Community Planning to Foster Resilience in Children

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Chapter 10

Responses to Terrorism
The Voices of Two Communities Speak Out

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Perhaps no other event in the history of our nation was as broadly traumatizing as the events of the September 11, 2001 disaster. Much of the population in the United States (U.S.) and in other nations were traumatized by the events related to their magnitude; tremendous loss of human life; constant media coverage and repeated exposure to horrific images; the heroic activities and injuries and deaths of police, fire-fighting and rescue staff; and the uncertainty of imminent or future terrorist attacks, among many factors (see Weist, et al., 2002). These traumatic events were followed relatively closely in time by Anthrax attacks, sniper shootings, continued escalation in terrorism in places around the world, especially the Middle East, war in Afghanistan, and now war in Iraq. In this new century and millennium, it indeed is a new world, characterized by stresses, concerns and traumas at levels unexperienced by many Americans and citizens of other nations. Terrorism and disaster have particularly strong effects on children and adolescents (Waddel & Thomas, 1999). However, even youth most affected by the September 11 disaster are resuming their lives, and showing resilience in their school, social and emotional functioning.

Importantly, the events of and subsequent to September 11, 2001 have both underscored that mental health issues are universal, and helped to destigmatize the receipt of mental health care, as people who normally would not seek such care have done so since the disaster (Weist et al., 2002). Relatedly, there is growing realization that we must do a better job of attending to the emotional and behavioral needs of children and adolescents, ideally in proactive ways in

settings where "they are" (U.S. Public Health Service, 2000; Weist & Ghuman, 2002). In New York City and Washington, DC, schools supporting a more comprehensive mental health approach were better able to respond to the events of September 11 and after, and this response has helped to propel advocacy and coalition building that is contributing to the further growth and improvement of the programs (Center for School Mental Health Assistance [CSMHA], 2001).

A central feature in the efforts of school mental health programs in Washington, DC and New York and many other places in the nation is moving from a focus on finding and treating pathology to implementing a full continuum of mental health promotion, early intervention, and treatment that prioritizes the enhancement of existing strengths and the development of resilience. This chapter seeks to reach a contemporary understanding of youth affected by terrorism, disaster, and trauma. The cultural context of trauma will also be considered as we examine cultural manifestations of trauma in New York City and Washington DC in relation to the September 11th disaster.

CONTEMPORARY UNDERSTANDING OF YOUTH AFFECTED BY TERRORISM, DISASTER AND TRAUMA

Child and adolescent reactions to terrorism are variable, with reactions including anger, depression, loss of control, and isolation (Waddel & Thomas, 1999). In addition, when disaster leads to the loss of basic security needs such as food, supplies and shelter for children, such losses can lead to or compound feelings of vulnerability, anxiety and concern about their own safety and the safety of family members (Duffy, 1988). Schuster, et al. (2001) conducted a phone survey five days after September 11, asking parents to rate the emotional reactions of their children and found that 47% reported that their children had significant anxiety about their own personal safety.

Reactions to terrorism are associated with reactions similar to those experienced from other forms of trauma. When trauma is more intense it may lead to Post-traumatic Stress Disorder (PTSD). Youth with PTSD may present symptoms such as avoidance of stimuli and situations associated with the traumatic event, intrusive thoughts and nightmares, hyper-vigilance, increased startle response, and detachment and withdrawal from friends and family and normal activities (American Academy of Child and Adolescent Psychiatry [AACAP], 1998). When youth are exposed to repetitive and/or chronic traumas dissociative symptoms may be present, including feeling out of touch with reality, losing one's sense of self, engaging in risky and self-harmful behaviors, and presenting emotions that appear disconnected from events (e.g., laughing when talking about violence) (AACAP, 1998; Terr, 1991).

Traumatic events often have long lasting impacts on children and adolescents. For example, following Hurricane Andrew, 70% of youth from the area of primary

impact continued to present noteworthy symptoms of PTSD over two years after the event (Shaw, Applegate, & Schorr, 1996). Similarly, youth affected by the Oklahoma City bombing showed signs of severe stress and trauma ten months after the event (Pfefferbaum, et al., 2000). Importantly, PTSD in youth is often associated with other problems such as depression and other mood disorders, adjustment disorders, and substance abuse (Shaw, 2000).

