Acute Mental Health Response to Children Affected by Terrorism

I. Introduction

In situations of terrorism involving mass casualties and related threats, consideration of children's acute mental health needs have to be addressed from several perspectives. Central to these is the notion that acute mental health services will best be provided not only in the form of direct clinical interaction with children and their families but also by a range of emergency responders and community providers with whom children will have contact. Equally important is the notion that children's responses to terror and disaster may share aspects of adult responses, but are distinguished by the developmental contexts in which children of varying ages experience, mediate and communicate the impact of overwhelming events.

Two other overarching, guiding principles inform this report. First, while national expertise may provide useful resources and necessary support to communities in times of crisis, the best response to a crisis is a local response. Second, crisis response planning and team building need to occur prior to critical events. This report will rely on a definition of Acute Mental Health Response as spelled out in "Mental Health and Mass Violence" (10/2001, etc.):

> *"…an early intervention is defined as any form of psychological intervention delivered within the first four weeks following mass violence or disasters. Once established, services may remain in place for the long term. Mental health personnel will provide some of the components of early intervention, while other components will be provided by non-mental health personnel."*

Early mental health assessment and interventions should first determine basic needs (e.g., survival, safety, food, shelter, etc.). If these needs are not addressed first, clinical mental health interventions will be futile.

Regarding the emotional well-being of children, the following are critically important basic needs and considerations:

- Re-uniting with parents, other family members and/or responsible care-givers
- Re-establishing/returning to daily routines as quickly as possible
- Emotional stabilization of caregivers
- In the immediate post-incident phase it is sensible to expect normal recovery over time
- Children may exhibit a broad range of post-event symptoms that do not necessarily predict the development of long term/chronic psychiatric problems.
- Anticipating a range of acute symptoms does not presume the development of clinically significant disorder except where there is a pre-existing condition
- Early brief and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents and children (CR, 2001)

- Clinical approaches that address the cognitive, behavior and emotional domains of psychological response may help reduce the incidence, duration and severity of acute stress disorder, post-traumatic stress disorder, depressive and additional anxiety disorders.
- Early interventions in the form of single one-on-one recitals of events and emotions evoked by traumatic events do not consistently reduce risks for later post-traumatic stress disorder or related adjustment difficulties (CR, 2001)
- The term "debriefing" should be used only to describe operational debriefings and are not done for the purposes of preventing or reducing mental disorders

Acute and early interventions should be based on the assessment for a range of factors that place children at greatest risk for post-event difficulties. These factors include:

- Acute stress disorder or other clinically significant symptoms stemming from the trauma
- Loss of a parent, family member or friend
- A pre-existing psychiatric disorder and significant histories of loss and trauma
- Requiring medical or surgical attention
- Exposure to the incident that is particularly intense and of long duration
- Parents falling into any of the above categories
- Parents or other significant figures injured or at great risk of injury or death as a result of proximity to the events (e.g., working in the area of attack or responding to the event as part of emergency services)
- Daily routines likely to be disrupted in significant and enduring ways (e.g., displacement of home, school, etc.,)
- Families at greatest risk for financial distress secondary to disruption of economy, employment

II. Areas and Challenges

A. Preparation and Intervention

1. Coordination of services

The most difficult time to establish new working relationships is in the midst of a crisis. Despite recent terrorist incidents, not all states and state agencies have developed disaster plans. Various state agencies with preparedness and response obligations may not be familiar with each other and may have had little opportunity to work together. It is critical to establish pre-existing person-to-person relationships between and among existing agencies and groups that will be involved in acute response. A primary aim of instituting new partnerships is to determine the capacities and deficits of each of the providers/responder groups prior to the advent of critical, potentially traumatic events. Transitions in service delivery, such as passing responsibility from the American Red Cross to a federally funded disaster mental health program, are particularly tense. Determining responsibilities, establishing relationships, and planning for these transitions pre-event could facilitate cooperation and transitions post event. Interagency agreements should

be formalized as part of the planning process. Too much time has been spent talking about collaborative links with too few systematic approaches to establishing them at the federal, state and local levels. Mental health must be represented in pre-event planning and preparation.

