

# **CRISIS INTERVENTION: A GUIDE FOR SCHOOL-BASED CLINICIANS**

**Center for School Mental Health Assistance  
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## **INTRODUCTION**

Crisis, as it applies within an educational venue, refers to an unanticipated event that actually or potentially disrupts or undermines the normal functioning of a significant segment of the school community. Crises may affect more than one school or district simultaneously, as in the case of natural disasters. Some crises involving threats to physical safety may be short in duration (e.g., drive-by shooting on school campus), though educational and emotional effects may endure. Due to children's experiential and cognitive limitations, even "close-call" events (e.g., tornado warning without actual touchdown, incidents affecting friends or neighbors) may be traumatizing. Psychological trauma is the term often used to describe individuals' reactions to traumatic stressors (e.g., natural disasters, humanly acts of violence or terrorism). Psychological trauma is characterized by an individual's real or perceived threat to life, bodily integrity, or sanity and by his or her compromised abilities to integrate consequent emotional experiences (coping resources). Although clinical and empirical writings often distinguish group-level crises from individual-level crises and emergencies (e.g., suicidal behavior or intent, homicidal behavior or intent, physical maltreatment, sexual assault), treatment goals for groups and individuals experiencing crises are similar (e.g., establish sense of safety, restore equilibrium).

### **Crisis Intervention**

Goals of crisis intervention are to provide counseling, screening, and referrals to any individuals potentially affected by a traumatic event. Rather than assume that individuals in need seek services independently, crisis intervention appropriately takes services to victims. For children exposed to traumatic events, schools are ideal loci for intervention, especially when collaborative relationships are forged with community-based resources. Crisis intervention seeks to mitigate the social and psychological effects of the stressful event. The primary therapeutic goal of crisis intervention is to restore a sense of equilibrium, characterized by the ability to creatively problem-solve and feel efficacious, as when coping resources are not taxed. Crisis intervention may include activities not usually associated with traditional mental health care, such as providing assistance with physical needs, shelter, financial matters, and reunification with family members. Again, this is best accomplished collaboratively by affected school systems, school-based clinicians, community agencies, students themselves, and their families.

### **Parameters of this Resource Guide**

Information and resource links in this guide are intended to be of immediate use for the school-based clinician seeking expanded knowledge regarding how to understand and counsel students in crisis and how to effectively function within a school crisis team. Unfortunately, perusal of this guide cannot confer instant expert status in crisis management. The interested clinician, however, should find it to be a useful map in his or her journey to establish competence in a field of growing importance and concern. Though our information and resource links primarily address group-level crisis response, practical recommendations surely may be applicable to individual emergencies.

This guide is organized into three topical sections, a general reference section, and a web-based resource key. The first topical section addresses developmental considerations for clinicians

working with children exposed to traumatic events. It should enhance clinicians' understanding of variations in symptom expression and can be easily adapted into presentations and/or handouts for practitioners to disseminate to school personnel and parents. The second section identifies specific clinical functions and strategies for school-based clinicians responding to crises. Additional readings relevant to crisis counseling are provided, here. The clinician's role within larger school- or district-wide crisis teams is addressed in this guide's third topical section. Although school-based clinicians rarely must develop school crisis plans independently, their expertise is valuable as school systems create or revise proactive crisis plans. This section is completed by a list of current resources and strategic guides germane to school- or district-level crisis planning.

## **CHILDREN'S RESPONSE TO CRISIS: A DEVELOPMENTAL PERSPECTIVE**

According to the National Institute of Mental Health, psychiatric trauma, or emotional harm, is a term used to describe what is essentially a normal response to an extreme event. Individual responses vary with exposure, measured by both physical proximity (e.g., physical distance from the event, witnessing injury and death) and emotional proximity (e.g., features of the event representing emotional involvement, such as injury or death of a loved one). Like adults, children sense loss of control and stability following disaster or trauma, and may become overly self-centered in response to trauma's assault to their personal safety. A child's reaction to a traumatic event is further influenced by his or her developmental level, mental health status prior to the trauma, community support availability, parental presence (or absence) during the event, as well as by the reaction of other significant adults. After experiencing disaster or trauma, children confront 4 primary psychological tasks: 1) accept the events that have occurred; 2) identify, label, and express emotions appropriately; 3) regain a sense of mastery and control [relative to age]; and 4) resume age-appropriate roles and activities.

