

Handout 1: Crisis Reactions

The majority of students exposed to a crisis event will be distressed and may display one or more of the following common crisis reactions:

Common Crisis Reactions

<p><i>Emotional Effects</i></p> <ul style="list-style-type: none"> • Shock • Anger • Despair • Emotional numbing • Terror/Fear • Guilt • Phobias • Depression or sadness • Grief • Irritability • Hypersensitivity • Helplessness/Hopelessness • Loss of pleasure from activities • Dissociation ^a 	<p><i>Cognitive Effects</i></p> <ul style="list-style-type: none"> • Impaired concentration • Impaired decision-making ability • Memory impairment • Disbelief • Confusion • Distortion • Decreased self-esteem • Decreased self-efficacy • Self-blame • Intrusive thoughts/memories ^b • Worry • Nightmares
<p><i>Physical Effects</i></p> <ul style="list-style-type: none"> • Fatigue • Insomnia • Sleep disturbance • Hyperarousal • Somatic complaints • Impaired immune response • Headaches • Gastrointestinal problems • Decreased appetite • Decreased libido • Startle response 	<p><i>Interpersonal/Behavioral Effects</i></p> <ul style="list-style-type: none"> • Alienation • Social withdrawal/Isolation • Increased relationship conflict • Vocational impairment • Refusal to go to school • School impairment • Avoiding reminders • Crying easily • Change in eating patterns • Tantrums • Regression in behavior • Risk Taking • Aggression

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

When considering this list of reactions it is important remember that different students will have different reactions to the same event. There is no one “normal” or expected crisis reaction (or set of reactions). In addition, a student’s developmental level is an important determinate of the type of reactions displayed. In general, the crisis reactions of preschool aged youth are not as clearly connected to the crisis event as might be observed among older children. For example, reexperiencing the trauma might be expressed as generalized nightmares. Further, crisis reactions tend to be expressed nonverbally and may include becoming clingier; tantruming, crying, and screaming more readily and often; and displaying trembling and frightened facial expressions. The temporary loss of recently achieved developmental milestones (e.g., loss of bowel and/or bladder control, bedwetting, thumb-sucking, fear of the dark, fear of parental separation, etc.) might be observed. Finally, the young child may reexperience the crisis event via trauma related play (which does not relieve accompanying anxiety) may be compulsive and repetitive in nature.

The reactions observed among youth in this age group tended to be more directly connected to the crisis event and event specific fears may be displayed. However, to a significantly degree the crisis reactions of children in this age group continue to be expressed behaviorally (e.g., behavioral regression, clinging and anxious attachment behaviors, refusing to go to school, irritability, anxiety). Less emotional regulation (e.g., irrational fears) and more behavior problems are observed (e.g., outbursts of anger and fighting with peers). In addition, feelings associated with traumatic stress reactions are often expressed in terms of concrete physical symptoms (e.g., stomach- and headaches). Finally, while symptoms of reexperiencing the trauma may continue to be expressed through play, among these older children such play is more complex and elaborate, and often includes writing, drawing, and pretending. Repetitive verbal descriptions of the event (without appropriate affect) may also be observed. Given these reactions it is not surprising that problems paying attention and poor school-work may also be noted.

As youth begin to develop abstract reasoning abilities, crisis reactions become more and more like those manifest by adults. Sense of a foreshortened future may be reported. This age group is more prone to using oppositional and aggressive behaviors as coping strategies as they strive to regain a sense of control. Other maladaptive coping behaviors reported in this age group include school avoidance, self-injurious behaviors suicidal ideation, revenge fantasies, and substance abuse. Again, given these reactions it is not surprising that school aged youth and adolescents may have particular difficulty concentrating and/or be moodier (which may cause learning

problems).

It is important to remember that in most cases the crisis reactions displayed by students are normal reactions to unusual circumstances. Consequently, it is expected that with the support of family, teachers, and friends most will “recover” and reactions will gradually become less acute. However, it needs to be acknowledged that some students will be more vulnerable to the crisis event and should be given special attention. Specifically, if the crisis event caused a physical injury, the death of a family member or significant other, and/or the student had pre-existing psychological problem, then any student should be considered at particular risk for crisis reactions that may require referral to a mental health professional. Regardless of perceived risk level, if after several week crisis reactions do not begin to lessen, then referral to a mental health professional would be appropriate. In addition, some students (typically a minority of those exposed to a crisis event) will demonstrate more severe crisis reactions that will signal the need for an immediate referral to a mental health professional. These reactions include the following:

Crisis Reactions That Indicate the Need for an Immediate Mental Health Referral

Peritraumatic Dissociation

1. Derealization (e.g., feeling as if in a dream world).
2. Depersonalization (e.g., feeling as if your body is not really yours).
3. Reduced awareness of surroundings (e.g., being in a daze).
4. Emotional numbness (e.g., feeling emotionally detached/estranged; lack typical range of emotional reactions; reduced interest in previously important/enjoyed activities; feeling as if there is no future career, marriage, children, or normal lifespan).
5. Amnesia (i.e., failure to remember significant crisis event experiences).