Collaborations require:

a) Pre-existing, formal relationships among various mental health providers and with other professionals already involved in emergency planning for acute response to terror events (e.g., police, fire, EMS, state and municipal emergency planners, public health, etc.)
b) Identification of mental health representative(s) that will participate in emergency response planning and as part of emergency response teams that are mobilized at the time of an event. Participation in both areas should occur at state, regional, and local levels
c) Identification of a network of mental health providers at state and local levels who will be part of the first response team in a terror event.
d) Immediate mapping of existing mental health resources at state, regional and local levels as well as existing working relationships/collaborations among mental health resources and services providers relevant to the care of children and families at times of terror events (e.g., law enforcement, protective services, hospitals and primary care facilities, schools, juvenile justice system, government, etc.)
e) Desired additional collaborative relationships should be identified and explained to relevant stakeholders (i.e., existing members of the state, regional and local emergency response teams). Responsibilities for developing and reporting on new collaborative efforts in training and planning of integrated services should be assigned.
f) Practice of communication and mobilization of response team members using simulation scenarios should be encouraged.
g) Materials that educate professionals and parents about recognizing and monitoring potential acute and longer-term impact of terror events on children's functioning and development as well as principles guiding intervention should be prepared in advance. (Additional information specific to the nature of attack can be added at the time of the event.)

2. Training for identified mental health providers

In addition to the paucity of general mental health resources in many parts of the country, services for specific, acute mental health needs of children affected by traumatic events are woefully inadequate. Most mental health professionals have little, if any experience in considering the developmental context of the acute mental health needs of terror/disaster affected children nor of intervention principles or strategies that might be most beneficial. Training in mental health disaster management and treatment is needed by many professionals of many disciplines who will respond to children post- event, including emergency management first responders, primary care, mental health, schools, clergy, and the media. Training in triage and referral is essential for those who will have first contact with children following an incident.

Those mental health professionals who are knowledgeable about clinical aspects of acute distress and trauma often have no awareness of the activities of other professionals involved in first response/early intervention or of the potential roles these professionals can play in ameliorating

the intensity and duration of the distressing impact of terror/disaster events. In order to maximize their effectiveness, acute response providers will need:

a) Cross-training that familiarizes mental health professionals with activities of first providers and others involved in acute response
b) Familiarizing other professionals with principles of child, family and community responses to trauma/overwhelming distress (both psychological and physiological) in a developmental context and how these principles inform therapeutic interventions—both clinical and non-clinical
c) Since the best response to a crisis is a local response, national experts should be identified in advance and prepared to provide consultation to local providers regarding optimal post-event care.
d) Disaster mental health approaches—both the federal disaster mental health model and the American Red Cross model—tend to discourage, under-recognize, and under-utilize specialized expertise that may exist across disciplines. This should be addressed pre event and in vetting professionals before they become involved in the aftermath of an incident.
e) Disaster mental health should be incorporated into the clinical training of all mental health disciplines.

3. Approaches to Treatment/Intervention and Training

Mental health professionals involved in acute/early intervention with children and families should have training in both clinical and extra-clinical aspects or response. Training content for mental health providers should include:

a) Disaster mental health organization, management, and coordination
    i. Legislation and authority
    ii. Federal, state, and local relationships
    iii. The American Red Cross
    iv. Provider networks
b) Response issues and considerations
    i. Providing for safety and security
    ii. Meeting basic needs
    iii. Obtaining disaster assistance
    iv. Evacuation
    v. Reuniting families
    vi. Quarantine
    vii. Public education—how to attend to children's emotional response including recognizing warning signs and symptoms of distress
c) Physical reactions and safety
d) Distinguishing symptoms associated with a biological or a chemical agent from those associated with mental conditions
    i. Biological and chemical agents may cause reactions that are confused with psychiatric symptoms
    ii. Anxiety and affective reactions may present as somatic complaints

