About the Author

WILLIAM STEELE

William Steele, PsyD, MSW, informally began his work in trauma in the early 1980s when he published the booklet, “Preventing Teen Suicide.” This led to requests for training from across the country. His experiences with nonfatal attempters and survivors of suicide was acknowledged in 1986 when the Michigan Chapter of the The National Academy of Television Arts and Sciences awarded Dr. Steele’s production of “Preventing Teen Suicide” a Michigan Emmy. In the mid-80s he also began working with survivors of homicide, which led to the production of “Where Have All The Children Gone,” which focused on childhood violence. In 1987 it was nominated for Outstanding Program Achievement by the Academy.

Dr. Steele’s work with children, teens and families exposed to tragic losses from both violent and nonviolent situations led him to founding the National Institute for Trauma and Loss in Children (TLC) in 1990. The mission of TLC was to bring trauma-specific training, intervention services and resource materials to professionals, schools and clinics nationally.

In 1997 he initiated a trauma and loss certification program. Today over 6,000 TLC Certified Trauma Specialist who Dr. Steele personally trained are using TLC’s published evidence-based intervention programs across the country. These programs which Dr. Steele developed are now registered as evidence-based programs at California Evidence Based Clearinghouse and the Substance Abuse Mental Health Services Agency (SAMHSA) Registry of Evidence Based Practices. He has assisted professionals over the years following such tragedies as the bombing of the Federal Building in Oklahoma, 9/11 in New York and Washington D.C., Hurricanes Katrina and Rita and the 2009 killings (while in school in the presence of students) of a high school coach in Iowa and a teacher in Texas to name but a few. He was one of the first Americans selected by the Kuwait government to assist them in the aftermath of the Gulf War and continues to consult with agencies related to childhood trauma.

Dr. Steele’s work is published in numerous books, such as “Understanding Mass Violence,” “Creative Interventions with Traumatized Children,” “Critical Incidents in Counseling Children” and its research outcomes in varied journals including, “National Social Sciences Journal,” “School Social Work Journal,” and “Journal of Residential Treatment for Children and Youth.” Dr. Robert Foltz, assistant professor of clinical psychology at The Chicago School of Professional Psychology, wrote this about Dr. Steele’s
most recent book, “Trauma Informed Practices With Children and Adolescents.”

“…this book is an essential resource for any treatment provider committed to using effective assessment and intervention strategies in their work with traumatized youth. The wisdom within this work will support the care of many trauma exposed youth for years to come.”

“Working with Grieving and Traumatized Children and Adolescents: Discovering What Matters Most Through Evidence-Based, Sensory Interventions,” authored by Dr. Steele and Dr. Caelan Kuban, is also being published in mid 2013 by Wiley & Sons, CA. Peter Levine and Maggie Kline wrote, "What Matters Most"… is helping children caught in the ravages of trauma and grief. The authors provide a clear theoretical framework AND demonstrate practical sensory-based activities so kids can discover and reconnect with their bodies' agency and vitality. Refreshingly, this vehicle creates an emotionally safe journey for the child into the mystery of the experiential, embedded in implicit memory. It's chock full of invitations to explore self-impressions and worldview in a way that children feel seen; not assessed.

Peter A. Levine, Ph.D. originator and founder of the Somatic Experiencing Trauma Institute and author of “Waking the Tiger and In an Unspoken Voice” & Maggie Kline, MS, LMFT, School Psychologist, SE Faculty, co-author of “Trauma through a Child's Eyes and Trauma-Proofing Your Kids.”

Over the years Dr. Steele has presented to over 50,000 professionals in schools, agencies clinics and community programs. He has written many times that he is most proud of TLC members who have contributed so much of their time to field testing and researching TLC's intervention programs. Their ongoing feedback and recommendations ensure that these interventions remain timely and practical but, most importantly that they do what they are intended to do - help traumatized children not only find relief from their traumatic experiences but go on to flourish.
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Critical Considerations

Creating A Trauma Informed Framework For Recovery

Whether it be exposure to mass killings like the killing of 20 early elementary school aged children and 6 of their school staff at Sandy Hook Elementary in Connecticut December, 2012, acts of terrorism, war, the murder of one child or adult in their home, school or community, the loss of life due to catastrophic incidents like the Rhode Island nightclub fire that killed 100 people in 2003 or Hurricanes Katrina and Rita in 2005 that killed 2,000 children and adults, the survivors of these deadly incidents benefit from varied levels of support and intervention. “Critical Considerations” presents 20 critical considerations that, addresses the common challenges and needs shared by all survivors, but also the unique challenges and needs created by the nature of their experiences that dictate how practitioners approach survivors. These considerations provide the framework to then safely and appropriately initiate TLC’s Trauma Recovery Interventions which are time specific beginning with first day through the end of the first week and the following two month period.
Chapter One
INTRODUCTION

What matters most is that we appreciate that there is no one intervention that fits every situation and that any intervention used inappropriately can and has put many survivors at greater risk for mental health challenges. Therefore, our interventions must support a trauma-informed approach and be initiated within a framework that survivors themselves have indicated to be safe and supportive of their efforts to recover from and manage their experiences. This is the case when responding to school related trauma and community violent or non-violent trauma.

“Critical Considerations” presents a framework detailing twenty critical trauma-informed approaches that we believe practitioners must endorse in their responses to and initiation of intervention with survivors in order to support the primary dictate of trauma-informed practices – Do No Harm. “Critical Considerations” is different from the many excellent ‘How To Help’ lists national organizations make available following tragic events. These lists often direct themselves at ways parents can help their children and the reactions to be anticipated by survivors following traumatic incidents. This information is helpful and needed as it provides the general public with immediate guidance.

However, “Critical Considerations” is directed at the intervention processes and unique issues facing practitioners that are not often addressed in the many resources made available. These considerations are the result of Dr. Steele’s thirty years of experience of working with survivors in addition to the experienced staff and Certified Trauma Specialists of The National Institute for Trauma and Loss in Children (TLC), which Dr. Steele founded in 1990 to assist survivors and professionals in the position to be helpful.

“Critical Considerations” was prepared following the December, 2012 mass killing of 20 early elementary school children and six adult staff members at Sandy Hook Elementary School in Connecticut. Mass killings raise a number of socio-political issues that this country has been unsuccessfully struggling with for years. And, they always bring attention to the psychological aspects of those who kill. The intent of “Critical Considerations” is not to address these issues, but what matters most for the victims, survivors, their families and the communities impacted by such tragic and traumatic incidents. However, a brief review of the history of such violent incidents certainly suggest that we must be prepared to anticipate and to accept that no community is immune from these senseless acts.

Following this review we briefly introduce new readers to the practice based and evidence based history of TLC practices and experiences that frame our considerations and support our recommendations. We then present twenty critical approaches to responding and intervening with survivors of violent and non-violent incidents, the reactions to be expected and shared across all ages following exposure and the differences unique to certain incidents such as homicide and devastating storms. References and links to numerous resources covering many different aspects of responding to survivors are also provided.
A Brief Review Of Mass Killings

Incidents like Sandy Hook Elementary School and the Columbine High School shooting that took the lives of 12 high school students will be remembered for many years, for many reasons. However, many other violent incidents, as equally devastating for victims, survivors, their families and communities, are either forgotten over time, rarely mentioned in news coverage of current incidents or at times are left out of historical timelines of mass killings in this country.

The following news report could be assigned to so many incidents but it is specific to one. Which incident might you assign to this report?

“The local community responded generously as reported at the time by the Associated Press. A sympathetic public assured the rehabilitation of the stricken community. Aid was tendered freely in the hope that the grief of those who lost loved ones might be even slightly mitigated. The Red Cross managed donations sent to pay for both the medical expenses of the survivors and the burial cost of the dead. The disaster received nationwide coverage in the days following and a national outpouring of grief. Vehicles, by the thousands, from outlying areas and surrounding states drove to the area where the tragedy took place. Some citizens regarded this armada as an unwarranted intrusion into their time of grief, but most accepted it as a show of sympathy and support from surrounding communities.” http://en.wikipedia.org/wiki/Bath_School_disaster

This was actually reported following the 1927 intentional bombing of the Bath Consolidated School in Michigan that killed 38 elementary students and six adults while 58 others were seriously injured. Such violence in this country has been occurring for years. Rarely is this mass killing ever mentioned in reports summarizing the taking of young, innocent lives. Sadly very little has changed. The list of mass killings in Table 1 is not inclusive but does send a very clear message. (http://www.bradblog.com/?p=9781)

Table 2 shows a number of other mass killings following the Columbine shootings in 1999.(http://anaverageamericanpatriot.blogspot.com/2013/01/timeline-of-mass-killings-since.html)

The Other Reality

The number of lives taken by violence in this country is likely to remain high. For every life lost, countless survivors are impacted. The reality is that the death of one student or teacher can leave hundreds grieving and many traumatized by what happened. Following is a list of those impacted by the Sandy Hook shooting. Listing survivors provides a visual that identifies the far-reaching impact of these violent, tragic and traumatic deaths. Each group of survivors may benefit from similar inter-
Table 1

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1, 1966</td>
<td>Charles Whitman killed 14 people at the University of Texas.</td>
</tr>
<tr>
<td>July 12, 1976</td>
<td>Custodian, Edward Allaway shot and killed seven people at the California State University, Fullerton.</td>
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<tr>
<td>January 29, 1979</td>
<td>16-year-old Brenda Spencer shot and killed a janitor, the principal and wounded eight students at a San Diego elementary school.</td>
</tr>
<tr>
<td>July 18, 1984</td>
<td>James Huberty entered a McDonald's restaurant and fatally shot 21 people, including five children in San Ysidro, California.</td>
</tr>
<tr>
<td>January 17, 1989</td>
<td>Patrick Purdy shot and killed five children and wounded 29 more at Cleveland Elementary School.</td>
</tr>
<tr>
<td>May 1, 1992</td>
<td>A 23-year-old and former student returned to his school in Sacramento, California, angry and despondent. He walked in the front door with two ammunition belts crisscrossed his chest. He carried a sawed-off shotgun. One staff person, his former history teacher was shot and killed point blank in front of his students. Three students were killed and ten wounded before he took another 60 hostages.</td>
</tr>
<tr>
<td>December 1, 1997</td>
<td>Three students were killed and 5 wounded in Paducah, Kentucky.</td>
</tr>
<tr>
<td>March 24, 1998</td>
<td>Four girls and a teacher were shot to death and 10 others wounded during a false fire alarm at Westside Middle School in Jonesboro, Arkansas, when two boys, ages 11 and 13, open fire from the woods.</td>
</tr>
</tbody>
</table>

ventions but will also need different interventions, responses and actions from us.

- Those impacted
- The families whose children were killed
- The friends and families of those staff who were killed
- The children who were directly exposed to the gunmen
- The entire student population
- The school staff
- The families of those children who survived
- The police officers and emergency personnel who directly witnessed those little bodies in that classroom
- The family of Adam Lanza
- All the members of that community
- The children across the country who may become frightened by the behaviors of adults in their environments and additional safety measures introduced by schools
- Families across the country who suffered from the violent and deadly loss of their own children, parents, relatives and friends from past acts of violence
- The teachers who will be wanting to know how to interact and respond to their students
- The millions of parents across the country and throughout the world who are once again reminded that their children’s life is very precious but also vulnerable
- The lawmakers, politicians and policy makers who will be pressured (hopefully) to review the
mental health care in this country, the issue of gun control and safety in facilities caring for children, and a country who’s culture of violence compared to many other countries seems out of control.

- The practitioners who are providing direct intervention to the survivors and their families of this community

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 21, 2005</td>
<td>Red Lake Reservation killing of five students and two adults.</td>
</tr>
<tr>
<td>October 2, 2006</td>
<td>Five young girls, ages six through 13 were shot and killed at an Amish schoolhouse.</td>
</tr>
<tr>
<td>April 16, 2007</td>
<td>The all-time deadliest school shooting in US history took place when Virginia Tech University student Seung-Hui Cho, shot up the campus killing 32 people.</td>
</tr>
<tr>
<td>March 10, 2009</td>
<td>A 28-year-old laid-off worker opened fire while driving a car through several towns in Alabama, killing 10 people.</td>
</tr>
<tr>
<td>March 29, 2009</td>
<td>A heavily armed gunman shot dead eight people, many of them elderly and sick people, in a privately-owned nursing home in North Carolina.</td>
</tr>
<tr>
<td>March 30, 2009</td>
<td>Six people were shot dead in a high-grade apartment building in Santa Clara, California.</td>
</tr>
<tr>
<td>April 3, 2009</td>
<td>A man shot dead 13 people at a civic center in Binghamton, New York.</td>
</tr>
<tr>
<td>July 23, 2009</td>
<td>Six people, including one student, were shot and killed in a drive-by shooting at a community rally on the campus of Texas Southern University, Houston.</td>
</tr>
<tr>
<td>November 5, 2009</td>
<td>U.S. army psychologist Major Nidal Hasan opened fire at a military base in Fort Hood, Texas, leaving 13 dead and 42 others wounded.</td>
</tr>
<tr>
<td>January 8, 2011</td>
<td>A gunman opened fire at a public gathering outside a grocery store in Tucson, Arizona, killing six people including a nine-year-old girl and wounding at least 12 others. Congresswoman Gabrielle Giffords was severely injured with a gunshot to the head.</td>
</tr>
<tr>
<td>February 27, 2012</td>
<td>17-year-old T. J. Lane fired 10 shots at a group of students in the cafeteria high school in Chardon, Ohio where three students were killed.</td>
</tr>
<tr>
<td>July 20, 2012</td>
<td>A masked gunman kills 12 people and wounded 58 when he opens fire on moviegoers at a showing of the Batman film “The Dark Knight Rises” in Aurora, a suburb of Denver, Colorado.</td>
</tr>
<tr>
<td>August 5, 2012</td>
<td>A gunman kills six people during Sunday services at a Sikh temple in Oak Creek, Wisconsin, before he is shot dead by a police officer.</td>
</tr>
<tr>
<td>August 24, 2012</td>
<td>Two people are killed and eight wounded in a shooting outside the landmark Empire State Building in New York City at the height of the tourist season.</td>
</tr>
<tr>
<td>September 27, 2012</td>
<td>A disgruntled former employee kills five people and takes his own life in a shooting rampage at a Minneapolis sign company from which he had been fired.</td>
</tr>
<tr>
<td>October 27, 2012</td>
<td>Three people are killed in a Milwaukee area spa including the estranged wife of the suspected gunman, who then killed himself.</td>
</tr>
<tr>
<td>December 14, 2012</td>
<td>Adam Lanza fatally shot twenty children and six adult staff members at Sandy Hook Elementary School.</td>
</tr>
<tr>
<td>January 25, 2013</td>
<td>Three adults are wounded on the Lone Starr College Campus in Texas.</td>
</tr>
<tr>
<td>January 29, 2013</td>
<td>A gunman in Alabama shoots and kills a school bus driver and then takes a five year old child hostage. The child was held hostage in a bunker with his killer for almost a week before the FBI were able to storm the bunker, kill the hostage taker and save the boy.</td>
</tr>
</tbody>
</table>
We must acknowledge the other reality, supported by extensive research, that survivors of any traumatizing incident, violent or non-violent, share many common reactions. Their individual reactions, regardless of the incidents they are exposed to, can be equally devastating and most need and benefit from varied interventions applied within a trauma-informed framework and designed to do no harm. However, a number of reactions will be unique to the situation experienced. We must be aware of these differences as they create different needs and challenges for survivors.

“Critical Considerations” is based on a history of experience and practice. The criteria used to support the professional credibility of an organization includes its practice based history, evidence based research, professional publications, support from other professionals and the kinds of situations that organization and its staff have experienced over time. Before discussing the critical considerations regarding intervention and the framework TLC proposes be used to guide the initiation of interventions, it is important for those new to TLC to review its history to best appreciate the credibility and source of the recommendations we present.

TLC’s Practice Based - Evidence Based History

Dr. Steele, the founder of TLC, actually began working with survivors of violent incidents following the 1967 Detroit Riot. In the years that followed he spent a good deal of time with survivors participating in such national groups as Parents of Murdered Children (POMC) and various grass roots groups such as Save Our Sons and Daughters (SOSAD). Throughout the 1980’s he provided training and consultation to hundreds of school districts across the country that were losing students to both suicide and homicide. It was his experience with survivors and professionals wanting to know how to help that led him to develop TLC. Today, TLC has over 6,000 TLC Certified Trauma Specialists practicing in 50 countries. Many of these professionals have field-tested and conducted research of TLC’s intervention processes and programs. Our trauma focused intervention programs have undergone rigorous evidence based research documenting their ability to significantly reduce trauma and related mental health reactions associated with exposure to traumatic incidents (Steele and Kuban, 2013).

TLC’s programs for children and adolescents 6-18 years of age are listed on the California Clearing-house of Evidence Based Practices and Substance Abuse Mental Health Services Agency (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP). Given Dr. Steele’s experience, in addition to the experiences of TLC staff and its Certified Trauma Specialists, TLC has a combined forty-year practice history and its outcome driven interventions are supported by a long history of research. TLC’s work has been published in such journals as the School Social Work Journal, Children and Schools, Residential Treatment for Children and Youth, National Social Sciences Associations, Reclaiming Children and Youth, and publications with Guilford Press, American Counseling Association, Allyn and Bacon. Our latest publications include Steele and Malchiodi, (2012). Trauma Informed Practices with Children and Adolescents. NY. Routledge, Taylor & Francis Group and Steele and Kuban, (July, 2013). Working with
TLC has a twenty-three year history of assisting survivors and the many professionals in school and community settings directly responsible for the emotional and psychological well being of those survivors. It has assisted survivors following a number of incidents given national media attention; some of these are included in Table 3.

| TABLE 3 |  
|---|---|  
| 1992 | Gulf War |  
| 1995 | Bombing of the Federal Building in Oklahoma that killed 168 adults and 19 children under the age of six |  
| 1999 | Wedgwood Baptist Church shooting in Texas that left seven dead |  
| 2000 | Killing of a six-year-old girl by a six-year-old boy in a Michigan school |  
| 2001 | 9/11 World Trade Center Attack, American Airlines Flight 77 that crashed into the Pentagon and the United Flight 93 that crashed in Pennsylvania after passengers attacked the terrorist on that flight |  
| 2003 | Staten Island Ferry disaster that killed 11 people and seriously injured another 71 adults many of whom were elderly |  
| 2004 | Indian Ocean Tsunami |  
| 2005 | Hurricanes Katrina and Rita that left 2,000 children and adults dead |  
| 2009 | The murder of well-known high school football coach Ed Thomas in Parkersburg Iowa in front of his students |  
| 2009 | Stabbing death of a special education teacher in Tyler, Texas |  
| 2011 | Hurricane Irene that caused 15 billion dollars in damage, destroying homes all the way up the East Coast and in many inland communities |  
| 2012 | Sandy Hook Elementary School shooting where twenty children and six adult staff members were murdered |  

**Everyday Incidents**

In reality TLC provides far more assistance to the survivors of those incidents that rarely receive national media attention. The 2012 murder of a fifteen-year old student attending Cristo Rey High School in Detroit was given local coverage only, as is often the case in many cities. TLC was asked to assist the teachers who knew this bright, well-liked student, as well as help the administration in its response to the student body and the families of the students in this school. However, shootings do not take place everyday but everyday children and adults are exposed to other violent and non-violent experiences that are traumatic for them—physical/sexual abuse, sudden accidental death, critical injuries, drowning, house fires, floods, loss of home, removal from the home, divorce.

The fact is, situations that are traumatic for some are not necessarily traumatic for all. It is impor-
tant to understand that the primary subjective experience of trauma is one of terror (Steele and Kuban, 2013, Steele and Raider, 2001). In that experience, survivors feel unsafe and powerless to do anything about what is happening to them or around them. It is not the situation that induces trauma but how that situation is experienced. For example, divorce is not traumatic for most, but if that divorce is causing children to feel unsafe and powerless, it then becomes a traumatic experience.