### **Post-Traumatic Stress Symptoms in Youth**

Emotional, cognitive, and behavioral changes may follow youths' exposure to violence, threats of violence, and injury or death by violent means. Children, like adults, may exhibit symptoms associated with Post-Traumatic Stress Disorder (PTSD) following exposure to trauma. Such symptoms include disturbing memories or flashbacks, repeated nightmares and dreams of death, pessimism about the future, avoiding reminders of traumatic experiences, behavioral re-enactment (often via repetitive play), emotional numbness (or emotional avoidance/denial), and persistent vigilance or "jumpiness." Generalized anxiety and fears of recurrence are also common reactions to trauma and may contribute to school phobia, truancy, and documented learning problems among youth. Children's responses to trauma may also include grief and loss reactions, separation anxiety, and the exacerbation or renewal of prior symptoms or disorders (e.g., attention disorders, oppositional behavior, phobias, major depression). Grief and loss presentations in children, as in adults, may include denial, anger, depression, guilt, bargaining, and acceptance. Children may or may not exhibit stages of loss in similar sequential order as adults.

Youth responses to trauma typically include some degree of fear and anxiety, sleep disturbance, and irritability, but vary among developmental levels, as noted. Developmental trends in post-traumatic symptom presentation are sorted by age level in the following table.

## Age-Associated Reactions of Children Exposed to Traumatic or Stressful Events

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0-5 years	crying, excessive clinging, regressive behaviors (e.g., thumb sucking, bedwetting, loss of bladder/bowel control, fear of darkness or animals, fear of being left alone, fear of crowds or strangers, inability to dress or eat without assistance), sleep terrors, nightmares, irritability, confusion, sadness, eating problems, reenactment via play.
6–11 years	regressive behaviors (bedwetting, excessive clinging, irrational fears), sleep terrors, nightmares, sleep problems, irritability, aggressiveness, disobedience, depression, somatic complaints, visual or hearing problems, school problems (e.g., school refusal, behavior problems, poor school performance, fighting, concentration problems, distractibility), withdrawal, lack of interest, peer problems, increased conflict with siblings.
12-17 years	withdrawal, isolation, somatic complaints (e.g., nausea, headaches, chills), depression/sadness, agitation or decreased energy level, antisocial behavior, poor school performance, sleep and/or eating disturbance, irresponsibility, risky behavior, alcohol and other drug use, diminished bids for autonomy, decreased interest in social activities, conflict with parents, concentration problems.

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## Educational Resources for Parents and Teachers

American National Red Cross. (2001). *American Red Cross materials dealing with terrorism and unexpected events*. Retrieved from <http://www.redcross.org/pubs/dspubs/terrorat.html>

- *Helping Young Children Cope with Trauma*: on-line brochure designed for parents and care givers
- *When Bad Things Happen*: on-line brochure designed for junior high school students
- *Why Do I Feel Like This?*: on-line brochure designed for high school students
- *Facing Fear: Lesson Plans Book & Activities Book*: Curriculum Materials for K-12 covering feelings, facts, perspectives about events, and preparing for the future.

American Psychological Association. (n.d.). *Reactions and guidelines for children following trauma/disaster*. Retrieved from <http://www.helping.apa.org/daily/ptguidelines.html>

Federal Emergency Management Agency. (1989). *After the disaster: A children's mental health checklist*. Retrieved from <http://www.fema.gov/kids/tch-mntl.htm>

Federal Emergency Management Agency, & American Red Cross. (2001). *Helping children cope with disaster*. Retrieved from <http://www.redcross.org/services/disaster/beprepared/forchildren.html>

Hamblen, J. (2002). *PTSD in children and adolescents: A National Center for PTSD fact sheet*. Retrieved from [http://www.ncptsd.org/facts/specific/fs\\_children.html](http://www.ncptsd.org/facts/specific/fs_children.html).