The events of September 11, 2001 had a strong influence on children and parents, with reactions by parents affecting reactions of children and vice versa (NIMH, 2001). For example, in the Schuster et al. (2001) phone survey five days after September 11, almost half of the parents reported experiencing substantial stress, with over 90% reporting at least one serious stress symptom. Another study found that the level of PTSD in parents was related to whether their children received counseling after the traumatic events of September 11th (Stuber, et al., 2002). In this study, parents with current PTSD were more likely to have their children seen for professional counseling. In another study, adolescents surveyed after the September 11th terrorist attacks were more likely to perceive the risk of dying from general causes (i.e., a tornado) as much higher than adolescents who were surveyed prior to the attacks (Halpern-Felsher & Milstein, 2002).

Alternatively, Fredrickson, Tugade, Waugh, and Larkin (2003) found that resilient individuals were buffered from becoming depressed after September 11th by positive emotions such as gratitude, love, and interest that were experienced in the face of the trauma. A study that looked at caregivers (i.e., psychologists) found more positive than negative responses regarding their interventions post September 11th, stating they felt they were truly helping individuals and the nation heal during a time of crisis (Eidelson, D'Alessio, & Eidelson, 2003). At the same time, the most negatively cited response on the survey was that practitioners felt inadequate or helpless in the face of such need.

Reactions to stress and trauma are partly determined by a child's age and developmental level (The American Academy of Experts in Traumatic Stress [AAETS], 1999). Research has shown that even the youngest members of our society, infants and toddlers, who may not comprehend the nature of a traumatic event, will still react to changes in routine or changes observed in their caregivers as a result of a distressing experience (Munson, 2002). Table 1 outlines such age-related traumatic symptoms.

YOUTH RESPONSES TO TREATMENT

Youth in New York City

In the report entitled *Effects of the World Trade Center attack on NYC public schools: Initial report to the NYC Board of Education* (Applied Research & Consulting [ARC], Columbia University Mailman School of Public Health, &

Table 1. Age-Related Traumatic Stress Reactions

Age Range	Relevant Traumatic Symptoms
1–5	• Feelings of helplessness and fear due to their dependence on others for protection and lack of understanding about the stressful situation (New York State Office of Mental Health [NYSOMH], 2000). • Often strongly affected by the emotional or behavioral reactions exhibited by their caregivers. • Fear of abandonment resulting in clingy behavior towards parents or caregivers or separation anxiety when being left alone or with strangers (NYSOMH, 2000). • Regressive behaviors (i.e., bed-wetting, a new fear of the dark, loss of bladder control if successfully potty-trained (AAETS, 1999).
5–11	• High levels of fear and anxiety related to a traumatic event as beginning to understand permanent change, loss, and death. • Preoccupied with the details of a disaster as a way to mitigate anxiety about the stressful situation (NYSOMH, 2000). • Irritability, school avoidance, poor concentration, physical complaints (AAETS, 1999). • Recurring nightmares, night terrors, and other sleep disturbances (Munson, 2002). • Need to discharge and gain mastery over stress that may result in aggressive behavior.
11–14	• Anxiety and depression may be expressed by an increase in oppositional behaviors. • School problems, unusual rebellion at home, and physical complaints (AAETS, 1999). • Engage in various activities, such as watching television or playing video games as a distraction (Munson, 2002).
14–18	• Stress and trauma may challenge developmental task of separation because families may feel a need to rely on each other more to cope with a traumatic event. • Adolescent responses may be mixed with childlike reactions, causing the adolescent to appear unpredictable and emotionally labile during stressful situations (NYSOMH, 2000). • Appearing withdrawn and unwilling to discuss their feelings with adults, which may indicate feeling overwhelmed by their emotions or an effort to assert their independence (Munson, 2002). • An increase in risk-taking behaviors, apathy and depressive feelings (AAETS, 1999).