The survivors of violent and non-violent experiences have taught us a great deal about what matters most to them at a time when their worlds become incomprehensible, terrifying and painful.

What Matters Most

Over the years, the thousands of children, adolescents and adults we have come to help, have said to us repeatedly,

“If you don’t think what I think…feel what I feel…experience what I experience…see what I see when I look at myself, others and the world around me…how can you possibly know what is best for me?”

This is a simple yet profoundly wise mandate. When we can appreciate how survivors are experiencing themselves, others and their lives as a result of what they experienced, we can assign far more timely, useful and appropriate responses and interventions. Our responses to survivors must not be simply presenting them with activities to alleviate their anxiety, but a process that allows us to assign interventions based on the subjective ways each survivor is experiencing what happened to them or around them, immediately and in the days, weeks and months that follow what happened. When we are able to actually hear their voices, see what they see when they look at themselves, us and the world around them we discover what experiences matter the most in their ability to remain resilient and flourish in the face of their terrifying pain.

The Framework

In essence this is the framework in which we recommend professionals approach survivors in order to:

• Determine what will be most helpful to them immediately and in the days weeks and months of follow
• To respond in ways that are safe, timely and specific to the unique needs of each survivor, and
• To interact in ways that empower survivors to be the best experts as to what is helpful and what is not.

The following considerations present a framework that supports a process that is trauma-informed
and honors the mandates of trauma-informed care, the mandate so many survivors have shared with us.

**Initial Considerations: The First Few Days and Weeks**

1. **Following tragic situations that generate media coverage, it is critical not to form conclusions about what is reported.**

   We can easily be misled by news that does not come directly from law enforcement investigations that will generally confirm what they know firsthand to be factual. For example following the 2012 Sandy Hook Elementary School shooting in Connecticut, we first heard Adam Lanza the shooter was the son of a teacher. We drew several conclusions. We then heard that his mother was not a teacher but a teacher’s aide and arrived at additional conclusions. We then discover that she had nothing to do with the staffing at Sandy Hook and draw yet more conclusions. We were initially led to believe that her son had acquired the guns used to kill twenty children and six staff and again came to a number of conclusions. We then discover that his mother actually was an avid range shooter and collected these guns herself. We were told that Adam Lanza had a personality disorder and began to form conclusions. We were then told that he may have been diagnosed with Asperger’s Syndrome and drew additional conclusions. The fact is that, one week after the shooting, police had not yet confirmed what they knew about Adam Lanza’s mental health.

   Unfortunately following misleading information, the conclusions, comments and actions of others, create new challenges. When it was reported that Lanza had Asperger’s Syndrome, it was also suggested in reports, that this was the cause of his violent behavior. The fact is there is no demonstrated link between Asperger’s Syndrome and violent behavior. The reality is that it often take weeks even months to sort out the facts. Drawing conclusions that are not based on factual information benefits no one, can mislead us in our responses to others and often makes healing more difficult for survivors.

2. **Following tragic situations it is critical to not make the assumption that everyone needs the same intervention as such an assumption can actually lead to over intervening and creating anxiety rather than preventing it.**

   Making the above assumptions ignores the fact that it is not the situation, but how children and adults subjectively experience that situation that determines what they will need to
best help them manage the many different reactions they experience. We can actually over-intervene and induce greater amounts of anxiety than were actually experienced when we assume that we know what it must be like for survivors. Resilience research, for example, clearly documents that not everyone exposed to what we might consider to be a trauma-inducing incident is necessarily traumatized by that incident (Bonanno, Papa, Wortman, et al., 2002). Ask two children exposed to the same situation what worries them the most since this happened. One will reply, “Does this mean we can’t go on our field trip?” while the other replies, “Is mommy going to die too?” These are two different experiences to the same exposure that dictate two different interventions.

The survivors of Sandy Hook Elementary School have had many different reactions needing different interventions. As some children were reported to have said, “All I want is Christmas.” They needed Christmas. Some adults were said to have taken down their Christmas decorations, “… as it just didn’t seem right to celebrate.” That is what they needed to do. Being helpful means being attuned to how survivors are experiencing what happened and helping them with what they need to do or have available to them at that point in time. “Assigning an appropriate intervention dictates that we first determine how survivors are experiencing what they are exposed to if we are to provide an intervention that itself is not traumatizing” (Steele & Kuban, 2013).

3 To determine what matters most to survivors immediately following exposure and in the days, weeks and months that follow we must remain curious as to how each is experiencing their world and themselves.

Being curious is a process that many are uncomfortable engaging because it means we accept that we do not know what is best for survivors, until we discover how they are experiencing what happened. Being curious, never knowing where children or adults are going to take us, can initially “stump” practitioners whose mind set is to attempt to figure things out, to apply the same intervention to all or to formulate insightful responses in hopes that survivors will agree and see things from their perspective.

The following example is taken from Steele & Kuban (2013):

“Children (all survivors) feel most comfortable when we take an interest in their world, when we are listening close enough to remain curious about what they tell us (or express through mediums like drawing) without being judgmental, interpreting their comments, or making assumptions. This is not always an easy process for many professionals who are trained to be analytical, to think ahead, and to try to figure out the meaning of the infor-
In TLC’s certification training for Trauma and Loss Specialist, it generally takes two days of active participation for even seasoned practitioners to become comfortable with being curious rather than being in the “why” mind set or trying to arrive at conclusions which actually prohibits them from being attentive to children (survivors). For example, one 7 year old child who saw his father kill his mother and was later kidnapped by his father only to witness further violence by his father and be left alone for long periods in a grungy room was asked, “What in that room let you feel the safest?” His response was “the couch.” When we present this story in our training and then ask the participants what they would ask next, those who have not yet “switched” to being curious find it difficult to answer because they are too busy trying to figure out the meaning for themselves. Those who, at this point in the training, are able to be curious are quite spontaneous. In essence they follow up immediately with the question, “What about the couch made you feel safe?”

This child’s response was, “It was so big I could hide in it.” This response and the child’s attachment behaviors now made perfect sense to this child’s grandmother. Learning how to become a “witness”, curious rather than analytical, is important to survivor’s sense of safety and comfort with us and to the success of the intervention process. Hughes (2009) wrote, “When curiosity is directed toward the child’s experience rather than toward the factual events in his life and when it is conveyed with both affective and reflective features, the child is likely to go with the therapist very deeply into his or her life story and experience a co-regulating of emotions related to what is being explored and the meaning given those events”. This is as true for adults as it is for children.”

Asking “why” questions or questions regarding feelings, simply does not yield the kind of useful information that questions related to a survivors subjective experiences yields. A few of these questions include, “Since this happened, what is your biggest worry? Where are you feeling this the most in your body? What is this making you want to do or not do? What is it you would like to do right now? What is it you would like me to do for you right now?” There are many other trauma specific questions directed at the subjective experiences of survivors that help to keep us curious and engaged in a process that creates an interactive empathy with survivors.

“Curiosity is also the cornerstone of empathy” (Smith, 2012). Putting ourselves in the role of being a witness, seeing what children (survivors) see when they look at themselves and us is really what provides insight into their world or what Siegel (2003) refers to as mind sight, knowing what another feels. Perry (2009) refers to this process as attunement or being present and in sync with traumatized children (survivors).

In the first few days adhering to a crisis intervention approach helps to meet the immedi-
ate needs of most survivors. It accepts that those in crisis do have the inner resources to heal. It creates an environment of empathy and helping those in crisis take the action needed for them to best manage their reactions. It is not about processing their reactions but regulating those that are the most challenging for them.

Crisis intervention is the initial intervention found most helpful in these situations. It can continue for several days, or for several weeks in situations that are kept alive by media and other external environmental conditions. TLC’s article, The First Few Days, presents a crisis model that incorporates TLC's experience with trauma and Dr’s. Echterling and Presbury (2005) crisis intervention approach detailed in “Crisis intervention: Promoting Resilience and Resolution in Troubled Times.” Their belief and ours is that people in crisis have the inner resources to heal and that we are there to help them discover those inner resources and what matters most to them in their efforts to manage what they experienced.

Providing crisis intervention in the first few days following exposure is a process of facilitating what matters most for each survivor. What matters most for younger children may include the need to be with parents or peers, to be able to play, to enjoy their favorite comfort foods more frequently, to be held, to be in the presence of adults who are not acting scared or worried but reassuring and comforting, for routine to be reinstated, to not be asked to talk about what happened, to not be watching media coverage of what happened and for their mornings and evenings to be predictable, comfortable and calm.

What matters most for adolescents and adults may also be spending time with peers, seeking information about what happened, some will need to watch the news reports while others will need to avoid them. Depending upon the nature of what happened, what matters most will be seeking physical safety and introducing new routines regarding safety at home while in school or out in the community. To some these behaviors may appear obsessive. Some will need to take some kind of action like helping others while, what will matter most for others is avoiding those who remind them of all that happened. Some will be glued to their phones continually texting, while others may need to place pictures, stuffed animals, notes, candles, etc near the incident as a way to help others remember those who died. For others such memories may create too much pain so they need to avoid that site. Those who have endured a severe storm and lost their homes may need safe shelter and food, to be reunited with family members, to seek out information as to how to obtain help and resources. Some will need to talk while others will need not to talk.

Being curious, within the context of providing crisis intervention by facilitating access to what matters most to survivors, also demands that practitioners be prepared with several responses to each of the specific ways survivors are reacting to what they have experi-
enced. If one response is not helping or actually activating the survivors reactions, another response can be initiated along with others until the response that best helps that survivor is discovered.

In our training we ask participants to identify the common survivor behaviors that could be anticipated following exposure to traumatic situations. We then select one behavior and ask them to provide at least five different responses to that one behavior. For example, possible responses for individuals who are agitated may be to ask them their name or give them a verbal directive like, “sit down here.” If that person in crisis can respond, it indicates they may be able to process other verbal communications and directives.

Asking them to follow you to a quiet area where there are fewer people, seeing if they can take a few deep breaths, asking who they may want to call, what it is they need and then helping them regulate their nervous system reactions are all possibilities. On the other hand, if they are unable to respond to verbal directives, they are likely to need more sensory-based responses like something to drink, walking around, sitting and rocking their bodies, being given something to hold onto, simply sitting until they can ask for something specific or if possible bringing their friends to them to offer support.

This process reinforces that there is no one intervention that fits every situation or individual. It also becomes a way to introduce practitioners to how our brains can react to extreme stress, how the simplest of tasks or actions now become difficult or impossible because reason, logic even the ability to hear and process what others are saying may not be possible.

1. Neuroscience confirms that when in trauma, attempts to help using cognitive approaches may be limited. Sensory, expressive interactions and interventions become more helpful for survivors at a time when reason, logic, comprehension and processing information is hindered by the over active limbic region of the brain.

Today neuroscience has confirmed that trauma is experienced in the midbrain, the limbic region, sometimes referred to as the “feeling” brain or the “survival” brain where there is no reason, logic nor language (Perry, 2009). Reason, logic, the use of language, to make sense of what has happened, are upper brain-cognitive functions and become difficult to access in trauma (Shore, 2001; van der Kolk, McFarlane, Weisaeth, 1996; Levine & Kline, 2008; Perry, 2009; Brendtro, Mitchell, McCall, 2009; Steele & Malchiodi, 2013). Therefore, non-verbal, sensory based interventions sometimes referred to as implicit interventions, initially become more appropriate (Steele & Kuban, 2013).

The developmental, cognitive and verbal challenges of children support that cognitive behavioral approaches may be limited in their efforts to help traumatized children. Gil (2006)
notes that traumatic events are experienced and stored implicitly in the right hemisphere of the brain (where there is no language, reason, logic) and that “this suggests that allowing children a period of time to access and stimulate the right hemisphere of the brain could eventually activate the necessary (explicit) functions of the left hemisphere, which appears to shut down during traumatic experiences” (p. 102). When in extreme fear, the right brain shuts down the capacity of our thinking brain. Perry (2004) reported that traumatized students often hear only about half the words spoken by their teachers.

Understanding children’s limited cognitive abilities to understand all that has happened or to even remember what has been said to them, supports the use of non-language, sensory, expressive based activities designed to a) alleviate whatever fears they may have, b) help them feel safe despite all that might be going on around them and c) provide them mediums to express what this is like for them when language or words are not accessible. TLC’s “Helping Children Feel Safe and One Minute Interventions” provide such activities. Games they like to play, music, singing, reading stories are examples of such activities that can be helpful for children when in crisis. TLC’s “Brave Bart: A Story for Grieving and Traumatized Children” has also helped thousands of children over the years and given parents strength based ways to connect with their children following sad, terrifying and traumatic situations (see resources).

“Drawing is a recognized sensory, expressive modality with children that has proven very helpful (Malchiodi, 1990; Roje, 1995; Riley, 1997, 2001). Gross and Haynes (1998) found in their research that drawing encouraged children to tell more than they would during a solely verbal interview. Research at the School of Creative Arts Therapies at the University of Haifa also found that drawing enhances emotional verbalization among traumatized children compared to verbal interviews alone. In their research (Science 20, 2009), when children in one group were asked to draw first, they included more feelings and sensations and were more descriptive of what happened to them than children in the other group who were asked to only talk about what happened to them” (Steele & Kuban, 2013).

TLC’s structured drawing process not only allows children and adults to give meaning to their life within the context of their experiences, but also serves as a trauma-informed, structured intervention process that evidence based research has clearly shown helps to significantly reduce trauma symptoms as well as related mental health reactions while improving children’s resilience (See Appendix).

7 We must appreciate that the many mindfulness approaches to managing acute stress, fear and terror, that in this country are not yet considered treatment, are in fact helpful for many especially adolescent and adult survivors.

Music, dance, meditation, yoga, guided imagery and the Emotional Freedom Technique
(EFT) or tapping can all provide relief, assist with emotional regulation, help survivors more effectively manage the many reactions and challenges such tragedies can create (Cahn & Polich, 2006). Simply ask the teachers in New York what was most helpful for them in the days following 9/11 and you will hear that it was not talking, but finding things they could do to alleviate their stress.

8 We must also accept that not wanting to talk about what happened, sometimes referred to as repressive coping, is what helps some individuals in the recovery process.

Repressive coping is a resilience factor found in some of those who do better than others when exposed the same or similar situations. When this is a response, our guide to whether it is helping is observing how survivors are functioning. If they are doing well in all areas of functioning or maintaining the baseline of functioning prior to the tragedy, it is likely a helpful way for them to cope. If they are not doing well in some areas, such as schoolwork, school behaviors, work, taking care of everyday responsibilities, relationships, self-care and health, it is likely they will need additional help focused on what they experienced.

9 Be careful not to be misled by behaviors and reactions of survivors by failing to evaluate survivors within the context of their experiences. What may look like specific criteria of a diagnostic category may in fact be quite appropriate to the experience of the survivor.

This excerpt is taken from Steele & Kuban (2013). “Following 9/11 a number of studies indicated that a large number of children were experiencing agoraphobia (Hoven, Duarte, et al., 2005). This research supported the extreme impact this act of terror had on a large number of children. However, if we approach trauma as an experience, we may want to ask whether this was true agoraphobia or agoraphobic like behavior. For example, what if we were one of the children, as was the case for many in New York that day, who saw people jumping to their death, who were only blocks away and covered in the white dust that covered Ground Zero, who saw others running terrified in the streets, who was being carried to safety by a teacher only to hit a police road block and told we would have to go back through the same chaotic terrifying environment in order to get to the available evacuation route: why after finally getting home, would we want to go back to that bad place where that bad thing happened? Is our reaction really agoraphobic or expressing the need for safety (Steele & Kuban, 2013)."

When we know the experience as the survivor knows the experience, we are far less likely to misdiagnose and or apply inappropriate interventions.

10 Because feeling unsafe and powerless are core subjective experiences of trauma, inter-
vention processes must be framed in choice and empowerment.

Those receiving intervention must first have a detailed understanding of how that intervention works and what will be asked of them and why. Once they have this information, they must be given the permission to say yes or no to that intervention. If they say no, it is our responsibility to offer other options that might be easier and safer for them. For example, asking a group of anxious children, or even adults, to close their eyes and imagine the best possible vacation they could enjoy may help some relax. Asking others to close their eyes may trigger images and memories of what happened. Choice is essential to keeping survivors and intervention safe.

Once survivors agree to the intervention proposed, they must be empowered to feel free at any time to say yes or no to anything they are asked to talk about or asked to do. When working with survivors in groups, participants must also be given several options for regulating adverse reactions they may experience during the group.

11 Any intervention used inappropriately is a dangerous intervention.

Debriefing is an intervention reserved for the most exposed survivors, those who witnessed or were part of what happened and those who are closest to the victims. It was designed as a group intervention for adolescents and adults because of its cognitive approach. It can be a very helpful intervention when used appropriately. However any attempt to debrief survivors in the first few days especially those exposed to external elements and environmental factors that keep survivors focused on the memory of what happened, makes it difficult to begin to process all they experienced. In those first few days their bodies and their nervous systems are not likely to have had time to defuse and regulate the impact their experience has had on them. Trying to cognitively process what happened, when what happened is still impacting their nervous systems, is inappropriate and places survivors at risk.

To say to people “To feel better you need to be participating in this intervention” is to suggest they will feel worse if they do not. They may feel worse if they do and are not ready. As we stated earlier, “repressive coping” can be a resilient response for some. To make a debriefing or any intervention mandatory is to ignore that individuals in crisis often do have a sense of what will be most helpful for them. It is an ethical responsibility not to mandate any one intervention, but offer several options and resources survivors can select from if they wish to do so and immediately stop if they find that what they are doing is only further activating their nervous systems, memories, sensations and emotions.

Currently the value of debriefing is being criticized as some research has shown that in some cases it may prolong or intensify reactions of survivors. On the other hand some of those
research outcomes are the result of debriefing individuals, which debriefing was never designed to do. TLC addresses this issue in detail in the Trauma Recovery Interventions section that follows Critical Considerations.

Many surviving families, parents and siblings can experience reactions and engage in behaviors that may appear troubling to those unfamiliar with reactions specific to traumatic incidents, but not be unusual given the elements or nature of their experience. However, if they persist in the months that follow the initial traumatic exposure, they can certainly become problematic and require additional trauma specific, evidence based intervention.

Six months after Hurricane Sandy killed 149 people in October 2012, hundreds who lost their homes had to endure freezing temperatures and winter conditions in shelters without heat, water or electricity. What they experienced six months earlier was still very much alive in the midst of the daily reminders of what happened. The pain, losses and the challenges survivors of this kind of tragedy face are no less devastating than those faced by survivors of violent incidents, just different.

There is no doubt that it takes a great deal of time for family members to find a way to cope following violent trauma. The challenges they face in attempting to make it through each day can be met and managed but they will be a challenge. Following a violent trauma there will also be a number of reminders that make it difficult for family members. I remember many years ago spending a great deal of time with a group called Save Our Sons and Daughters. These were parents of sons and daughters who had been violently murdered. I remember one mother whose son was killed outside her home saying that she watched that spot 24 hours a day. Living in the home where their child once filled their lives with so many memories will be difficult. Following homicide the legal system can move very slowly, making it difficult for survivors to hopefully experience some justice through the conviction of the killer. For some a conviction is a turning point in the healing process; for some the sentencing may simply not be enough to lessen their pain.

We have indicated throughout this paper that survivors must be given the opportunity to grieve in their own way. When traumatic losses, like Sandy Hook are associated with a holiday, it becomes difficult not to return to unwanted and painful memories. The holidays can be difficult for many in the years to come. Establishing new traditions, focusing on the positive memories of their loved one, staying focused on the needs of the surviving siblings and family members, allowing family members to do what they need to do to best manage, and finding ways as a family to give to others in need can be helpful. However, we know that for some families holidays are more a time of stress and relational conflicts than being a time of joy. When a
holiday is also associated with unimaginable loss those families in conflict will need additional support to focus on what really matters. Unfortunately, traumatic losses can further fragment families with a previous history of fragile relationships and limited coping skills.