International Society for Traumatic Stress Studies (ISTSS). (2000). *Children and Trauma*.

Retrieved from <http://www.istss.org/children.htm>

National Association of School Psychologists. (2001). *Children and fear of war and terrorism: Tips for parents and teachers*. Retrieved from [http://www.nasponline.org/NEAT/children\\_war.html](http://www.nasponline.org/NEAT/children_war.html)

Monahan, C. (1993). *Children and trauma: A parents' guide to helping children heal*. New York: Lexington Books.

Myers-Walls, J. (1999). *Talking to children when the talking gets tough*. Retrieved from [http://ces.purdue.edu/Living\\_on\\_Less/Pubs/FF-35.html](http://ces.purdue.edu/Living_on_Less/Pubs/FF-35.html)

Purdue Extension. (n.d.). *Strategies for parents and teachers*. Retrieved from <http://www.ces.ncsu.edu/depts/fcs/humandev/disas3.html>

Samarzija, J., & Myers-Walls, J. A. (n.d.). *Helping children cope with stress*. Retrieved from <http://ces.purdue.edu/terrorism/children/helpingchildren.html>

Sidran Traumatic Stress Foundation. (1999). *Helping a child manage fears after a traumatic event*. Retrieved from <http://www.sidran.org/sept11fears.html>

Sidran Traumatic Stress Foundation. (2001). *When a terrorist act occurs*. Retrieved from <http://www.sidran.org/sept11terror.html>

Waddell, D., & Thomas, A. (1999, Spring). Disaster: Helping children cope. *Communique*, 28, 6-7.

## CLINICAL FUNCTIONS AND STRATEGIES FOR SCHOOL-BASED CLINICIANS RESPONDING TO CRISES

### **Clinical Functions**

Following a crisis, mental health clinicians working in school settings may be called upon to employ their expertise beyond direct therapeutic intervention with children.

***Education and Outreach.*** Educators and administrators may ask clinicians how to address children and parents, or may ask what information to relay. School professionals may also have questions about children's typical reactions to crises. Information and resources presented in the prior section may help clinicians provide succinct responses to educator or parent inquiries. Clinicians can facilitate consistency among different environments by providing educators and parents with information and behavioral strategies to help children in crisis. Consistent messages, in turn, foster children's sense of regularity and predictability, enhancing their return to equilibrium.

***Supporting Other Professionals.*** Although school-based clinicians' realm of expertise typically centers on children and adolescents, clinicians should be mindful of adults' responses. All professionals working with students in crisis situations are responding in their own manner to

the traumatic event, as well as are indirectly (*vicariously*) traumatized by their empathic reactions to affected students. Clinicians can be aware of adult responses to trauma and can help to normalize reactions, to lead processing groups for professionals, and to provide referral information, if needed. Relevant references and resources for clinicians fulfilling this function will follow this section. *Emotional First Aid* and *CISM* (see following) are relevant for staff, as well as students.

***Group and Individual Intervention with Affected Youth.*** Of course, most crisis work performed by school-based clinicians will address the youth who have experienced a crisis or traumatic event. Many crisis response theorists emphasize that crisis counseling is fundamentally different from psychotherapy. Though a clinician's traditional therapeutic repertoire (e.g., active listening, establishing empathy and trust, reflecting, summarizing) is applicable to crisis counseling, the following crisis counseling strategies may help the clinician to adopt an efficient, practical role in acute circumstances.