New York State Psychiatric Institute, 2002), it was found that New York City children in public schools at or near Ground Zero were the most physically exposed to the events of September 11th. Children in New York City schools outside Ground Zero were more likely to have family members present at the World Trade Center on September 11th. The rates and estimated number of New York City public school students with specific mental health problems after September 11th from fourth to twelfth grades were high. Table 2 presents the seven

Table 2. Estimated Rates of NYC 4th–12th Graders with Mental Health Problems Post 9–11

Disorder	# of Students (estimated)	Rate (%)
Agoraphobia	107,395	15%
Separation Anxiety	88,064	12.3%
Conduct	78,040	10.9%
PTSD	75,176	10.5%
Generalized Anxiety	73,744	10.3%
Panic	66,585	9.3%
Major Depression	60,141	8.4%

Note: Table based on date from the following source: Applied Research & Consulting, Columbia University Mailman School of Public Health, & New York State Psychiatric Institute (2002). *Effects of the World Trade Center attack on New York City public schools: Initial report to the New York City Board of Education.* New York: Applied Research & Consulting, Columbia University Mailman School of Public Health, & New York State Psychiatric Institute, p. 2.

most common problems that students in this age group faced, going from the most to least prevalent that include: Agoraphobia, Separation Anxiety, Conduct, PTSD, Generalized Anxiety, Panic, and Major Depression. Clearly these findings speak to the enormous mental health difficulties New York City youth face post September 11.

The report to the Board of Education also found several factors increased children's chances of developing PTSD. Being younger accounted for a 400% increase in the chance of having PTSD, followed by having a family member exposed (200%), being female (88%), having any prior trauma (65%), having personal physical exposure (64%), and identifying as being Latino, Mixed, or Other for cultural/ethnic background (22–28%). Despite these prevalence rates, the study found that the proportion of New York City school children with probable PTSD who sought help was much less than the prevalence of the disorder. Only 22% of children with probable PTSD sought help through a school counselor, only 22% sought help through an outside professional, and only 34% of youth sought help from either the school counselor or an outside professional (ARC, Columbia University Mailman School of Public Health, & New York State Psychiatric Institute 2002). This means that of the 75,176 students with probable PTSD, only 25,560 students sought some kind of help. The other 49,616 students never sought out or received services.

Youth in Washington, DC

The *Terrorism-Related Mental Health Needs Assessment Project* served as a basis for assessing need and planning for a mental health response in Washington DC (DC Department of Mental Health [DCDMH], 2001). Youth focus groups

Table 3. Percent of Students Referred with Various Mental Health Problems to the DC School Mental Health Program Pre- and Post-September 11, 2001

Referring Problem	Percent endorsed for September 2000 ($N = 132$)	Percent endorsed for September 2001 ($N = 110$)	Percent endorsed for October 2001 ($N = 84$)	Percent endorsed for September 2002 ($N = 188$)
Disruptive Behavior	53%	44%	36%	49%
Hyperactive/Impulsive	22%	15%	2%	13%
Depressed/Withdrawn	19%	12%	26%	14%
Poor Academics	20%	9%	17%	11%
Poor Peer Relations	33%	15%	11%	33%
Family Problems	14%	20%	42%	37%

Note: Figures represent a percentage of the number of referring problems endorsed by the number of students referred and seen that month (September 2000 = 16 schools, September 2001 = 12 schools, October 2001 = 12 schools, September 2002 = 20 schools). Referral sources can identify up to three (3) predominant issues to include on the referral form. This data does not account for changes in numbers of referrals or in presenting problems that may be accounted for by maturity of the mental health program, increases in knowledge about mental health issues among school staff, or fluctuations due to external events occurring during the academic year.

were comprised of 66 children and adolescents divided into three age groups (8–10, 11–13, and 14 and older) from the four quadrants of the city. Youth participating in focus groups reported a general increase in feelings of fear and anxiety and a greater reluctance to venture outdoors or to travel by subway immediately following the September 11th attacks. Youth participants also endorsed a heightened sensitivity to previously normal events (i.e., planes flying overhead) and reported an increase in risk-taking behaviors following their rationale to "live for the moment."

Utilization data from the Department of Mental Health, School Mental Health Program, operating in 16 public schools in the fall of 2000 and expanded into 24 schools by the spring of 2003, revealed increases in some categories of referring problems immediately following the tragic events of September 11th. However, by the following year, referral patterns mirrored pre-September 11 (see Table 3). In October 2001, there was an increase in the number of referrals to the program for students who were exhibiting depressive symptoms and/or were suspected of using substances. Interestingly, the number of students referred because they were having "family problems" also increased significantly after September 11th (from 20% to 42% of the referring problems) and has remained an area of concern for children and youth to date. This suggests that family units and family communication were adversely affected by the culmination of stressors that plagued the area.

