones’ second grade math class.

An appropriate announcement was made to inform the students and staff. The Crisis Intervention Team was available to answer questions and deal with the grieving process. Support from the team and from the school counselor(s), will be available to those students and staff who may continue to have difficulty dealing with their feelings of loss.

Please be aware that your child may show varying reactions to this loss. While some may not experience difficulty dealing with the death, we would like to inform you of some of the more subtle reactions or changes your child may experience. For example, some students may have difficulty with eating and sleeping, prolonged crying, anger, confusion, school refusal, and temporary withdrawal from friends and family. You may contact your school counselor or administrator for additional guidance and support. Your openness and willingness to listen to your child as he/she grieves will provide important support.

Funeral arrangements are incomplete at this time. We will inform you* once more information is available.

Please feel free to contact the school if you have further questions.

Sincerely,

Principal

*Make sure to follow up as indicated.
SAMPLE LETTER FOR ANNOUNCING THE DEATH OF A STUDENT AFTER A LONG ILLNESS

To All ________ Families

Dear Parents,

It is with deep regret and profound sorrow that I must inform you of the death of ____________, a fifth grade student in Mrs. ______________'s class at _____________ Elementary School. ____________ passed away last evening at home with family after a seven-month struggle with brain cancer. ______________ is the daughter of ______________. She was a student in Mr. ____________' third grade class and Ms. ______________'s fourth grade class. Funeral arrangements are, at this time, incomplete.

Members of our Crisis Response Team met today with the students in fifth grade to inform them of ____________'s death and to provide support and guidance through this difficult time.

My purpose for sharing this information with you is twofold. First, the death of a child is a tragedy in which we are not often asked to respond. As children and fellow classmates, parents, and staff, we are struck by a wide range of emotions and a deep sense of loss over the death of one so young. However, these emotions are particularly difficult for young children to understand, and they may have many questions. Our Crisis Response Team will continue to be available to meet with individual children to assist them and to provide support here at school.

Second, please understand that the support that we provide to children this age addresses only the illness itself and answers only those questions that can be answered by school staff. However, there are and will be questions and concerns that arise in the days and weeks ahead that can best be answered by a child's parent(s). Therefore, Crisis Team members and our resource materials on this topic will also be made available to you as parents if you need them. I encourage you to contact one of us if you wish to avail yourself of these resources.

Please join us in keeping ____________'s family in your thoughts and prayers in the days and weeks ahead as they face this difficult time.

Sincerely, Principal
Crisis Response Team
__________, School Nurse
__________, Principal
__________, Assistant Principal
__________, School Counselor
__________, School Psychologist
**DEATH OF A STAFF MEMBER**

Dear Parents or Guardian:

This past weekend, ________________________________, our head engineer, passed away after falling while working on the roof. He was a very special friend to many of the children. They saw him working around the building, fixing things in their classrooms, and each day in the lunchroom. ________________________________ took the time to visit with children and they greeted him by name when they saw him. He will be greatly missed by all of us.

Children have been told about ________________________________’s death. We are working with our school psychologist and school counselor to help children understand, and to help them with questions or concerns which they might have.

I want you to know of our loss so that, if your child talks to you about ________________________________, you will be better able to respond to their questions.

Sincerely,

Principal

______________________________

**DEATH OF STUDENT- ILLNESS**

Dear Parents/Guardians:

Today we were saddened to learn of the death of one of our students. ________________________________, a 5th grader in Room 305, died from leukemia and other complications. In the short time she attended our school, she endeared herself to staff and students, both in fifth grade and in her Girl Scout Troop #______.

We have talked with the students who were in ________________________________’s classroom about her death. We also have our school psychologist, ________________________________, who is available all this week to talk with any children who might need some extra support.

We suggest that you discuss this matter with your child and respond to any questions that arise. If you wish to have one of our Crisis Response Team staff members talk individually with your child, or to talk with someone yourself, please contact our school counselor, so that we can make those arrangements. If you wish to join the staff in contributing to a fund for the family, you may contact us at the school.

Sincerely,

Principal
Sample Letter to Announce the Death of a Student due to an Automobile Accident

I regret to inform you that a former student, __________, died as a result of injuries sustained in an automobile accident. The accident, which occurred on Thursday afternoon around 4:30 p.m., was witnessed by several of our students. Additionally, many of Janie's neighbors and friends attend our school and many of our present fifth graders knew her when she attended here last year.

In order to assist any children who may have difficulty dealing with death, Mr. _______, our school counselor, and Mr. ________, our pupil personnel worker, are available to meet with groups and individuals. At present, they have met with all fifth grade classes and with selected children from other grades when either they or their parents expressed a need to have feelings and fears shared. If your child is in need of assistance as a result of ______'s death, please contact the school.

We have been informed there will be visitation and a service at __________'s Funeral Home, ______________________, on Saturday, February 29th, from 2:00 to 3:00 p.m.

I know you join me in extending to Mr. and Mrs. ______________, _____________ Elementary School's deepest and heartfelt sympathy for the loss of their daughter.

Sincerely,

Principal
SECONDARY SCHOOL

ANNOUNCEMENT TO PARENTS

Dear Parents:

We at __________ High School are deeply saddened by the tragic loss of fifteen year-old student, ______________. She was struck by an automobile and consequently passed away during the weekend. We, the faculty, students, and staff of __________, wish to extend our deepest sympathy and condolences to ______________________________’s family, relatives, and friends.

To assist our students and staff in coping with the great sadness and shock of this tragedy, I requested the support and resources of the school system's Crisis Response Team. Today, this specially trained team will join in working with our students and staff. We will continue to have resources available to us through this most difficult time. Should you find that you are in need of these resources or have questions about how to approach your children regarding this tragic incident, please do not hesitate to call us at (xxx) xxx-school.telephone number. When such a tragedy touches a school, it affects us all.

Sincerely,

Principal of __________ High School

Dear Parents:

We at ______________ are deeply saddened by the tragic loss of ______________ in the _____ grade, who died in a fire that destroyed his home on Monday of this week. We, the faculty, students and staff of __________, wish to extend our deepest sympathy and condolences to ______________’s family, relatives, many friends and classmates. ______________ was a sensitive young man who cared greatly for the well-being of others. ______________ was an Honor student and a talented athlete, playing varsity baseball and football.

To assist our students and staff cope with the great sadness and shock of this tragedy, I requested the support and resources of the school system's Crisis Response Team. Today, this specially trained team will join in working with our students and staff. We will continue to have resources available to help us through this most difficult time. If you find that you are in need of these resources or have questions concerning the approaching of your children regarding this tragic incident, please do not hesitate to call us at ______________. When such a tragedy touches a school, it affects us all.

Sincerely,

Principal
Student Suicide  (Undisclosed)

Dear Parents and Guardians:

School suffered the tragic loss of one of its students last night. It is the second death of one of our students in recent months, and many students and staff members are grieving the loss of these students.

We were notified this morning of the student's death, and we observed a moment of silence in her memory before beginning classes. Students who needed the opportunity to talk were excused from class to speak to counselors. Extra counselors are available at the school for students and staff. We also provided an area for students who needed quiet time to reflect or to gather their thoughts and emotions.

Traumas, such as the sudden death of a young person, leave teenagers feeling helpless and in need of extra support. As parents, there are a number of things you can do to help your children, although knowing what to say is often difficult. Your expression of love, concern and support is most important. The National Association of School Psychologists offers the following advice for parents whose children have experienced a trauma.

- Establish a sense of safety and security - teens need a lot of reassurance.
- Listen actively to your children - try to understand before trying to be understood.
- Help your children express their emotions - it is important to talk about the tragedy and to address its suddenness and irrationally.
- Validate your children's feelings by helping them understand that following a trauma, all feelings are acceptable.
- Be open and honest about what has happened and make sure your children know that you are aware of the seriousness of the situation.

Parents should also look for signs of depression in their children, which can include: changes in eating and sleeping habits; withdrawal from friends, family or regular activities; rebellious behavior; drug and alcohol use; unusual neglect of personal appearance; changes in personality; difficulty concentrating or a decline in grades; and frequent complaints about physical symptoms such as stomachaches, headaches and fatigue. If you notice any of these signs in your child, talk to your child about your concerns and seek professional help if the concern continues. Support is available for you and your children at the school through the guidance office. Community support is also available at the appropriate agencies in your respective counties.

Sincerely,

Principal

-----------------------------------------------
Student Suicide - (Disclosed)

Dear Parent of _________________ Students,

The _________________ Middle School community was saddened to learn of the reported suicide of one of our seventh grade students. The death of any young person is a loss that, in one way or another, affects each of us. The tragic circumstances of a suicide death are perhaps more difficult to accept.

We have asked the assistance of the crisis team to help our school community deal with this loss. We are providing support to all students and staff to help them cope with this tragedy. We may never know why this death occurred and will not focus on trying to figure it out. Instead, we will focus on suicide prevention in our society. You may anticipate questions and a need to talk about the death with your child.

If you have any concerns regarding your child's reactions to this loss, please do not hesitate to call the school for assistance. Ask for _____________________ (Specific names of key contacts you may want to include are those such as counselors, nurses, or psychologists.)

Sincerely,
Principal

Sample Letter For Informing Parents Of An Accident That Took Place On School Grounds

Dear Parents and Guardians,

We have been informed by the Police Department and the Board of Education that yesterday a 22-year-old _______________ man, _______________, committed suicide by hanging. At approximately 2:30 p.m., some of our students, including two busses, passed the scene and may have witnessed the police investigation.

In response to those incidents, psychologists, school counselors, and pupil personnel workers were available. These support personnel met with the two busses of students who witnessed the incident early this morning. As information was released by the police, all students were informed and given the opportunity to see counselors. Counseling help will continue to be available to any student in need.

Situation such as this may create a variety of reactions ranging from no response, concern, to lots of questions. Your child may experience many emotions and may exhibit sleep disturbances, temporary loss of appetite, anxiety or fear about personal safety. Children may also use humor to deal with their feelings, and although this may seem odd, it is a common coping mechanism. Here are suggestions for dealing with concerns your child may have:
• **LISTEN TO YOUR CHILD'S STORY** - You may not have all the answers to his or her questions, but your child will benefit from your attention.

• **ARRANGE FOR A SUPPORT SYSTEM** for students home alone, such as the availability of neighbors or friends, or phone contacts.

• **PROVIDE STRUCTURE** to assist your child in returning to normal routine as much as possible.

• **TALK TO YOUR CHILD** about your personal value system regarding death or loss.

Please feel free to call the guidance office, _________________, if you have any questions or concerns.