e) The range of acute trauma reactions and associated areas of concern
    i. Normal and pathological reactions and differential diagnostic issues
    ii. Differing developmental contexts and modes of presentation
    iii. Family, social, and cultural influences
    iv. Traumatic bereavement
f) Ability of parents and other familiar adults to accurately assess the response of children
g) Mental health interventions tailored to needs of those with normal and pathologic reactions
h) Acute Mental Health Mental Status Examination must include specifics concerning acute and post-traumtic symptoms
    i. Evaluation of dissociative symptoms
    ii. Hyperarousal
    iii. Sleep disturbance
    iv. Extreme anxiety (new generalized anxiety, panic attacks etc.)
    v. Profound appetite loss
    vi. Profound mood decrease with neurovegative symptoms
    vii. Developmental regression (new onset bowel and bladder difficulties, speech loss)
    viii. Constant inconsolable tantrums (especially with aggression towards self or others)
    ix. At present there is not any clear evidence for particular psychiatric medication for children who have posttraumatic symptoms. However, close collaboration with child psychiatric and primary physicians in order to assess specific acute symptoms that are amenable to pharmacological intervention (sleep disturbance, panic attacks, hyperarousal etc.) can be especially useful and effective in the acute phase.
i) Assessment of risk factors
j) Treatment, indications for their use, and limitations in use for various interventions including
    i. Triage and referral
    ii. Critical incident stress management
    iii. Crisis intervention
    iv. Death notification
    v. Supportive approaches
    vi. Outreach
    vii. Specific treatments such as cognitive, behavioral and dynamic therapies
k) How to work with the media
l) Vicarious trauma and needs of providers
m) Specialized training such as that offered by the American Red Cross
n) Specific support for Emergency Department staff in hospitals
    i. Screening instruments and interview techniques in dealing with child victims
    ii. Up-to-date, centralized referral system
    iii. Coordination of emergency medical staff with psychosocial teams

iv. Given that only 24% of children's hospitals in the country have mental health services in the ED, prior contact and working relationships with outside mental health providers need to be established and mobilized at the time of a terror event.

o) Specialized training in school-based crisis response is needed for school administrators, teachers, nurses, mental health and related professionals, security/law enforcement. (See section below on school-based crisis response.)

(Also see attached training outline-Appendix I)

4. Credentials

Clinicians who are part of local, state, and federal responses need training as outlined above in addition to established, documented professional credentials and licensure in their area of mental health services and, whenever possible, specifically in child mental health practice. A mechanism for establishing credentialing should be built into the recruitment and training of mental health first responders as described under *Coordination of Services* and should be implemented well before the critical event. National qualifying standards would be useful in identifying and registering mental health professionals who have had significant experience and training in responding acutely to events involving violence, terror, disaster and mass casualties.

B. Linkage to existing mental health services

As part of the mapping of mental health and emergency response services, agency, clinic, private and hospital-based providers need to be identified. Relationships between the emergency management team (via the mental health representatives) need to be established in order to determine the scope of services that existing mental health providers could offer at the time of a mass terror/disaster event. This would include both staffing levels and consultative roles that already exist among community-based providers and day-care, schools, law enforcement, fire/EMS, juvenile justice, etc., Similarly, a system of referral for sub-acute, secondary and tertiary care needs to be established with community-based mental health services well in advance of events and be part of simulation exercises developed by the management team, (e.g., linkages between hospital emergency rooms and community-based mental health facilities would be essential in the triage system, especially in the event of mass casualties and overwhelming demand on ER medical and psychosocial staff.) In addition to formal linkages, community-based mental health providers will need to receive training in evaluation, differential diagnosis and treatment of post-event related difficulties in new patients and those whose pre-existing difficulties are exacerbated by terror/disaster events.

Linkages between existing mental health services and those that are part of the emergency management response approaches are easier said than done. They need to be mandated and funded as part of federal and state supported emergency management planning and response.