Throughout the aftermath of September 11th there was a pervasive sentiment that services for youth in DC's low income neighborhoods were limited and generally poorly distributed across the city. The School Mental Health Program, in

collaboration with other district agencies, community providers, and a district-wide crisis response team, offered crisis support throughout the city. Over the course of 18 months, mental health providers conducted crisis debriefings (as intensive as possible), group, family, and individual counseling/therapy, and school staff consultation to address the varied responses from children and adolescents to September 11th, and later to the anniversary of September 11th, the Anthrax incident, and the sniper attacks. Yet it soon became clear that the supply of qualified, child-trained mental health professionals available to perform community outreach, offer mental health education, and commit to ongoing support services was far below the overwhelming clinical demand.

THE CULTURAL CONTEXT OF TRAUMA

Other considerations for effective treatment concerned the cultural context in which services were provided. The Surgeon General's report entitled *Mental Health: Culture, Race, and Ethnicity*, broadly defines culture as "a common heritage or set of beliefs, norms, and values. It refers to the shared, and largely learned attributes of a group of people" (U.S. Department of Health and Human Services, 2001, p. 9). Given this definition, it would make sense that culture shapes how individuals interpret traumatic events as well as how distress manifests itself (Clauss-Ehlers & Lopez-Levi, 2002a; 2002b). The following sections highlight some of the specific cultural issues related to the aftermath of traumatic experience.

Cultural Manifestations of Trauma in New York and Washington, DC

Self-Blame, Gender Roles, & Interpretation of the Event

Understanding how the individual interprets the traumatic event was a critical aspect of work with one Latina woman, who will be called Miranda.* Miranda's husband was working in Tower One on September 11th. That morning he left for work like any other, hugging his wife and 5-year-old son good-bye. Miranda was out doing errands when the plane hit Tower One, unaware of the events that had unfolded.

Miranda was never able to communicate with her husband that morning. In treatment she blamed herself for her husband's death. She truly believed she was at fault because she hadn't called him in time, to warn him to leave. Had she been at home, Miranda believed she could have called right away and her husband could have evacuated the building. Despite the reality that her husband was on the

* Names and identifying information have been changed to protect confidentiality.

top floor and the plane hit the building in the 80s, it was important to understanc Miranda's interpretation of this event within a cultural context.

The cultural concept of *marianismo* was one way to make sense of Miranda's experience. The idea of marianismo is that the women's role is to liken herself tc the Virgin Mary, to sacrifice and suffer for the good of her husband and childrer (Chin, 1994). For Miranda, the tragic loss of her husband and her inability tc save him through her own suffering were too overwhelming to bear. It was almos as though Miranda needed to believe the ability to save her husband was in her control (i.e., she was not at home) than come to terms with the reality that she had no control over such a tragic situation. Here education about the crisis was helpful and involved explaining the logistics of where the plane hit the building. It was also important to be a consistent caring person, giving witness to Miranda's story while insisting she was not to blame for her loss.

Stigma

In working with trauma from a culturally-focused framework, it was also important to recognize that individuals and families might have different thoughts about the helping process itself. According to the Surgeon General's Report, stigma was portrayed as the "most formidable obstacle to future progress in the arena of mental illness and health" (as quoted in USDHHS, 2001, p. 29). Stigma can be viewed as negative beliefs and attitudes about mental health problems and/or people who present them (see Clauss-Ehlers & Weist, 2002). When working across cultures it was important to consider the stigma issues at play for the individual and his or her family. For instance, when asking one Latina mother about getting support from extended family, she quickly shared that members didn't even know she was in therapy. This mother decided not to tell extended family she had sought help because she feared they would think she was "una loca" (a crazy person) who couldn't handle the loss of her husband within the context of family support.

Religious Persecution

On numerous occasions following the events of September 11th, Muslim residents reported that they were repeatedly threatened, harassed, and singled-out due to misunderstandings about their religion and questions posed about their national loyalty. These real and persistent threats caused some women to temporarily stop observing Hijab, a covering of the head and body that addresses the requirement for modesty among Muslim women, due to fear of continued persecution and misguided blame for the attacks on the Pentagon and the World Trade Centers. Hijab not only describes a particular style of dress among Muslims, but it connotes behavior, manners, and appearance in public that ties one to a common set of beliefs about being a Muslim "believer." The lack of cultural awareness and sensitivity on

the part of the mainstream population caused a group of devout individuals to feel great reluctance to express pride in their heritage, culture, and religious customs for fear of persecution.