Some parents will need more attending to and to be watched and protected from their own forgetfulness and the emotional reactions that may cause them to do things that they would not normally do, that are not safe for them or the rest of the family. The mother who said she watched that spot where her son was killed outside her home 24 hours a day later said, “Some days I am cooking and walk away and I don’t remember I was cooking and leave the stove on.” For some, the impact of trauma increases their risks and the risks of those around them.

If there are other children at home they may be neglected as a result of their parents own emotional reactions. In some situations parents may unknowingly create a shrine of the child no longer with them. This too is understandable, however it places siblings at risk, as they discover they no longer can get the kind of attention they once had from their parents.

Siblings may find that they cannot possibly live up to the idealized way that their parents talk about their deceased brother or sister and begin to pull away from their parents or engage in challenging behaviors to get their parents attention. They may be prohibited from really talking about the things that may not have been so nice about their deceased brother or sister. Surviving children may be afraid to fully express themselves with their parents for fear of making things worse for their parents or for themselves and because of the way their parents may or have responded. They may, at this point, begin to engage in self-defeating and even self-destructive behaviors. The behaviors and emotional status of siblings in these situations can certainly become problematic and unfortunately be reinforced by their grieving parents inability to appreciate what their children are asking from them-to be there as they were before there brother or sister was killed.

Do not be surprised to see adults expressing childlike reactions. Another mother whose son was shot and killed reached his body, but said to me, "I was afraid to touch him because if I touched him he would die." This is magical thinking, a process that is generally reserved for younger children. However, in intense grief and trauma, pain is pain, terror is terror no matter our age, our gender, our culture. This is why the reactions we might attribute to children can also be attributed to adults and the reactions we attribute to adults can often be observed in children.

During the first several weeks, even several months, talk will be very limited in its ability to help. There will be no explanation as to why this happened. No amount of verbal reassurance will be helpful. More important is helping these parents find ways to engage in activities that are comforting, soothing and calming and help them begin to regulate their reactions over time.

In many ways, surviving parents need the same kind of intervention we would provide sur-
viving children. We need to be curious as to how they are actually experiencing all that is happen-
ing, to focus on their subjective experiences to discover what will matter most at that point in their efforts to manage. We need to provide them choices as to the many ways they can express themselves other than by talking about what happened and what is happening to them. We need to help them engage in mindful activities as ways to begin to regulate their many reactions, to calm their overly activated nervous systems so they can be more consistently available to their children and families. With help from other loved ones and friends, books that share how others have managed such tragic losses, many will find ways to live with the pain of the violent loss of their loved ones. Others will need more specific, trauma focused interventions. TLC’s *Adults and Parents in Trauma* has proven helpful for many traumatized parents.

What we do know helps most is persistent connection to other strong adults who will not push but allow these parents to move through their terrible loss at their own pace and in their own way, short of that way being self-defeating and/or self-destructive to themselves and/or to other family members. Many parents have multiple responsibilities and for some continuing those responsibilities will make it easier to manage in the weeks that follow, but for others make it far more stressful. Supportive adults can make themselves available to help families so parents can take care of those critical responsibilities. They can provide support, attention and time with surviving children when their parent’s grief makes it difficult for them to do so in ways that are most helpful to their children.

It will be important not to refer to surviving children as heroes. It is natural do so when children engage in behaviors that seem heroic such as leading other children to safety. However, referring to children as heroes can make life difficult for those children.

In today’s world children’s heroes are super heros. To identify any of these children as heroes predisposes them to begin to wonder why they weren’t able to save all their friends. Children, who are not called heroes may feel a tremendous amount of guilt about what they did or did not do. The reality is that in these situations, most are generally driven by survival responses generated by intense fear that defies reason and logic and are not cognitively determined at the point in time that such tragedies occur. At such a young age, all children in school need to feel connected to one another, each as equally important as the other. The referred to hero may find it difficult to be less than whatever a hero is in his mind. He may find that others shy away from him because he is now so different from them. These responses can create new problems for that child, the children around him, his teachers and parents.

Children will do best having routine, being able to play and being reassured that it’s okay to enjoy themselves. The best way to help young children feel safe is to build predictability
into the beginning of their day and end of their day at home. Predictability and consistency is
very important to children’s sense of safety. This is a time to be curious as to what children do
find safe, calming and pleasant. Young children loved to be read to before the lights go out.
Many children have a favorite stuffed animal they take with them to bed. These very simple yet
profoundly simple acts, teach children that despite what may happen that they may have little
control over, they always have a safe place to go to at the end of the day and wake up to the
next morning.

It is essential that we evaluate for secondary wounding or self-induced wounding sur-
vivors frequently experience following traumatic experiences.

Secondary wounding following a traumatic incident is common. Acknowledging and
helping survivors process the various forms of secondary wounding is far less common. The
pain and hurt caused by secondary wounding prolongs and intensifies the survivors trauma
experience and can significantly delaying recovery.

Secondary wounding is caused by statements made to survivors that minimize the pain
and fear survivors experience, blame the survivor for their behavior leading up to and follow-
ing the trauma, and by questions that challenge the survivors description of what happened
as well as their reactions to what happened. Following are several examples of statements that
may cause secondary wounding taken from TLC’s *Adults and Parents in Trauma* program.

- You are exaggerating!
- It couldn’t have happened that way.
- You really can’t remember that kind of detail.
- Your imagination is running away with you.
- He/she would never do that.
- There are people who have had it harder than you.
- Consider yourself lucky.
- You’re still young.
- You’re overreacting. You need to put this in perspective.
- What happened, happened. You don’t need to be upset.
- Well maybe if you hadn’t...
- Well maybe if you had...
- If only you...
- You should have never...
- That wasn’t very smart of you.
- How many times have you been told...
• It wouldn’t have happened if you...
• You need to be more careful.

Secondary wounding can also be self-induced when comparing our actions and reactions to the behaviors and reactions of other survivors, by real or perceived expectations others have of us or we have of ourselves, or when we compare our behaviors and reactions to norms in our society or culture that are associated with being an “okay person” versus “not okay person.”

Earlier we discussed the issues that can arise when we refer to a surviving child as a hero. Imagine being one of the students at Sandy Hook Elementary. While one of your peers is leading other children to safety, you’re crying or shaking, trying to find a safe place for yourself or are frozen and unable to move. Later, when your peer is called a hero, you become silently ashamed about the way you did or did not respond. This would be no different for teachers who may be blaming themselves for not doing more or, even doing what they did in that situation, compared to the actions of other staff.

Additional examples of self-induced secondary wounding include:
• “He was my best friend. I should have known he was thinking about killing himself. It is my fault.”
• “They tell me I’ll be better if I talk about what happened, but I don’t want to. It’s too hard. What’s wrong with me?”
• “They told me not to, but I wanted to prove I could. I’m so stupid.”
• “Had I not been so scared maybe I could’ve helped the others. I’m such a coward.”

These are silent acts of secondary wounding survivors rarely make us aware of until we normalize these responses within a process that safely allows them to talk about how each experienced what happened to them.

Secondary wounding within families can tear families apart. Parents may silently blame themselves or one another and children can feel responsible for what they did or did not do as well as for what happened. The silent shame, guilt, feelings of incompetence, and low self-worth can result in diminished support for one another, numerous avoidant or aggressive behaviors, new conflicts and becoming fearful to express one’s needs, opinions or wishes.

The possible presence of secondary wounding, whether caused by others or self-induced, must be evaluated and processed with survivors. Educating survivors to what it is and how it happens and normalizing the pain, hurt, guilt, shame and behaviors that secondary wounding can cause is the first step. For some this is all that is needed. Others may need additional help. Being curious as to how survivors now think about themselves and their family members will be necessary. Sensory-based and play-based activities can provide safe mediums for children and adult survivors to access, express and find relief from their secondary wounding.
When school aged children are killed or die suddenly, that child’s peers and teachers can be significantly impacted. When death actually takes place in the school setting the number of people impacted can be even greater. When this happens there are critical protocols schools need to initiate to ensure the physical and emotional safety of everyone involved. All school staff have a critical role in helping their students manage the many reactions and responses their students can experience. Following are just a few considerations in addition to those mentioned in the Trauma Recovery Interventions section that follows these considerations.

How children begin and end every school day following a traumatic experience supports their ability to begin to regulate the many reactions they can experience. Their reactions are often new for them and create varied levels of anxiety. When attention is not directed at helping them regulate their anxiety, cognitive processes and behaviors can become problematic. As at home, when the beginning and ending of every class and school day is predictably consistent and involves some brief activity that is calming, children do better. If they struggle in one class, they know what to expect in the next class, which can help them regulate their reactions. Following such tragedies, involving young children and adolescents, brief group activities that are calming are critical over the next several weeks and from our perspective ought to be a regular part of the school experience.

It will be very important for staff to model behaviors of generosity, respect towards others and confidence. It will help to engage students in expressing, what they knew about and liked about the children who were killed. Writing their thoughts and memories on cards or in drawings to be presented to the surviving family members will benefit them and the surviving families. Survivors have told us so many times that what meant the most to them was reading and seeing how well their child was liked by their friends and peers.

It will be important for teachers and the staff of the school to learn all they can about trauma and the ways that they can be helpful, not only for their students, but for themselves. The TLC website, www.starrtraining.org/tlc provides a great deal information about grief and trauma, provides access to its bookstore and the grief and trauma related resources available for parents as well as professionals and details the training it provides in school and community settings.

Children and adults often need to create some kind of memorial following these situations. For some, memorial sites and displays become a medium to recognize the life of that individual. It allows those in grief and trauma to express what they cannot express in words. Memorial displays also become a place for friends to gather for support. However, memorial displays can also create challenges. Wanting to create a permanent memorial in the school setting can lead to even greater challenges. We recommend that you read our article about creating permanent memorials within the school setting (see the Resource section). In essence a
memorial may be helpful to many, but also hurtful and painful to many. For some, the constant reminder of what happened, that’s created by a memorial they cannot avoid, can make it difficult for them to continue to develop and grow emotionally even academically. The reasons for this are supported by what we now know about the impact of trauma on survivors.

In some situations the school is the largest facility in the community and used for many non-school meetings and activities. This creates a unique community culture that may support having a permanent memorial on school grounds. There is no right or wrong in some of these situations, but we encourage decision makers to understand that when memorials become a part of the community, as opposed to a permanent place in the school setting, it allows for those who need to go to that memorial to do so freely, but also allows those who need to avoid it to also do so freely. In our article, we suggest what can be helpful when lockers or other areas are filled with mementos and we suggest ways to help students find a way to honor the victims of such tragic situations.

**Weeks-Months Later**

Currently, the duration criteria used for assigning PTSD is four weeks following the initial exposure. The DSM5, being published in 2013, is not changing the duration criteria. Most professionals support the World Health Organizations ICD-9 six month duration criteria given the factors that keep the memories of so many traumatic events alive. However, we recommend that if reactions persist, intensify or appear after two months, it is an indication that the initial support that often helps most survivors, is not as helpful for those experiencing reactions beyond two months. It does suggest that these survivors may need additional help in the form of trauma specific, evidence based intervention.

Although we support the six month duration criteria, our twenty-three year practice history and evidence based research supports providing structured, trauma focused, sensory based intervention for those survivors continuing to experience unwanted reactions two months following their initial exposure. In some cases survivor’s reactions will be limited initially but become more frequent and or intense in the months that follow. This is due to the kind of initial support that was provided or not provided as well as the environmental factors that may be keeping the experience alive.

If initiated, the proposed interventions should certainly be evidence-based interventions documented to be able to reduce the grief related, trauma and other mental health related re-
actions that often follow such traumatic situations. They also should be framed within a trauma-informed context and use approaches that are supported by the criteria that constitutes a trauma-informed intervention approach (Steele and Malchiodi, 2012). Interventions, that are not evidence-based, but have at least a 10 year history of demonstrated outcomes specific to reducing intense grief, trauma and related mental health reactions are also appropriate. TLC interventions have 23 years of outcome history and are registered as evidence based interventions with the California Clearing House of Evidence Based Programs and with the SAMSHA Registry of Evidence Based Programs.

Furthermore interventions should be supported by assessment outcomes to insure that the intervention is appropriate and helping the survivor. Unfortunately, assessment outcomes alone are not sufficient to determine best practices.

**Assessment outcomes alone are not enough to determine the interventions we might use to help survivors.**

If all we did was complete an assessment on a traumatized child and found, for example, that trauma had created sensory integration challenges, we would have a basis for treatment. However, if we design that treatment without being aware of the kinds of experiences that child actually faced, the treatment may further traumatize that child. If, for example, a weighted blanket is recommended as part of the sensory integration treatment to help calm that activated child, but the child has been sexually abused and the full weight of adult on top of the child was part of that experience, that treatment, that blanket and the sensation of heaviness could in fact re-traumatize that child. Not having information about the details of the survivor’s experiences associated with trauma places that survivor at greater risk when determining treatment.

**Following trauma inducing situations, intervention accountability is necessary to insure that survivors are receiving best practices and that the trauma-informed mandate of “Do No Harm” is being supported by outcome driven intervention.**

We believe interventions should include benchmarks that clearly identify the gains survivors are making. If interventions do not, how can we possibly determine the value of that intervention for those who desperately need help finding ways to manage their reactions to all that happen? We simply cannot. TLC uses pre-post evaluations to support its intervention as effective or to identify the need for other interventions. There are also distinct behaviors, thoughts and feelings that help distinguish victims from survivors and survivors from thrivers.
These provide healing benchmarks to verify that survivors are making meaningful changes over time. (See Appendix).

19 Experiences do frame our thoughts. To change unwanted behavior induced by trauma, we must change the survivor’s experience.

If you tell me you are a friend then hurt me, I will not think of you as a friend. My private logic (Adler, A., 1930) regarding you is that you are not to be trusted, you are no longer safe because of the experience I had with you. I will do all I can to avoid to ignore you or, if needed, fight you. The terror of 9/11 changed how we thought about ourselves as well as how we thought about others. It stripped away our secure sense of safety and our belief that our country was immune from such terror. In the days that followed, we did not think of ourselves as powerful and safe, but as vulnerable. As a result of just this one thought, we began to behave differently. We were more suspicious of others, more cautious perhaps we avoided larger events even though not directly victimized as were those in New York, Virginia and Washington DC.

Traumatized individuals can develop a complex list of thoughts, a private logic, as a result of their experiences. One example of the private logic that develops in children who have been abused is “I will fight any person that I feel is a threat to me, any person who tries to control me because if I do not, I will be hurt again, and again and again.” This private logic is what drives behavior.

If a survivor’s behavior does not make sense to us, it does not mean that it does not make sense to the child. If we have to ask why behaviors are being repeated, we need to remember the experience of trauma as being one where the survivor feels unsafe and powerless. We need to remember that all efforts are driven by the need to survive, to find a safe place, a safe person, to feel empowered to get what he needs in his world – control. These survival responses include aggression, assaultive behaviors, avoidance behaviors, rigidity, cognitive confusion, inability to follow directions, basic flight, fight and freeze responses.

Attempting to reassure a survivor who is terrified with words rarely helps. The traumatized brain, especially when activated by what is experienced as an impending threat, will have a difficult time even processing words, making sense of them or remembering what was said (Steele, W. 2003). Private logic is the result of what is experienced. It is going to be very difficult to change through cognitive interventions or verbal reassurance. It was created because of previous experiences, and will only be altered or replaced with a different logic as a result of new experiences.

For this reason, we must direct our efforts at helping survivors with how they are experiencing their world, with what they now see when they look at themselves and others as a re-
result of their exposure to trauma. We must engage them in non-verbal, sensory based experiences that allow them to “rework” their traumatic related sensations, images and feelings in ways that now allow them to see themselves as survivors and thrivers, not victims. We must help them to see and experience others as helpful and supportive, rather than threatening and unsafe, and to see and experience life as promising rather than continually painful. This is difficult to accomplish using cognitive based interventions alone. TLC’s intervention programs provide the kinds of experiences that direct themselves to the specific experiences or themes of trauma: fear and terror, worry, hurt, anger, revenge, accountability, feeling unsafe, powerless and trapped by victim thinking versus survivor thinking. These experiences are designed to alter their private logic and support a flourishing of strength based, resilient view of self and response to life.

We must also direct our efforts at helping survivors regulate their reactions to what happened. Trauma related behavior is driven by fear. Fear induces both emotional and physiological reactions that activate trauma related memories and intensify fears that these reactions will never be overcome. It is critical to teach survivors that they can regulate the physiological and emotional reactions activated by a threat by using their body as a resource. Traumatized survivors need to constantly be directed to their body’s response during stressful difficult times as well as during relaxing periods (safe periods). They need to be taught how to control the physiological manifestations of arousal by inducing the physiological manifestations of safety. It is a skill that must be repeated many times, until the survivor becomes confident that they can call upon this resource at any time. Basic breathing and relaxation techniques, sensory based interventions and mindfulness activities can all be used to teach self-regulation to survivors.

In today’s world, all professionals in the position to offer support and intervention to survivors must be trained to distinguish trauma-related behaviors from other behavior. They must understand the importance of distinguishing between explicit and implicit processes, the neuro-developmental impact of trauma, the importance of titrating interventions, the body’s role in healing from trauma, what is meant by “trauma as an experience” versus “trauma as a diagnostic category,” why cognitive interventions alone are limited in their success, knowing how to become a witness to that child’s experiences, the importance of being active not reactive, knowing precisely how our behavior, personality and even mannerisms can further victimize the traumatized child.

In today’s world, we believe it is an ethical responsibility to be trauma-informed and trained to provide a variety of implicit and explicit interventions to support a trauma-informed approach to assisting survivors. This is why we continually upgrade TLC’s web site with new information and new online courses and trainings.

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Summary

The nature of the survivor’s experience should be at the core of what guides us in determining what will be most helpful. To accomplish this, we must be curious rather than analytical. Intervention must begin with experiences that meet the needs of traumatized individuals in their world. Those experiences must always be safe, empowering and directed at altering the way survivors view themselves, others and the world around them. For this to happen, experiences must help survivors discover they have the inner resources to recover, they must be trauma-informed, address the major experiences of trauma and be structured in ways to influence changes in the thoughts and behaviors associated with trauma to those associated with being a survivor, a thriver, resilient and able to flourish.

More than ever before, we are learning that traditional approaches to treating trauma are failing. The findings of neuroscience related to trauma’s impact on the brain are quickly changing the way we respond to survivors. TLC has trained well over 60,000 thousand professionals since 1990. The content of our current trainings is far different from what it was 23 years ago because of practice history, research and advances in neuroscience. As we continue to learn, conduct research and obtain ongoing feedback from our 6,000 TLC Certified Trauma and Loss Specialists practicing our interventions, we work hard to translate that feedback and our findings through our on line courses, trainings and resource materials. It is this collective expertise that allows us to stay attuned to the current trends in the trauma field. We hope you will join us so together we can teach one another while bringing the best of practices to survivors.
Chapter Two

TLC’S RECOVERY INTERVENTION

Recovery Interventions for Schools and Agencies: A Trauma Informed Revision
William Steele PsyD, MSW

Since 1990, TLC has provided training to thousands of school crisis team members and provided very comprehensive protocol manuals covering safety, Psychological First Aid (PFA), crisis intervention and trauma-informed recovery interventions. We have learned a great deal over the years from the hundreds of school districts we have had the privilege to train as well as assist following traumatic situations they have experienced. These experiences in addition to what we know today about disaster recovery, critical incident responses, trauma and the core principles of trauma-informed care has led to a revision of our recovery interventions for schools. Following is the rationale and the detailed trauma-informed changes we now recommend. Questions can be directed to Dr. Steele at bsteele@tlcinst.org or by calling 1-877-306-5256.

Rationale

The following revisions are based on three critical considerations.