(Also see Appendix II-Linkage to Existing Mental Health Services/Administrative)

C. Assessment instruments

Uniform clinical screening instruments need to be developed for use by mental health clinicians and primary health care providers as part of the evaluation of individual children. Systematic evaluation can serve two major functions. First, clinical screening instruments used in the early intervention or peri-traumatic post-event phase will help establish baselines that will enable clinicians to follow the unfolding clinical status and recovery of patients. Second, uniform screening measures can also serve as needs assessments in the larger populations. If routinely employed in the aftermath of any event of terror and disaster, screening instruments will be crucial in helping to determine funding and allocation of personnel and other resources to the most affected individuals and communities.

1) Parents and other adults may not recognize the problems or needs of traumatized children, due to their own overwhelming problems and needs, the failure of children to disclose their distress, or purposeful concealment of suffering by children to avoid burdening others. Therefore, it is essential that children themselves be evaluated.
2) Acute distress may be ubiquitous following a terrorist incident, clouding findings of early screenings and making it difficult to identify those with clinically significant problems. On the other hand, studies indicate that a child's subjective initial reactions are related to later symptoms, suggesting that these early reactions may be used to identify children who need ongoing attention.
3) Studies following the Oklahoma City bombing revealed a small but significant relationship between exposure to disaster media coverage and posttraumatic stress reactions in children in the general community. This does not establish a causal relationship. It is quite possible that those with the most intense reactions are drawn to media coverage or that other factors underlie the association (Pfefferbaum et al., 2001). It is recommended that professionals conduct a media history in children they see post event and advise parents and caretakers to limit and monitor exposure to media coverage, to monitor content and reactions to coverage, and to process the trauma and media coverage with the child.
4) Pre-event surveillance mechanisms and data related to children could provide important baseline information following events.
5) Victims may not access services in the post event environment; canceled appointments, late arrivals, and termination of treatment are not uncommon. These behaviors may reflect avoidance of mental health care or may be due to other priorities associated with physical or resource needs. Since many individuals fail to utilize services, the earliest encounter and every encounter are crucial.
6) In a study of Oklahoma City children who were not related to survivors or direct victims of the 1995 bombing, Pfefferbaum and colleagues (in press) found no correlation between posttraumatic stress reactions and seeking counseling for children with the highest levels of posttraumatic stress. This suggests that children with the greatest need may not be identified in screening. Therefore, the most symptomatic children should be assessed individually to determine their treatment needs.

D. School-base Crisis Response

Schools provide convenient access to children and families in a developmentally appropriate environment. School personnel are a natural source of support for children and classrooms provide formal and informal opportunities for assessing and addressing psychological responses and for correcting misperceptions. School-based programs can normalize the trauma experience and minimize the stigma associated with mental health care. The structure and routine of school are important aspects of the recovery environment for children.

School-based interventions must not supplant efforts to identify, refer, and treat children in need of more traditional and intensive treatment. They should be part of a network that provides not only outreach but also triage and referral to those with specialized training and expertise who can offer more comprehensive and intensive treatment. These linkages can and should be established pre event:

1) Parents should be included in the child's treatment. If parental needs are not addressed, their ability to provide support is diminished.
2) Similarly, the needs of teachers and other school personnel must be addressed if they are to be effective in working with children.
3) School personnel may benefit from education about the presentation and management of trauma reactions in children.
4) Schools may be inundated with outside proposals to provide services and conduct research. They must review them to determine their appropriateness for the setting and to balance the needs for supportive intervention and normalization.
5) Schools and school districts may want to establish a formal mechanism to review such proposals or may rely on existing mechanisms.
6) An organizational model/plan needs to be developed to coordinate necessary services and interventions. Safety/security, mental health, and public information tasks should be integrated and not addressed by separate, independent teams.
7) Plans and teams should be multidisciplinary and integrated, yet adaptable and flexible to the unique needs of each school/district. The crisis response plan should outline roles and responsibilities of crisis team members, with generic response protocols as well as unique adaptations for various types of crisis events (e.g., natural disaster, suicide post-intervention, criminal activity).
8) Community-school partnerships: crisis teams should also incorporate the expertise of community professionals from a broad range of relevant disciplines (e.g., mental health, public health, medical, police, fire, safety, youth groups, etc.).
9) Relationships should be established prior to a crisis event and maintained actively.
10) School crisis response plans should not be developed in isolation from the community; community-response plans must incorporate schools.
11) Crisis response plans should address the broad range of potential events and not be solely designed for rare catastrophic events. Crisis response plans and teams should also be mobilized to respond to more common crisis events such as the death of students or staff from natural or accidental causes. This allows the teams to develop and maintain the necessary skills and emerge as a functioning team that recognizes the often-profound impact these events may have on children and school staff.