### **Clinical Strategies for Crisis Response**

Crisis counseling initiatives can include restoring affected clients' sense of equilibrium, providing information, and bolstering coping strategies. Crisis counseling differs from traditional psychotherapy, as it is briefly executed and may foster temporary client dependency. Of course, as clinicians acutely try to lessen the impact of an event and facilitate future coping, they also must monitor the need for more extensive treatment and must know where to refer indicated students. Although practical guidelines are easily available to clinicians via books and internet resources, most authors or training centers warn that clinicians who practice crisis intervention should receive specialized training in this subspecialty of behavioral health.

***General Principles of Crisis Counseling.*** Practical resources may differ in their content foci, but share some process guidelines. First, clinicians should commence crisis intervention ("postvention") as soon after the crisis as possible. This is important, as misinformation and personal distortions proliferate after crisis events and can exacerbate and prolong stress symptoms, if not promptly addressed.

Connect children to others. Following a crisis, we need to know that we are safe and secure, and that others can be trusted to watch out for our safety and security. This is especially important for children, as they are typically in dependent roles. Help children determine who in their families and communities they can talk to about the crisis. Introduce yourself as a person who will listen to children and will offer support as they try to understand the crisis. Identify important adults who are maintaining the ongoing safety of the environment.

To reconnect those affected by a crisis to the present, and to orient them toward coping with present circumstances, clinicians should emphasize the accuracy and reality of tragic circumstances, avoiding unnecessarily gruesome details. Reiterate what has occurred in simple, plain language. Help children glean facts and dismiss rumors. In the case of human loss, children should be informed of the physical reality and permanency of death to prevent fantasies of "fixing" the dead or expectations for the deceased to return. Returning students to daily routines as quickly as possible also facilitates connection to the present, as well as addresses the need for security and predictability.

To encourage emotional expression, teach that stress responses are “normal responses to abnormal situations.” Very little a child or adolescent could believe or feel following a traumatic event is “wrong,” given the immense task of trying to assimilate and make sense out of the disorganized and nonsensical. Help the child find words for, reflect, and validate his or her feelings.

Help children understand what might happen next and prepare for what is to come. The National Organization for Victim Assistance (NOVA), recommends orienting participants toward the future when concluding crisis work. Again, clinicians can reiterate emotional, physical, behavioral, and cognitive changes which commonly occur after exposure to crises. Prediction may entail teaching about emotional triggers which children may encounter. Also, fielding practical questions (e.g., “Where will I sleep tonight?” “How are they going to put our houses back together?” “Are we going to have metal detectors at our school, now?”) can help children predict what life will be like after a crisis. Preparing for life after a crisis can entail reviewing coping strategies, settling practical tasks (e.g., obtaining clothing and emergency shelter), [re]establishing a daily routine, and identifying social supports or specific support buddies.

School-based professionals are generally sensitive to the developmental differences between children and adults. However, we are not immune to expressing typical adult responses to critical circumstances, such as the avoidance of or minimization of effects, or the need to establish causality or responsibility. These responses may undermine our best intentions as we help children learn to cope with extraordinary circumstances. We must monitor ourselves, as well as our colleagues in teaching and administrative roles. Practices we should *avoid* include: diverting conversations or refusing to answer questions about the critical event, denying the scope or seriousness of the event, attempting to simplify or expedite recovery (e.g., “everything will be all right,” “just be brave”), and encouraging or supporting blaming. We should be especially sensitive not to dampen or deny a child’s emotional response (e.g., “Stop crying, it can not change things.”). Finally, promote security and a sense of safety, but do not overstate or provide false reassurance (e.g., “Don’t worry, this will never happen again.”).