1. Not everyone exposed to a traumatic situation is traumatized by that situation.

   To mandate any intervention is in conflict with the core principle of trauma-informed care “do no harm” (Hodas, 2006). Mandating intervention assumes everyone needs the same intervention and without that intervention will not do well. The research shows that for some mandated intervention worsen their reactions (Mayou, Ehlers & Hobbs, 2000). The research also shows that many survivors do have an inner resilience that allows them to do quite well with minimal support such as Psychological First Aid (PFA) and crisis intervention (Punamaki, Qouta et al., 2011).

   Both Psychological First Aid (PFA) and crisis intervention are supported world wide as safe and appropriate recovery interventions following critical incidents (World Health Organization, 2013; Greenstone & Sharon, 2011). PFA provides non intrusive, practical care and support to help survivors meet their basic needs. It provides comfort, efforts to calm and connect sur-
vivors to needed resources including peers, friends and families and to protect them from further harm. It is not counseling. It is not debriefing. It is not about helping people analyze what happened but finding ways to manage what has and is happening around them during the crisis. PFA’s primary objectives as listed by The National Child Traumatic Stress Network (NCTSN, 2013) involves engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with several social supports, information on coping and linkage with collaborative services.

Crisis intervention, the origins of which dates back to 1944 and Lindemann’s work with survivors of the Coconut Grove fire (Jackson-Cherry & Erford, 2010), includes PFA objectives as well as the objectives of helping survivors problem solve, initiate appropriate strategies, and be provided with the tools needed to return to some sort of order and normalcy (Echterling, Presbury & McKee, 2005). Crisis intervention has been used by mental health centers for years and The National Education Association (NEA, 2013) supports its use in schools. Today schools across the country have Crisis Response Teams whose recovery interventions involve PFA and various crisis intervention processes. Some are more orderly and comprehensive than others. However, in many cases the various recovery interventions that must be time specific, developmentally appropriate and trauma-informed are either absent, not time specific, or are inappropriately mandated.

Survivors must be provided a choice as to a variety of interventions and whether they wish to participate in any of the interventions being offered throughout their recovery process. TLC provides non-mandatory, multiple recovery interventions which are developmentally appropriate, non intrusive, educational, appropriate to the range and intensity of reactions being experienced. They are also time specific for the reason cited in the next consideration.

People in crisis need time to process the many reactions, thoughts and challenges that crises can precipitate.

Neuroscience clearly shows that a stressed nervous system must have time to regulate its reactions (Levine and Kline, 2008). Providing time for recovery supports the deactivation of initial stress responses, protects some survivors from unnecessary interventions and allows others to determine their need for additional assistance when initial support is not enough. Therefore, initial interventions must be directed at meeting the basic needs of those in crisis - the need for safety, information, choice and structure. This is why TLC’s Recovery Interventions offer basic crisis intervention the first three days. This includes psychological first aid and educational processes, such as our Classroom Presentation and End of Day Reviews. These are non intrusion support processes. This is why we also require that those most exposed to the incident be given at least four days of basic crisis intervention before meeting with them as a
group to address reactions that are unique to the most exposed but may not always be resolved or managed well by initial crisis intervention. Some will manage well, with the support provided the first three days, others will need additional support.

3 **No one intervention fits every situation or every individual.**

TLC provides a continuum of interventions for this reason. For example, included in crisis intervention and initiated simultaneously is what we refer to as *Defusing*. *Defusing* is a sensory-based intervention, frequently used with younger children, to alleviate any anxieties they may have about what happened (See *Defusing*). Simple calming and soothing activities rather than talking about what happened are presented to help children regulate their reactions. What survivors need will vary. For example, some children will do quite well with just the *Classroom Presentation* while others will need to also be involved in Defusing activities, while still others may need extended crisis intervention.

**NOTE:** There has been a great deal of controversy surrounding Critical Incident Stress Debriefing (CISD). The World Health Organization and the National Institute for Mental Health no longer support CISD. Both organizations now support interventions framed within a psychological first aid (PFA) approach. The criticisms regarding CISD were brought about as a result of CISD being a mandated intervention for all exposed, applied within 72 hours and one in which survivors were engaged in a process of clarifying and ventilating their emotions, which research showed led to somewhat greater activation in the months that followed.

TLC has never mandated debriefing, only recommended it for the most exposed after 72 hours to give initial interventions the opportunity to reduce the need for debriefing. Furthermore, TLC’s debriefing model has never supported ventilation, clarification or processing of emotions. In essence, our processes supported PFA and were very trauma-informed and sensitive to the critical considerations just described. However, given the controversy with even the term debriefing, the disaster intervention approaches being accepted today and what we know about trauma, TLC has updated its processes to support both a PFA and trauma-informed approach.

**Recovery Timelines**

**Note:** Most schools today have organized safety and security protocol and procedures. These procedures are addressed in TLC’s Trauma Event Crisis Intervention Plan (TECIP). They include such activities as the Staff Fan-Out Meeting, Rapid Assessment, Classroom An-
nouncements, Referral Behaviors, Letters to Parents.

These differ from recovery procedures, which are directed at initiation of processes that support interactions with students/clients and other staff reacting to what happened while in a safe environment. We have included in the Appendix PFA outlines for community and school incidents. These are placed in the Appendix because, as you review them, you will realize that they include a combination of what school settings would consider to be directly related to safety protocol and organizational procedures in addition to recovery protocol.

Our focus is on the actual recovery processes that are identified but not outlined in detail under PFA guidelines. The following timelines are used to guide the initiation of TLC’s recovery interventions. A detailed summary of each of these interventions follows the timelines.

**Day One**
Initiate crisis intervention inclusive of Defusing, Classroom Presentations, End of Day Staff Review, End of Day Crisis Team Review.

**Days Two and Three**
Continue crisis intervention and Classroom Presentations as needed.

**Day Four**
Continue crisis intervention and offer Crisis Intervention Support for the Most Exposed.

**Day Five**
Complete a final End of Day Staff Review and continue crisis intervention over the next 4 to 6 weeks as needed with individuals. Crisis states generally subside and become manageable anywhere within an eight week period of time. For many, recovery time is much less.

**Second to Third Week**
Complete the Final Crisis Team Review

**Fourth Week to Two Months**
Continue crisis intervention as needed, observe the most exposed and provide support as needed. Remember that PTSD is assigned only six months following exposure although depression can be assigned within two months following a loss (DSM-5, 2012). These new duration criteria are highly debated for the concerns they raise regarding treatment. The reality is such that if survivors are still experiencing reactions two months following exposure they may desire and benefit from additional support.
Two Months and Beyond
For individuals continuing to struggle two months and beyond we recommend a referral to TLC for its evidence-based “Structured Sensory Interventions for Children, Adolescents and Parents” (SITCAP®). One of these evidence-based, school-based intervention programs is “I Feel Better Now” (Steele, et al., 2007) for children 6 to 12 years. This program is used in schools and clinical settings. “SITCAP®-ART” (Steele et al., 2007) is the evidence-based program for adolescents most frequently used in clinical settings as time to provide interventions is far less available at our high schools. Many of our high schools rely upon TLC’s “One Minute Interventions” (Kuban and Steele, 2008) and “More One Minute Interventions” (Kuban and Slamer, 2011) to provide brief focused interventions with their students.

Agencies
The interventions processes that follow are easily adaptable to agency settings. The only difference is the reference made to students versus clients. The timelines and processes of each recommended intervention remains the same.

TLC’s Recovery Interventions
(Complete processes are detailed for each intervention presented.)

Meeting Our Immediate Needs When In Crisis
Exposure to any unexpected and overwhelming situation that occurs to ourselves, ones we love, to our friends or peers, can leave us in crisis. In crisis we prepare for the worst, experience unfamiliar emotions and can find it difficult to think or to know what to do. The question becomes, “What do we need to do to take ourselves out of that crisis state before it also becomes traumatic?” Imagine that a loved one is going into major surgery. The doctor informs us that he will be notifying us at three o’clock in the afternoon to let us know how our loved one is doing following the surgery. We have been sitting in the waiting room for a couple hours and then decide to go to the cafeteria or take a walk as there are about two hours remaining before the surgery is to be completed. We return to the waiting room at about two o’clock because we want to be sure not to miss the doctor. Time goes by very slowly. At one point we look at our watch and it’s now three o’clock but there still is no doctor. We again check our watch ten minutes later but there still is no doctor. We reassure ourselves that surgeries never start on time and that everything is going to be okay. However, we look at our watch again
and it is now 3:20 and still no doctor. Despite what we try to tell ourselves, our anxiety soars and we worry that something may have gone wrong. It is now 3:30 and still there is no doctor. For all practical purposes we are now in crisis because all we can do is wait helplessly and worry.

What is it that we need more than anything else in this situation? We need to see that person in authority, in this case the doctor, approach us in a way that immediately lets us know, without words being spoken that everything is okay. We need to then hear the doctor provide us the information that everything is fine and inform us as to what’s going to happen over the next several hours/days. We need to know how we can reach the doctor or his informed associate should we have questions because in our anxiety we may have only heard half of what the doctor said to us in the waiting room. However, not until we see our loved one, do we finally feel in control of that situation. Even though it may be hard to see our loved one lying there in their hospital bed, we begin to feel better because we are with our loved one, and can now be in a helpful role by making sure that the nurses and doctors provide the care that is needed. We call other family members and friends to let them know all is okay, which is also helpful because of the support they provide. Before leaving the hospital that night, after what has been an emotionally exhausting day, we need to feel confident that the nursing staff is aware of our loved one’s needs and will provide care as written in the doctor’s orders. The first thing the next morning we call the hospital to see how our loved one is doing. If they do not answer, our anxiety is activated reinforcing the need to actually see our loved one. When we arrive at the hospital and everything is fine, we then seek information as to what is going to happen next, what the doctor said or when the doctor might arrive so we can begin to make plans for the next several days.

This example illustrates the core components of crisis intervention and a number of processes referenced in the PFA outlines found in the Appendix. It cites those factors that should frame the type of intervention and the timelines, which are needed to first calm and then stabilize those in crisis. Timely applied interventions beginning with the least intrusive are critical to preventing further escalation of the crisis state in order to also lessen vulnerability to trauma.

**Begin With the Least Intrusive Response**

What interventions do we apply when? The first three days is the time to focus on meeting the basic needs of students and staff impacted and giving them time to process and manage their reactions to any shocking unexpected incident. All too often we simply do not give people the time or space to process their reactions nor the opportunity to call upon their resilience.

**People in crisis need:**

1. Help meeting their basic needs for safety and sense of control or choice which needs to be integrated into immediately initiated protocol staff are to follow in order to provide a physically safe
environment and one which remains organized in its responses to the adjustments needed. This also involves the ongoing communication of critical information. These protocol are presented in Carlton et al., (2011) *After the Crisis: Traumatic Event Crisis Intervention Plan* (TECIP), a TLC program.

2. Comforting and supportive connections (crisis intervention/defusing) until they indicate they can manage their reactions or their reactions and behaviors indicate the need for additional interventions,

3. The normalization of their reactions and information related to the support available and what will be happening throughout the day (*TLC’s Classroom Presentation*),

4. Support for the most exposed, and

5. School based trauma interventions (SITCAP).

**NOTE:** Interventions directly related to school/agency/staff include End of Day Review (1st and 5th day), Support for the Most Exposed (4th day), Initial Crisis Team End of Day Review and Final Crisis Team Review (at the end of one week or before the end of the third week depending on duration of situation).

**Crisis Intervention**  
(*Initiated the first day and continued as needed for two months*)

Following a critical incident, a wide variety of reactions will be experienced. Some may be trauma specific or cited as acute stress reactions, others may reflect generalized anxiety and or grief reactions such as worry, shock, numbness and disbelief. A wide range of physiological reactions will also be experienced such as crying, agitation, wandering about aimlessly, needing to leave the site, needing to talk or being unable to talk. Crisis intervention is the appropriate intervention in the first few days, however we want that crisis intervention to be framed within a trauma-informed context.

“Crisis Intervention: Promoting Resilience and Resolution in Trouble Times” presents excellent intervention strategies (Echterling, Presbury & McKee, 2005). We have worked very closely with Dr. Echterling, the primary author of this detailed description of a crisis intervention strategies that are trauma-informed, support the integration of sensory and cognitive based responses to the person in crisis who may also be in trauma. Appropriate crisis intervention is designed to meet the basic needs of people in crisis and then help them discover they have the strength and resilience to cope with what they have experienced. This also involves helping them regulate their emotional and physiological reactions. The very first chapter of the above cited text is titled “Resilience and Transcendence: Surviving Crisis, Thriving in Life.” The authors state that all too often we focus on those in crisis as victims and that focusing on only the victim can blind us to the survivor. The entire model is based upon entering the individual’s world by being curious and allowing what is learned about how survivors are
now experiencing their world and what matters most to them to determine what we provide them at the time. This supports the primary process used in the trauma-informed SITCAP® programs.

**Crisis Intervention Helps Regulate Survivor’s Reactions**

In training we ask participants to identify all the reactions they can anticipate from students and staff exposed to a critical incident. We then take one reaction and ask participants to identify a minimum of five different ways they could possibly respond to that one reaction. When we solicit their responses we develop an extensive listing of responses that may help survivors process and begin to regulate their reactions. If we take the very common reaction of crying, participants often list the following possible responses: provide tissue, provide a glass of water or other resources that may help (See Defusing), normalize their reactions, sit quietly with them, verbalize that they are now safe and can have as much time as needed, asking them who they would like to be with and facilitate that connection if possible, asking who they might like to call and again facilitating that if possible, assisting them with finding a quiet place so they can express themselves without worrying about what others might think about them. These are basic sensory and PFA interventions that support attending to basic needs.

We would also ask some very basic questions to see if, despite their emotional responses, they can cognitively begin to process what they have been exposed to that day. Examples of questions might include:

- What might I do to help you?
- What do you think we could do to help others?

When answers are specific in their content, it’s a way of indicating to us that they can begin to process their experiences at a cognitive level. If they cannot answer these questions, it suggests that they are still in their limbic region and needing continued sensory-based interventions rather than cognitive based intervention. Once they are able to engage their cognitive processes, questions over the next several days are designed to help them manage/regulate their emotions and behaviors, take action and move from victim thinking to survivor thinking and, in time, make meaning out of their experience.
Crisis Intervention Outline

Objectives

• To meet the basic needs of those in crisis
• To return survivors to their previous level of functioning (Stabilization)
• To help survivors discover their inner resources and strengths
• To help survivors cultivate a resilience against future crises

Process

In a time of crisis everyone has inner resources. We help victims discover their inner resources by, Making Contact, Making Meaning, Managing Emotions, Taking Action, Finding Resolve, Focusing On The Survivor. Following are examples specific to each of these categories. Crisis intervention can be conducted with individuals or in groups.

Adapted from “Crisis Intervention: Promoting Resilience and Resolution in Trouble Times” (Echterling, Presbury & McKee, 2005) and TLC’s structured sensory interventions, “Working with Grieving and Traumatized Children and Adolescents: Discovering What Matters Most Through Evidence-Based, Sensory Interventions” (Steele & Kuban, 2013)

MAKING CONTACT

• Empathetic Action:
  • Let’s clean you up. Let’s find you a place to sit.
  • Let me help you find your friends. Let me just sit with you just in case you need something.

• Active Understanding:
  • Repeat or paraphrase what is said. Use words and phrases similar to what the person used.

• Active Validation:
  • Nodding affirmatively and slowly as the child speaks. Smile warmly. Show your confidence by NOT GIVING ADVICE.
• **Active Listening:**
  - Face the child and give your undivided attention. Assume an open, receptive posture. Lean in; touch the person with expression of concern. Maintain eye contact. (Note: They may not be able to look at you, but when they do glance and see you looking at them, contact is made.)

• **Making Meaning:**
  We help victims make meaning by asking “making meaning” questions such as:
  - What worries you the most right now?
  - What advice would you give someone else going through the same situation?
  - What do you think you can possibly learn from this?

• **Getting Through:**
  We help victims by asking “getting through” questions such as:
  - Where are you finding it in your heart to be so brave to get through this as difficult as it is?
  - Have you ever had this kind of feeling before, even if it wasn't to this degree?
  - How did you get through that?
  - What helped the most?
  - Who helped the most?
  - What did you do to feel a little bit better then?

• **Managing Emotions/Regulation**
  We help victims lower emotional stress by:
  - **Acknowledging feelings:**
    - I can't imagine not feeling scared, confined, etc (normalizing).
  - **Reminding them they are safe right now:**
    - Now that you are here and safe for a while it’s okay to …

• **Physiologically finding a “safe place, a safe activity, a safe resource”***:
  - Use activities that can bring some calmness and respite. What would make you feel the most comfortable now, even for just a few minutes? What would make you feel the safest? What part of your body feels the calmest, most relaxed right now... stay there for a moment... (see *Defusing*).
TAKING ACTION

- We help victims take action by thinking in terms of simplistic actions:
  - What can you do just for a brief time to give your brain a rest? Walk, exercise, listen to music, etc…

- By thinking in terms of short periods of time:
  - What can you do the rest of today that will help you … until we meet again tomorrow?

- By thinking in terms of the possibility of helping other survivors in small ways:
  - As difficult as this is, you’re showing me a lot of compassion. What do you think you might do that might help the others that are having a difficult time? (surviving family members, etc.)
  - By connecting with friends and peers for support as well as accepting additional support from other providers.

FINDING RESOLVE

- We help victims find resolve by beginning in the present:
  - How you feel later today will be a little different than how you feel right now. We know that because you’re likely to have new information, others who come to your support. Sometimes it’s just having the time to feel whatever you feel that helps to get through this.

- By moving to the future asking “what if?” future-oriented questions:
  - What if you had the opportunity tomorrow to experience more relief or feel a bit stronger. What would you do when you woke up tomorrow?
  - It’s been two days now. What has made it possible for you to get through this? How have you managed all your worries, your fears?

- By offering encouragement:
  - You’ve shown me a lot of courage. I don’t know how I would respond if something like this were to happen to me, but I do know I’ll remember you and know that I will find a way.

- By focusing on the survivor:
  - Now that you’ve had a few days to try to make sense of all that happened; What one thought stands out the most in your mind?
• What have you learned that you did these past few days that helped you the most?
• What did others do that really made a difference for you?
• Where do you think you’ve gotten the strength to go on?
• If something similar were to happen again what might you do differently?
• What really surprised you the most about yourself these past few days/weeks?
• How has this changed the way you think about yourself?
• How has this changed the way you think about those closest to you?
• How has this changed the way you think about life in general?
• If you give me one piece of advice to help me better help others in the future what would it be?

**Normalizing the Future**

• Every time we make it through one crisis, we learn a little more about ourselves, especially our strength. There will be other crises – that is a definition of life – the end of one chapter and the beginning of another chapter in our life. Future crises may be less difficult, they may be more difficult, but your strength will help you find a way to get through those tough times too. You really are a survivor.

**Classroom Presentations**

(*Initiated first two days*)

**Objectives:**

• To gather information related to students reactions, concerns and questions
• To provide factual information, minimize rumors, change misperceptions
• To normalize reactions
• To identify appropriate behavior
• To encourage students as to the help that is available if needed and how to access that help
• To inform students of schedule changes, upcoming related activities

The following outline can be used regardless of the type of incident. We strongly recommend that a core group of staff be trained to assist team members in conducting classroom presentations so all students can be reached within the first two days. Immediate presentations help diffuse unwanted student responses. This outline does not include the different reactions survivors may have following different types of incidents such as: suicide, murder, non-violent trauma, grief, etc. Each situation will dictate a change
in reactions to be normalized. We recommend “After the Crisis: Traumatic Event Crisis Intervention Plan” (TECIP) (Carlton et al. 2012) and “Handbook of Interventions Following Suicide and Trauma in Schools” (Steele, 2001) for this information.

**NOTE:** Be prepared for silence. Students may not always know what to say or ask. They may not initially give you credibility or simply be so overwhelmed they can only listen. If students do not respond to your initial questions ask and then answer the questions you anticipated students might have asked.