Yours truly, Principal
CRISIS TEAM RESOURCE GUIDE: READINESS, RESPONSE, AND RECOVERY

Handout 15: Individual Vulnerability to Psychological Trauma Subsequent to Crisis Event Exposure

A variety of factors make some individuals more vulnerable to psychological trauma secondary to crisis event exposure. These factors can be broadly classified as internal vulnerabilities (personal characteristics, traits, and experiences) and external vulnerabilities (environmental characteristics).

Internal Vulnerability Factors

Coping style. Resiliency research makes distinctions between active (or approach) and avoidance coping strategies. Active coping strategies are direct and deliberate actions aimed at solving crisis problems. Avoidance coping involves thoughts and actions that attempt to focus away from a stressful situation (e.g., to stop thinking about and dealing with the stressor). This type of coping behavior is consistently associated with a greater incidence of mental health concerns, although in extremely high stress situations some initial avoidance coping may be adaptive. For example, a woman held up at gunpoint in the parking lot of a local shopping center calmly gives the robber her purse, walks to her car, and drives home. It is only when she gets into her driveway that she breaks down, cries, and begins to feel panicked. In this instance, avoidance coping bought the woman time to get to a place where it was physically and emotionally safe to confront the reality of what had happened to her. Clearly, however, the individual who continues to employ avoidance coping as a longer-term problem-solving strategy is more likely to have a poorer mental health outcome. Consistent with this observation, Silver, Holman, McIntosh, Poulin, and Gil-Rivas (2002) in their nationwide longitudinal study of psychological responses to 9/11 make the point that “Several coping strategies, particularly those involving denial or a complete disengagement from coping, relate to higher levels of distress 6-months after the event.” Active coping strategies, such as accepting the event, are associated with less long-term stress.

Pre-existing mental illness. Mentally healthy individuals generally are better able to cope with crisis events than are those with pre-existing mental illness. For example, Breslau (1998) reports that pre-existing major depression and anxiety disorders increase the risk of PTSD. Similarly, Gil-Rivas, Holman, and Silver (2004) report that “…the consequences of the September 11th attacks were not limited to adolescents who were directly exposed. Our finding suggest that adolescents with a history of mental health disorders or learning difficulties are more likely to report experiencing high levels of event-related acute trauma symptomatology, which places them at risk for higher levels of symptomatology over time” (p. 138).

Poor self-regulation of emotion. Typically, children with easy temperaments are less prone to emotional reactions subsequent to crisis exposure. Consequently, individuals known to have a negative temperament, be easily upset, and have difficulty calming down should be given crisis intervention service priority as they appear to be more vulnerable to psychological trauma. For example, McNally, Bryant, and Ehlers (2003) state:

…From the NASP School Prevention and Intervention Training Curriculum. Used with permission.
“proneness to experience negative emotions (irritability, anxiety, depression) is higher among trauma-exposed people with PTSD than among those without the disorder” (p. 50).

**Low developmental level and poor problem-solving skills.** Once an event is judged threatening, and all other factors are held constant, the lower the developmental level of the crisis survivor the greater the psychological trauma. When compared to older children, this greater vulnerability is likely due to a relative lack of coping experience and skill, a smaller social support network, and less well-developed emotional regulation (Lonigan, Phillips, & Richey, 2003). In addition to chronological age, relative cognitive ability is related to risk for PTSD among people exposed to trauma. For example McNally et al. (2003) sites research suggesting lower intelligence was associated with greater severity of PTSD symptoms following exposure to traumatic stressors (e.g., war, witnessing violence, being sexually abused). “Of those with above-average IQ scores, 67% had neither PTSD nor subthreshold PTSD. Of those with below-average IQ scores, only 20% had no PTSD symptoms” (p. 50). Specific research findings relevant to this vulnerability factor include the following:

1. Schwarz and Kowalski (1991) report that following a school shooting PTSD rates were significantly lower among adults exposed to this trauma (19%) as compared to similarly exposed children (27%).
2. King, King, Foy, and Gudanowski (1996) report that soldiers who were younger when they went to war were more likely to develop PTSD.
3. Hoven and colleagues (2004) report that younger children had a higher prevalence of probable separation anxiety disorder 6 months after September 11th.
4. Singer and colleagues (2004) report that "being in a higher grade was associated with significantly lower trauma symptom scores" (p. 500).
5. Caffo and Belaise (2003), report that a child's age and developmental level influenced "...perception and understanding of trauma, susceptibility to parental distress, quality of response, coping style, skills, and memory of the event" (p. 501).
6. Applied Research Consultants et al. (2002), who in their study of the New York public schools, report that factors that "place children at higher risk for PTSD (and potentially other mental health problems as well) following the 9/11 attacks included younger age (being in 4th or 5th grade rather than middle or high school)" (p. 39).

While lower developmental level is generally a risk factor for psychological trauma, an important exception needs to be noted. In some cases high developmental level may facilitate understanding of an event as threatening, and low developmental level can be protective. Consistent with this possible exception, Stallard and Salter (2003) state: "Children of this age [7 to 11 years] may not, however, have the necessary knowledge or level of cognitive development to understand the degree of threat or potential implications posed by the trauma" (p. 451).

**History of prior psychological trauma.** Children who have repeated traumatic stressors are more likely to disassociate and display mood swings. It is especially important to identify individuals who have experienced prior crises similar to the current crisis. Research conducted by Galea and colleagues (2002) highlights the importance of assessing for trauma history. In a phone survey of Manhattan Island residents several weeks after
the WTC attacks it was found that among individuals who had no prior trauma history, only 4.2% reported symptoms of PTSD. On the other hand, of those individuals with two or more significantly stressful events in their personal histories, 18.5% reported PTSD symptoms. In addition, among those with no trauma history only 5.6% reported symptoms of depression, while among those with two or more stressful events 24.1% reported such symptoms. There is some suggestion in the literature that having coped with previous stressful events in an adaptive way might help people to cope with potentially traumatic events in the future.

However, this appears to be true only when the exposure to new crisis events is low. "When exposure is high, the 'protective' value of having coped with previous life stressors seems to disappear" (Lecic-Tosevski, Gavrtovic, Knezevic, & Priebe, 2003, p. 547). Additional research findings relevant to this internal vulnerability factor include the following:

1. Repeated exposure to traumatic events can change the central nervous system of a child in such a way that he or she experiences increased responsiveness to stress. These changes have been linked to an increased risk of psychopathology in later life. According to Nemeroff (2004), "Preclinical and clinical studies have shown that repeated early-life stress leads to alterations in central nervous systems...leading to increased responsiveness to stress. Clearly, exposure to early-life stressors leads to neurobiological changes that increase the risk of psychopathology in both children and adults" (Nemeroff, 2004, p. 18).
2. Möhlen, Parzer, Resch, and Brunner (2005) report that "The number of traumatic experiences was highly associated with the severity of posttraumatic and depressive symptoms and additionally with the impairment of global psychosocial functioning after traumatization" (p. 85).
3. Hoven and colleagues (2004) report that "...we detected an association between Separation Anxiety Disorder...and prior exposure to trauma..." (p. 179).

**Self-efficacy and external locus of control.** Other internal resources such as self-efficacy, mastery, perceived control, self-esteem, hope, and optimism do protect crisis victims, as indicated by the following empirical results: (a) beliefs about coping were more important than actual coping strategies. How crisis survivors perceive their capabilities to cope is critical. Individuals who believe they are able to cope with the traumatic stress are typically able to (Morris, Byrne, Diaz, & Kaniasty, n.d.). Research in support of this observation is offered by Frazier, Tashiro, Berman, Steger, and Long (2004), who found that among female sexual assault survivors (n = 171), "The factors most related to reporting positive life change soon after the assault were social support, approach and religious coping, and perceived control over the recovery process. Increases in these factors were also associated with increases in self-reported positive life change over time" (p. 19).

**External Vulnerabilities**

**Living with family members.** Among Cambodian refugee youth, living with a nuclear family member was found to be important to adaptive adjustment. Kinzie, Sack, Angell, Marson, and Rath (1986), who studied these youth, concluded "...having reestablished some contact with family members in this setting mitigated some of the symptoms of the severe trauma, while being alone or in a foster family exacerbated the disorder." Similarly
Singer, Flannery, Guo, Miller, & Leibbrandt (2004) reports: "...living in a two-parent household was associated with significantly lower trauma symptoms scores" (p. 500), and Yorbik, Akbiyik, Kirmizigul, and Sohmen (2004) stated: "...fewer PTSD symptoms are observed in cases of those living with their families than in cases of those who are separated from their families. This shows that after the trauma, children should remain living with their families in order to prevent the emergence of PTSD symptoms' (p. 54).

**Parent-child relationships.** The quality of the parent-child relationship is important. Specific parenting characteristics that have been associated with resiliency include warmth, structure, and high expectations (Doll & Lyon, 1998), and degree of family support predicts children's long-term emotional response to stressful events (Shaw, 2003). According to Qouta, Punamaki, and El Sarraj (2005): "It is well accepted that supportive and wise parents enhance children's mental health and favorable cognitive-emotional development, in general... and in traumatized families in particular" (p. 150).

**Family functioning.** Well-functioning families promote resiliency, while family dysfunction (e.g., alcoholism, violence, mental illness) is associated with vulnerability to traumatic stress. Among Vietnam combat veterans, those with PTSD had higher rates of childhood physical abuse (King et al., 1996). Both maternal and paternal mental health appears to be determinants of how well children cope with traumatic events (Kilic, OzgQven, & Sayil, 2003; Qouta et al., 2005). According to Hilarski (2004): "Children or adolescents living with a nonresponsive caregiver suffering from perceived traumatic stress responses are likely to reside in a family environment that is chaotic, unemotional, deceptive, or in denial. As a consequence, youth adaptation to life stressors is difficult, and he/she may feel the need for help in coping. This aid may come in the form of substance use" (p. 123). Similarly, Barenbaum, Ruchkin, and Schwab-Stone (2004) state: "...greater severity of symptoms in children is associated with having a mother with poor psychological functioning and living in a family with inadequate cohesion" (p. 50).

**Parental traumatic stress.** According to Shaw (2003): "The younger child's psychological response resonates with the parental response as they have less cognitive capacity to independently evaluate the dangers" (p. 244). Thus, it is not surprising that parental PTSD is associated with vulnerability to traumatic stress. It is also critical to acknowledge that when a child is living in an environment wherein caregivers are significantly distressed, caregivers may be less likely to independently recognize children's needs of mental health intervention (Brown & Bobrow, 2004). According to Qouta, Punamaki, & El Sarraj (2003): "Our results confirmed the classical argument that the way mothers respond to danger and threat influences their offspring. The mothers' own PTSD symptoms and educational level were important determinants of their children's PTSD... Young children seek cues about their mother's ability to protect them, and feel highly vulnerable if her psychological state of mind communicates failure in providing protection. Children are tuned in to the mother's emotional responses, and their mental health is at risk if she is, for example, unable to control her frightening mental images and fear" (p. 269).