Children and adolescents from Muslim families expressed confusion and anger about how they and their families were being treated. A school-based clinician recalled one student who continuously lashed out at her teacher (who dressed in Hijab) after September 11th due to the dissonance she experienced over public messages telling her she should fear Muslims and the reality that she was attached to and dependent upon Muslim adults in her school. The same school-based mental health provider noted that another Muslim student's emotional and behavioral problems exacerbated following September 11th due to defensive encounters with his peers who made him feel different and unwelcome.

A general reluctance to look outside of one's group for help or support can be expected among a group of people that are targeted for persecution, especially if the helpers are believed to be aligned in any way with those within the mainstream population (and therefore may be potential victimizers). Members of the Muslim community, both children and adults, demonstrated reluctance to share their experiences with unfamiliar and historically culturally insensitive mental health providers. It was only through relationship building within the second author's community and school-based programs that trust was gained and successful outreach was performed for those demonstrating the greatest need for mental health support during this volatile time.

Incorporating Culture into Trauma Relief Efforts: New York City and Washington DC

As we reach out to diverse communities, we are challenged to look at how service provision might incorporate, or leave out, cultural diversity. The following highlights new areas we might begin to consider in attempts to incorporate cultural sensitivity into trauma relief efforts.

Police Presence

Access to services is one area that is relevant to cultural inclusion. Faced with the aftermath of September 11th, many organizations set up booths to provide various services. Due to the lock down state of New York City at that time, a police presence was in view of many of these service outlets. Unfortunately, the police presence acted as a deterrent to seeking services for many individuals and families from culturally diverse communities. Having escaped torture, come to the US for political refuge, or been victimized in their countries of origin, the police presence acted as an unintentional re-traumatization for many. It is a difficult position to try to balance security versus services during a time of crisis. A possible

alternative might be to provide access to some services separate and apart from law enforcement, or if this is not appropriate, for security personnel to be dressed less formally.

Mistrust of Government Authorities

The *Terrorism-Related Mental Health Needs Assessment Project* underscored that residents of Washington, DC from all age groups harbored a general mistrust of the local and federal government, believed that the authorities were keeping information from them, and worried that the government was generally unprepared to protect them from future harm (DCDMH, 2001). This was a significant finding given the heightened state of alert for both Washington DC and New York City and the public's dependence on the government for information, protection, and services. The report also pointed to "an absence of a coordinated system for community outreach and information dissemination, particularly for those who are more isolated from the mainstream, including... immigrants..." (DCDMH, 2001, p. 11). This was particularly noteworthy given that Washington, DC ranks as the fifth most common destination for legal immigrants nationwide (Giorgis & Roberts, 2001).

Number of Sessions

Another issue concerned parameters of treatment, particularly the number of sessions offered. When the first author started to work with families affected by the tragedy, a mere three sessions were allowed by a mental health service contract. As families bonded with the clinician, it became apparent that ending treatment after three sessions would perpetuate, and even re-create the loss and acute crisis. To make a connection in the face of crisis and then be forced to disconnect when the family was not prepared to do so was counter to cultural values such as *personalismo* where the relationship is highly valued (see Clauss-Ehlers & Lopz Levi, 2002a). While advocacy led to an eight month extension with some families, this was certainly not the reality for many others.

Benefit Maze

Access to benefits was another complication for many families and often related to language barriers between services and families. Without Spanish-speaking service providers, for instance, many families were at a loss about how to negotiate the maze of benefits before them. This left some families feeling powerless. One family, for instance, shared that they weren't going to pursue benefit options because it was so stressful. Other families had their children translate—acting as the communicator between service system and family system. This new "role" in

the face of trauma placed an additional burden on children and their families. One adolescent girl, for instance, shared that she became deeply saddened as she translated information about procedures that would be used in attempts to identify her father's body. Being too close to the information and taking on the responsibility of being the transmitter of knowledge were factors that risked re-traumatizing this girl (Clauss-Ehlers, 2003).