You may wish to express some of your own personal reactions initially, this sometimes give students “permission” to express their reactions.

Inform students of the related activities which are planned over the next several days and that they will be kept informed of new information and upcoming activities.

The classroom presentation may be as short as 25 minutes or last the entire class period with very vocal students. The important fact is that you are there trying to help. That makes you pertinent in the lives of survivors and can help diffuse unwanted reactions that can emerge when staff fail to sit down with students face to face. The assembly method simply is not as effective as smaller classroom presentations.

We also recommend classroom presentations be conducted by your own staff. Children in crisis look to their counselors, teachers, administrators for protection and help. Using outside sources frequently angers students, distances them from staff, “chips away” at their trust in staff.

**NOTE:** If you are responding to a suicide it will be critical to be very direct with students about suicide being an unacceptable choice, what they might do if they have friends who are talking about it. TLC’s Handbook Following Suicide and Trauma In Schools provides detailed information related to the common questions and concerns survivors have following suicide.

# Introduction

This is very difficult for us all. It is not easy to know what to say or how to act. Sometimes our own reactions frighten us because they are so new to us or seem so strong.

We are here with your teacher to talk about______, to answer your questions if we can and to tell you of some of the reactions you may have that are very normal.
2 Beginning

This is what we know so far…
Have any of you heard anything different about (the way he/she died, was killed, injured, kidnapped, etc.)?

Did any of you play/spend time with or have conversations with ________ in the past couple of weeks? Tell us about that. What do you remember?

Have any of you had a similar incident happen to a family member or friend? What upsets you most about____’s (death, murder, injury, etc.)?
What questions do you have about what happened or even about what will be happening over the next few days?

3 Normalize

Let us describe the kinds of reactions that most people have following this kind of situation. (Use appropriate survivor reactions i.e. suicide, homicide, trauma. Briefly identify and explain the possible reactions and then relate the following.)

You may already have experienced some of these reactions or you may experience them weeks, even months, from now. They are very normal reactions so do not be alarmed. It will help, however, if you can talk to someone about them.

4 Identifying Appropriate Behavior

This will vary somewhat depending upon the incident. If the incident is suicide, the students need to clearly hear what they are to do if a friend talks about ending his/her life. (See TECIP)

Basic Expectations Students Need to Hear

This is a time when it is not unusual for us to look for reasons why this happened. A lot of rumors can get started that are not at all helpful to the family or to close friends. If you hear stories that are different from the information we give you, please let us know so we can check them out, correct them, or confirm them.
Sometimes we want to blame others. This is normal but not something we want to do. It simply doesn’t help and can, in fact, cause the person or persons being blamed to retaliate (want to fight back) and that doesn’t help anyone.

Although it is very normal to be angry, it is not acceptable to seek revenge on those we think may be the cause of ___i’s death. We simply will not accept anyone going after anyone else.

Sometimes situations like this cause us to ask many questions we never thought of before. It is important that you ask the questions. Some of your questions may be personal. You can certainly feel free to ask any one of us, or your teacher.

Conclusion

Ask, “Are there any other questions before we end? If at any time over the next several days you want to talk with someone, let your teacher know and we’ll be contacted - or come and see us directly. Here are the names of the other staff on the trauma response team who can help...”

Defusing

*(Initiated as early as the first day and as needed thereafter)*

Defusing is an intervention that limits cognitive processing of an incident and is more appropriate for younger children. Only two basic questions are asked of non-witnesses in defusing. They include, “What have you been told or heard about what happened” and “Since this happened what is your biggest worry?” The two questions asked with those who were witnesses are, “What do you remember most about what happened” and “What is your biggest worry now? The responses of children are normalized, rumors and exaggerations of details are clarified and the opportunity to ask questions is presented. Following this brief cognitive focus, children are engaged in sensory -based activities designed to alleviate anxiety and help them self-regulate their reactions. Defusing is also beneficial with adolescents when they simply do not want to talk about what happened yet need to find ways to regulate their reactions.

**Defusing Objectives:**

- To identify what children believe happened and correct misinformation as needed
- To identify worries/anxieties the children may have to help determine additional intervention that may be needed
- To help children regulate the worrisome/anxious reactions they may be experiencing

www.starrtraining.org/tlc
Defusing Research

We use sensory-based activities to help deactivate the arousal reactions commonly experienced by most children following exposure to critical incidents. The emotional, sensory arousal their bodies may experience simply cannot be altered through cognitive processes alone (Levine and Klein, 2008; Perry and Szalavitz, 2006; LeDoux, 2000). When younger children are helped to regulate their reactions by involving them in sensory-based activities shortly after exposure, they feel safer, less frightened and less worried. This helps to accelerate recovery. In one study children explained that they learned to feel better by playing and taking part in fun activities (Alisic, Boeije, Jongmans and Kleber, 2008).

“Helping Children Feel Safe” (Steele, Malchiodi and Klein, 2002) is a series of sensory based experiences developed for students from K through sixth-grade. These activities are designed to safely reduce children’s anxiety while also empowering them with ways to regulate their fears. TLC’s “One Minute Interventions” (Kuban & Steele, 2008) provides developmentally appropriate defusing activities to calm and regulate.

Kellet (2012) reports that caregivers can help restore children’s sense of emotional wellbeing through the use of appropriate games or other activities or by simply talking with the child in a caring supportive way. Because younger children have difficulty verbally communicating what they are experiencing emotionally and in their bodies they need the opportunity to discharge those experiences. Children do this best by participating in safe, fun activities. Perry (2005), states that play, more than any other activity, fuels healthy developmental resilience in children. Drawing is another sensory activity that helps children discharge, defuse and manage their many reactions.

Following 9/11 The World Trade Center Children’s Mural Project was unveiled on March 19, 2002. It depicted over 3,100 portraits drawn by children. This drawing project “served to lessen feelings of isolation and helplessness felt among those children who had a hard time understanding the complexity of this tragedy” (Straussner & Phillips, 2004, p.111) These children could not explicitly (cognitively) communicate the many ways this tragedy impacted them but they could do so through drawing, a sensory, implicit way to communicate what words cannot.

Defusing Guidelines:

1. Defusing can be initiated the very first day.
2. Working with younger children dictates we remain flexible in our interventions. Be prepared to present children with several defusing activities as some will be more enjoyable and meaningful than others. Also Defusing may be all that is needed for some while others may need additional crisis intervention.
3. Students fully expect the adults in their environment to be the individuals taking care of them. Whenever possible, staff familiar to the children should be present.
4. There will be students who need to be provided additional crisis intervention should this initial intervention not be helpful.
5. Defusing can be initiated anytime in the days and weeks that follow especially when reactions are delayed or triggered by reminders.

One type of sensory support that appears unrelated to the type of the event and can be very beneficial to the healing process as reported by children themselves comes from cuddly toys (Alsic, Boeije, Jongmans and Kleber, 2012). Cuddly toys and blankies were very comforting for many children following 9/11 and are now often given to children by police, fire departments and hospitals immediately following critical incidents. It is believed that these tangible, comforting resources bring support when parents and others are not available. These supports also come in the form of imaginary friends, which that teddy bear can become, but which may also be strictly the imaginary friends children create when tangible objects like teddy bears are not available (Taylor, 1999; Henry, 2011).

End of Day Review Questions

(This process is included in our recovery interventions because it helps to meet the basic needs of staff, who have been busy throughout the day meeting the needs of their students/clients)

Objectives:

• To evaluate current status of staff and students/clients
• To share new information & clarify rumors
• To determine additional need for immediate resources and support
• To prepare staff for possible upcoming problems
• To help staff care for themselves
• To reinforce positive aspects emerging from this event

Time Frame: one hour

Group Membership:

• Schools - all staff.
• Agencies - due to issues common to most agencies we recommend meeting with line staff separate from administrators/ managers/supervisors. Smaller agencies and/or administrators who insist on total staff participation at the same session are the exception.
Questions Related To Students/Clients:

1. What behaviors of students/clients most upset you?
2. What were you not prepared to see or hear from students/clients?
3. What worries you the most about students/clients?
4. What happened with students/clients that didn’t need to happen?
5. What didn’t happen that should have happened or still needs to happen?

Related To Staff:

1. What one thought stands out the most in your mind about anything you saw or overheard?
2. Of all the thoughts, emotional reactions, and things you’ve done during this crisis, what surprises you the most? (This question is not what surprised them about other’s actions/reactions but their own. Keep them focused on their reactions).
3. What behaviors among other staff surprised you the most?
4. What has been the worst part for you?
5. Where have you felt the impact most in your body?
6. If you were to go through this again, what would you do differently?

Related To Days That Follow:

1. What still needs to happen, either immediately or over the next several days, to help you out?
2. Are there any unanswered questions or additional information you need?
3. What have been some of the positive things that have happened? (Questions 2 and 3 can be partially answered by administrative staff, if present).

Related to Ending The Review

1. This is the time to normalize staff’s reactions, what they might experience in the following days and ways to care for them selves.
2. It is important not only to normalize the reactions they have experienced but also to normalize the system response, especially if this is the first critical incident experienced. It is essential to be honest regarding the need for additional training, and improvements needed on their crisis plan, policies and procedures. An honest appraisal now will help them be better prepared in the future. It is also important to stress the strength that has emerged, the dedicated caring, etc.
3. It is also appropriate to ask if they have any questions of you and they often will. Questions generally refer to your experiences with other systems and how they managed in comparison. Inform them that you will be having a detailed consultation with the principal, superintendent, executive director, etc. about their recommendations and your own. It is appropriate to mention what some of your recommendations may be if you know at the time.

4. Notify them that you will be available for a few minutes should they have personal questions or comments to share with you.

5. Provide them with encouragement and affirmations for their care and concern and dedication to students/clients. Thank them.

6. Remind them that if they do have concerns about specific individuals to see one of the crisis team members immediately following this meeting.

Your responsibility does include a consultation with the appropriate sources. This can be done following the conclusion of this process and followed if needed with a written report.

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End of Day Crisis Team Review

*(To be completed end of first day and as needed throughout the week)*

**Objective:**

- To determine actions and resources needed for the following day

**Duration:** Thirty minutes to no more than one hour. This review follows the End of Day Staff Review.

**Process:** Keep in mind that it has been a very long day for team members. They need to get home and relax as much as other staff. This meeting should be kept as brief as possible. Information from the End of Day Staff Review will help to define some of the actions that may be needed for the following day. Team members need to also identify what will be most helpful for them the following day. Before closing the meeting, it is important to review exactly who will be doing what the following day. Member’s nervous systems will be hyper-aroused. After being hyper-aroused all day the nervous system will not slow down on command. It takes time. We recommend that the Team Leader stress the importance of taking twice as much time as normal in whatever activity they use to reduce their stress.
Crisis Intervention Support for the Most Exposed
*(Not to be initiated until the fourth day)*

It is not uncommon that the most exposed will have the most intense reaction that continue beyond the reactions experienced by those not directly exposed. Often the most exposed benefit from one additional structured group intervention whose primary objectives are:

- To allow the most exposed to discover that they are not alone with their thoughts and reactions
- To normalize these thoughts and reactions
- To educate about additional reactions they may have in the days/weeks that follow
- To identify the kind of support and resources they feel may make life a little easier for them
- To learn ways to care for themselves over the next several days, weeks, months
- To provide referral resources should they wish to talk with someone in the future

**Duration:** Not to be initiated/offered until the fourth day after exposure so participants can better determine whether the initial support provided was helpful or they feel they could benefit from additional help because of the unique reactions, which can emerge for those directly exposed.

**Participation:** Voluntary. Appropriate for adolescents and adults. Not everyone directly exposed needs additional assistance. Choice and safety is a trauma-informed priority. Those who were direct witnesses must be in their own group as some of their reactions will be somewhat different form those who were related to the victim.

**Time Frame:** The actual group should be completed within two hours.

**Group Size:** No more than eight participants at a time.

**Process:** This is a supportive educational process. Its purpose is not to process or explore feelings, nor to allow for the ventilation of feelings. To allow this to happen places the participants at risk of losing control, of revealing more about them selves than should be revealed in a group of peers and exposing other participants to an emotional intensity that may intensify and otherwise regulated emotional state. It is designed to meet the listed objectives safely without processing feelings.

Simply ask the questions, allow the participants to respond and then move to the next question without comment. As other participants hear what their colleagues have to say, they come to discover the commonality they all share as survivors. That is healing.
**Group Leaders:** We recommend two group leaders, male and female so participants who may have gender issues can feel more comfortable than they might with same gender leaders. Both leaders can be involved in the closing portion of the group when they summarize what has been learned, normalize reactions and provide additional helpful information.

**Team Member Introductions/Participant Guidelines**

It is unfortunate that such a traumatic incident has brought us together. I'm sorry you have had to experience such a difficult thing.

My name is _________. These are my colleagues _______ and ________. (You may provide a very brief statement about your experiences with debriefing.)

We have been asked to meet with you to give you some information about trauma and all its possible reactions, which are very likely new for you, but very normal reactions following these kinds of situations. We are here to pass on to you what others have experienced following similar incidents.

This session must be confidential. This means no one is to talk to anyone about anything that is said here today. You may tell others of your reactions but not what others talk about today. Do we all agree?

We will start by asking you about your relationship to ________ (or what happened). Each of you will have an opportunity to respond as we go around the group. You may pass on a question but we will come back to you later. We will go in the same order for each question.

This is not about how well you responded. It is about looking at all the kinds of reactions you are experiencing and may yet experience in the weeks to come. There is no right or wrong reaction. This is not about blaming; about what was done right or wrong. It is about learning what you need to know about trauma that can help you heal.

We will also give you the opportunity to make some recommendations as to what might be helpful for you in your workplace. After your principal/administrator will join us to determine which recommendations they can act on immediately.

Listening to what one another has to say will be very helpful to healing and feeling better. We must ask that you not interrupt while one of the other participants is talking.

Also ________ will be taking some notes to help when we get to the point where we give a review and a summary of all we have learned. There will be a lot said and we want to be sure to capture as
much as we can. If taking notes is a problem, just let us know and we’ll put the note pad away. When we are finished, we will rip up our notes. No records will be kept.

Just one last issue. If you have beepers/phones, could you please turn them off or place them on the silent mode. Backup staff are assigned to cover for you so there is no reason for interruption during this meeting. Is everyone okay with that. And, I believe you have been told that we will finish within two hours. The time varies with each situation, but we will not go beyond two hours. Let’s begin....

Questions for Participants:

1. First can you please tell us who you are and what your relationship is to ________ (victim). Allow each one to answer in order then continue.
2. Where were you when this happened or when you first found out and what did you do?
3. What was the first thought you can recall having at the time it happened, or when you first found out about it?
4. As you think about it now, what one thought stands out the most in your mind?
5. Of all the thoughts you had, the things you did, or the reactions you experienced, which one thought or reaction are you most surprised you even had? (What surprised you the most about you?)
6. If something similar were to happen again how do you think you might react differently?

Thank you. At this point, I’m going to let _________ continue.

7. What was the worst moment for you?
8. Where did you feel it the most in your body?
9. What reactions are you having that you might be afraid to let others know about because you think these reactions are not normal?
10. What worries you now that did not worry you before?
11. How has this incident changed your view of your life right now? (How you look at yourself, others around you, your work environment...)
12. What recommendations might you have that may help you feel a little better over the next several days?

The Summary

Let us first summarize the main issues that came up today:

1. Normalize the reactions they identified during the session. "The reactions you de-
scribed are not at all unusual . . . feeling responsible, having dreams, being easily startled, wanting it to be over, (be sure to address shame as a common reaction), etc."

2. Prepare them for ongoing reactions by using a handout listing trauma specific reactions (Attached) . . . “Do not be surprised if weeks, even months, from now you experience one or more of the following . . .”

3. Use an additional handout (Attached) to encourage them to take very good care of themselves physically.

4. Discuss the fact that current reactions may continue or new reactions may yet emerge. This is normal during the first two months. Encourage them to call for assistance if the reactions go beyond 8 weeks or to call earlier if their reactions are causing them to perform or function poorly. (Important exception: Reactions may extend beyond two months when a person is involved in disasters or other external events where physical reminders cannot be avoided. The same may occur when the details of an incident are kept alive in the media for an extended period of time. Such events often necessitate follow-up sessions and extend recovery time.)

5. Ask: “Do you have any final questions?”

6. (Closing) Thank you very much . . . I know how difficult it can be to revisit such a traumatic incident, but I think you’ll find this will be helpful to you. You have our phone numbers. Please call anytime.

7. Have their administrator or responsible person join the group before dismissing them in order for that person to determine what recommendations can be initiated immediately and what will take more time to implement.

8. Mingle for a few minutes after to answer personal questions and/or discreetly recommend to a participant that additional assistance might be helpful.

Handouts
Helpful Strategies For Trauma Victims/Survivors

• It is very important to your recovery to get enough rest, especially the first 4 - 6 weeks following the trauma.
  - If you cannot sleep at night, take “cat” naps of 15 minutes - 1/2 hour during the day.
  - If waking up during the night because of traumatic dreams know they will pass in time. Do what comforts you. Read a good book until you become sleepy again. Snack, watch television, listen to music, write, do some housework. Remember, this will be a temporary change.
• Exercise of some kind is important to help relieve you of the tension that traumatic experiences create. Even if you have not been exercising, go for a short walk. Walk the dog an extra time. Do housework or add a few minutes to your usual exercise routine.
• Avoid too much caffeine, alcohol, as they can stimulate your already over aroused brain or can intensify your emotions. Do not self medicate. **NOTE:** If you are having difficulties with relaxing or sleeping following the trauma, then call for a temporary prescription to help you sleep but if this persists beyond two months consult with a trauma specialist immediately.

• Pull back on making a commitment to additional responsibilities for the first four weeks. The tendency for some is to take on additional responsibilities thinking it will help them forget. In reality, it frequently drains them of energy, delays the healing process and intensifies future reactions when they finally emerge.

• Be protective and nurturing of yourself. It’s okay to want to be by yourself, or just stay around home with the family. Eat whatever your comfort foods are, as frequently as you need. Let family, friends know that they can best help by taking care of themselves over the next several days while you do what helps you feel a bit better.

• Expect, during the two months following the event, that new memories and reactions related to your experience are likely to emerge. This does not mean things are getting worse. It takes time to heal.

• If any trauma reaction continues beyond two months from when the trauma occurred, you really do need to talk with a trauma consultant. If you do not, such reactions can become chronic as well as create additional problems for you.

• We all have different reactions. What scares you may not scare someone else. If you are experiencing reactions after the two month period, it does not mean something is terribly wrong with you. It means your past experiences are such that you just don’t know how to respond to what happened. Generally, talking to a trauma specialist a few times will resolve the problem.

• A traumatic experience can, however, terrorize the strongest and healthiest. It can induce such terror that our lives become disorganized or disoriented. We become someone strange or act in ways we have never acted before. This can panic us.

• Trauma is not an experience we want to keep to ourselves. It is, in fact, an experience we want to resolve as quickly as possible. Do not hesitate to consult with a trauma specialist when your reactions are overwhelming or interfere with normal functioning. The specialist can help you sort out which reactions are normal and can help you prepare for possible future reactions.

• Finally, traumatic experiences tend to change the way we look at life, our behaviors, activities, relationships and our future. Expect in the weeks to come to see the world differently, your friends, loved ones, work relationships. In time, you will redefine what you want for yourself.

• The first two months therefore is not a time to be making any major decisions. Put what you can on hold. During recovery from a trauma everything is a bit distorted. You want to
wait whenever possible to deal with major decisions until after you have had time to re-order your life and feel stable once again.

**When To Call for Help**

Should you experience any of these reactions beyond the initial two month period following the incident, please call us immediately. You certainly may call early if you need to talk with someone or have questions.