**Poverty.** Childhood poverty has been found to be a consistent predictor of dysfunction in adulthood. Lewis' (1970) *A Death in the Sanchez Family* illustrates how poverty exacerbates a crisis (in this case the death of the family patriarch). Also, Galea et al. (2002) reported that
a lower household income was associated with a high rate of depression among individuals living in Manhattan following the terrorist attacks of 9/11/01. In addition, Gala et al. reported that the loss of a job subsequent to the attacks was associated with both PTSD and depression (Lost job, 25.9/28.6%, PTSD/depression; did not lose job, 6.22/8.5% PTSD/depression).

**Social resources.** Individuals who must face a crisis without supportive and nurturing friends or relatives have been found to suffer more from PTSD than those with such resources (McNally et al., 2003). Close peer friendships, access to positive adult models outside of the family, and strong connections to pro-social organizations or institutions are protective, as are positive school experiences (academic or nonacademic). Individuals who have social supports are expected to show lower levels of distress following a crisis. For example, study of World Trade Center 9/11 survivors by Galea and colleagues (2002) indicates that while 10.2 and 15.5% of individuals with low levels of social support reported having symptoms of PTSD and depression respectively, only 4.4 and 5.6% of individuals with high levels of such support reported having symptoms of these disorders. To be effective early school crisis interventions need to systematically evaluate the social supports available to students in the recovery environment as well as students' history of using these supports under stressful circumstances (Litz, Gray, Bryant, & Adler, 2002).

Not only is received social support important, but so are perceptions of such. For example, according to Norris et al. (n.d.): "With few exceptions, disaster survivors who subsequently believe that they are cared for by others and that help will be available if needed, fare better psychologically than disaster survivors who believe they are unloved and alone" (Norris et al., n.d., 3). Further, according to McNally et al. (2003)"... perceived lack of social support is strongly linked to heightened risk for PTSD. Thus, assessing and, if necessary, facilitating social support may promote recovery from trauma. Many survivors have good support networks and may prefer to rely on their trusted confidants, but others may need help in activating social support because they do not have access to good support (whether because of the loss or separation from significant others, preexisting poor support, or the perception that previously trusted people do not understand their plight)." The "perception of negative social interactions with others in the aftermath of trauma predicted chronic PTSD to a greater extent than did lack of perceived positive support" (McNally et al., 2003, p. 67).

**References**


Handout 15: Individual Vulnerability to Psychological Trauma Subsequent to Crisis Event Exposure


From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
CRISIS TEAM RESOURCE GUIDE:  
READINESS, RESPONSE, AND RECOVERY

Handout 16: Possible Questions to Ask When  
Identifying and Prioritizing Crisis Problems  
(Adapted from National Center for Child Traumatic Stress, 2005, pp. 24-28)

NOTE: Crisis interveners will need to exercise caution when asking these questions. Different students in different situations will be more or less able to participate in this problem-identification activity.

1. To determine the nature and severity of the student's crisis experience ask:
   • I know that you’ve been through a lot of difficult things. Would it be helpful to talk about any of what you have been through?
   • Where were you during the crisis?
   • Did you get hurt?
   • Did you see anyone get hurt?
   • How afraid were you?

2. To help identify problems generated by the death of a family member or close friend ask:
   • Did someone close to you get hurt or die as a result of the crisis event?
   • What happened?

3. To help identify problems generated by the immediate post-disaster circumstances and ongoing threat ask:
   • Do you need any information to help you better understand what has happened?
   • Do you need information about how to keep you and your family safe?
   • Do you need information about what is being done to protect the public?

4. To help identify problems generated by being separated from, or concerned about the safety of loved ones ask:
   • Are you worried about anyone close to you right now?
   • Do you know where they are?
   • Is there anyone especially important like a family member or friend who is missing?

5. To help identify problems generated by physical illness and/or the need for medication ask:
   • Do you have any physical or medical condition that needs attention?
   • Do you need any medications that you don't have?
   • Do you need to have a prescription filled?
6. To help identify problems generated by losses incurred as a result of the disaster (e.g., home, school, personal property, pets) ask:
   - Was your home badly damaged or destroyed?
   - Did you lose other important personal property?
   - Did a pet die or get lost?
   - Was your business, school, or neighborhood badly damaged or destroyed?

7. To help identify problems generated by extreme feelings of guilt or shame state:
   - It sounds like you are being really hard on yourself about what happened.
   - It seems like you feel that you could have done more.

8. To help identify if prior losses and/or crisis experiences are generating problems state/ask:
   - Sometimes events like this can remind individuals of previous bad times.
   - Have you ever been in a hurricane or other disaster before?
   - Has some other bad thing happened to you in the past?
   - Have you ever had someone close to you die?

9. To help identify if a history of psychological problems is exacerbating problems generated by the current stressor state/ask:
   - Sometimes events like this can make existing psychological problems worse.
   - Have you ever had any treatment or taken medication for a mental health problem?

10. To help identify if there were any specific activities that are being (or will be) disrupted by the crisis event ask:
    - Were there any special things or events (birthday, graduation, beginning of the school year, vacation) coming up that were disrupted by the crisis?

11. To help identify any other problems that might have been generated by the crisis event ask open-ended questions such as:
    - Is there anything else we have not talked about that is important for me to know?

From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
Handout 17: The Relationships Between Psychological Triage and Crisis Interventions Possible

From the National Association of School Psychologists' School Prevention and Intervention Training Curriculum. Used with permission.
Handout 18: Matching Psychological Trauma Risk to the Appropriate Crisis Intervention

Practice Activity

Divide into small groups and making use of Handout 5 (Checklist for Determining Levels of Risk for Psychological Trauma), discuss the essential features of individuals in each of the three different psychological trauma risk classifications (low risk, moderate risk, high risk). Then, among the crisis interventions just discussed specify the crisis interventions that you feel provide the best match for individuals with the given risk classification. Record your thoughts on this worksheet and be prepared to share your thoughts with the large group.

LR = Low Risk for Psychological Trauma (i.e., students who are likely to recover from crisis exposure more or less independently). Appropriate crisis interventions: ____________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

MR = Moderate Risk for Psychological Trauma (i.e., students who may require some support and guidance to recover from crisis exposure, but will not likely develop significant psychopathology such as PTSD). Appropriate crisis interventions: ____________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

HR = High Risk for Psychological Trauma (i.e., students who are not expected to recover from their crisis exposure without significant support, and may develop a psychopathology such as PTSD). Appropriate crisis interventions: ____________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
1. To help identify coping behaviors that involve any degree of lethality state/ask:
   
   • Sometimes situations like these can be very overwhelming for individuals. Have you had any thoughts about suicide?
   • Have you had any thoughts about harming someone else?

2. To help identify if social support networks are available as a coping resource ask:
   
   • Are there family members, friends, or community agencies that you can rely on for help in dealing with problems you are facing as a result of the crisis?

3. To help identify if drugs or alcohol is/are being used (or considered) as a coping strategy ask:
   
   • Do you tend to use alcohol, prescription medications, or drugs as a way to cope with stress?
   • Have you had any problems in the past with alcohol or drug use?
Coping with the stress that results from difficult life events requires understanding, sensitivity, acceptance, and patience. When these events endure over an extended period of time and the stress becomes cumulative it is even more important to take steps to reduce the effects of the cumulative stress. When choosing stress reduction techniques it is important that the individual chooses what is right for him or her. Each person handles stress differently. It is important not to judge individuals about the methods they choose or force them to choose particular strategies. As long as the stress reduction strategies chosen offer the individual comfort and relief without any harmful effects they are appropriate choices for managing the stressful situation.

Suggestions for reducing stress during a crisis

- Write down specific worries and thoughts about how they could be addressed by yourself or other individuals.
- Keep a journal of thoughts and feelings, including what happened right before they occurred.
- Make a list of things you have done to get through other tough situations. Use these strategies again.
- Develop a personal safety plan with names and phone numbers of support people.
- Practice what to say and do in a difficult or stressful situation.
- Give yourself a treat - a warm bath, a massage, a candy bar, or time spent doing an activity you enjoy.
- Spend time with family, friends, or a favorite pet.
- Pursue activities that allow you an opportunity to take a break from the stressful situation. For example, watch a funny movie or play a game.
- Give yourself or a child permission to take a break from regular activities.
- Get enough rest and food to stay healthy and strong.

Sources and resources

Information contained in this document was developed with input from the following source: "Caring for Kids after Trauma and Death: A Guide for Parents and Professionals" written by Robin F. Goodman, Ph.D.
CRISIS TEAM RESOURCE GUIDE:
READINESS, RESPONSE, AND RECOVERY

Handout 21: Crisis Reactions

Most students and staff members will exhibit some reactions after exposure to a crisis event, although there is no one “normal” or expected crisis reaction or set of reactions. Different students will have different reactions to the same event. Factors contributing to an individual’s reactions can include age, degree of exposure to the event, pre-existing risk factors, and family and culture. Common crisis reactions include:

Common Crisis Reactions

<table>
<thead>
<tr>
<th>Emotional Effects:</th>
<th>Cognitive Effects:</th>
<th>Interpersonal/Behavioral Effects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Shock</td>
<td>- Grief</td>
<td>- Alienation</td>
</tr>
<tr>
<td>- Anger</td>
<td>- Irritability</td>
<td>- Social withdrawal/isolation</td>
</tr>
<tr>
<td>- Despair</td>
<td>- Hypersensitivity</td>
<td>- Increased relationship</td>
</tr>
<tr>
<td>- Emotional numbing</td>
<td>- Helplessness</td>
<td>- conflict</td>
</tr>
<tr>
<td>- Terror/Fear</td>
<td>- Hopelessness</td>
<td>- Vocational impairment</td>
</tr>
<tr>
<td>- Guilt</td>
<td>- Loss of Pleasure</td>
<td>- Refusal to go to school</td>
</tr>
<tr>
<td>- Phobias</td>
<td>- from Activities</td>
<td>- School impairment</td>
</tr>
<tr>
<td>- Depression or Sadness</td>
<td>- Dissociation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Effects:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fatigue</td>
<td>- Impaired immune response</td>
<td>- Avoiding Reminders</td>
</tr>
<tr>
<td>- Insomnia</td>
<td>- Headaches</td>
<td>- Crying easily</td>
</tr>
<tr>
<td>- Sleep Disturbance</td>
<td>- Gastrointestinal</td>
<td>- Change in eating pattern</td>
</tr>
<tr>
<td>- Hyperarousal</td>
<td>complaints</td>
<td>- Regression in behavior</td>
</tr>
<tr>
<td>- Somatic Complaints</td>
<td></td>
<td>- Risk Taking</td>
</tr>
<tr>
<td>- Decreased Appetite</td>
<td>- Decreased libido</td>
<td></td>
</tr>
<tr>
<td>- Startle Response</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes. a. Examples include perceptual experience like seems “dreamlike,” “tunnel vision,” “spacey,” or on “automatic pilot.”
   b. Reenactment play among children.