E. Public information

Decisions about what information to provide about terror threats and the reality of terror attacks and how to present it should informed by a psychological understanding about their importance and impact on the general population. These issues are a crucial part of planning and coordination of emergency responses. Too often warnings about potential dangers or announcements made after critical events are delivered in vague and unclear terms that increase rather than decrease public concerns about real threats and dangers. The public must able to trust that that the information they are receiving is both accurate and straightforward. All information, even if limited, needs to be directly related to what is known about threats or real events. Even in a time of crisis, the news media are not governed by public health priorities and are subject to the same vulnerability and anxiety as the general public.

Establishing pre-existing relationships with media personnel about the role and impact of their reporting in critical events can help to insure consideration of the public's mental health while providing up-to-date news. Spokespersons for the emergency management team should be identified prior to events and messages delivered should be based on discussion and consensus amongst the emergency management response team, insuring that adequate attention is paid to mental health implications of announcements (e.g., threat warnings) and preparedness activities (e.g., impact of participation in disaster drills, impact of smallpox vaccination strategies or troop deployment, etc.). Information should be provided simply, directly, and without unnecessary detail. Behaviorally relevant information should be coupled with concrete advice on how to decrease risk and/or to promote coping.

1) Develop public information and education and pre-event messages with specific content related to mental health concerns, planning, and preparedness that is sensitive to and specifically about children and families.
2) Create programs for schools, primary care, and mental health that promote the development of resilience.
3) Relationships with the media should be established prior to an event. This should include education and pre-event planning.
4) Careful consideration of the mental health impact of media coverage should be promoted (e.g., work with the media to consider limiting graphic footage and link reporting of the event with information regarding supportive services).
5) Ensure that developmentally appropriate information regarding the event is readily available for children (with the same timeliness as for adults), which can be conveyed directly to children (such as through children's television news media for older children and adolescents) and via parents, teachers, and other caring adults.
6) Readily available written information on how to identify adjustment difficulties and promote adjustment and coping should be provided after a crisis event.
7) Media campaigns should be employed after a major crisis event to normalize adjustment reactions, share information about available supportive services, and decrease the stigma associated with help seeking after a crisis event.
8) School-based educational and preparedness programs for children have the potential to educate parents and families.

(Also see Appendix III-Guidelines developed by the NCCEV)

F. Funding Issues

Federal emergency management and other funding streams need to make specific provisions for service coordination, training, assessment and intervention or public information to take place at federal, state and local levels. Mental health professionals' involvement in state and local level emergency management planning and implementation needs to be stipulated as part of federal funding grant requirements. A review of current federal funding streams for preparation and response to terrorism at federal, state and local levels has been suggested as an important activity for the Centers for Disease Control, as a necessary first step in examining ways of incorporating child mental health services into subsequent funding initiatives.

Federal Approach

Federally funded disaster mental health services are designed to address mental health problems caused or aggravated by a disaster and prevention of future problems. They are available to residents of the community in which the disaster occurred, to those who work in areas impacted by the disaster, and to those who are present at the disaster.

Built on decades of experience with natural disasters, the federal approach provides funding, training, and coordination for state and local agencies. An expanded federal role may be indicated for terrorist incidents because the target of terrorism is not only those present or the communities in which the attack occurs but also is the government and nation at large. Terrorism raises serious national security concerns, geographic boundaries may not be clear, and morbidity and mortality may be greater than in other types of disasters.

The federal model focuses on normal reactions and emphasizes crisis intervention and support services, triage and referral, and outreach and public education for affected individuals. The program is not meant to supplant existing services and is not intended to serve those with serious psychiatric illness. It relies heavily on paraprofessionals and training is a key component.