Peritraumatic Hyperarousal

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

Persistent Reexperiencing of the Crisis Event

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

Avoidance of Crisis Reminders

1. Deliberate efforts to avoid thoughts, feelings, discussions, activities, places, or people that are associated with and/or bring back memories of the crisis event.
2. Agoraphobic-like social withdrawal (e.g., refusal to leave one’s home).
3. Virtually complete isolation from significant others.

Depression

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

Psychotic Symptoms

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

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

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

While most of the reactions displayed following exposure to a crisis event are normal, some students may demonstrate crisis reactions and/or crisis coping behaviors that demonstrate the need for referral to a mental health professional. It is important for all caregivers to be aware of when such a referral is indicated.

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Handout 2: Individual Vulnerability to Psychological Trauma Subsequent to Crisis Event Exposure

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

Internal Vulnerability Factors

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

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

Poor self regulation of Emotion. Typically, children with easy temperaments are less prone to emotional reactions subsequent to crisis exposure. Conversely, individuals known to have a negative temperament, be easily upset, and have difficulty calming down should be given crisis intervention service priority as they appear to be more vulnerable to psychological trauma. For example, McNally and colleagues (2003) state: “...proneness to experience negative emotions (irritability, anxiety, depression) – is higher among trauma-exposed people with PTSD than among those without the disorder” (p. 50).

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

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

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

History of prior psychological trauma. Children who have repeated traumatic stressors are more likely to disassociate and display mood swings. It is especially important to identify individuals who have experienced prior crises similar in nature to the current crisis. Research conducted by Galea and colleagues (2002) highlights the importance of assessing for trauma history. In a phone survey of Manhattan Island residences several weeks after the WTC attacks it was found that among individuals who had no prior trauma history, only 4.2% reported symptoms of PTSD. On the other hand, those individuals with 2 or more significantly stressful events in their personal histories, 18.5% reported PTSD symptoms. In addition, among those

with no trauma history only 5.6% reported symptoms of depression, while among those with 2 or more stressful events 24.1% reported such symptoms. There is some suggestion in the literature that having coped with previous stressful events in an adaptive way might help people to cope with potentially traumatic events in the future. However, this appears to be true only when the exposure to new crisis events is low. “When exposure is high, the ‘protective’ value of having coped with previous life stressors seems to disappear” (Lecic-Tosevski et al., 2003, p. 547). Additional research findings relevant to this internal vulnerability factor include the following:

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

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

External Vulnerabilities

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

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

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

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

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

Social resources. Individuals who must face a crisis without supportive and nurturing friends or relatives have been found to suffer more from PTSD than those with such resources

(McNally et al., 2003). Close peer friendships, access to positive adult models outside of the family, and strong connections to pro-social organizations or institutions are protective as are positive school experiences (academic or nonacademic). Individuals who have social supports are expected to show lower levels of distress following a crisis. For example, study of the WTC survivors by Galea and colleagues (2002) indicates that while 10.2 and 15.5% of individuals with low levels of social support reported having symptoms of PTSD and depression respectively, only 4.4 and 5.6% of individuals with high levels of such support reported having symptoms of these disorders. To be effective early school crisis interventions need to evaluate systematically the social supports available to students in the recovery environment as well as the student's history of using these supports under stressful circumstances (Litz et al., 2002).

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

Handout 3: Initial Risk Screening Form

(adapted from Brock et al., 2001, pp. 138-139)

Name: _____
 Referred by: _____
 Dominant Language: _____

M ___ F ___ Date: _____
 Room: _____ Teacher: _____
 Screener: _____

A. Crisis Exposure

Proximity to the Crisis Event

10	5	4	3	2	1
Crisis victim, <u>with</u> life threat and/or injury	Crisis victim, <u>without</u> life threat and/or injury	Directly exposed to the crisis event (eyewitness)	Present on the site of the crisis event	Not present on the site of the crisis event	Out of the vicinity of the crisis event

Elaborate: _____

Duration of Exposure to the Crisis Event (optional)

5	4	3	2	1
Days	hours	minutes	seconds	none

Elaborate: _____

Relationship(s) with Crisis Victim(s)

5	4	3	2	1
Relative(s)	Best and/or only friend(s)	Good friend(s)	Friend(s) or Acquaintance(s)	Did not know victim(s)

Elaborate: _____

B. Personal Vulnerability(ies)

	Yes	No	<i>Elaborate</i>
Known/Suspected mental illness			
Developmental immaturity			
Previous trauma or loss			
Lack of resources			<input type="checkbox"/> social <input type="checkbox"/> financial <input type="checkbox"/> familial
Total			