Developmental Factors in Crisis Reactions

Preschool. In general, the crisis reactions of preschool-aged youth are not as clearly connected to the crisis event as might be observed among older children. For example, in this age group re-experiencing the trauma might be expressed as generalized nightmares. Crisis reactions also tend to be expressed nonverbally and may include clingingness, tantrums, crying and screaming more readily, and often, trembling and frightened facial expressions. The temporary loss of recently achieved developmental milestones (e.g., loss of bowel and/or bladder control, bedwetting, thumb-sucking, fear of the dark, fear of parental separation, etc.) might be observed. Finally, the young child may re-experience the crisis event via trauma-related play (which does not relieve accompanying anxiety), which may be compulsive and repetitive in nature.

Younger School Aged. Reactions among youth in this age group tend to be more directly connected to the crisis event and event-specific fears may be displayed. However, to a significant degree the crisis reactions of young school-aged children continue to be expressed behaviorally (e.g., behavioral regression, clinging and anxious attachment behaviors, refusing to go to school, irritability, anxiety). Diminished emotional regulation (e.g., irrational fears) and increased behavior problems may be observed (e.g., outbursts of anger and fighting with peers). In addition, feelings associated with traumatic stress reactions are often expressed in terms of concrete physical symptoms (e.g., stomach- and headaches). Older children may continue to “re-experience” the trauma through play but such play will be more complex and elaborate, and often includes writing, drawing, and pretending. Repetitive verbal descriptions of the event (without appropriate affect) may also be observed. Given these reactions it is not surprising that problems paying attention and poor schoolwork may also be noted.
Peritraumatic Dissociation
1. Derealization (e.g., feeling as if in a dream world)
2. Depersonalization (e.g., feeling as if your body is not really yours)
3. Reduced awareness of surroundings (e.g., being in a daze)
4. Emotional numbness (e.g., feeling emotionally detached/estranged; lacking typical range of emotional reactions; reduced interest in previously important/enjoyed activities; feeling as if there is no future career, marriage, children, or normal lifespan).
5. Amnesia (e.g., failure to remember significant crisis event experiences)

Peritraumatic Hyperarousal
1. Panic attacks.
2. Disturbed memory and difficulty concentrating.
3. Hypervigilance and exaggerated startle reactions (e.g., unusually alert and easily startled).
4. Increased irritability (e.g., fighting or temper problems) and motor restlessness.
5. Difficulty falling and/or staying asleep (sometimes a result of the re-experiencing symptom of disturbing.

Persistent Re-experiencing of the Crisis Event
1. Behaving and/or feeling as if the trauma was happening again (among children this may manifest as repetitive and automatic re-enactment play).  
2. Extremely terrifying and reoccurring nightmares about the event (among children this may manifest as frightening dreams not specifically tied to the crisis).  
3. Reoccurring intrusive/distressing thoughts, images, or feelings associated with the event (among children this may manifest as repetitive play expressing crisis themes).  
4. Intense distress (both psychological and physiological) when presented with reminders (e.g., locations, sensations, symbols, etc.) of the trauma.

Avoidance of Crisis Reminders
1. Deliberate efforts to avoid thoughts, feelings, discussions, activities, places, or people that are associated with and/or bring back memories of the crisis event.
2. Agoraphobic-like social withdrawal (e.g., refusal to leave one’s home).
3. Virtually complete isolation from significant others.
Crisis Reactions That Indicate the Need for an Immediate Mental Health Referral (continued)

**Depression**

1. Significant Feelings of hopelessness and worthlessness
2. Significant loss of interest in most activities
3. Wakening early
4. Persistent fatigue
5. Virtually complete lack of motivation

**Psychotic Symptoms**

1. Delusions
2. Hallucinations
3. Bizarre thoughts or images
4. Catatonia

Notes. Among younger children symptoms of re-experiencing the trauma may be primarily displayed through re-enacting play and is considered pathological only when it appears to be repetitive and automatic.

**Extreme Maladaptive Coping Behaviors**

In addition to the reactions described above, maladaptive coping strategies that present a risk of harm to self or others sometimes emerge as a consequence of exposure to crisis events. The presence of the following behaviors (typically displayed in an attempt to cope with the crisis) also signals the need for an immediate referral to a mental health professional: (a) extreme substance abuse and self-medication, (b) suicidal and homicidal thinking, (d) extreme inappropriate anger toward and/or (c) abuse of others. It is important for all caregivers to be aware of when such a referral is indicated.

**Sources**


From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
Handout 22: Cultural Considerations in Crisis/Traumatic Loss Response

Group Exercise #1  **GEOGRAPHIC IDENTIFICATION**

1. Display a large, recent version of the world map. (It may also be projected onto a wall or screen)
2. Assign everyone a completed nametag sticker and have them stand.
3. Instruct everyone (either in line format or from table to table) to place their nametag onto their geographic region of origin.
4. Have everyone return to their seats.

*For Discussion:*
*What conclusions can we draw from this exercise?*
*Do our current environments mirror or differ from places of origin?*
*Aside from geography, what else defines us as individuals?*

Group Exercise #2  **Assessment of Cultural Exposure**

Randomly assign approximately 10 participants to one of the following five cultural groups:

1. Hispanic American/Latino
2. Native American
3. African American
4. Jewish
5. Asian

*For Discussion:*
*What has society told us about this ethnic group?*
*Do our current environments mirror or differ from places of origin?*
*Aside from geography, what else defines us as individuals?*

*Adapted from Deborah Spungen (1998)*
Handout 23: Evaluating the School Crisis Intervention

School/District: ________________________________ Date: ________________

Crisis Event: ________________________________

Evaluator(s): ________________________________

School Crisis Interventions Provided:

☐ Reconnection with parents
☐ Caregiver trainings
☐ Individual psychological first aid

☐ Reconnection with teachers
☐ Psycho-educational groups
☐ Group psychological first aid
☐ Referrals for psychotherapy

Other (describe): ________________________________

Intervention Evaluation Questions: (Check “Yes” or “No”)

1) Psychological Triage Summary Sheet data indicates that all students have been provided the appropriate school crisis intervention.  Yes  No

2) Individuals with a psychopathology have been provided appropriate treatment.  Yes  No

3) Individuals with maladaptive coping behaviors (e.g., suicide, homicide) have been referred to the appropriate professional(s) and lethality has been reduced.  Yes  No

4) Students attend school at or above pre-crisis attendance rates

   a) School attendance rates in the ____ weeks prior to the crisis.  ____ %
   b) School attendance rates in the ____ weeks after crisis resolution.  ____ %
### Intervention Evaluation Questions, continued (Check “Yes” or “No”)

5) School behavior problems (i.e., aggressive, delinquent, and criminal behavior) occur at or below pre-crisis levels

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Office discipline referrals in the _____ weeks prior to the crisis.</td>
<td>N= _____</td>
<td></td>
</tr>
<tr>
<td>b) Office discipline referrals in the _____ weeks prior to the crisis.</td>
<td>N= _____</td>
<td></td>
</tr>
</tbody>
</table>

6) Student academic functioning returns to pre-crisis levels (from Teacher Survey Form)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Average of teacher reports of instructional time currently spent talking about the crisis</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>b) Average of teacher reports of time engaged in academic instruction prior to the crisis</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>c) Average of teacher reports of time currently engaged in academic instruction</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>d) Average rating (on a 1 to 5 scale) of the extent to which students have returned to pre-crisis levels in academic functioning</td>
<td>M=</td>
<td></td>
</tr>
<tr>
<td>e) Average of teacher reports of percent of assignments completed by students in the week prior to the crisis event</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>f) Average of teacher reports of percent of assignments currently completed by students in the past week</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
Suicide as an International Problem

Suicide is an international problem and a major public health concern.

Suicide claims approximately 1 million lives worldwide each year, resulting in one suicide every 40 seconds. There is an estimated 10 to 20 suicide attempts per each completed suicide, resulting in several million suicide attempts each year.

Suicide and suicidal behavior affects individuals of all ages, genders, races and religions across the planet. Suicide affects more men than women in all countries but China. Risk factors remain essentially the same from country to country. Examples include mental illness, substance abuse, previous suicide attempts, hopelessness, access to lethal means, recent loss of loved ones, and unemployment.

Protective factors are also the same in all corners of the world. High self-esteem, social connectedness, problem-solving skills, supportive family and friends are all examples of factors that buffer against suicide and suicidal behaviors.

Suicide is the 11th leading cause of death in the United States with one suicide occurring on average every 16 minutes. Suicide is the 3rd leading cause of death among 15- to 24-years-olds. The elderly make up 12.4% of the population, but comprise 16.6% of all suicides. Approximately 816,000 Americans attempt suicide each year.

Experts believe that most suicidal individuals do not want to die. They just want to end the pain they are experiencing.

Experts also know that suicidal crises tend to be brief. When suicidal behaviors are detected early, lives can be saved.

Youth Suicide Fact Sheet

In this fact sheet, youth refers to the age groups of 15 to 19 and 20 to 24. Unless otherwise specified, information presented refers to the latest available data (American Association of Suicidology, U.S.A. 2005 Official Final Data)

- In 2005, suicide ranked as the third leading cause of death for young people (ages 15-24); only accidents and homicides occurred more frequently. Whereas suicides accounted for 1.3% of all deaths in the U.S. annually, they comprised 12.3% of all deaths among 15-24 year olds.
In 2005, 32,637 people completed suicide. Of these, 4,212 were completed by people between the ages of 15 and 24. Suicide rates, for 15-24 year olds, have more than doubled since the 1950’s, and remained largely stable at these higher levels between the late 1970’s and the mid 1990’s. They have declined 28.5% since 1994.

In the past 60 years, the suicide rate has quadrupled for males 15 to 24 years old, and has doubled for females of the same age (CDC, 2002). Suicide rates for those 15-19 years old increased 19% between 1980 and 1994. Since the peak in 1994 with 11.0 suicides per 100,000, there has been a 34% decrease. In 2004, the rate was 8.2 per 100,000. Males between the ages of 20 and 24 were 5.8 times more likely than females to complete suicide. Males between 15 and 19 were 3.6 times more likely than females to complete suicide (2005 data).

Each year, there are approximately 10 youth suicides for every 100,000 youth. Each day, there are approximately 12 youth suicides. Every 2 hours and 11 minutes, a person under the age of 25 completes suicide.