Conflict may arise in the aftermath of an event due to disparate cultures of disaster mental health and traditional treatment providers, public health and medical models, and clinicians and researchers.

Administration

Use of federal funding requires adherence to administrative conditions that may be difficult to meet and that may interfere with efficient and effective service provision.

Federal funding requests typically require an assessment of need, which may be difficult in the chaos of the post disaster environment, especially if the threat continues.

Available funding may arrive late, creating concerns about the extent to which services that must be provided early will be covered and complicating the organization and administration of services.

Subcontracts with local entities may help in establishing and coordinating the network of care. These local provider agencies may need oversight and technical assistance.

A committee on unmet needs, with representatives from various agencies that provide post incident support, can identify and address unusual uncovered needs of victims including financial, legal, social, and other concerns.

While the extensive use of paraprofessionals may be necessary, untrained providers may not recognize significant psychopathology especially in children. The emphasis on normal reactions and a policy against supporting comprehensive psychological evaluation and treatment further exacerbate the potential to miss children most in need of services. This argues for the utilization of trained child specialists in the triage process and in a supervisory capacity.

Federal funding does not traditionally provide for treatment, as opposed to crisis intervention and support services, potentially ignoring those with the greatest need. Regulations that limit interventions to a set number or type of intervention confuse the needs of clients and providers. Decisions about treatment, referral, and termination of care should be based on the needs of the client at any given time, not on seemingly arbitrary rules that suggest that the number of sessions and the treatment modality (e.g., individual, group, or psychoeducation).

Reimbursement for providers that is based on the number of sessions provided creates incentives to hold onto clients without regard for their needs and tends to discourage referral even when needed.

Recommended Modifications

Federal guidelines and regulations regarding use of funding should be examined and modified to increase flexibility with respect to services. A longer period of service with specialized treatment services may be needed to address terrorist victims.

Mental health service and delivery should be guided by the degree to which psychopathology is expected and by the factors that influence it in the post event recovery environment. Large-scale, human-caused disasters may result in greater psychiatric impairment of direct victims than do natural disasters (North et al., 1999), though studies of children are lacking. A recent empirical review of the disaster mental health literature supports this suggestion. In an analysis of 160 samples of disaster survivors, those who experienced mass violence were far more likely to be severely or very severely impaired than those who experienced either natural or technologic disasters (Norris et al., 2002). This suggests a need to review priorities in the focus of care and the allocation of resources, increase flexibility and application of current regulations, and/or develop additional mechanisms for federal support to address the needs of terrorism victims.

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Appendix I-Training Outline

What is Psychological Trauma?

- Overwhelming, unanticipated danger that cannot be mediated/processed in way that leads to fight or flight
- Immobilization of normal methods for decreasing danger and anxiety
- Neurophysiological dysregulation that compromises affective, cognitive and behavioral responses to stimuli

What is Psychological Trauma?

- Events are not traumatic, but they are potentially traumatogenic.
- There are types of events that are more likely to be traumatic than others
- However, the individual's subjective experience is likely the most salient factor
  An upcoming exam may cause stress in one child, but not in another or the World Trade Center attack may cause serious symptoms in one while being mildly disturbing to another

Event Factors

- How directly events affect their lives:
- Physical proximity to event
- Emotional proximity to event (threat to child, parent versus stranger)
- Secondary effects-of primary importance (does event cause disruption in on-going life)

Individual Factors

- Genetic vulnerabilities and capacities
- Prior history (i.e. consistent stress or one or more stressful life experience/s)
- History of psychiatric disorder
- Familial health or psychopathology
- Family and social support
- Age and developmental level

Developmental Phase

- Children have different paradigmatic reactions to stressful events at different developmental phases
- Children are more sensitive to different events and situations at different phases of development

Posttraumatic psychopathology

Childhood Disorders:

- Posttraumatic Stress Disorder
- Reactive Attachment Disorder
- Depressive disorders
- Attention Deficit Disorders
- Anxiety and Phobic Disorders
- Somatization Disorders
- Changes in personality and identity (chronically angry, impulsive, bitter, anxious, distrustful and pessimistic) (DESNOS, Complex PTSD)
- Conduct disorder/delinquency