***Psychological First Aid.*** Pynoos and Nader (1988) recommend a developmental approach for helping children adjust after a traumatic event. Liaisons with community (or school) leaders should be forged prior to postvention services (as immediate as possible) being set up in school-based sites. Goals include restoring the school community and providing specific help to individuals and groups. General suggestions follow:

- 1) *Elementary Age:* reinforce natural support systems, monitor/relieve sense of guilt/responsibility, assure safety, clarify misconceptions, encourage emotional expression, validate and normalize individual reactions, provide structure, maintain discipline, reinforce/praise children as much as possible, provide opportunities for success (to enhance sense of self-efficacy).
- 2) *Adolescence:* reinforce a sense of purpose and realistic expectations for how event could have been avoided, normalize and elicit peer validation, prevent maladaptive responses linked to helplessness and anger (e.g., plans for revenge,

aggression, drug use, risk-taking), encourage support seeking (peers, parents, other trusted adults).

***Critical Incident Stress Management (CISM).*** This crisis intervention method intends to help participants relive traumatic events (“critical incidents”) in a safe environment, to begin to identify intense emotional reactions, to provide education about stress management, to identify individuals who may be at-risk and in need of additional support, and to offer support (Everly & Mitchell, 1997). Its goal is to reduce the effects of a stressful event. Ideally, one primary clinician and one or more peer counselors lead groups of less than 20 participants through seven phases of debriefing:

- 1) *Introduction:* discuss confidentiality, right to withdraw, establish boundaries and ground rules.
- 2) *Fact Phase:* elucidate known facts about the incident and participants’ roles or involvement, if applicable; control rumors; discuss individual experiences.
- 3) *Thought Phase:* help participants reflect upon immediate thoughts as they experienced or learned about the critical incident.
- 4) *Reaction Phase:* participants identify personally most traumatic aspect of event, permit voluntary discussion of emotions, provide validation and support.
- 5) *Symptom Phase:* return participants to cognitive processing of event, identify possible symptoms, share symptoms and reactions.
- 6) *Teaching Phase:* relate symptoms to reactions, normalize reactions to traumatic event, emphasize that symptoms should gradually get better and that exposure via thought and feeling (in a safe environment) will facilitate process, elicit examples of coping and positive reactions to event (e.g., “Is there anything positive that you think has come of this?”).
- 7) *Closure/Re-Entry:* final opportunity to summarize event and review predominant reactions, clarify issues, answer questions; invite participants to articulate what they intend to do to cope; identify supports (peer, family, community).

Opportunities for more individualized follow-up after a group session (e.g., allow participants to linger, provide refreshments) can facilitate referrals for more intensive services, when indicated.

***Identifying Children who May Need Follow-Up Care.*** Routine screening of affected populations using appropriate trauma assessment instruments or brief interviews is recommended to determine which individuals need more individualized therapeutic care (see AACAP, 1998; Pfefferbaum, 1998; Pynoos & Eth, 1986). Severe responses on objective measures, as well as disorientation or bizarre behavior warrant further treatment. Expression of suicidal ideation or harm to self or others (actual or potential) always warrants more intensive care.



## **Outreach Materials for Educators, Parents, and Colleagues**

- Carter-Obayuwana, A. L., & Obayuwana, A. O. (2000). *The model of hope: A practical guide for coping with tragedy*. Retrieved from <http://www.nasponline.org/NEAT/modelhope.html>
- Center for Mental Health Services. (n.d.). *After a disaster: Self-care tips for dealing with stress*. Retrieved from <http://www.mentalhealth.org/publications/allpubs/KEN-01-0097/default.asp>
- Center for Mental Health Services. (n.d.). *Self-care tips for emergency and disaster response workers*. Retrieved from <http://www.mentalhealth.org/publications/allpubs/KEN-01-0098/default.asp>
- International Critical Incident Stress Foundation, Inc. (n.d.). *CIS information, signs & symptoms*. Retrieved from <http://www.icisf.org/CIS.html>
- International Critical Incident Stress Foundation, Inc. (n.d.). *Some things to try to mitigate CIS effects*. Retrieved from <http://www.icisf.org/totry.htm>
- International Society for Traumatic Stress Studies (ISTSS). (2000). *Indirect trauma*. Retrieved from <http://www.istss.org/indirect.htm>
- International Society for Traumatic Stress Studies (ISTSS). (2000). *What is traumatic stress?* Retrieved from <http://www.istss.org/traumatic.htm>
- Office for Victims of Crime (OVC). (2001, September). *OVC handbook for coping after terrorism: A guide to healing and recovery*. Retrieved from [http://www.ojp.usdoj.gov/ovc/publications/infores/cat\\_hndbk/welcome.html](http://www.ojp.usdoj.gov/ovc/publications/infores/cat_hndbk/welcome.html)