For every completed suicide by youth, it is estimated that 100 to 200 attempts are made. Based on the 2003 Youth Risk Surveillance Survey (YRBSS) 8.5% of students in grades 9-12 reported making an attempt at suicide in the previous 12 months (11.5% female and 5.4% male). These percentages decreased from grades 9 (10.1%) to 12 (6.1%). A prior suicide attempt is an important risk factor for an eventual completion. In fact, according to the YRBSS, 16.9% of students seriously considered attempting suicide in the previous 12 months and 16.5% of students made plans for an attempt (2003).

Firearms remain the most commonly used suicide method among youth, accounting for 49% of all completed suicides. In the last decade, for youths aged 15 to 19, the suicide rate by firearm decreased (from 7.3 in 1992 to 3.5 in 2005); correspondingly, suicide rates by suffocation increased (from 1.9 in 1992 to 3.06 in 2005). Firearms remain the most commonly used method.

Research has shown that the access to and the availability of firearms is a significant factor in observed increases in rates of youth suicide. Guns in the home are deadly to its occupants!

Suicide Among Children

In 2005, 270 children ages 10 to 14 completed suicide in the U.S.

Suicide rates for those between the ages of 10-14 increased 50% between 1981 and 2005.

Although their rates are lower than for Caucasian children, African American children (ages 10-14) showed the largest increase in suicide rates between 1980 and 1995 (233%). In 2005, the rate for African American males ages 10-14 was .62 per 100,000.(the rate for Caucasian males was 1.92 per 100,000).
In the 10 to 14 age group, Caucasian children (ranked 3rd leading cause of death) were far more likely to complete suicide than African American children (ranked 5th leading cause of death). Caucasian males between 10 and 14 years of age were 1.8 times more likely to complete suicide than Caucasian females of the same age.

The trend of methods used by children has followed a similar pattern to that of youths 15 to 19 years old. Since 1993, suicide by firearm decreased and suicide by suffocation increased. Suicides by suffocation among 10 to 14 year olds have occurred more frequently than those by firearms since 1999.

Other factors

Research has shown that most adolescent suicides occur after school hours and in the teen’s home.

Although rates vary somewhat by geographic location, within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.

The typical profile of an adolescent nonfatal suicide attempter is a female who ingests pills, while the profile of the typical suicide completer is a male who dies from a gunshot wound.

Not all adolescent attempters may admit their intent. Therefore, any deliberate self-harming behaviors should be considered serious and in need of further evaluation.

Most adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.

Repeat attempters (those making more than one nonfatal attempt) generally use their behavior as a means of coping with stress and tend to exhibit more chronic symptomology, poorer coping histories, and a higher presence of suicidal and substance abuse behaviors in their family histories.

Many teenagers may display one or more of the problems or “signs” detailed below. The following list describes some potential factors of risk for suicide among youth. If observed, a professional evaluation is strongly recommended:

- Presence of a psychiatric disorder (e.g., depression, drug or alcohol, behavior disorders, conduct disorder [e.g., runs away or has been incarcerated]);
- The expression/communication of thoughts of suicide, death, dying or the afterlife (in a context of sadness, boredom, hopelessness or negative feelings);
- Impulsive and aggressive behavior, frequent expressions of rage;
- Increasing use of alcohol or drugs;
• Exposure to another’s suicidal behavior;

• Recent severe stressor (e.g., difficulties in dealing with sexual orientation; unplanned pregnancy, significant real or anticipated loss, etc.); and/or

• Family instability, significant family conflict.

Sources

The information for this fact sheet was gathered from the National Center for Injury Prevention and Control (NCIPC) website (www.cdc.gov/ncipc/wisqars/default.htm), a division of the Centers for Disease Control and Prevention (CDC), and the Morbidity and Mortality Weekly Reports (May 21, 2004, 53 (SS-2); June 11, 2004, 53(4), p. 471-474).

* Safeguarding your Students Against Suicide - Expanding the Safety Net: Proceedings from an Expert Panel on Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses (2002), a report co-sponsored by the National Mental Health Association (NMHA) and the Jed Foundation.


* The Jed Foundation and the National Mental Health Association websites.
SUICIDE

In 2005, suicide was the eleventh leading cause of death in the U.S., claiming 32,637 lives. Suicide rates among youth (ages 15-24) have increased more than 200% in the last fifty years. The suicide rate is highest for the elderly (ages 65+) than for any other age group.

Four times more men than women complete suicide, but three times more women than men attempt suicide.

Suicide occurs across all ethnic, economic, social and age boundaries.

Many suicides are preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems. Most suicidal people give definite warning signals of their suicidal intentions, but those in close contact are often unaware of the significance of these warnings or unsure what to do about them.

Talking about suicide does not cause someone to become suicidal.

Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk for suicide and emotional problems.

DEPRESSION

Major Depressive Disorder (MDD) is the most prevalent mental health disorder. In the U.S., the lifetime risk for MDD is 16.6% according to a recent study (Kessler et al., 2005). According to the National Institute of Mental Health (NIMH), 9.5% or 18.8 million American adults suffer from a depressive illness in any given year.

The symptoms of depression (listed below) interfere with one’s ability to function in all areas of life (work, family, sleep, etc).

Common symptoms of depression occur almost every day for a period of two weeks or more:

- Depressed mood (e.g. feeling sad or empty)
- Lack of interest in previously enjoyable activities
- Significant weight loss or gain, or decrease or increase in appetite
- Insomnia or hypersomnia
- Agitation, restlessness, irritability
- Fatigue or loss of energy
- Feelings of worthlessness, hopelessness, guilt
- Inability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or plan for completing suicide

A family history of depression (e.g., a parent) increases the chances (11-fold) that a child in that family will also have depression.
The treatment of depression is effective 60 to 80% of the time. However, according to the World Health Organization (WHO), less than 25% of individuals with depression receive adequate treatment.

Depression often is accompanied by co-morbid (co-occurring) mental disorders (such as alcohol or substance abuse) and, if left untreated, can lead to higher rates of recurrent episodes and higher rates of suicide.

**THE LINK BETWEEN DEPRESSION AND SUICIDE**

Major Depressive Disorder (MDD) is the psychiatric diagnosis most commonly associated with completed suicide. Lifetime risk of suicide among patients with untreated MDD is nearly 20% (Gotlib & Hammen, 2002).

About 2/3 of people who complete suicide are depressed at the time of their deaths.

In a study conducted in Finland, of 71 individuals who completed suicide and who had Major Depressive Disorder, only 45% were receiving treatment at the time of death and only a third of these were taking antidepressants (Isometsa et al., 1994).

About 7 out of every 100 men and 1 out of every 100 women who have been diagnosed with depression at some time in their lifetime will go on to complete suicide.

The risk of suicide in people with Major Depressive Disorder is about 20 times that of the general population.

Individuals who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.

People who have a dependence on alcohol or drugs in addition to being depressed are at greater risk for suicide.

Individuals who are depressed and exhibit the following symptoms are at particular risk for suicide:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – as if there’s no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, inability to sleep or sleeping all the time
- Dramatic mood changes
- Expressing no reason for living; no sense of purpose in life

**Suicide is the major life-threatening complication of depression.**
Handout 26: General Warning Signs Of Youth Suicide

- Suicide Threats/Notes
- Plan/Method/Access
- Depression
  - Masked Depression (risk-taking behaviors, gun play, substance abuse)
  - Helplessness/Hopelessness
- Giving Away Prized Possessions
- Effort to Hurt Self
  - Running into Traffic
  - Jumping from Heights
  - Scratching, Cutting, Marking the Body
- Death/Suicidal Themes
- Sudden Changes in Friends, Personality or Behavior

An Easy-to-Remember Mnemonic for the Warning Signs of Suicide:

**IS PATH WARM?**

I Ideation -Expressed or communicated ideation
  - Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or
  - Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or
  - Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

S Substance Abuse -Increased substance (alcohol or drug) use

P Purposelessness -No reason for living; no sense of purpose in life

A Anxiety -Anxiety, agitation, unable to sleep or sleeping all the time

T Trapped -Feeling trapped (like there’s no way out)

H Hopelessness -Hopelessness

W Withdrawal -Withdrawal from friends, family and society

A Anger -Rage, uncontrolled anger, seeking revenge

R Recklessness -Acting reckless or engaging in risk activities, seemingly without thinking

M Mood Change -Dramatic mood changes

*These warning signs were derived as a consensus from a meeting of internationally-renowned clinical researchers held under the auspices of the AAS in Wellesley, MA in November 2003.*
Handout 27: Protocol For Intervening With A Potentially Suicidal Student

1. Take all threats seriously and take immediate action.

2. Do not leave the student alone.

3. Refer student to counselor who will meet immediately with the student and inform administration of the situation.

4. Contact the school psychologist to further assess the seriousness of the situation and to assess the risk of the student in crisis.

5. Collaborate with appropriate crisis team members to arrive at a consensus of the interventions to be implemented.

6. Designate a case manager who will:
   - Ensure that the parents/guardians are informed
   - Assess parent/guardian’s ability to provide support
   - Refer family for assessment/treatment and provide referral information as needed
   - Arrange for monitoring in school as long as necessary
   - Transport or request transport to emergency facility if danger is imminent

7. Link student with 24-hour crisis centers to use should the situation escalate after school hours.

Hotline: 1-800-422-0009 Maryland
1-800-448-4663 National
CRISIS TEAM RESOURCE GUIDE:
READINESS, RESPONSE, AND RECOVERY

HANDOUT 28: Preventing Suicide In Troubled Children
And Youth

National Association of School Psychologists

It has been well documented that children exposed to violence, life-threatening events or traumatic losses are at greater risk for depression, alcohol and substance abuse, and suicide. In the aftermath of tragedies such as the September 11 terrorist attacks, a school shooting, natural disaster, or even a personal crisis, students may display warning signs of suicidal behavior. Parents and school personnel should be particularly observant of children and youth who may be more vulnerable because of individual circumstances. This includes youngsters who have experienced a personal loss, abuse, or previous traumatic event or who suffer from depression or other mental illness. Youngsters who have these risk factors and who have been directly impacted by or witnessed another crisis are most vulnerable.

Although many suicidal children and adolescents do not self-refer, they do show warning signs to their peers, parents or trusted school personnel’s. Never ignore these signs. Suicide can be prevented with proper intervention. Warning signs may not appear during the immediate aftermath of a tragedy. Parents and school personnel must be good listeners and observers over the weeks to follow. Below are some guidelines for intervening with a suicidal student.