Acute Stress Disorder (ASD)

- Avoidance of Internal/External Reminders
- Hyperarousal (Anxious, Irritable, Insomnia, Poor Concentration, Hypervigilant, Reactive)
- Significant psychosocial and health impairment

ASD

- 3+ of 5 Dissociative Sx (Detached, Dazed, Derealization, Depersonalization, Amnesia)
- Recurrent Unwanted Memories Awake/Asleep or Biopsychological in response Distress 2nd Reminders
- Duration 2-30 days

Posttraumatic Stress Disorder (PTSD)

- Recurrent Unwanted Memories Awake/Asleep or Biopsychological Distress 2nd Reminders
- Avoidance of Internal/External Reminders, Emotional Numbing, Social Detachment, Amnesia
- Hyperarousal (Anxious, Irritable, Insomnia, Poor Concentration, Hypervigilant, Reactive)
- Significant psychosocial/healthcare impairment
- Duration 30+ days (may be delayed or chronic)

Traumatic Grief

Traumatic Loss

- Sudden unexpected death of significant other(s)

Traumatic Grief

- Terror: yearning, searching
- Horror: preoccupation, crying, denial
- Numbing: stunned, disbelief, denial, dysphoria
- Distinct from Depression (which involves apathy, guilt, hypochondriasis, insomnia, anxiety, suicidality, hostility, loneliness, & worthlessness, as well as dysphoria, denial)

Post Traumatic Disorders: Not Automatic & More than PTSD

- Most adults and children recover without a lasting post-traumatic psychiatric disorder
- In adults 10-20% develop depression or PTSD (often both)
- In adults subclinical depression or substance use common
- Classic PTSD not common in children-but incidence increases with age (especially adolescents)

Current Knowledge

- We know very little about what is the most effective forms of crisis and early intervention
- Few controlled treatment studies
- We know more about what doesn't work
- Know some about treatment of children with ASD and PTSD symptoms

Symptomatic Sexually Abused Preschoolers

- Cognitive-Behavioral Therapy (CBT) versus Nondirective Therapy in a controlled trial found that the CBT group maintained symptom reduction at one year after completion at a greater
- Inclusion of the non-offending parent in the treatment process was an important element that increased treatment efficacy. (Cohen & Mannarino, 1997, 1998)

Treatment of PTSD and ASD

- Various forms of exposure therapy
- Anxiety management training and parental psychoeducation and training? (Bryant, Sackville, Dang, Moulds, & Guthrie, 1999; Cohen, Berliner, & Mannarino, 2000; Gist & Devilly, 2002; National Institute of Mental Health, 2002; Ruggiero, Morris, & Scotti, 2001)

Treatment of PTSD and ASD

- Treatment elements included interventions fall under the framework of CBT and sometimes Eye Movement Desensitization and Reprocessing Therapy (EMDR).
- EMDR is no more effective that other forms of exposure therapies. (Cohen et al., 2000; P. R. Davidson & Parker, 2001)

Crisis and Early Intervention

- Scant research and inconclusive results and controversial findings.
- Widely held that early identification; intervention and continued follow-up are valuable methods to prevent the onset of posttraumatic sequalae. (Creamer, 1996; Gordon, Farberow, & Maida, 1999)
- Principals were employed September 11th attacks considered optimal practice for individuals and groups exposed to potentially traumatizing episodes of violence.