## **Practical Resources for Clinicians**

- American Academy of Child and Adolescent Psychiatry [AACAP]. (1998). Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37 (10S) Supplement, 4S-26S.
- Brooks, B. & Siegel, P. (1996). *The scared child: Helping kids overcome traumatic events*. New York: Wiley.
- Center for Mental Health Services. (n.d.). *Disaster counseling*. Retrieved from <http://www.mentalhealth.org/publications/allpubs/KEN-01-0096/default.asp>

DeWolfe, D. J. (2000)\*. *Training manual for mental health and human service workers in major disasters* (2<sup>nd</sup> ed.; DHHS Publication No. ADM 90-538). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

\*This can be obtained at no cost from <http://www.mentalhealth.org/publications/>

Everly, G. S., & Mitchell, J. T. (1997). *Critical Incident Stress Management (CISM): A new era and standard of care in crisis intervention*. Ellicott City, MD: Chevron.

National Association of School Psychologists. (2002). *Coping with a National Tragedy*. Retrieved from [http://www.nasponline.org/NEAT/crisis\\_0911.html](http://www.nasponline.org/NEAT/crisis_0911.html)

National Organization for Victim Assistance. (2001). *Crisis intervention*. Retrieved from <http://try-nova.org/Victims/Crisis.pdf>

Pynoos, R., & Eth, S. (1986). Witness to violence: The child interview. *Journal of the American Academy of Child Psychiatry*, 25, 306-319.

Speier, A. H. (2000). *Psychosocial Issues for Children and Adolescents in Disasters* (2<sup>nd</sup> ed.; DHHS Publication No. ADM86-1070R). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

\*This can be obtained at no cost from <http://www.mentalhealth.org/publications/>

Walker, G. (1990). Crisis-care in critical incident debriefing. *Death Studies*, 14, 121-133.

## **THE CLINICIAN'S ROLE WITHIN A SCHOOL CRISIS TEAM**

### **School-Based Clinicians' Roles**

In general, a community's school district is responsible for providing mechanisms to form school-based crisis committees, who plan and revise crisis response procedures; and crisis teams, who directly implement crisis procedures. School-based clinicians may receive specialty training to designate them as crisis workers in school-based teams. However, it is likely that district crisis workers will be invited to lead crisis counseling and will rely on school-based clinicians for auxiliary services, namely individual and small group follow-up for youth who present with severe or enduring stress responses. Clinicians may be valuable consultants to a school's crisis committee and crisis team, given their expertise in child development, childhood stress response, and assessment procedures (see preceding sections). Importantly, school-based clinicians may be able to identify children who bear special risk for atypical stress presentations due to prior trauma or other vulnerabilities. The National Education Association *Toolkit* (see following resources) lists additional roles and duties for school-based psychologists/counselors responding to crises.

### **Developing a Crisis Intervention Plan for Schools**

Having crisis response provisions in place prior to an actual crisis event can prevent or diminish many aspects of affected individuals' stress response. School crisis plans need flexibility to address a full range of potential traumas to students, including student or teacher deaths due to illness and accidents, natural and manmade disasters, and acts of violence, all of which can

occur on school grounds or in surrounding communities. Every member of a crisis team should have some training in typical stress reactions and general principles of crisis response. Other crisis plan responsibilities include determining how to announce events, how to route students and personnel, and how to address the media. Several texts and resources for schools address best practices in crisis team planning and are referenced at the end of this section. The following example illustrates the nature and complexity of crisis team responsibilities. Warner and Weist (2001) present a crisis intervention plan for schools including individual, family, school, and community foci. The five goals of this plan are to:

1. Reduce the effects of crisis and trauma on students and schools staff by providing mental health and educational support services as close to the time of the trauma as possible,
2. Decrease the interference of emotional and behavioral issues in the educational process,
3. Provide support for teachers and school staff in their own reactions to the crisis,
4. Equip teachers, administrators and staff with the tools to provide support to students in times of crisis, and
5. Establish and strengthen liaisons between schools and communities.