Warning Signs of Youth Suicide

1. **Suicide notes.** These are a very real sign of danger and should be taken seriously.
2. **Threats.** Threats may be direct (“I want to die.” “I am going to kill myself”) or, unfortunately, indirect (“The world would be better without me,” “Nobody will miss me anyway”). In adolescence, indirect clues could be offered through joking or through references in school assignments, particularly creative writing or art pieces. Young children and those who view the world in more concrete terms may not be able to express their feelings in words, but may provide indirect clues in the form of acting-out, violent behavior, often accompanied by suicidal/homicidal threats.
3. **Previous attempts.** Often the best predictor of future behavior is past behavior, which can indicate a coping style.
4. **Depression** (helplessness/hopelessness). When symptoms of depression include pervasive thoughts of helplessness and hopelessness, a child or adolescent is conceivably at greater risk for suicide.
5. **Masked depression.** Risk-taking behaviors can include acts of aggression, gunplay, and alcohol/substance abuse.
6. **Final arrangements.** This behavior may take many forms. In adolescents, it might be giving away prized possessions such as jewelry, clothing, journals or pictures.
7. **Efforts to hurt oneself.** Self-mutilating behaviors occur among children as young as elementary school-age’s Common self-destructive behaviors include running into traffic, jumping from heights, and scratching/cutting/marking the body.

8. **Inability to concentrate or think rationally.** Such problems may be reflected in children’s classroom behavior, homework habits, academic performance, household chores, even conversation.

9. **Changes in physical habits and appearance.** Changes include inability to sleep or sleeping all the time, sudden weight gain or loss, disinterest in appearance, hygiene, etc.

10. **Sudden changes in personality, friends, behaviors.** Parents, teachers and peers are often the best observers of sudden changes in suicidal students Changes can include withdrawing from normal relationships, increased absenteeism in school, loss of involvement in regular interests or activities, and social withdrawal and isolation.

11. **Death and suicidal themes.** These might appear in classroom drawings, work samples, journals or homework.

12. **Plan/method/access.** A suicidal child or adolescent may show an increased focus on guns and other weapons, increased access to guns, pills, etc., and/or may talk about or allude to a suicide plan. The greater the planning, the greater the potential.

**Tips for Parents**

1. **Know the warning signs!**
2. **Do not be afraid to talk to your child.** Talking to your children about suicide will not put thoughts into their head’s In fact, all available evidence indicates that talking to your child lowers the risk of suicide. The message is, “Suicide is not an option, help is available.”

3. **Suicide-proof your home.** Make the knives, pills and, above all, the firearms inaccessible.

4. **Utilize school and community resources.** This can include your school psychologist, crisis intervention personnel, suicide prevention groups or hotlines, or private mental health professionals.

5. **Take immediate action.** If your child indicates he/she is contemplating suicide, or if your gut instinct tells you they might hurt themselves, get help **Do not leave your child alone.** Even if he denies “meaning it,” stay with him. Reassure him Seek professional help. If necessary, drive your child to the hospital’s emergency room to ensure that she is in a safe environment until a psychiatric evaluation can be completed.

6. **Listen to your child’s friends.** They may give hints that they are worried about their friend but be uncomfortable telling you directly. Be open. Ask questions
Tips for Teachers

1. **Know the warning signs!**
2. **Know the school's responsibilities.** Schools have been held liable in the courts for not warning the parents in a timely fashion or adequately supervising the suicidal student.
3. **Encourage students to confide in you** Let students know that you are there to help, that you care Encourage them to come to you if they or someone they know is considering suicide.
4. **Refer student immediately.** Do not “send” a student to the school psychologist or counselor. **Escort the child** yourself to a member of the school’s crisis team If a team has not been identified, notify the principal, psychologist, counselor, nurse or social worker. (And as soon as possible, request that your school organize a crisis team!)
5. **Join the crisis team.** You have valuable information to contribute so that the school crisis team can make an accurate assessment of risk.
6. **Advocate for the child.** Sometimes administrators may minimize risk factors and warning signs in a particular student Advocate for the child until you are certain the child is safe.

Where to Get More Information

American Association of Suicidology (303) 692-0285 [www.suicidology.org/](http://www.suicidology.org/)

National Association of School Psychologists (301) 657-0270 [www.nasponline.org](http://www.nasponline.org)
Suicide Awareness/Voice of Education (SAVE) [www.save.org](http://www.save.org)

School crisis teams can get more detailed information in “Times of Tragedy: Preventing Suicide in Troubled Children and Youth, Part II: Tips for School Personnel or Crisis Team Members,” at [www.nasponline.org](http://www.nasponline.org).

From the National Association of School Psychologists’ School Prevention and Intervention Training Curriculum. Used with permission.
CRISIS TEAM RESOURCE GUIDE:  
READINESS, RESPONSE, AND RECOVERY

HANDOUT 29: Tips For School Personnel Or Crisis Team Members

Children and youth exposed to extreme trauma like the terrorist attacks on the United States or a school shooting can be at increased risk of suicide, particularly youngsters who have experienced a personal loss, abuse, or previous traumatic event or who suffer from depression or other mental illness. School personnel will need to be more vigilant the weeks following a large-scale crisis, identify students who may be at greater risk, and watch for warning signs. The following information is a companion piece to *After A National Tragedy: Preventing Suicide in Troubled Children and Youth, Part I*, which outlines warning signs and tips for parents and teachers, available from the National Association of School Psychologists online at [www.nasponline.org](http://www.nasponline.org). (See also “Save a Friend: Tips for Teens to Prevent Suicide”, also on the NASP website.)

Tips for School Personnel or Crisis Team Members

1. **Collaborate with colleagues** Having support and consultation from an administrator and one other staff member (perhaps the school nurse, counselor, or social worker) is both reassuring and prudent.

2. **Assign a “designated reporter.”** Schools should identify one or more individuals to receive and act upon all reports from teachers, other staff and students about students who may be suicidal. This individual is frequently the school psychologist, counselor, nurse or social worker.

3. **Supervise the student.** It is best to always inform the student what you are going to do every step of the way. Solicit the student’s assistance where appropriate. Under no circumstances should the student be allowed to leave school or be alone (even in the restroom). Reassure and supervise the student until a parent, mental health professional or law enforcement representative can assume responsibility.

4. **Mobilize a support system.** Assessment of the student's support system will contribute to evaluating the student’s risk. It is often sensible to just ask the student, “who do you want or who do you think will be there for you now?” and assist the student achieving that support. It is important for students to feel some control over their fate.

5. **No-Suicide Contracts.** No-suicide contracts have been shown to be effective in preventing youth suicide. In cases where the suicide risk is judged to be low enough not to require an immediate treatment (e.g., there is only ideation and no suicide plan), a no-suicide contract is still recommended to provide the student with alternatives should their suicide risk level increase in the future. Such a contract is a personal agreement to postpone suicidal behaviors until help can be obtained. The contract can also serve as an effective assessment tool. If a student refuses to sign, they cannot guarantee they will not hurt themselves.
6. assessment immediately rises to high risk and the student should be supervised until parents can assume responsibility in taking the student for immediate psychiatric evaluation.

7. **Suicide-proof the environment.** Whether a child is in imminent danger or not, it is recommended both the home and school be suicide-proofed. Before the child returns home and thereafter, all guns, poisons, medications, and sharp objects must be removed or made inaccessible.

8. **Call police.** All school crisis teams should have a representative from local law enforcement. If a student resists, becomes combative or attempts to flee, law enforcement can be of invaluable assistance. In some cases they can assume responsibility for securing a “72-hour hold” which will place the youth in protective custody up to three days for psychiatric observation.

9. **Documentation.** Every school district should develop a documentation form for support personnel and crisis team members to record their actions in responding to a referral of a suicidal student.

### A Suicide Intervention Model

1. **Assessment.**
   Designated Reporters are often asked to make critical risk assessments under extraordinary time constraints. Thus, it is important for a risk assessment protocol to have a specific set of questions that will quickly and reliably obtain needed information. Questions often used address the following:

   - What warning signs(s) initiated the referral?
   - Has the student thought about suicide (thoughts or threats alone, whether direct or indirect, may indicate low risk)?
   - Has the student tried to hurt himself before (previous attempts may indicate moderate risk)?
   - Does the student have a plan to harm herself now?
   - What method is the student planning to use and does he have access to the means (these questions would indicate high risk)?
   - What is the support system that surrounds this child (including the parent in the risk assessment is critical to determining the adequacy of the student’s support system)?

2. **Duty to Warn Parents**
   There is no question that parents must be notified. In addressing this aspect of suicide intervention, four critical questions need to be addressed:

   - First, is the parent available?
   - Second, is the parent cooperative?
   - Third, what information does the parent have that might contribute to the assessment of risk?
   - Fourth, what mental health insurance, if any, does the family possess?
**Handout 29: Tips for School Personnel or Crisis Team Members**

If the parent is available and cooperative and the student is judged high risk, the psychologist or social worker must provide parent(s) with community referral resources specific to where the family resides and based on health insurance status. With parental permission, the school psychologist should contact the agency, provide pertinent referral information and follow up to insure the family’s arrival at the agency. If necessary, assist the parent in transporting the student to the agency. The psychologist should obtain a parent signature on a release of information form and assist school staff in working with parents to develop a school support plan. All actions must be documented.

If a parent is unavailable and the student is judged high risk, then, at the discretion of the school site administrator, two members of the crisis team should escort the child to the nearest emergency mental health facility and coordinate efforts with the agency’s Social Services to contact parent. Alternatively, school law enforcement, local police or a mobile psychiatric response team may be asked to assist in transporting the suicidal youth.

Some parents are reluctant to follow through on crisis team recommendations to secure outside counseling for the suicidal child and may simplify or minimize warning signals (e.g., "she's just doing this for attention"). Cultural and language issues are frequent. Give the parents appropriate opportunity and encouragement to follow through before collaborating with crisis team members on when to proceed to the next step. The school crisis team must decide when it is appropriate to report a parent to child protective services if their reluctance is truly negligence and endangers the life of the child.

If it is determined that a parent is uncooperative and the student is judged to be at high risk for a suicidal behavior, then local law enforcement or child protective services should be contacted and child neglect and endangerment report made.

If the parent is uncooperative and the student is judged low risk for suicidal behavior, then it is recommended that the parent to sign a “Notification of Emergency Conference” form which serves to document that the parents have been notified of their child’s suicidal assessment in a timely fashion.

There will be occasions when a student does not want a parent notified. When children are thinking of harming themselves, they are not thinking clearly and, therefore, may not be the best judge of what might be their parent's response. The crisis team has only one decision to make: Will the child be placed in a more dangerous situation by notifying the parent? In such a situation, child protective services will typically be notified. The parents must still be notified and it is the challenge to school personnel to elicit a supportive response from parents.