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, other memories of the incident.
2. Recurrent distressing dreams (nightmares) of the incident itself or any dream content that is terrifying.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience).
4. Intense psychological distress at exposure to internal reminders that symbolize or resemble an aspect of the traumatic event. (Fear, anxiety and anger are possible examples.)
5. Physiological reactivity upon exposure to internal or external reminder that symbolize or resemble an aspect of the traumatic event. (Nausea, difficulty breathing, startle reaction and faintness are a few examples.)

**Numbing and Avoidance:**

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma are not helping.
2. Efforts to avoid activities, places, or people that trigger memories of the trauma are not helping.
3. Markedly diminished interest or participation in significant activities often those having some association with the trauma.
4. Feeling of detachment or estrangement from others.
5. Restricted range of emotion (e.g., unable to have loving feelings).
6. Sense of a foreshortened future (e.g., do not expect to have a career, marriage, children, or a normal life span: cannot even think about a few days in advance).
Persistent Symptoms of Increased Arousal:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance/ constant worry about something else happening
5. Easily startled by sounds, smells, images, sights, that remind you of what happened.

These reactions are not at all unusual during the first two months following a traumatic event. When involved in disasters or other external events in which physical reminders cannot be avoided and/or various aspects of the incident are kept alive such as in the case of media coverage, reactions may extend beyond the two months.

Should any of these symptoms persist and/or emerge as delayed reactions months later, we strongly recommend consultation with a trauma consultant.

NOTE: Trauma can induce biological and neurological changes, which play a part in the ability to sleep, levels of anxiety, concentration, and other trauma-specific reactions. Should reactions persist beyond the two month period, consultation for temporary medication should be considered. The loss of sleep, intrusive thoughts, anxiety, and other reactions induced by trauma can deplete an individual of much needed physical rest and inner emotional calmness and precipitate yet more problems for the individual. Medication, at times, is simply a necessity. However, medication should only be temporary and in addition to trauma specific intervention.

Final Crisis Team Review
(To be completed within two weeks following the incident)

Participants
This model is designed for use with school crisis team members or agency staff who have been frontline responders. In school situations some may be members of the local school crisis team and others from the district-wide team who assisted local school members during their crisis.

Objectives:
- To identify procedural or systemic issues of the school/agency which positively or negatively impacted efforts to support staff, students or clients
- To identify the reactions participants have in common
• To evaluate the overall team performance and actions to be taken to improve preparedness.

Duration: One to two hours.

Introduction
The Team leader begins the session by identifying the three objectives of the process. He then explains that questions will be raised to explore and clarify what was done, what needed to happen, what changes if any are needed in the team’s protocol, the strengths of the team and what members can do to take care of themselves.

Systemic Issues:
1. What surprised you most about the school/agency response to the incident?
2. Of the responses identified, which leave you with additional questions. What are those questions?
3. From where or from whom did you receive your strongest support for completing your tasks?
4. From where or from whom did you receive your greatest resistance?
5. What would you recommend that the school/agency do differently to more effectively respond to future traumas?
6. What would you recommend be repeated?
7. What additional information or resources would have been helpful or may be helpful in the future?

Individual Reactions:
1. What were you not prepared for?
2. What was the worst part/moment for you?
3. What specific details or situations stand out most in your mind at this time?
4. As you think about it now, what one thought stands out the most for you?
5. Of all the reactions you had (cognitively and/or emotionally), or the things you did which reactions are you surprised that you even had?

Team Evaluation:
1. On a scale of one to five with five being the highest value, how would you rate the effectiveness of your intervention? Explain the reason for your rating.
2. What, if anything, would you have done differently as a team?
3. If each of you were a supervisor, what one suggestion would you make to your team to 
   enhance, reinforce and prepare it for future interventions?
4. What will each of you do over the next few weeks to take care of YOU?
5. Are there any additional questions/issues?
6. Does any one have any final comments?

Summary
The Team Leader should close with a comment similar to the following: “Every crisis situation will
present unique challenges. Our strength and value as a team will continue to improve with each
experience as long as we are open to looking at what we did well or not so well in the face of the
challenges these situations present and then take the action needed to be better prepared for the
next crisis. Given all that we were presented, we did exceptionally well as a team. It’s now time for
us to take care of ourselves.”

“Structured Sensory Interventions for Children,
Adolescents and Parents” (SITCAP®)
(To be initiated two months following the initial incident
or any time in the future if reactions persist or emerge in the future.)

Research related to TLC’s SITCAP® programs can be found on our website
(www.starrtraining.org/tlc) These interventions are registered as best practices on the California Evi-
dence Based Clearinghouse and the Substance Abuse Mental Health Services Agency (SAMHSA)’s Na-
tional Registry of Evidence based Programs and Practices (NREPP).

Documentation as to their trauma-informed approach, detailed descriptions of their core
processes and numerous case examples of the process are presented in Steele & Kuban, (2013). “Work-
ing with Grieving and Traumatized Children and Adolescents: Discovering What Matters Most Through
Evidence-Based, Sensory Interventions. CA: John Wiley and Sons.

Information regarding training to achieve TLC’s Certification as a Trauma and Loss School Specialist
or Trauma and Loss Consultant can also be found on our web site.

TLC is a program of the Starr Global Learning Network.
Appendix A

PSYCHOLOGICAL FIRST AID MODELS

Three Psychological First Aid (PFA) models are presented; one for community tragedies and the other two for school tragedies. These are placed here rather than in the main text because the models involve protocols, which schools usually align with their safety protocol and the overall organized responses of primary administrators or incident command leaders. However, they also contain protocol directly related to recovery interventions for survivors that front line crisis team members in school settings are responsible for providing. By using TLC’s Recovery Interventions and resources, the components of PFA are carried out in a systematically structured process within time specific guidelines. Although the PFA’s presented provide a detailed and comprehensive outline of the actions to be taken, they do not provide the specific processes, necessary timelines and developmentally appropriate processes and resources found in TLC’s Recovery Interventions for Schools and Agencies. On the other hand these PFAs provide an excellent frame work for those developing their crisis protocol.
Overview of Psychological First Aid: (In the Community)
National Center for PTSD
http://www ptsd.va.gov/index.asp

(TLC Certified Trauma and Loss Specialists respond primarily to critical incidents in schools. However, many are Certified via TLC’s association with FEI Behavioral Health Care, who as first responders provide PFA to survivors of critical incidents involving the larger community. At the same time, many of the categories listed here are also found in the components of TLC’s Recovery Interventions directed at schools and agencies. The two models that follow this community model are specific to schools and can be easily applied to agency settings. We have added to these models TLC’s Recovery Intervention references related to the various actions recommended.

Preparing to Deliver Psychological First Aid:

1. Preparation
2. Entering the setting
3. Providing services
4. Group settings
5. Maintain a calm presence
6. Be sensitive to culture and diversity
7. Be aware of at-risk populations

Contact and Engagement:

1. Introduce yourself/ask about immediate needs
2. Confidentiality

Safety and Comfort (TECIP, Crisis Intervention, Support for the Most Exposed):

1. Ensure immediate physical safety
2. Provide information about disaster response activities and services
3. Attend to physical comfort
4. Promote social engagement
5. Attend to children who are separated from their parents/caregivers
6. Protect from additional traumatic experiences and trauma reminders
7. Help survivors who have a missing family member
8. Help survivors when a family member or close friend has died
9. Attend to grief and spiritual issues
10. Provide information about casket and funeral issues
11. Attend to issues related to traumatic grief
12. Support survivors who receive death notification
13. Support survivors involved in body identification
14. Help caregivers confirm body identification to a child or adolescent

**Stabilization** (Crisis Intervention, Support for the Most Exposed):

1. Stabilize emotionally-overwhelmed survivors
2. Orient emotionally-overwhelmed survivors

**Information Gathering: Current Needs and Concerns** (Crisis Intervention):

1. Nature and severity of experiences during the disaster
2. Death of a loved one
3. Concerns about immediate post-disaster circumstances and ongoing threat
4. Separations from or concern about the safety of loved ones
5. Physical illness, mental health conditions, and need for medications
6. Losses (home, school, neighborhood, business, personal property, and pets)
7. Extreme feelings of guilt or shame
8. Thoughts about causing harm to self or others
9. Availability of social support
10. Prior alcohol or drug use
11. Prior exposure to trauma and death of loved ones
12. Specific youth, adult, and family concerns over developmental impact

**Practical Assistance** (TECIP, Crisis Intervention):

1. Offering practical assistance to children and adolescents
2. Identify the most immediate needs
3. Clarify the need
4. Discuss an action plan
5. Act to address the need

**Connection with Social Supports** (Crisis Intervention):

1. Enhance access to primary support persons (family and significant others)
2. Encourage use of immediately available support persons
3. Discuss support-seeking and giving
4. Special considerations for children and adolescents
5. Modeling support

**Information on Coping** (Crisis Intervention, Classroom Presentation, Defusing, Support for the Most Exposed):

1. Provide basic information about stress reactions
2. Review common psychological reactions to traumatic experiences

**Information on Reactions:**

1. Talking with children about body and emotional reactions
2. Provide basic information on ways of coping
3. Teach simple relaxation techniques
4. Assist with developmental issues
5. Assist with anger management
6. Address highly negative emotions
7. Help with sleep problems
8. Address alcohol and substance use

**Linkage with Collaborative Services** (Crisis Intervention):

1. Provide direct link to additional needed services and referrals for children and adolescents
2. Promote continuity in helping relationships
Providing Psychological First Aid: Principals and Administrators
The National Child Stress Network
http://www.nctsn.org/content/psychological-first-aid-schoolspfa

(The majority of Action Steps for Principals and Administrators, forms etc. are covered in TLC’s Traumatic Event Crisis Intervention Plan-TECIP. It is not unusual for schools to have separate safety and security protocol that address issues other than recovery interventions that will be found in this PFA. Some districts combine their initial safety and security protocol with recovery interventions provided by school crisis teams-see PFA for Health Related Professionals/Crisis Teams following this PFA.)

PFA-S Core Action 1: Contact and Engagement (TECIP, Crisis Intervention)

Provide Leadership: To be most effective, be visible to the school community, delegate extensively, and provide steady, reassuring, and accessible leadership. Call on your school’s district and community partners for their help and resources. Avoid closing off the school to agencies that can help in recovery. When you delegate specific and appropriate roles to your staff, they will feel more empowered and better able to stabilize students, parents, and others.

Reach out to Those Affected: Make contact with groups most affected by the incident, including family members of deceased students/staff, injured and hospitalized individuals, and staff members who have been directly affected. If you are unable to make contact, assign an administrative designee. In addition, assign a staff member to act as the Liaison Officer with community services (e.g., police, fire, mental health) and other response organizations.

Consider Consultation: If your safety plan does not apply to the incident at hand, contact the school district’s emergency office, other local and state resources, or other administrators familiar with similar events to help you with the series of decisions you will have to make. You might also contact disaster mental health experts who have developed school-based recovery programs. Your state education agency, the US Department of Education, or local professional organizations can help identify such experts.

PFA-S Core Action 2: Safety and Comfort (TECIP, Crisis Intervention, Staff Reviews)

Provide Regular Updates: Communicate regularly about the situation and services offered at the school or in the community. Set up mechanisms, such as staff meetings, to get updates from teachers and other staff members about ongoing safety concerns.

Address Identified Safety Concerns: Use a multidisciplinary team (including police, legal advisor, and school counselor) to assess and address the safety concerns of students, staff, and/or families.
Consider developing a Threat Assessment Team, if your school does not already have one, so that students, staff, and parents have a reporting system through which they can anonymously share critical, sensitive information or report rumors.

**Limit Media Access:** Work with the district or your Public Information Officer on which messages will be released about the event, when, and how. Maintain a good working relationship with local media and provide regular updates in a pre-designated location during and after the emergency. Enforce policies to limit the amount of media exposure on school grounds. Monitor media stories to see how they may influence the safety concerns of the school community.

**Help Manage Grief:** Give special attention to those affected directly by the incident. Form a group of representative administrators, teachers, student leaders, community leaders, and parents to decide about memorial events, displays, or other ways to honor those who died, when temporary displays should be removed, and what information to include in the yearbook or how to honor the deceased at graduations.

**PFA-S Core Action 3:** Stabilization (Crisis Intervention, Defusing, Support for the Most Exposed)

**Stabilize the School Environment:** You can be a calming influence in the days and weeks after an incident. Stay visible. Try to greet students and staff as they enter school, visit classrooms, attend student gatherings or activities and/or community meetings.

**Identify Possible Reminders:** Meet with staff as soon as possible to discuss possible reminders of the incident within the school setting. Sounds, sights, or specific areas of the school may cause significant distress to others. Take steps, to the extent possible, to eliminate potential reminders. Remember: what serves as a memorial for some may serve as a trauma/loss reminder for others.

**Identify Students at Risk:** (Crisis Intervention, Staff Reviews)
Make sure there are mechanisms in place to monitor those who need additional mental health support and other services. Encourage trainings be offered to all staff highlighting the common courses of recovery, signs of risk, and how to promote recovery.

**PFA-S Core Action 4: Information Gathering** (TECIP, Crisis Intervention)
Become Fully Informed about the Incident: Take the time to understand fully what happened. When “mapping” the event, identify which groups may have been more affected than others. Obtain information from interviews, attendance records, nursing and/or teacher reports, police reports, and crisis team debriefing meetings. In a multi-agency response to an emergency, make sure a member of your administration is part of the Incident Command System.
Actively Reach out to Students: Work actively with your staff to identify how students are coping. Establish clear lines of communication and referral between staff and school counselors. You may want to encourage your health-related staff to conduct brief screenings to proactively identify students who are in need of additional support.

PFA-S Core Action 5: Practical Assistance (TECIP)

Coordinate Donations and Volunteers: Other schools and community agencies may offer their assistance, and donations may arrive from various sources. Assign a staff member to monitor and coordinate these efforts; otherwise, you may be overwhelmed trying to manage such donations.

PFA-S Core Action 6: Connection with Social Supports (Crisis Intervention)

Integrate New Students: Students who have been through an emergency may transfer to your school temporarily or permanently. Encourage staff to integrate these students into the school culture and orient them to the school procedures as quickly as possible. Avoid singling out these students in a way that alienates them from the rest of the student body.

Establish Peer-to-Peer Programs: Help students reach out to each other. Peer-to-peer programs facilitate a sense of belonging among students and help connect incoming students to peers.

Maintain School Community Connections: If your school is unable to reopen immediately, establish ways students can get in contact with each other (e.g., website, social media, an event).

PFA-S Core Action 7: Information on Coping (TECIP, Classroom Presentations, Staff Reviews)

Provide Psychoeducation and Information: Hold staff and parent meetings as soon as possible. Clarify what happened, describe available resources, and explain next steps. Be prepared for intense conversations and questions that you do not have answers to yet. Have a team, that includes police (when relevant) and mental health professionals, with you to address these questions.

Promote Your School as an Environment for Recovery: Stress that there are different courses of recovery and that you are doing your best to put in place policies and procedures that will support recovery and promote learning and academic functioning. Let individuals know if the school will continue to provide services for those having difficulties in the future or will provide additional support (staff, respite, resources) for staff dealing with their own recovery.

Maintain School/Academic Routines: Students do better when they can return to their regular routine. Reopen school as quickly as possible, help reestablish school routines, and make modifications as needed. For example, advise teachers if they should consider adjusting their teaching plan and to be prepared to postpone some events if safety concerns remain.
PFA-S Core Action 8: Link with Collaborative Services (TECIP)

Activate Mutual Aid Agreements: Contact agencies with whom your school has preexisting mutual aid agreements and identify others needed to assist in your school's recovery.

Seek and Apply for Funding: Financial resources may be available to provide services to those affected by the crisis (e.g., Victims of Crime, American Red Cross) or to your school (e.g., Dept. of Ed Project SERV grants; SAMHSA SERG grants). Research the agency's sites regarding eligibility requirements and assign staff to work on the applications.

In the days and weeks following an emergency, the school becomes a recovery milieu. Due to your leadership role, you will be under extraordinary stress at this time. Secondary traumatic stress is common for those in these positions. As you create an environment to promote recovery in those around you, be sure to practice self-care.* In doing so, you will model self-care for your staff and students, and you will be able to meet your responsibilities most effectively. *(Staff Reviews and Crisis Team Reviews address self-care)
Providing Psychological First Aid in Schools: Health-Related Professionals/Crisis Teams
http://www.nctsn.org/content/psychological-first-aid-schoolspfa

(Under each Core Action we identify the TLC programs, which support each action).

You play a unique role in caring for the needs of the school community during and after times of crisis. The acute phase is not the time to provide therapy. It is the time for immediate assistance to those affected by the emergency. If you are called to a situation that is beyond your usual scope of practice, do not hesitate to consult providers more experienced in this type of event. If you are from an outside agency responding to a school crisis, you may be more helpful by assisting staff and parents than providing direct care to those most impacted, freeing the school health and mental health staff to provide the direct support needed after such events.

PFA-S Core Action 1: Contact and Engagement (TECIP, Crisis Intervention)

Be Aware of Cultural and Developmental Issues: Before working directly with students and staff, learn about the school culture and the cultural and developmental issues of the survivors to whom you will be providing services. Modify contact based on these factors.

Reach out to Those Affected: Outreach to students and staff, even though they may avoid asking for or seeking help. If you are new to the school, work with teachers or other staff who are more familiar with the school community. At a minimum, talk to school officials about the individuals who were most impacted in the emergency, and find out if there are prior events or situations that may put this group at increased risk for distress.

Work as a Team: Always work within the Incident Command System and within a team, so that you can utilize each member’s unique skill sets. Communicate frequently with your team to learn about changing needs and concerns.

Plan for Students’ Ongoing Needs: Students with the greatest exposure and those who have experienced a death or witnessed the death of a friend or loved one will need continuing support at school. Make sure a school staff member is assigned to support these individuals, rather than a PFA provider from the community who may not be able to assist the students’ long-term needs.

PFA-S Core Action 2: Safety and Comfort (TECIP, Crisis Intervention, Defusing, Classroom Presentations, Support for the Most Exposed)

Ensure Safety: Ask staff and students if they have any current safety concerns at school. Listen for rumors or threats of subsequent incidents, and report any such rumors or threats immediately to the
school's Safety Officer or administration.

Watch for High-Risk Behavior: Students may increase substance use or participate in other high-risk behaviors (e.g., driving recklessly, initiating fights), endangering themselves or others. Students are the first to know if a peer is troubled, so ask them directly if they are concerned about anyone's safety. Address these concerns immediately. Seek additional assistance if needed (e.g., school resource officer, threat assessment team).

Support Those Overwhelmed with Grief: Support and comfort those overwhelmed with the death of a friend or family member. You might work with teachers on how to talk to their class about the death of a student or staff member, help administration with memorial events and displays, and/or assess at-risk students.

PFA-S Core Action 3: Stabilization (Crisis Intervention, One Minute Interventions)

Identify Vulnerable Students and Staff: Those with a history of prior mental health problems or who have had similar past traumas may have more difficulty in the current crisis. Be sure to ask about prior experiences and coping strategies. Check in with these individuals frequently, particularly if there are continuing safety concerns at the school. Be aware that they may have distressing reactions to reminders of former traumatic events or may become unstable, more so than the rest of the school population. Offer to guide them in relaxation and grounding techniques, and check back with them to assess how they are doing.

Differentiate between Physical and Emotional Distress: Some students and staff members may present with physical reactions and may have frequent visits to the nurse or a medical doctor. Ask about their experience during the crisis and how they are coping. Find out if the physical reactions are related to the recent trauma (e.g., Did the symptoms start around the time of the event? Do they become more severe when the person is reminded of the event?), and consider a referral to a mental health specialist.

PFA-S Core Action 4: Information Gathering (TECIP)

Know All You Can about the Incident: Find out what happened during the event and who was affected. When “mapping” the event, learn which individuals may have been more impacted than others. Obtain information from interviews, attendance records, nursing and/or teacher reports, police reports, and crisis team debriefing meetings.