Language Barriers

As mentioned, the inability for a growing number of New York City and Washington, DC residents to communicate to officials in English caused significant frustration (Clauss, 1998; Giorgis & Roberts, 2001). The diversity of backgrounds and lack of non-English speaking mental health providers (especially child mental health providers) for youth and families who speak Chinese, Vietnamese, Amharic, and Spanish, represents an alarming gap in our service delivery infrastructure. Washington DC focus group participants urged government officials to make information available in multiple languages, using standard linguistic adaptations, and to use multiple formats for disseminating information (both oral and written) to increase the likelihood of reaching marginalized members of this diverse community.

Religion

In work with trauma across cultures, it was also important to consider faith and religious background (Owens, et al., 2004). Clinicians should explore the ways a family's religious beliefs may provide comfort to family members and the ways they may be a source of stress so that coping mechanisms can be incorporated successfully into valued family belief systems. Should the family agree, clergy and mental health professionals can work together as a crisis team. It may also be that the family doesn't want clergy present during treatment, but does want to participate in religious ceremonies outside the treatment forum. Certainly this will expand the family's support system and outlets for grieving.

The importance of integrating mental health practice and religious practice was particularly important when a family must cope with religious questions that result from the trauma. The first author worked with one family who was very distressed that the father's body was never found. They had deep concerns about what not having the physical body meant for life after death. The family also had questions related to not knowing whether their loved one jumped off the World Trade Center. They wondered if God would view this as suicide or understand the reasons for jumping. Family members themselves grappled with trying to comprehend the amount of pain their loved one must have suffered if jumping became the only option. Incorporating religion and mental health helped the family process

and cope with the situation from a perspective of both religious commitment and personal well-being.

Family-centered Interventions

Finally, immediate and extended family members play a vital role in coping with trauma or stress. Non-traditional members of a family can provide significant support to children and youth, such as Godparents or neighbors that are affectionately called "tia" (aunt) or "tio" (uncle). Respondents in the Washington DC focus groups were quoted as saying "I thanked God my mother and grandmother were still alive" and "we went back to school too soon... there was not enough time with our family." Given the importance of the family unit in helping to counteract feelings of anxiety that accompany unpredictable events, a goal within the School Mental Health Program was to help families and caregivers be better able to support their children through the various crises. Clinicians defined their roles as educators and consultants and assisted caregivers through one on one family consultations that addressed how to talk to children about coping with the many feelings and reactions they might have.

It is from these experiences that valuable lessons can be learned about how to integrate culture into trauma response. Table 4 organizes culturally relevant recommendations based on the National Association of School Psychologists (NASP) website (www.nasponline.org, downloaded 9/3/02; Young, 1998). These recommendations are meant to provide general guidelines when working with issues of trauma in a cross-cultural context. Approaching diverse clients in crisis from a cultural framework that addresses practical problems and provides specific cross-cultural intervention is a starting point for being responsive to all our families.

CONCLUSION: THE SCHOOL RESPONSE

Reaching people in need following large scale traumatic events is uniquely challenging. For youth, school-based approaches to outreach present many advantages in reaching them as well as many adults "where they are" (Jamieson, Curry, & Martinez, 2001). In addition to educational and support functions, schools usually have elaborate communication mechanisms in place and often serve as a gathering place in communities and for emergency response (e.g., they are often the site where people are evacuated to during severe weather related events). Optimally, a full range of activities should be conducted in schools to prepare for and respond to terrorism and disaster. These activities include the development of crisis response plans and teams, ensuring that these teams and plans become part of the fabric of the school (versus unused documents), school-wide mental health educational activities before disaster (e.g., on strategies for positive mental health,

Table 4. Culturally-Inclusive Responses to Trauma

Cultural Framework	Practical Problems	Specific Cross-Cultural Intervention
Search for the meaning of suffering and pain relevant to the culture	Deal with immediate problems that the individual is having difficulty handling	Ask survivors what you would like to do to be of assistance to them and then tell them truthfully what you can and can't do
Search for the meaning of death in the culture	Build trust	Reduce isolation
Search for the meaning of life in the culture	Assist with financial resources if possible	Relaxation techniques/Meditation
Traditions may help survivors feel re-oriented	Help survivors focus on something tangible that they can accomplish over the next few days	Education About Crisis in Culturally Relevant Terms
Ask survivors what they would like you to do to be of assistance to them, tell them truthfully what you can and can't do		• Help Individual Develop Control • Increase Self-Esteem • Be Aware of Specific Communication Techniques: -Eye contact -Integration of food and drink -Pace of conversation -Body language