The parent often has critical information necessary to make an appropriate assessment of risk. Thus it is critical to include parents in the risk assessment. This information may include previous school and mental health history, family dynamics, recent traumatic events in the student's life, and previous suicidal behaviors. Interviewing the parent will also assist the psychologist in making an appropriate assessment of the support system that surrounds this student.

Finally, it is important to determine what mental health insurance does the parent/family have? This information is essential in directing families to appropriate community agencies. All modern mental health intake interviews include questions regarding insurance coverage and it is wise for the school psychologist to be aware of the various local providers. If a student is directed to an emergency clinic, they may later require emergency transport to an appropriate HMO provider. This may not only
Further traumatize a suicidal student (because most transports must be done under restraints) but also generate a bill of great expense for the parent. It is certainly in the best interest of the child and family to limit the trauma of any student in need of emergency action.

3. Duty To Provide Referrals.
B It is critical to stress the importance of identifying and collaborating with community agencies before the crisis occurs. It is recommended that the school crisis team representative call the agency to provide accurate information that the parent may omit or forget. School districts have an obligation to suggest agencies that are non-proprietary or offer sliding scale of fees.

4. Follow up and support the family.
Finally, it is important for school staff to provide ongoing modifications to the students program, perhaps utilizing student study teams.

Resources for School Teams

National Association of School Psychologists www.nasponline.org

Center for Mental Health in Schools http://smhp.psych.ucla.edu/resource.htm#crisis

National Victim's Assistance Organizationhttp://www.try-nova.org

NASP represents 22,000 school psychologists and related professionals throughout the United States and abroad. NASP’s mission is to promote educationally and psychologically healthy environments for all children and youth by implementing research-based, effective programs that prevents problems, enhance independence and promote optimal learning. This is accomplished through state-of-the-art research and training, advocacy, ongoing program evaluation, and caring professional service.

Modified from material posted on the NASP website, September 2001.

Additional Resources
American Foundation for Suicide Prevention Samaritans USA(AFSP)
www.samaritansnyc.org
www.afsp.org

Suicide Awareness Voices of Education (SAVE)
Centers for Disease Control and Prevention (CDC)
www.save.org
www.cdc.gov

Centre for Suicide Prevention
The Jason Foundation www.suicideinfo.ca
www.jasonfoundation.com
Suicide Prevention Action Network
The Jed Foundation (SPAN USA)
www.jedfoundation.org
www.spanusa.org

The Links National Resource Center for Suicide Prevention and Research Center
Suicide Prevention and Aftercare (SPRC)
www.thelink.org
www.sprc.org

National Center for Injury Prevention and Yellow Ribbon Suicide Prevention Program
Control (NCIPC) www.yellowribbon.org
www.cdc.gov/ncipc/default.htm

National Institute of Health (NIH)
www.nih.gov

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

National Organization for People of Color Against Suicide (NOPCAS)
www.nopcas.com

National Strategy for Suicide Prevention (NSSP)
http://www.mentalhealth.org/suicideprevention

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org

Office of the Surgeon General
www.surgeongeneral.gov

Organization for Attempters and Survivors of Suicide and Interfaith Services (OASSIS)
www.oassis.org

Articles/Books:

National strategy for suicide prevention: Goals and objectives for action. Rockville, MD:
U.S. Department of Health and Human Services, Public Health Service, 2001. (Also available on the
web at http://www.mentalhealth.org/suicideprevention.)
Handout 29: Tips for School Personnel or Crisis Team Members


Handout 29: Tips for School Personnel or Crisis Team Members


Special thanks to Lori Bradshaw, Librarian at the Suicide Prevention Resource Center (SPRC), for the articles in this section.
Handout 29: Tips for School Personnel or Crisis Team Members

References


These recommendations were produced in the spirit of the public-private partnership recommended by the Surgeon General’s National Strategy for Suicide Prevention.

We would like to thank the many journalists and news editors who assisted us in this project. The Annenberg Public Policy Center’s involvement was funded by The Robert Wood Johnson Foundation.

**Resources**

<table>
<thead>
<tr>
<th>United States</th>
<th>International</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Association of SuicidologyPhone: 202-237-2280 <a href="http://www.suicidology.org">www.suicidology.org</a></td>
<td>M0 M Canterbury Suicide Project (New Zealand) Phone: 64 3 364 0530  <a href="http://www.chmeds.ac.nz/RESEARCH/SUICIDE/Suicide.htm">www.chmeds.ac.nz/RESEARCH/SUICIDE/Suicide.htm</a></td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration Phone: 1-800-487-4890 <a href="http://www.samhsa.gov">www.samhsa.gov</a></td>
<td>M0 M Suicide Information and Education Centre Phone: 403 245-3900 <a href="http://www.suicideinfo.ca">www.suicideinfo.ca</a></td>
</tr>
<tr>
<td>Office of the Surgeon General National Strategy for Suicide Prevention <a href="http://www.mentalhealth.org/suicideprevention">www.mentalhealth.org/suicideprevention</a></td>
<td>M0 M World Health Organization Phone: +00 41 22 791 21 11 <a href="http://www.who.int">www.who.int</a></td>
</tr>
</tbody>
</table>
Handout 30: Preventing Youth Suicide - Tips For Parents And Educators

Suicide is the third leading cause of death among youth between 10 and 19 years of age. However, suicide is preventable. Youth who are contemplating suicide frequently give warning signs of their distress. Parents, teachers, and friends are in a key position to pick up on these signs and get help. Most important is to never take these warning signs lightly or promise to keep them secret. When all adults and students in the school community are committed to making suicide prevention a priority and are empowered to take the correct actions, we can help youth before they engage in behavior with irreversible consequences.

Suicide Risk Factors

Certain characteristics are associated with increased suicide risk. These include:

- Mental illness including depression, conduct disorders, and substance abuse.
- Family stress/dysfunction.
- Environmental risks, including presence of a firearm in the home.
- Situational crises (i.e., traumatic death of a loved one, physical or sexual abuse, family violence, etc.).

Suicide Warning Signs

Many suicidal youth demonstrate observable behaviors that signal their suicidal thinking. These include:

- Suicidal threats in the form of direct and indirect statements.
- Suicide notes and plans.
- Prior suicidal behavior.
- Making final arrangements (e.g., making funeral arrangements, writing a will, giving away prized possessions).
- Preoccupation with death.
- Changes in behavior, appearance, thoughts and/or feelings.

What to Do

Youth who feel suicidal are not likely to seek help directly; however, parents, school personnel, and peers can recognize the warning signs and take immediate action to keep the youth safe. When a youth gives signs that they may be considering suicide, the following actions should be taken:

- Remain calm.
- Ask the youth directly if he or she is thinking about suicide.
- Focus on your concern for their wellbeing and avoid being accusatory.
Handout 30: Preventing Youth Suicide - Tips For Parents And Educators

- Listen.
- Reassure them that there is help and they will not feel like this forever.
- Do not judge.
- Provide constant supervision. Do not leave the youth alone.
- Remove means for self-harm.
- **Get help:** Peers should not agree to keep the suicidal thoughts a secret and instead should tell an adult, such as a parent, teacher, or school psychologist. Parents should seek help from school or community mental health resources as soon as possible. School staff should take the student to the designated school mental health professional or administrator.

**The Role of the School in Suicide Prevention**

Children and adolescents spend a substantial part of their day in school under the supervision of school personnel. Effective suicide and violence prevention is integrated with supportive mental health services, engages the entire school community, and is imbedded in a positive school climate through student behavioral expectations and a trustful student/adult relationship. Therefore, it is crucial for all school staff to be familiar with and watchful for risk factors and warning signs of suicidal behavior. The entire school staff should work to create an environment where students feel safe sharing such information. School psychologists and other crisis team personnel, including the school counselor and school administrator, are trained to intervene when a student is identified at risk for suicide. These individuals conduct suicide risk assessment, warn/inform parents, provide recommendations and referrals to community services, and often provide follow up counseling and support at school.

**Parental Notification and Participation**

Parent notification is a vital part of suicide prevention. Parents need to be informed and actively involved in decisions regarding their child’s welfare. Even if a child is judged to be at low risk for suicidal behavior, schools will ask parents to sign a Notification of Emergency Conference form to indicate that relevant information has been provided. These notifications must be documented. Additionally, parents are crucial members of a suicide risk assessment as they often have information critical to making an appropriate assessment of risk, including mental health history, family dynamics, recent traumatic events, and previous suicidal behaviors.

After a school notifies a parent of their child’s risk for suicide and provides referral information, the responsibility falls upon the parent to seek mental health assistance for their child. Parents must:

- Continue to take threats seriously: Follow through is important even after the child calms down or informs the parent they didn’t mean it. Avoid assuming behavior is attention seeking.
- Access school supports: If parents are uncomfortable with following through on referrals, they can give the school psychologist permission to contact the referral agency, provide referral information, and follow up on the visit. The school can also assist in providing transportation to get the parent and child to the referral agency.
- Maintain communication with the school. After such an intervention, the school will also provide follow-up supports. Your communication will be crucial to ensuring that the school is the safest, most comfortable place for your child.
Resiliency Factors
The presence of resiliency factors can lessen the potential of risk factors to lead to suicidal ideation and behaviors. Once a child or adolescent is considered at risk, schools, families, and friends should work to build these factors in and around the youth. These include:

- Family support and cohesion, including good communication.
- Peer support and close social networks.
- School and community connectedness.
- Cultural or religious beliefs that discourage suicide and promote healthy living.
- Adaptive coping and problem-solving skills, including conflict-resolution.
- General life satisfaction, good self-esteem, sense of purpose.
- Easy access to effective medical and mental health resources.

NASP Resources Available Online
NASP has a number of resources available to assist families and educators in preventing youth suicide. These can be accessed at www.nasponline.org. Additionally NASP has published numerous chapters that relate directly to this topic. Information can be found on the NASP website.

Suggested Resources
Save a Friend: Tips for Teens to Prevent Suicide
Times of Tragedy: Preventing Suicide in Troubled Children and Youth, Part I
http://www.nasponline.org/resources/crisis_safety/suicidept1_general.aspx
National Association of Secondary School Principals, b Taking the Lead on Suicide Prevention and Intervention in the Schools. It will be posted at
www.nasponline.org/resources/principals/nassp2006.aspx. This will be a helpful resource to share with your school administrators.