The plan incorporates four stages:

1. Pre-planning: Committees identify members of a crisis intervention plan and assign them specific roles (team coordinator, resource and training staff, communications staff, security staff, medical providers, family liaison, counseling staff,).
2. Assessment: Key members of the team meet and determine whether the crisis warrants involvement of the entire team by systematically assessing the crisis according to impact, information about the trauma victim(s), characteristics of the students, physical safety, and identification of students and staff in need of assistance.
3. Intervention: The first step of intervention should be to ensure the physical safety of students and school personnel, and to arrange for medical care as needed.
4. Follow-up: Counseling staff should continue to be available after the crisis has subsided.

### **Resources for a School Crisis Team Library**

American Academy of Experts in Traumatic Stress. (1999). *A practical guide for crisis response in our schools* (4<sup>th</sup> Ed.). Commack, NY: Author.

Bartow [GA] County School System. (2000). *Crisis intervention resource manual*. Retrieved from <http://www.bartow.k12.ga.us/psych/crisis/cimanual.html>

Brock, S. E., Lazarus, P. J., & Jimerson, S. R. (Eds.). (2002). *Best practices in school crisis intervention and prevention*. Bethesda, MD: National Association of School Psychologists Publications.

Brock, S.E., Sandoval, J., & Lewis, S. (1996). *Preparing for crises in the schools : A manual for building school crisis response teams*. New York: Wiley

Center for Mental Health in Schools at UCLA. (2000). *A resource aid packet on responding to a*

*crisis at a school*. Los Angeles, CA: Author.

Goldstein, A. P., & Conoley, J. C. (Eds.). (1997). *School violence intervention: A practical handbook*. New York: Guilford.

Johnson, K. (1993). *School crisis management : A hands-on guide to training crisis response teams*. Alameda, CA: Hunter House

National Association of School Psychologists. (1991). *Resources in crisis intervention: School, family, and community applications*. Bethesda, MD: Author.

National Education Association. (n.d.) *Crisis communications guide and toolkit*. Retrieved from <http://www.nea.org/crisis>

Petersen, S., & Straub, R. L. (1992). *School crisis survival guide : Management techniques and materials for counselors and administrators*. West Nyack, NY: Center for Applied Research in Education.

Pitcher, G., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford.

Poland, S. (1994). The role of school crisis intervention teams to prevent and reduce school violence and trauma. *School Psychology Review*, 2, 175-189.

Poland., S., Pitcher, G., & Lazarus, P. (in press). *Best practices in crisis intervention*.

### **GENERAL REFERENCES ADDRESSING CRISIS AND TRAUMA**

Note: *The text of this resource guide was informed by sources in the following reference list. In addition to the readings already identified under the topical subheadings, clinicians may find these to be useful, as well as comprehensive, additions to their practical libraries.*

Aptekar, L., & Boore, J. (1990). The emotional effects of disaster on children: A review of the literature. *International Journal of Mental Health*, 19, 77-90.

Hull, R. V. (2001). Guidelines for school based crisis intervention: Training course for school based personnel. Baltimore, MD: Baltimore City Public School System.

Leenars, A. A., & Wenckstern, S. (1998). Principles of postvention: Applications to suicide and Trauma in schools. *Death Studies*, 22, 357-391.

Pfefferbaum, B. (1998). Caring for children affected by disaster. *Child and Adolescent Psychiatric Clinics of North America*, 7, 579-596.

Pynoos, R., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress*, 1, 445-473.