Develop a Referral System: Educate staff members as to how they can refer students for evaluation or services. Provide staff psychoeducation on common risk factors and developmentally-specific signs that a student is at risk. Routinely ask teachers about how their students are behaving in the classroom and whether they have any concerns.
Proactively Screen/Assess Students and Staff: Use standardized measures to screen students and staff in terms of their experiences during the event in order to identify those in distress. Systematic screening is the most effective way to identify those who are at risk or who need additional services.

PFA-S Core Action 5: Practical Assistance (TECIP, Crisis Information)
Don’t Underestimate the Importance of Practical Assistance: Assisting with practical needs is a protective factor that enhances recovery. You are in a key position to identify the needs of students and staff and to identify barriers to obtaining resources. Link staff and students to support staff or to an agency contact who can provide these services.

Coordinate Needs: Work with your team leader to ensure that requests for supplies (food, water, toys) are relayed up the chain of command. Also work with families to help with such things as transportation, recouping costs from recovery, and so forth. While some of these activities may be beyond your typical job responsibilities, coordinating practical needs is essential and may require you to expand your role.

PFA-S Core Action 6: Connection with Social Supports (TECIP, Crisis Intervention)
Establish Social Connectedness Programs: Develop venues to increase interaction among students and staff. You might facilitate group discussions on various health- or mental health-related topics pertinent to the crisis, or you might help publicize upcoming, supportive community events. Encourage individuals to reconnect with their family members, friends, and members of their faith community or other social or community organization. For students, make recommendations specific to extramural student group activities or facilitate a peer-to-peer program that may provide a venue for social support.

Integrate New Students: Students may transfer to other schools temporarily or permanently. Attempt to integrate these students into the school culture and orient them to the school procedures as quickly as possible. Avoid singling out these students in ways that might alienate them from the rest of the student body. For example, too much attention from faculty and staff may result in peers distancing themselves from the new students. Do try to connect these students with former friends or classmates, as connectedness is an important protective factor.

PFA-S Core Action 7: Information on Coping (TECIP, Crisis Intervention)
Meet with Parents: Attend the parents’ meetings and provide information about common reactions, address safety concerns, and discuss available resources. Be prepared for these meetings to be stressful, as parents will be anxious and may have significant safety concerns. Parents, like students and staff, cope best when provided with support. School-sponsored meetings can provide parents
with the opportunity to build their own social support network. Always conduct these meetings in partnership with the administration and law enforcement.

**No One Way to Recover:** You will often get questions about the natural course of recovery. Emphasize that there is no one “right” way to recover and that different people will recover at different points in time. Most importantly, emphasize that everyone should respect individual differences. To this end, teach students and staff about typical reactions after emergencies, trauma/loss reminders, reestablish schedules and routines, and effective coping strategies. *

**PFA-S Core Action 8: Link with Collaborative Services** (TECIP, Crisis Intervention)

- **Provide Information on Available Services:** Inform families, students, and staff about the location of mental health and other services and the steps required to access them. You may have to broaden your list of community services to fully address the students’ and staff members’ current needs.

- **Update the Referral List to Include Trauma and Loss-Informed Services:** Do the research to make sure that the providers on the referral list have experience in the type of event that occurred. If you have or are given a standard referral list, review it in light of the situation; and do your best to add the names of professionals who can offer more specialized, developmentally appropriate, and trauma/loss-informed services.

- **Facilitate Access to Services:** To ensure that students and staff are connected with relevant services, help make the calls, double-check that the agency is accepting referrals, and address any concerns students or staff members might have about the services.

  In the days and weeks following an emergency, the school becomes a recovery milieu. Health-related professionals play an important role in monitoring the course of recovery of the students and staff. By actively reaching out to the school community, creating a referral system, and providing state-of-the-art services and programs, health-related professionals can help the school stabilize and accelerate recovery. Secondary traumatic stress is common for those in the helping professions and in leadership roles. As you create an environment to promote recovery in those around you, be sure to practice your own self-care. **

  *TLC interventions are not mandatory, multiple interventions are available for survivors and interventions begin with the least intrusive processes.

  **Self Care for all staff is addressed via TLC’s End of Day and Five Day Review. For first responders self-care is addressed via the End of Day Team Review and the one to two week Final Team Review.

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Appendix B

TLC HANDOUTS AND TOOLS

The materials in this Appendix were developed by The National Institute for Trauma and Loss in Children. These materials will be helpful to have on hand in an emergency and save your team the time they would otherwise need to develop them. These resources are used in schools across the country. For additional support and resource materials see the catalog at the end of this manual or go to www.starrtraining.org/tlc. These materials can be duplicated in their current form. Any adaptations must be approved in writing from The National Institute for Trauma and Loss in Children. Email ckuban@tlcinst.org for permission.

Fan Out Meeting Agenda
Referral Behaviors
Classroom Presentation Outline
When Someone We Know Dies Suddenly…
Grief Reactions to Normalize
Non-Traumatic, Non-Violent Losses
Suicide Factors to Normalize in Classroom Presentation
Questions Kids Frequently Ask
Responses to Suicidal Challenges
Common Reactions to Normalize in Teens and Adults
Trauma Team Response
Following a Traumatic Incident
Protocol Checklist for Parents
Checklist - Parent and Student Reunification
...And more
Fan-Out Meeting Agenda/Traumatic Event Briefing

First (Fan-Out) Staff Meeting

The meeting with staff to inform them of the incident and prepare them for student response needs to present the following messages.

1. Factual data related to death. Warning: if method of death is questionable, students, parents, etc. are to be told only that the manner of death is still under investigation by the coroner's office.

2. Rumors about the incident are to be reported immediately to the Trauma Team (Identify a specific person if possible).

3. This is a time when many students may discharge a residue of emotion which has nothing to do with the deceased, but provides them with an acceptable vehicle for catharsis. Any concerns about student emotional stability and risk is to be directed to the team immediately for assessment.

4. How to "transport" upset students to the Trauma Team or how to bring the Team to the student(s) if necessary.

5. All media questions etc. are to be directed to the assigned Administrator i.e. principal, superintendent.

6. Staff will be informed of any new information that is provided Administration.

7. Staff are expected to meet again after school to debrief what took place during the day.

8. Staff need to hear that no one can predict what kinds of reactions they may see in students, staff, or even themselves and that at the after school meeting possible reactions will be further addressed.

9. The announcement to be read or presented to students must be reviewed and teachers given some guidance as to responding to stu-
dent reactions such as:

a. students having a difficult time can be seen by the Trauma Team
b. students can be assured they will have an opportunity as a group to hear and talk more
c. let students ask questions; note those questions the teacher cannot answer so that they can be addressed in the classroom presentation or as new information becomes available
d. it is okay for them, as teachers, to express their shock, sadness, tears, or difficulty with talking about the deceased and that they too are looking forward to the classroom presentation

10. Staff need reassurance that there is enough staff support available, i.e. substitute teachers, team members from other schools, etc. should the response demand additional support. It is advisable that one or two trained people be identified as available during the day for staff people to talk with about their own reactions and concerns if needed.
Referral Behaviors
(Handout for Staff at Fan-Out Meeting)

If students exhibit any of the following reactions call your team members immediately. Someone from the team or assigned by the team will come to you and escort the student to the appropriate location.

Referral Behaviors

- Witness to or close friend of victim
- Any disruptive behavior
- Students making threats to harm others (often happens following suicide, accidental and violent incidents)
- Any verbalizations of suicide
- Uncontrollable crying
- Any behavior that appears unusual/inappropriate at the time
- Students asking questions you cannot answer
- Students who are preoccupied and or insistent on knowing all the details
- Students indicating that they want to be with their friends or want to talk with a counselor
- Students in the same grade, who know the victim, and appear detached, numb or indifferent
- Students who talk about having nightmares, not being able to sleep, feeling jittery, confused, unable to concentrate
- History of emotional disturbance
- Confusion or disorientation
- Ritualistic behavior
- Extreme pressured speech
- Expressed concern for safety of self or others
When Someone We Know Dies Suddenly…

At First:

- It is hard to really believe it happened.
- We have thoughts we never had before. We have questions we never thought about before or had to ask.
- We sometimes get sick, find it hard to sleep, have nightmares, find it hard to pay attention in class.
- We sometimes are confused because we feel numb or because we don’t seem to react the same way others are reacting.

At the Memorial Service and Funeral:

- We sometimes feel shaky inside, our hearts pound, we sweat.
- We worry about what to say, or worry that we cannot seem to say anything, or that we may say something wrong.
- We sometimes are confused about what is happening.
- We sometimes are mad with how others are acting or do not understand why they are acting like they are.
- Sometimes at the casket it can seem as if the person who died is breathing. This is not real. It is hard to believe our best friend or loved one is dead.
- Sometimes when we are at the service we wish we were someplace else.

Weeks or Months Later:

- We may have a few reactions, or we may have reactions weeks, even months later, that we never had before.
- We may start thinking about what happened, start dreaming about what happened or start worrying about someone else close to us dying.
• We may at times see someone else who looks just like the person who died and think there is something wrong with us for thinking, just for a second, that who we saw was the person who died.

• Sometimes certain sounds or places or things we see will remind us of the person who died and at the same time make us feel the same feelings we had the day we found out or saw them die.

• Sometimes we think we may have caused it or that we could have stopped it from happening.

• Sometimes we are afraid to let anyone know we are still thinking about the person who died, or afraid to let anyone know what we are thinking.

• We may just be very mad that this happened and at the same time feel bad that we are mad.

These are all common reactions which may happen right away or not for weeks or months. We all experience some of these reactions when someone we know dies.

It is best to have someone you can talk to if you have any of these reactions or ones we have not mentioned that worry you. It is important that you not keep your reactions, questions or worries inside yourself. If you cannot talk to your parent or friend, see your teacher or counselor at school.
Grief Reactions to Normalize

Grief reactions vary according to age. Attached is information detailing the understanding of death, how grief is expressed, and grief associated behavior for different developmental levels. In addition are verbalizations and thoughts common to most grieving children.

For an initial classroom presentation these thoughts and verbalizations can be normalized. We recommend that following the initial classroom presentation regarding a specific grief inducing incident that a class presentation be provided on loss including death. Too often children experience a variety of losses and they are never given the opportunity to talk about its impact on them. Multiple unattended loss experiences can lead to depression, problems with learning, relationships and performance.

Factors Affecting Student Grief

Most children have concerns about death. Studies have shown that nearly 80% or children think about death at one time or another. These concerns are reinforced by the death-denying attitudes of our culture. Before parents and school personnel can help children accept the death of someone, they must first have an understanding of how children of various ages perceive death.

Children’s belief structures surrounding death and how they respond when a death occurs are determined in part by four factors: their age and developmental level, the manner of the death and their relationship with the deceased. As a child grows and matures, his/her earlier ways of thinking about death change. It is important to be aware of and address these differences for children.

Age and Developmental Level

Birth - 2 Years of Age

Some say that before the age of 6 months infants show only a non-specific distress reaction to the absence of their mother, while others believe they present specific grief reactions. Regardless, the body and its neuro system do respond to the loss. It is speculated that this could be the beginning of early grief responses. After 6 months and up to around 2 years, infants begin to experience normal grief reactions in response to the absence of their mother.
If the separation continues, the child manifests despair and sadness. And if separation continues over a long period of time, the child will eventually become detached from everyone, unless a constant caring person takes over. During this stage, if the loss is someone other than the mother, such as a father or sibling, it is difficult to tell if the child’s reaction is truly a reaction to the loss itself or if the child is simply mirroring the grief of the mother.

**Ages 2 - 5**

Children in this age group see death as temporary, impersonal and reversible. They have little understanding of time. A day, a week, a year, or forever can all seem the same. A child can miss a person who is gone and is very aware of non-verbal communication such as changes in their personal family routine or in the moods of others.

Frequently, young children are concerned about the physical well being of the deceased wondering how they keep warm and get food after burial. They are not yet capable of cognitive reciprocity, they cannot learn outside the realm of their own experiences. They will react to death in light of their own experiences. Four and five year olds can be quite interested in dead things and may want to see and touch the deceased.

It is not unusual for children of this age group to repeatedly ask the same questions about the deceased, such as, “Will Billy be at school tomorrow?” Although this can be frustrating to an adult, children get reassurance from hearing the same answer over and over. Many don’t know how they should act so they confront visitors or strangers with statements like, “my daddy died.” in order to pick up clues on how to respond or react. At times, they may act as if death never happened, while at other times they may react in a regressive manner. These are all normal reactions.
Ages 6-9

These latency-age children have a more complex understanding of death and dying. They have begun to understand that death is forever; however their own increasing sense of power and control make it difficult for them to believe such a thing could ever happen to them. To them, death only takes other people. Death is personified in the forms of monsters, ghosts or other frightening creatures. This fantasy allows the child to be able to hide or run away from it, thereby keeping him/her safe.

Another characteristic of this age group that can be particularly troublesome for them is their tendency to engage in magical thinking. Children of this age will often think or wish “bad” things to happen to other people. If a person they wished harm to should die, it could cause guilt and fear.

Their lack of vocabulary to express how they feel is one of the reasons they act out these feelings in their behavior. Children at this age have strong feelings of loss but have extreme difficulty expressing it. Crying, withdrawal, frightening dreams, aggressiveness, and misbehavior are common. They often need permission to grieve, boys particularly have difficulty with this and frequently exhibit aggressive responses and play patterns.

Ages 9 -12 Pre-Adolescence

Children of this age group can understand and accept a mature, realistic explanation of death as final and inevitable. Normally, these children have short attention spans. It is typical for them to be crying, depressed one minute and playing as if nothing happened the next minute. This behavior becomes an issue for a child in this age group when adults interpret it as if the child is not upset over the loss. Statements like, “How can you behave like that with your mother lying in her grave?” can intensify a child's feelings of guilt and low self-worth. This disruptive nature of death is a prime egocentric concern of these children. Concerns such as who will take care
of them or who will they play with are common.

Although their vocabulary is advanced enough to express their feelings, they may not talk about what is bothering them. Instead, it will build up inside them and manifest itself in behavior problems. School is a primary environment for these children so it is realistic to expect misbehavior, lack of concentration and a drop in grades. Children at this age must be encouraged to talk about the loss and express their feelings.

There is an interest and curiosity in the physical aspects of death and what happens after death. They may identify with the deceased and imitate their mannerism. Boys in this age group are more aggressive in how they act out their feelings.

**Ages 13 - 18**

Adolescents understand the meaning of death much like adults do. They realize that it is irreversible and that it happens to everyone.

Adolescents appear to have the most difficult time making sense of death and dying. Unlike younger children, teenagers have the additional problems of frustration, anxiety, and confusion of normal puberty which intensifies their grief. Death adds to their already conflicting feelings of unattractiveness, insecurity, not belonging, not being in control of self and surroundings.

At a time when adolescents need to be comforted and supported, they are often put in the position of being the protector, comforter and caregiver. Statements such as, “We need you to be strong,” make some adolescents feel they must be a comfort to others. By keeping their own emotions suppressed, they give the outward appearance that they are handling things well, while on the inside they are falling apart.

Adolescents philosophize about life and death while they search for mean-
ing to these mysteries. They also experience conflicting feelings about death. They may feel as if they are immune to death, while at the same time experiencing anxiety and fear over thoughts of their own death. Some adolescents challenge this fear by taking unnecessary chances with their own lives, such as playing dangerous games with automobiles, or abusing alcohol or drugs.

Academic achievement and competition are also a part of the bereaved teen’s world. While they are trying to survive the death of someone in their lives, pressure exists to get good grades or get into the right college. Struggling with the death of someone often makes it difficult for adolescents to perceive the value others place on academics.
Non-Traumatic, Non-Violent Losses
(Accidental or Terminal Illness)

Thoughts, Verbalizations and Associated Feelings

- I could have fixed it. (guilt, magical thinking)
- If only I had not been so bad. (guilt)
- I never got to say goodbye. (yearning)
- My Mom and Dad were divorced and my Mom wouldn't let me see my Dad. When he died, I felt sad that I hadn't seen him. (sadness, anger, guilt)
- I was so bad Mommy didn’t want to be around me anymore. (guilt)
- I was afraid to go see my grandmother in the hospital. (vulnerability, fear)
- I wouldn’t believe it was real until the funeral when my heart started pounding and I felt like I couldn’t breathe. (denial, alarm)
- This really can’t be happening. If it was, I would feel bad and I don’t, so it isn’t happening. (denial)
- I didn’t need him anyway. (denial)
- I was mad. I didn’t want her to die. (anger)
- Why did he have to die today? Why couldn’t she wait until after our field trip? (anger, denial)
- It makes me wonder if something is going to happen to me too. (fear)
- I want to put Daddy’s golf hat in the casket with him. (love, yearning)
- I don’t know what I’ll do. Everything is going to change. (anxiety, despair)
- My Dad doesn’t pay very much attention to me since my sister died. (anger, jealousy)
- I’ll never find another friend like Billy. (abandonment, anger, fear)
- I’m going to die so I can be with Daddy. (yearning)
Questions (Children)

- Where is dead?
- Why did Mommy die? (feeling betrayed)
- Will I die too?
- Did it hurt?
- I thought Daddy was strong? (feeling vulnerable)
- Was Mommy mad at me?
- Maybe if I behave better Mommy will come back?
- Jackie wasn’t bad, why did God kill him?
- I thought if you were good, this wouldn’t happen?
- Will I catch what Shelly had?
- Why are people laughing (at the funeral home)?
- Who will keep me safe now?
- Will Mommy leave too?
Suicide Factors to Normalize in Classroom Presentation

It is important to normalize the following reactions to a student / staff suicide. In describing these reactions the thoughts which accompany such feelings also need to be described. These thoughts and feelings are:

**Anger:** She was my friend. I'm really mad she did this.

**Guilt:** I should have known. I should have been able to stop him.

**Confusion:** Why? It doesn't make sense. What's it all mean?

**Fear:** Am I going to end up doing the same thing? I've thought about it before. Does that mean it's going to happen?

**Shame:** I wish I never knew him. I don't want anyone to know I was a friend.

**Stigma, Taboo:** If I don't talk about it maybe it will go away.

**Indifference:** It's just one of those things. I don't have feelings one way or another. It was her choice, not mine.

**Disbelief:** I can't believe it. I don't believe it. Something else happened. It was an accident.

**Blame:** If it weren't for his parents this never would have happened.

Students need to know these are normal reactions and that they may have several of them over the weeks to come, if they haven't already, because it takes time to work through such a tragedy. They especially need to know who they can go to in school and out of school, if they feel suicidal or have a friend who is suicidal.

It is important to try to remove the sense of guilt from students close to the deceased, and instill a sense of responsibility in all students for preventing future suicides.

Certainly, no one person can be blamed for a person's suicide. Children can sometimes be cruel, however. Those closest to the deceased may, in fact, blame one of their own or each other for letting their friend die. It needs to be made very clear that without previous education on how to recognize clues, what to say, and what to do for a friend who's talking about suicide, their response was pretty typical.

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It's hard to believe that someone will really kill themselves even though they talk about it. It helps to add that even people trained in suicide prevention don't always, or can't always, prevent suicide. Students do need to know, however, that they can be responsible for helping to prevent the suicide death of friends once they know what to say and what to do. Although this meeting is not the place for presentation on suicide, they can be informed of upcoming presentations and that until then there are some things they can say and do.

It is equally important to emphasize the tragedy in order to prevent the romanticization and glorification of the act which can lead to contagion.

The tragedy must be emphasized. Regardless of the intent of the deceased, his/her act leaves behind many victims. Suicide is an ultimate rejection of those who loved and were close to the deceased. It creates turmoil in the lives of the family members. It helps to point out graphically what it must be like to have to live in a house where a child killed himself. Ninety percent of the time the suicide attempt takes place in the home.

It is also a tragedy because there are alternatives, there are options. It helps, if in this presentation, a couple of non-fatal attempters can be brought in to talk about their tragedies and how well they are doing now after they got some counseling. It's not until after their attempts that they realize talking really makes the difference.