Other Online Resources
American Association of Suicidology, http://www.suicidology.org
Depression and Bipolar Support Alliance (DBSA), www.dbsalliance.org
National Institute of Mental Health Suicide Prevention Resources,
http://www.nimh.nih.gov/suicideprevention/index.cfm
National Mental Health Association, www.nmha.org
S.O.S High School Suicide Prevention Program,
http://www.mentalhealthscreening.org/highschool/
Suicide Awareness/Voices of Education (SAVE), www.save.org
U.S. Department of Health and Human Services, National Strategy on Suicide Prevention,
http://www.mentalhealth.samhsa.gov/suicideprevention/
CRISIS TEAM RESOURCE GUIDE:
READINESS, RESPONSE, AND RECOVERY

Handout 31: Save A Friend: Tips For Teens To Prevent Suicide

Growing up is not easy—children and teenagers face many tough decisions and difficult life experiences that, at times, seem overwhelming. For some kids, a difficult, scary or threatening situation like the recent terrorist attacks can cause so much distress that they start to think about killing themselves. Suicide is one of the leading causes of death for kids in middle school and high school and it can be prevented if adults and friends are aware of the warning signs and know what to do.

Although kids thinking about suicide are not likely to seek help, they do show warning signs to their friends, classmates, parents or trusted school personnel. Never ignore these signs. You can help! Some situations that might cause some kids to think about suicide include breaking up with boyfriend or girlfriend, failing in school, problems with parents, rejection by friends, etc. After a disaster such as a school shooting or terrorist attack in our country, some students may display warning signs of suicidal behavior. Children and youth who have experienced a personal loss, abuse, or an earlier tragic or frightening event, or who suffer from depression or other emotional problems, have a higher risk of suicide. Youngsters who have these risk factors and who have been directly impacted by or witnessed the attacks are most likely to consider suicide. Warning signs may not appear right away, following the event. Parents, teachers and friends must be good listeners and observers over the weeks to come. Below are some tips to help prevent suicide and get help.

Suicide Warning Signs

1. **Suicide notes.** These are a very real sign of danger and should be taken seriously.
2. **Threats.** Threats may be direct statements (“I want to die.” “I am going to kill myself”) or, unfortunately, indirect comments (“The world would be better without me”, “Nobody will miss me anyway”). Among teenagers, indirect clues could be offered through joking or through comments in school assignments, particularly creative writing or artwork. Younger children and those who may have some delays in their development may not be able to express their feelings in words, but may provide indirect clues in the form of acting-out, violent behavior, often with threatening or suicidal comments.
3. **Previous attempts.** If a child or teenager has attempted suicide in the past, there is a greater likelihood that he or she will try again. Be very observant of any friends who have tried suicide before.
4. **Depression** (helplessness/hopelessness). When symptoms of depression include strong thoughts of helplessness and hopelessness, a child or adolescent is possibly at greater risk for suicide. Watch out for behaviors or comments that indicate that your friend is feeling overwhelmed by sadness or pessimistic views of their future.
5. “**Masked**” depression. Sometimes risk-taking behaviors can include acts of aggression, gunplay, and alcohol/substance abuse. While your friend does not acted “depressed,” their behavior suggests that they are not concerned about their own safety.
6. **Final arrangements.** This behavior may take many forms. In adolescents, it might be giving away prized possessions such as jewelry, clothing, journals or pictures.
7. **Efforts to hurt oneself** Self-injury behaviors are warning signs for young children as well as teenagers. Common self-destructive behaviors include running into traffic, jumping from heights, and scratching/cutting/marking the body.

8. **Inability to concentrate or think clearly** Such problems may be reflected in classroom behavior, homework habits, academic performance, household chores, even conversation. If your friend starts skipping classes, getting poor grades, acting up in class, forgetting or poorly performing chores around the house or talking in a way that suggests they are having trouble concentrating, these might be signs of stress and risk for suicide.

9. **Changes in physical habits and appearance**’s Changes include inability to sleep or sleeping all the time, sudden weight gain or loss, disinterest in appearance or hygiene.

10. **Sudden changes in personality, friends, behaviors.** Parents, teachers and friends are often the best observers of sudden changes in suicidal students Changes can include withdrawing from friends and family, skipping school or classes, loss of involvement in activities that were once important, and avoiding friends.

11. **Death and suicidal themes.** These might appear in classroom drawings, work samples, journals or homework.

12. **Plan/method/access.** A suicidal child or adolescent may show an increased interest in guns and other weapons, may seem to have increased access to guns, pills, etc., and/or may talk about or hint at a suicide plan. The greater the planning, the greater the potential for suicide.

**What Can You Do to Help a Friend?**

1. **Know the warning signs!** Read over the list above and keep it in a safe place.

2. **Do not be afraid to talk to your friends** Listen to their feelings. Make sure they know how important they are to you, but don’t believe you can keep them from hurting themselves on your own. Preventing suicide will require adult help.

3. **Make no deals** Never keep secret a friend's suicidal plans or thoughts. You can not promise that you will not tell—you have to tell to save your friend!

4. **Tell an adult.** Talk to your parent, your friend's parent, your school’s psychologist or counselor--a trusted adult. And don’t wait! Don’t be afraid that the adults will not believe you or take you seriously—keep talking until they listen! Even if you are not sure your friend is suicidal, talk to someone. It’s OK if you “jump the gun”—this is definitely the time to be safe and not sorry!

5. **Ask if your school has a crisis team.** Many schools (elementary, middle and high schools) have organized crisis teams, which include teachers, counselors, social workers, psychologists and principals. These teams help train all staff to recognize warning signs of suicide as well as how to help in a crisis situation. These teams can also help students understand warning signs of violence and suicide. If your school does not have a crisis team, ask your Student Council or faculty advisor to look into starting a team.

*Adapted from “A National Tragedy: Preventing Suicide in Troubled Children and Youth,” available at www.nasponline.org. Modified from material posted on the NASP website in September 2001.*

B) 2002, National Association of School Psychologists, 4340 East West Highway, #402, Bethesda, MD 20814; (301) 657-0270; www.nasponline.org
CRISIS TEAM RESOURCE GUIDE: READINESS, RESPONSE, AND RECOVERY

Handout 32: Survivors Of Suicide Fact Sheet

A survivor of suicide is a family member or friend of a person who died by suicide.

Some Facts…

- Survivors of suicide represent “the largest mental health casualties related to suicide” (Edwin Shneidman, Ph.D., AAS Founding President).
- There are currently over 32,000 suicides annually in the USA. It is estimated that for every suicide there are at least 6 survivors. Some suicidologists believe this to be a very conservative estimate.
- Based on this estimate, approximately 5 million American became survivors of suicide in the last 25 years.

About Suicidal Grief

The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex, and long term. Grief work is an extremely individual and unique process; each person will experience it in their own way and at their own pace.

Grief does not follow a linear path. Furthermore, grief doesn’t always move in a forward direction.

There is no time frame for grief. Survivors should not expect that their lives will return to their prior state. Survivors aim to adjust to life without their loved one.

Common emotions experienced in grief are:

<table>
<thead>
<tr>
<th>Shock</th>
<th>Denial</th>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guilt</td>
<td>Anger</td>
<td>Shame</td>
</tr>
<tr>
<td>Despair</td>
<td>Disbelief</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>Stress</td>
<td>Sadness</td>
<td>Numbness</td>
</tr>
<tr>
<td>Rejection</td>
<td>Loneliness</td>
<td>Abandonment</td>
</tr>
<tr>
<td>Confusion</td>
<td>Self-blame</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Helplessness</td>
<td>Depression</td>
<td></td>
</tr>
</tbody>
</table>

These feelings are normal reactions and the expression of them is a natural part of grieving. At first, and periodically during the following days/months of grieving, survivors may feel overwhelmed by their emotions. It is important to take things one day at a time.

Crying is the expression of sadness; it is therefore a natural reaction after the loss of a loved one. Survivors often struggle with the reasons why the suicide occurred and whether they could have done something to prevent the suicide or help their loved one. Feelings of guilt typically ensue if the survivor believes their loved one's suicide could have been prevented.
At times, especially if the loved one had a mental disorder, the survivor may experience relief. There is a stigma attached to suicide, partly due to the misunderstanding surrounding it. As such, family members and friends of the survivor may not know what to say or how and when to provide assistance. They may rely on the survivor’s initiative to talk about the loved one or to ask for help.

Shame or embarrassment might prevent the survivor from reaching out for help. Stigma, ignorance and uncertainty might prevent others from giving the necessary support and understanding. Ongoing support remains important to maintain family and friendship relations during the grieving process.

Survivors sometimes feel that others are blaming them for the suicide. Survivors may feel the need to deny what happened or hide their feelings. This will most likely exacerbate and complicate the grieving process.

When the time is right, survivors will begin to enjoy life again. Healing does occur.

Many survivors find that the best help comes from attending a support group for survivors of suicide where they can openly share their own story and their feelings with fellow survivors without pressure or fear of judgment and shame. Support groups can be a helpful source of guidance and understanding as well as a support in the healing process.

**Children as Survivors**

It is a myth that children don’t grieve. Children may experience the same range of feelings as do adults; the expression of that grief might be different as children have fewer tools for communicating their feelings.

Children are especially vulnerable to feelings of guilt and abandonment. It is important for them to know that the death was not their fault and that someone is there to take care of them. Secrecy about the suicide in the hopes of protecting children may cause further complications. Explain the situation and answer children’s questions honestly and with age-appropriate responses.

**Helping Survivors of Suicide: What Can You Do?**

The single most important and helpful thing you can do as a friend is listen. Actively listen, without judgment, criticism, or prejudice, to what the survivor is telling you. Because of the stigma surrounding suicide, survivors are often hesitant to openly share their story and express their feelings. In order to help, you must overcome any preconceptions you have about suicide and the suicide victim. This is best accomplished by educating yourself about suicide. While you may feel uncomfortable discussing suicide and its aftermath, survivor loved ones are in great pain and in need of your compassion.

Ask the survivor if and how you can help. They may not be ready to share and may want to grieve privately before accepting help.
Handout 32: Survivors Of Suicide Fact Sheet

Let them talk at their own pace; they will share with you when (and what) they are ready to. Be patient. Repetition is a part of healing, and as such you may hear the same story multiple times. Repetition is part of the healing process and survivors need to tell their story as many times as is necessary.

Use the loved one’s name instead of ‘he’ or ‘she’. This humanizes the decedent; the use of the decedent’s name will be comforting.

You may not know what to say, and that’s okay. Your presence and unconditional listening is what a survivor is looking for.

You cannot lead someone through their grief. The journey is personal and unique to the individual. Do not tell them how they should act, what they should feel, or that they should feel better “by now”.

Avoid statements like “I know how you feel”; unless you are a survivor, you can only empathize with how they feel.

Survivors of suicide support groups are helpful to survivors to express their feelings, tell their story, and share with others who have experienced a similar event. These groups are good resources for the healing process and many survivors find them helpful. Please consult our website (www.suicidology.org) for a listing of support groups in or near your community.
CRISIS TEAM RESOURCE GUIDE:  
READINESS, RESPONSE, AND RECOVERY 

Crisis Response Team Resource Guide References


Merriam-Webster Online: www.merriam-webster.com