Sandoval, J. (1985). Crisis counseling: Conceptualizations and general principles. *School Psychology Review, 14*, 257-265.

Sandoval, J. (Ed.). (2002). Handbook of crisis counseling, intervention, and prevention in the schools (2<sup>nd</sup> ed.). Mahwah, NJ: Lawrence Erlbaum.

Shaw, J. A. (2000). Children, adolescents and trauma. *Psychiatric Quarterly, 71*, 227-243.

Warner, B. S., & Weist, M. D. (2001). Community-based crisis intervention plan for the schools. Manuscript submitted for publication, University of Maryland School of Medicine.

Vernberg, E. M., & Vogel, J. M. (1993). Psychological responses of children to natural and human-made disasters: II. Interventions with children after disasters. *Journal of Clinical Child Psychology, 22*, 485-498.

Vogel, J. M., & Vernberg, E. M. (1993). Psychological responses of children to natural and human-made disasters: I. Children's psychological responses to disasters. *Journal of Clinical Child Psychology, 22*, 464-484.

## **WEBSITES ADDRESSING CRISIS AND TRAUMA**

### **Grief and Loss**

The Dougy Center: A National Center for Children & Families  
<http://www.dougy.org/>

Hospice Net  
<http://www.hospicenet.org/html/bereavement.html>

Tragedy Assistance Program for Survivors  
<http://www.taps.org/>

### **Natural Disasters**

Center for Mental Health Services  
<http://www.mentalhealth.org/cmhs/EmergencyServices>

Disaster Relief  
<http://www.disasterrelief.org/>

Federal Emergency Management Agency  
<http://www.fema.gov>

University of Illinois Extension: Disaster Information and Resources  
<http://www.ag.uiuc.edu/~disaster/infor.html>

## **PTSD/Traumatic Stress**

National Center for Post Traumatic Stress Disorder (PTSD)  
<http://www.ncptsd.org/>

National Organization for Victim Assistance  
<http://www.try-nova.org/>

International Society for Traumatic Stress Studies  
<http://www.istss.org/children.htm>

Trauma Information Pages (of Dr. David Baldwin)  
<http://www.trauma-pages.com/>

## **School and Community Violence**

American Psychological Association: *Raising Children to Resist Violence/Warning Signs*  
<http://www.apa.org/pi/pii/raisingchildren.html>  
<http://helping.apa.org/warningsigns>

National Crime Prevention Council: On-Line Resource Center  
<http://www.ncpc.org/>

National Education Association: Safe Schools Now  
<http://www.nea.org/issues/safescho/>

Office of Juvenile Justice and Delinquency Prevention  
<http://ojjdp.ncjrs.org/>

Office of National Drug Control Policy (ONDCP): Drug Abuse Prevention Programs  
<http://www.whitehousedrugpolicy.gov/prevent/programs.html>

US Safe Schools  
<http://www.ussafeschools.org/>

## **Suicide**

American Foundation for Suicide Prevention  
<http://www.afsp.org/>

Suicide Awareness\Voices of Education (SA\VE)  
<http://www.save.org/>

Suicide Information and Education Centre (SIEC)  
<http://www.siec.ca/>

Suicide Prevention Advocacy Network  
<http://www.spanusa.org/>

Yellow Ribbon Foundation  
<http://www.yellowribbon.org/>

### **Training Organizations/Professional Societies/General**

The American Academy of Experts in Traumatic Stress  
<http://www.aaets.org/>

Association of Traumatic Stress Specialists  
<http://www.atss-hq.com/>

International Critical Incident Stress Foundation, Inc.  
<http://www.icisf.org/>

National Emergency Assistance Team (of National Association of School Psychologists)  
<http://www.nasponline.org/NEAT>

Prepare Respond Recover: Safety Planning and Disaster Response & Recovery  
<http://www.PrepareRespondRecover.org/>

Sidran Traumatic Stress Foundation  
<http://www.sidran.org/training.html>