Finally, familiarize students with outside resources. It is very helpful to bring into these meetings a representative from a suicide prevention center. They have a broad perspective on all the issues related to suicide, and are often perceived by students to have answers. If nothing else, their presence encourages students to ask questions about their experiences with suicide. This joint effort can also make the school's effort more credible.

Be prepared after such meetings to spend time with students who will come up afterwards (make time available) with questions about situations they are currently involved in or know about. During this meeting, you may also identify some students who may be potentially suicidal. They may have said something or acted in a way that clued you to the possibility. Trust your instinct and follow-up immediately.

Finally, if there has not been any previous education on suicide, such presentations need to begin.
Questions Kids Frequently Ask

Following are those questions kids most frequently ask about helping a suicidal friend. You need to be prepared to answer these in a classroom presentation.

**What if my friend refuses to talk with someone and says if I tell anyone he's thinking of suicide, he'll kill himself for sure?**

This is not an unusual response. It is a form of testing and can be interpreted as a question. The suicidal person will be unsure of anyone who wants to help. Some will be more unsure than others. This response is from a person who is not quick to trust because of previous hurts and betrayals by others of his confidence. Still, what this person is checking out is how much his friend is willing to fight to save his life. If the friend agrees not to tell anyone, he will lose his respect.

What needs to be said to the potentially suicidal person in this situation?

A good response to the threat is, "Look, you let me know you were feeling suicidal. If you didn't want help, you would never have said anything to me, so I'm not going to let it go. Come on. Both of us will go see someone."

This kind of response lets the person know how serious you are and how much you care. It brings him back in touch with that part that wants to live. In most cases he will agree to see someone after hearing this.

If he still insists on not talking and takes off, it is critical that someone who can get to that youngster be told immediately.

Kids need to know exactly who they can tell and in what situations. When in school, there are the teachers, counselors, etc. When out of school, there are their own parents, police, the phone operator for the Suicide Prevention Center, friends, etc. Make sure they know where to go for help.
immediately. Schools can work out an arrangement with a 24-hour prevention center so that when kids call and identify the school they attend, the center can, if necessary, notify an identified person in the school.

**What do I do if I want to break up with a boyfriend, but he'll kill himself if I do?**

When this occurs, the suicidal person is often very angry but unable to direct the anger appropriately. He is also devastated by the "rejection." In most cases, the breakup brings to the surface feelings around a much earlier rejection by a parent that the suicidal person is unable to separate out emotionally from the current situation, or be consciously aware that the tremendous hurt he feels now goes back to a time long before the girlfriend.

The girl who is breaking up with the boyfriend will also experience a lot of anger for such a drastic retaliation as well as fear that it may actually happen. The tendency is to act on the anger and say something like, "Go ahead," or "That's your problem, not mine." Sometimes the person reacts to the fear and either becomes immobilized or gives in, promising not to tell.

About the only response in this situation is something like, "I know you're really upset, so am I, but I can't keep going out with you. You make me really mad when you dump suicide on me, but you are also making it clear that you really are hurt, too. Both you and I need to go talk to someone. I don't want you to hurt yourself, but I can't lie to you and say I want to keep going out with you, either. If you don't go with me to talk this out with someone, I'll have to tell someone, because I'm still your friend and I don't want you to hurt yourself."

If he is still talking suicide after this, it is imperative that someone is told. It's helpful to let students know that if they do this much, they have done as much as they can possibly do. Stress the importance of telling someone, as this will help relieve them of the horrendous burden of guilt should the person kill him/herself. A promise to talk to someone is not enough in this
situation. He must talk with someone immediately. Once contact is made with a professional, they can take over, and the responsibility of the friend has ended. She was honest and did all she could possibly do.

**What do I do if no one believes me or does nothing if I tell them about a friend I think is thinking about suicide?**

The only thing to do when an adult, whether they are parents or counselors, refuses to believe it is necessary to act immediately is to go to someone else.

**What if the counselor my friend is seeing isn’t helping?**

Sometimes counselors and therapists are thought to be miracle workers, and clients are said to be resistant or at fault if they are not making progress. There is no therapist/counselor who can work well with everyone. Personality clashes happen, backgrounds get in the way, and some problems are simply outside of the therapist’s skill and knowledge. Yes, it is true that sometimes clients unknowingly sabotage counseling, but it is also true that even the best therapist is unable to help some people who would do better with another counselor.

If counseling doesn’t seem to be helping, first let the counselor know. A good counselor will agree and suggest taking another direction for a period of time, and if that doesn’t help, recommend another counselor. A good counselor will also recognize the need for an immediate referral if it is felt that continuing a while longer will not be helpful.

The counselor who does not do the above, but quickly says the problem is with the client, is likely not to be the therapist to continue to see.

**I would feel dumb asking a friend if he is suicidal. What if he wasn’t? Won’t he think I’m crazy?**
Yes, your friend may call you crazy, but not really think you’re crazy. By asking, you are showing how much you care, how much you pay attention to him, and how much courage you have to risk being wrong rather than assume he can handle things.

What if someone wants to die because things are bad and aren't likely to change - shouldn't they have the right to die?

Ultimately, the person does make the final choice as to whether they will live or end their life. It is critical to remember, however, that the person who is certain that suicide is the only way usually does not tell anyone or leave clues. Those who leave clues or talk to you about ending their life are crying out for help. If the response to their cry is "That's your choice," it may be interpreted as a rejection, and as a decision on your part not to get involved because you think they are not worth saving.

Remember, the suicidal person often does not want to die, they just want the hurt to end and know of no other way or have not had the experience of someone being there for them when they need it most.

How do I get my friend to talk when she says it doesn't help to talk?

Sometimes people find it difficult to talk because they are confused and don’t know what they are thinking. Sometimes they are scared that they will say something to upset the listener. There may also be a fear that as they talk, they may not like what they hear themselves say.

Silence is a different situation to deal with because the silent person is in control. It leaves the listener feeling frustrated, angry, and anxious about what to say or do. It helps in this situation to let your friend know that her silence probably has protected her before from people who were insensitive, mean, critical, or made her feel that what she had said was crazy, stu-
pid, or not serious enough to get so uptight over. If you can let your friend know you understand this and that you’re not one of those people and ask her who hurt her so badly that she feels like suicide, she is likely to open up. If this doesn’t help, and she continues her silence, get help.

Why should I call a suicide prevention center? What can they do over the phone?

The counselors at these centers are trained to talk with people in crisis. They generally know what to say, how to say it, and when. They can also call others to come to the aid of the person in need, or if you are calling about a friend, the counselor can call the friend directly.

It needs to be made clear, however, that in some centers the philosophy is that a person has a right to choose whether they live or die. This attitude is not one that I personally support because psychologically, the person in need is desperately hoping someone will stop them from ending their life. To say to the person that it is their choice is to ignore their cry for help and not understand the psychological dynamics. Ultimately, it can become the reason for their attempt and death. We must try.

What about someone who draws pictures of a body hanging?

Remember that any reference to dying, verbal or written, is a clue that the person is suicidal. Drawing pictures of death does not always indicate suicide, but this can’t be determined until the person is asked about possible suicidal thoughts. It should be taken seriously.

I know someone who jokes about it. What do I do?

Suicide is no joke. Even people who joke about it are serious. The joking is sometimes unknowingly used because the person knows of no other way to communicate. These people often joke about everything that is serious to them.
This girl I know never does anything she threatens to do when she's mad. How do I know if she'll do something dumb one of these times? I get tired of her.

This kind of person makes us angry after awhile. We tend not to listen to or even want to spend time with them. This is a normal reaction. The anger comes from our own fear that the one time we don't take the person seriously, they'll do something. That's a lot of pressure and makes us feel like we can't win.

The fact is that each threat must be taken seriously because the risk is high if it is ignored. It helps sometimes to say to this person, "You upset me when you keep threatening to kill yourself. I know you're mad, but why would you want to give the person you're mad at the satisfaction of saying you're crazy because of your suicide threats? It really doesn't help, and killing yourself is not likely to change much of anything. Let's go talk to someone who can help straighten things out."

This may or may not help. The threat still needs to be taken seriously. If you don't feel comfortable dealing with this girl, then tell someone else who can get to her.

Conclusion
Yearly suicide prevention education in classrooms is strongly recommended. Every student must hear that suicide is not viewed as an acceptable option and that there are other choices and people available to help them. Students need to know exactly what to say to friends and that it is their difficult but necessary act of friendship that dictates they tell a responsible adult, i.e. counselor, team member, etc. that their friend is possibly suicidal. Students need to understand that most suicidal individuals really do not want to die, they just want to end the pain, sense of powerlessness, hopelessness, and helplessness that they are experiencing. They need to understand that these feelings are not permanent. They can change and there are people available to help them change.
Responses to Suicidal Challenges

What if the person refuses help and says, "If you tell anyone, I'll kill myself for sure!" This response can be viewed as the teenager's need to test the sincerity of the helping person. It is a way of asking "Just how far are you willing to fight for my life?" He needs to be reminded that he revealed his suicidal feelings earlier because he wanted help and that you are going to do everything to help. This often moves the person to agree to talk with someone. If he still threatens and refuses to see anyone immediately, then you must let him know you are going to tell someone who can help because you do not want him to die.

Statements that the suicidal person needs to hear:

- "I did not know how serious things had gotten. Let's talk about it."
- "It sounds as if you are feeling totally hopeless. I understand how you can feel like ending it all. Have you told anyone else? We've got to talk to someone about this."
- "I don't want you to do anything to hurt yourself. I don't know how we can change the feeling, but there are people who can help." (Know who they are and how to reach them.)
- "I can't watch you 24 hours a day. If you want to die, you'll find a way but I don't want you to and I will do anything to prevent you from killing yourself."
- "I want to hear all that has been happening. I've got time."

Don't say:

- "You'll get over it. Things will be better tomorrow." Things may not be better tomorrow. This cannot be promised and leaves you open to becoming just another one of those who don't understand. It is also a minimizing of the seriousness of the adolescent's feelings and will be perceived as a rejection by the adolescent.

- "You have your whole life ahead of you. If you think things are rough now, wait until you're an adult and have to work for a living." These com-
ments minimize the suicidal person’s feelings, while at the same time express an attitude of “Don’t bother me now,” as if the child is a burden.

In short, do not moralize or minimize. Do not promise anything that cannot be delivered. Do not criticize, ridicule, or infer that the person is crazy. Don’t ignore and in no way tell the person, “Go ahead, do it.”
Common Reactions to Normalize

The following are common statements often made by teens and children following an exposure to a traumatic event. The related emotional reactions are included in parenthesis.

Teen’s Responses

- I never thought it would happen to us (disbelief).
- I don’t know what I’m doing or what I’ve done for several days (shock, disorganization).
- There aren’t any answers (helplessness).
- It’s like I’m on automatic pilot. I automatically get up, eat breakfast, but at the end of the day I don’t remember what I’ve done (shock, disorganization).
- Nothing makes sense. Two plus two doesn’t equal four (disorganization).
- The hardest thing is flashbacks. They come at the strangest times, even two years later. It’s like I’m there the day it happened (intrusive images, anxiety producing).
- When you lose a parent, you lose a part of your past, but when you lose a child, you lose part of your future (helplessness).
- I was angry. I wondered why the innocent suffer while the guilty go free (anger).
- I was afraid if I touched him he would die (anxiety produced by magical thinking from an adult which is not unusual in a trauma).
- I didn’t want anyone to tell me he was going to die (denial).
- I saw him laying there just like a baby. Like he was saying “help me” and I couldn’t (guilt).
- He’s the only one who ever told me he loved me (anger, abandonment).
- I know I have to accept his death or I’ll end up crazy or hurt someone (loss of control, powerlessness).
- My sister blames me (guilt).
- I know deep in my heart that he is dead, but there’s something that tells me he can’t be (disbelief).
- My mind works 3,000 times faster than normal (shock, alarm).
• I sit there dumb-founded (disorganized).
• I sit there in limbo wondering how, why it happened (powerless).
• I look at the spot where he died twenty-four hours a day (fixation, obsessive detailing).
• I have a picture of him. I talk to him and wait for him to answer but he never does (hopelessness).
• I try to be strong but it’s hard (powerlessness).
• The boy who killed him didn’t get but a second in jail, because four years or a million years isn’t enough (anger).
• I started taking some pills because I miss him so much (hopeless, suicidal).
• I want to turn back time and make it better (yearning, bargaining).
• The last day we were together I wanted to hug him but I didn’t. Now I can’t touch him, I can’t hold him (guilt, remorse, yearning).

Children’s Responses

• My best friend was murdered, I was scared. I watch where I walk now (anxiety, fear, hyper-vigilance).
• Sometimes in school while I’m doing my work, I can still see my friend lying there in his hospital bed (anxiety, intrusive images).
• I remember when I was at my friend’s house and she was shot through the window. It’s been a year and I still jump when I hear a loud noise (startle reaction, fear).
• I dream he’s calling me to help him and I can’t. I can’t get to him. I can’t help him (guilt, powerlessness).
• Nothing really scares me anymore (dissociation, numbing, absence of fear).
• I’m going to get a gun and blow away whoever killed my brother (revenge).
• They killed my brother. Are they going to kill me too? (fear.)
• I didn’t want my Mom to know what other kids were saying because I didn’t want her to hurt anymore (repression of feelings via concern, protection of others).
Trauma Team Response

There simply is no way to predict how students or staff will respond to the murder. The response could be subdued or chaotic. Being prepared ahead of time is critical to minimizing the impact such an event can have on all involved.

The most dangerous of reactions is revenge. Following a murder of a student it is not uncommon for gangs, factions to form or emerge calling for revenge. They may inappropriately blame close surviving peers and the potential for additional violence significantly increases.

Recommendation
Protocols related to safety, security, violence prevention, or intervention during violence should be reviewed and staff reminded of the responses you expect from them should they suspect violence, overhear of fights being arranged, etc. Securing school grounds from non-students is also important. If this is a daily practice, a murder may necessitate increased efforts. If this incident has involved a weapon, certainly locker searches are in order as well as searches of school bags.

Student Safety
Students will fear for their own safety. Those fears must be normalized but reassurance also needs to be provided related to overall safety of facility and additional precautions that will be initiated. Obviously discussion and communication will be ongoing over the next several weeks following a violent incident. It is critical to keep students informed but also ask for their input as they often can be aware of safety issues unknown to staff.

Most Exposed
Those who actually witnessed the event generally experience the greatest number and the most intense trauma reactions. Those who were intended victims and survived, generally experience the highest level of intensity.

Least Exposed
The least exposed refer to those who are related to the intended victim but who do not witness the event. Parents, siblings, close friends, peers, students in the same school in either upper or lower grades, staff acquainted with the victim, and staff acquainted with the perpetrator can all experience a range of trauma reactions that, can in some cases be as intense as if they witnessed the event. Survivor guilt is often high in this group.
What must be understood is that any incident can induce in both the least and most exposed, trauma reactions that were induced by their own personal exposure to previous traumas in their life, and therefore, intensify and compound their reactions to the current event.

**Trauma Behaviors/Reactions**

Reactions will vary at different age levels. Some reactions will be immediate, others may not emerge for several days, or even months for some students who may initially seem to be coping, but who in reality have temporarily shut down. When a feeling of safety and security return these individuals can unravel.

Emotional catharsis, revenge, and fear will be the most immediate and common reactions that crisis teams will be confronted with. Once these have been contained, individual interventions with those survivors most exposed will be needed to address any of the following reactions that are possible among the different age groups.

**Reactions**

1. Desires and plans to take revenge
2. Blame
3. Accountability - Survivor Guilt
4. Detachment - no emotional reaction (can become target of angry/hurt students who perceive detachment as non-caring)
5. Absence of fear (very dangerous as instinctive and healthy responses to dangers are not available)
6. Intrusive thoughts, images (unpredictable, interfere with concentration)
7. Sleep disturbances, traumatic dreams
8. Startle Reactions (conditions similar to conditions at time of event that re-traumatize person)
9. Avoidance behavior (need to avoid site, etc., that are reminders)
10. Cognitive disturbances (memory, concentration)
11. Changes in relationships (sometimes will align self with a rougher group)
12. Fear of being labeled abnormal if emotional reactions are made public
13. Emergence of or increase in self-destructive, at-risk behavior, i.e., riding
bike down busiest street challenging cars

14. Impulse control problems, especially around anger
15. Somatic complaints
16. Hypervigilance
17. Increase in aggressive/assaultive behavior

In Younger Children (3 - 12 Years) You May Also See:

1. Repetitive play themes
2. Telling and retelling of the event
3. Regressive behaviors
4. Hypervigilance
5. School phobias
6. Attachment behaviors
7. Confusion
8. Loss of skills
9. Anxious behaviors
10. Increase in aggressive/assaultive behaviors
Following a Traumatic Incident

Following are the most common trauma reactions to emerge the first several days following a traumatic event.

Normalize the Following

- Overwhelmed, confused, disbelief, shock, can’t understand, fearful - what next?
- Worry about present and near future.
- Helplessness, sense of powerlessness.
- Unable to sleep, nightmares.
- Intrusive thoughts, images (especially for witnesses, close friends).
- Easily startled, jumpy - triggered by sounds, sights.
- Can’t think clearly, confused, forgetful, can’t make sense of things, hard to concentrate.
- Headaches, fatigue, other physical ailments.
- Detached, numb.
- Don’t want to talk about it (survivors do but need our help), don’t want to think about it.
- Anger (revenge following violent, sometimes non-violent incidents).
- Guilt.
- Compulsive-like behaviors.
- Fearful of leaving parent, younger children afraid of going to school.
Protocol Checklist for Parents

✔ Assign secretaries, even teachers, to communicate to parents who call in or come to school that their child is “okay” and “safe.” (The “Okay Factor” is a term originated by Mrs. Sterling Russell, Asst.Principal of Southfield Public Schools, Southfield, Michigan.) Let parents know that the school is the safest place for their child because they are surrounded by adults trained and prepared to deal with such situations. When dealing with parents in person, explain that children need to be with their friends and that during school hours it can be far more frightening and difficult for children if they are not surrounded by friends, classmates, and teachers. Stress this whenever possible so when incidents occur parents will be less panicky.

✔ Assign a staff person (administrator if possible) to the main entry (only one entry point) to let parents who come to school know, that their children are okay. Most parents simply need a verbal okay from someone in authority, after which they feel comfortable leaving their child at school.

✔ Contain parents who arrive at the facility for their children. Escort the parents to the predetermined “parent waiting area.” Keep it orderly. It may help to identify before hand which PTA/PTO parents would be comfortable assisting during a crisis. These parents know that their child is safe while in your care and can be available to “transport” other children from the classroom to their waiting parents.

✔ Ask for a picture ID from parents who pick up their children. (When crisis situations are not responded to in a structured form the opportunity exists for a new crises to develop, such as an unauthorized parent attempted to take a child, or a non-parent seizing the opportunity to kidnap a child.)

✔ Have handouts available to give to parents. Parents need developmentally appropriate information about what to say to their children, and how to help them. Have these documents on hand for easy copying when needed.

✔ Provide crisis intervention/support for grieving families. Some of the parents may have friends or family members who died in the attack. These families will need various levels of intervention. The children, if left in school, will certainly need attending to by crisis team members trained to provide the different levels of trauma intervention taught through The National Institute for Trauma and Loss in Children.

✔ Have parents provide the location (address and phone number) where they are taking their child.
NOTE: Not all parents may have access to their children, nor children to their parents during the hours immediately following an attack. This is why it is important for someone to stay behind to pass on to the parents, who do make it though, where students have been evacuated to or who is now caring for their child.

Be sure that this person is given a written record of who picked up whom and where they were going. For example, on 9/11, mothers picked up their children, but when the fathers made it to school, they didn’t know where to tell them to go, as not all parents were going to able to go back home because of barricades, etc.
REFERENCES


Additional Resources and Tools To Help The Helper following grief and trauma situations can be found at the following link: http://tlcinstituteonline.org/store/