Initial Risk Screening Rating

<i>Initial Risk Screening Category</i>	<i>Rating</i>
Proximity to the crisis event	
Duration of exposure to the crisis event	
Relationship(s) with crisis victim(s)	
Personal vulnerability(ies)	
Total	

Comments:

Handout 4: Crisis Intervention Referral Form

(adapted from Brock et al., 2001, pp. 152-154)

DATE: _____ PARENT: _____
STUDENT: _____ ADDRESS: _____
BIRTHDATE: _____ PHONE: H _____
TEACHER: _____ W _____
GRADE: _____ PRIMARY LANGUAGE: _____
Student: _____
Parent(s): _____

REASON FOR REFERRAL: *Please state why you are concerned.*

How close was the student to the crisis event? _____

How long was the student exposed to the crisis event? _____

How close was the student's relationship(s) to crisis victims? _____

Did the students perceive a threat to self or others? _____

Has the student experienced a similar event in the past? YES NO

(If YES please elaborate) _____

Has the child experienced any other traumas within the past year? YES NO

(If YES please elaborate) _____

Does the student have a known or suspected emotional disturbance? YES NO

(if YES please elaborate) _____

Is the student in any way developmentally immature YES NO

(if YES please elaborate) _____

Are there any known resources that might help the student cope? YES NO

(please elaborate) _____

Crisis Reaction Symptom Check List¹

(Check all that you believe apply to the student you are referring for crisis intervention)

GENERAL FEELINGS/BEHAVIORS GENERATED BY THE EVENT

Fear Helplessness Horror Disorganized behavior Agitated behavior

SPECIFIC FEELINGS/BEHAVIORS GENERATED BY THE EVENT

Dissociative Reactions

Feeling as if in a dream world.

Feeling as if one's body is not one's own.

Being in a daze.

Feeling emotionally detached/estranged.

Lacking typical range of emotions.

Reduced interest in previously important/enjoyed activities.

Feeling as if there is no future career, marriage, children, or lifespan.

Amnesia (i.e., failure to remember significant crisis event experiences).

¹ Adapted from the American Psychiatric Association (2000), Schäfer et al. (2004) and Young, Ford, Ruzek, Friedma, & Gusman (1998)

Symptoms that Suggest an Increased Level of Arousal

- Panic attacks.
- Disturbed memory and difficulty concentrating.
- Hypervigilance and exaggerated startle reactions (e.g., unusually alert and easily startled).
- Increased irritability (e.g., fighting or temper problems).
- Motor restlessness.
- Difficulty falling and/or staying asleep (sometime a result of disturbing dreams).

Reactions that Suggest a Re-experiencing of the Event

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

Reactions that Suggest an Avoidance of Event Reminders

- Avoids talking about the event.
- Avoids situations/locations that are associated with the event.
- Avoids reminders of the event.
- Agoraphobic-like social withdrawal (e.g., refusal to leave one's home).
- Isolation form significant others.

Reactions that Suggest Depression

- Significant feelings of hopelessness and worthlessness.
- Significant loss of interest in most activities.
- Wakening early.
- Persistent fatigue
- Lack of motivation.

Reactions that Suggest Psychosis

- Delusions.
- Hallucinations.
- Bizarre thoughts or images.
- Catatonia.
- Isolation form significant others.

Symptoms that Suggest Dangerous Coping Behaviors

- Suicidal thinking.
- Homicidal thinking.
- Abuse of others.
- Extreme substance abuse and/or self-medication.
- Extreme rumination and/or avoidance behavior
- Taking excessive precautions.

INTERVENTIONS ALREADY ATTEMPTED: *Please list the things already tried to assist the student.*

SERVICES RECOMMENDED: *Please indicate how you think a crisis intervener can help.*

Handout 5: Traumatic Stress Screening Measures

Measure	Author	Age Group	Admin. Time	Availability
Trauma Symptom Checklist for Children	Briere (1996)	7-16 years	20-30 min.	www.parinc.com
Child PTSD Symptom Scale	Foa (2002)	8-15 years	15 min.	foa@mail.med.upenn.edu
Parent Report of Posttraumatic Symptoms	Greenwald & Rubin (1999)	Grades 4-8	15 min.	http://www.sidran.org/catalog/crops.html
Child Report of Posttraumatic Symptoms	Greenwald & Rubin (1999)	Grades 4-8	15 min	http://www.sidran.org/catalog/crops.html
Children's Reactions to Traumatic Events Scale	Jones (2002)	8-12 years	5 min	rtjones@vt.edu
Children's PTSD Inventory	Saigh (2004)	6-18 years	15-20 min	www.PsychCorp.com
Pediatric Emotional Distress Scale	Saylor (2002)	2-10 years	5-10 min.	conway.saylor@citadel.edu
UCLA PTSD Reaction Index for DSM-IV	Steinberg et al. (n.d.)	7-adult years	20 min.	rpynoos@mednet.ucla.edu