Note: Select recommendations are included here. See NASP website for a full listing of their recommendations. Table created for this chapter, not a reproduction of any NASP table.

trauma symptoms, strategies for effective trauma response), school-wide plans for response after disaster; and more intensive therapeutic services for affected students, families and staff. It is beyond the scope of this chapter to review each of these areas in detail. The interested reader is referred to two resources: a book on crisis response in schools by Jonathan Sandoval (Sandoval, 2002); and a comprehensive review of school preparedness and response to terrorism and disaster by the third author and collaborators (Weist et al., 2002).

A critical action for all schools to both assist in preparedness for disaster, and to promote resilience is to initiate programs that broadly train students, families and staff on mental health. There is a particular need for training on the impacts of trauma, for example, on topics such as the psychosocial impacts of disaster, cultural factors, PTSD symptoms, grief and bereavement, and holiday and anniversary reactions (Arman, 2000; NASP, 2001; Call & Pfefferbaum, 1999). It is critically important that this mental health training be provided in advance of crises, since once crises occur learning and motivation for training are impaired (see Sandoval, 2002). Unfortunately, such broad training on mental health in schools occurs very rarely; in reality even basic crisis preparation and response functions are often

extremely limited in schools (Weist et al., 2002). These realities point to a significant need for advocacy, training, and resource enhancement to ensure that schools are equipped to take on the critically important tasks of mental health education and preparation for effective response to crises, trauma, terrorism and disaster.

Assuming school staff have had some level of mental health training and preparation for response to significant traumas, their actions can play an important role in helping students in the recovery and healing process. In discussions about the crisis, school staff should be honest with students, help them to feel safe, and allow them to express their concerns, questions and feelings (Waddell & Thomas, 1999). Also, following a significant trauma such as student or staff deaths and/or terrorism, school staff should convey that it is OK for students to express a range of emotions, including anger, sadness, worry, and even some level of acting out. This can be challenging for schools to basically tread a line that on the one hand allows students to express real emotion, yet on the other hand manages student behavior and avoids widespread discipline problems (see Poland, 1994). Following severe crises such as a terrorist attack the most helpful response to affected individuals often involves "assistance with physical needs, re-location and shelter, and financial matters" (Pfefferbaum, Flynn, Brandt, & Lensgraf, 1999, p. 110). Since people may be unlikely to seek these services in specialized health or mental health centers, schools may be looked on to provide these services (Weist, Evans, & Lever, 2003).

Finally, schools represent one of the most, if not most powerful communication mechanisms in communities. Following terrorism or disaster, a critical activity is to get information out to the public. While print, radio and television media can and do perform this function, these media can also cause harm, as in the repeated coverage of the September 11th disaster, including horrific images of people jumping out of buildings in some media. It is also critical to get information out to people deemed important by mental health, health and education experts. The Office for Victims of Crime (OVC, 2001) at the U.S. Department of Justice, for instance, has developed a *Handbook for Coping After Terrorism*, which reviews reactions to a traumatic disaster, and presents practical strategies for coping such as: 1) "Whenever possible, delay making any major decisions. You may think a big change will make you feel better, but it will not necessarily ease the pain. Give yourself time to get through the most hectic times and to adjust before making decisions that will affect the rest of your life" and 2) "Take care of your mind and body. Eat healthy food. Exercise regularly, even if it is only a long walk every day. Exercise will help lift depression and help you sleep better, too . . . " The handbook presents 15 additional strategies to assist in coping, as well as information on additional resources and sources of assistance. There are many other written resources that would be helpful in schools' response to disaster. However, interviews with schools and school staff members following September 11th indicated that many of them did not identify the most useful written materials for dissemination, or logistical issues

such as making hundreds of copies, prevented their broad dissemination throughout the school (CSMHA, 2001). This underscores key infrastructure needs for schools to be able to assume a more prominent role in assisting students, families, staff and community members in recovering from trauma (Weist et al., 2002).

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