References:

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Handout 6: Psychological Triage Summary Sheet (from Brock et al., 2001, p. 140)

(Confidential, for Crisis Response Team use only)

Date	Name	Teacher	Risk Rating ¹	Risk Category ²	Crisis intervener	Parental Contact ³	Status ⁴
	1.						
	2.						
	3.						
	4.						
	5.						
	6.						
	7.						
	8.						
	9.						
	10.						
	11.						
	12.						
	13.						
	14.						
	15.						
	16.						
	17.						
	18.						
	19.						
	20.						

¹ Record initial risk screening rating from the *Initial Risk Screening Summary* form.

² Record the risk category(ies) that is (are) likely to have caused psychological trauma.

Category Codes: V = Victim; I = directly involved; W = witness; F = familiarity with victim(s); MI = pre-existing mental illness; DIm = developmental immaturity; TH = trauma history; R = lack of resources; Em = severe emotional reactions; PT = perceived threat.

³ Record information regarding parental contact.

Parental Contact Codes: SM = school meeting; HV = home visit; Ph = phone contact.

⁴ Record information regarding the current need for crisis intervention services and support.

Status Codes: A = active (currently being seen); W/C = watch and consult (not currently being seen); FU = needs follow-up; I/A = inactive (not being seen and no follow up is judged to be needed); PT = psychotherapeutic treatment referral (psychological first aid not sufficient).

Handout 7: Primary Assessment of Psychological Trauma

Crisis Situation 1: A local gang, in response to the physical beating of a fellow gang member by a student at your high school, has come on campus. A fight breaks out in the student parking lot between the gang and the student's friends. A 15-year-old gang member is hospitalized with a stab wound, and one of your students is killed by a gunshot wound to the head. The principal was in the immediate area and tried to intervene; she was hospitalized with serious stab wounds and is not expected to live.

Level of Response Required:

No Response	Site-Level Response	District-Level Response	Mutual-Aid Response
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Justification: _____

Crisis Intervention Treatment Priorities:

Which students and/or staff members will need to be seen immediately?

Justification: _____

Which students and/or staff members will need to be seen as soon as possible, but not right away?

Justification: _____

Which students and/or staff may not need to be provided crisis intervention at all? _____

Justification: _____

Crisis Situation 2: A very popular sixth-grade teacher at an elementary school was supervising his students on a field trip to a local lake. He tragically drowns after hitting his head on a rock while trying to rescue one of the students who had fallen into the lake.

Level of Response Required:

No Response	Site-Level Response	District-Level Response	Regional-Level Response
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Justification: _____

Crisis Intervention Treatment Priorities:

Which students and/or staff members will need to be seen immediately? _____

Justification: _____

Which students and/or staff members will need to be seen as soon as possible, but not right away?

Justification: _____

Which students and/or staff may not need to be provided crisis intervention at all? _____

Justification: _____

Crisis Situation 3: An irate father has come on to your elementary school site at 8:30 a.m.; a half hour after school has started. He heads to his kindergarten-age daughter's classroom without checking in with the office. The father enters the classroom and begins to hit his daughter. As the astounded class and the teacher watch, he severely beats her. Leaving the girl unconscious, he storms out the door and drives off in his pick-up truck. The event took place in less than 5 minutes.

Level of Response Required:

No Response	Site-Level Response	District-Level Response	Regional-Level Response
-------------	---------------------	-------------------------	-------------------------

Justification: _____

Crisis Intervention Treatment Priorities:

Which students and/or staff members will need to be seen immediately? _____

Justification: _____

Which students and/or staff members will need to be seen as soon as possible, but not right away?

Justification: _____

Which students and/or staff may not need to be provided crisis intervention at all? _____

Justification: _____

Crisis Situation 4: A third-grade teacher is presenting a lesson to her students. She has just soundly reprimanded students for continuing to talk out; in fact, she is still very upset. Suddenly, she turns pale, clutches her chest and keels over in front of 29 horrified children. Two frightened children run to the office, sobbing the news. The teacher is taken by ambulance to the nearest hospital, where it is discovered that she has suffered a massive heart attack. She never regains consciousness and succumbs the next morning.

Level of Response Required:

No Response	Site-Level Response	District-Level Response	Regional-Level Response
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Justification: _____

Crisis Intervention Treatment Priorities:

Which students and/or staff members will need to be seen immediately? _____

Justification: _____

Which students and/or staff members will need to be seen as soon as possible, but not right away? _____

Justification: _____

Which students and/or staff may not need to be provided crisis intervention at all? _____

Justification: _____