Crisis and Early Intervention

- One time interventions show no evidence of effectiveness (Gist & Devilly, 2002)
- No evidence that debriefings models are effective and may be harmful (Gist & Devilly, 2002; Mayou, Ehlers, & Hobbs, 2000)
- Concerns that group models model have contamination effects (Laor, 2002)

Treatment of ASD

- Exposure Therapies (CBT and EMDR) show some effectiveness
- Exposure to trauma memories should be done only if initiated by the client and in a manner that enhances self-regulation, not simply catharsis or habituation

Event Factors

- How directly events affect their lives:
- Physical proximity to event
- Emotional proximity to event (threat to child, parent versus stranger)
- Secondary effects-of primary importance (does event cause disruption in on-going life)

Individual Factors

- Genetic vulnerabilities and capacities
- Prior history (i.e. consistent stress or one or more stressful life experience/s)
- History of psychiatric disorder
- Familial health or psychopathology
- Family/parental and social support
- Age and developmental level

Rationale

- Engagement
- Assessment
- Monitoring

Engagement

- Early engagement provides the opportunity for on-going follow up contact and monitoring of children, their families and ecologically relevant issues that may impact symptom formation and functioning

Assessment

- Assess children's risk factors early and thereby identify children who have known vulnerabilities before they manifest difficulties.
- Treaters and others may put extra special efforts towards working with these high-risk children and their families in an effort to decrease the likelihood that they will develop posttraumatic symptoms.

Monitoring

- Symptoms related to traumatic events may appear at almost any time after an event and may be triggered by secondary reminders that were previously unrecognized. (J. R. Davidson, 2001; McFarlane, 2000; North et al., 2002)
- Continued monitoring allows for treatment to take place early in symptom formation and before they become potentially refractory.

Role of Parents

- At no time is the role of parents as mediators of experience more essential and necessary than at periods of real danger to life and limb. Parents are forced to play multiple roles in not only ensuring their own physical safety and that of their children, but also in ameliorating the accompanying psychological danger that ensues.

Parents and Families Mediate Experience for Children

Follow up from SCUD missile attacks (1996 Laor et. al)

- Children under 6 did as well as their primary caregiver.
- Children 8-12 trended toward primary caregiver, but not statistically significant
  12 and up faired as well as pairs

Role of Parents

- Among the risk factors that may be both most amenable to early intervention efforts as well as most salient in preventing poor outcomes for children is helping parents to have more capacity to understand the impact of exposure on their children and take supportive steps to mediate it. (J. E. Richters & P. E. Martinez, 1993)

Role of Parents

- Identification of parental difficulties and treatment if necessary is essential
- May be more effective than treatment of child in certain situations (e.g. very young children)

Role of Parents

- Supplying parents with developmentally framed psychoeducational information about children and adult's typical reactions to upsetting and overwhelming events, helping them understand what behaviors are worrisome or not and providing parenting and management techniques are some of the useful practices that providers should adopt.

Physical Displacement and Social Disruption

- Physical displacement and social disruption has been found to be the highest correlated factor related to outcome after traumatic events. (Laor, Wolmer, & Cohen, 2001; Laor et al., 1997; Laor, Wolmer, Mayes, Golomb, & et al., 1996; Lonigan et al., 1994)

Physical Displacement and Social Disruption

- Advantage in recognizing this risk for a particular family and bringing community and other resources to bear
- May include housing displacements, economic hardship due to job loss or expenses associated with the event, isolation from friends and extended family related to the many issues that may be associated with the episode of violence etc.

Physical Displacement and Social Disruption

- School provides needed support and structure
- When children are removed from their school environment they lose many of the resources of known adults, friends and schoolmates on whom they often rely.

Continuing Threat

- Children's worry about their safety can be a powerful contributor to or source of depressive and anxiety symptoms and may also lead to oppositional and aggressive behavior as children's anxiety leads to a misunderstanding of environmental cues in an attempt to reassert some sense of control. (Ford, 2002)

Continuing Threat

- Early intervention strategies are well placed to identify and assess the nature, degree and reality of the threat and, in turn, help the child and family cope with the current situation as best as possible

Continuing Threat

- If the threat is imagined or greatly exaggerated, psychotherapeutic treatments may be very useful
- However if credible, early interveners should work with law enforcement and court personnel to ensure the child and families' physical and emotional safety

Principles of Intervention

- Do no harm
- Child Development is basis of intervention
- Parents or primary caretakers are essential therapeutic agents.
- Restoration of external structure and authority
- Amelioration of threat

Principles of Intervention

- Do not assume knowledge of what is the most salient event, image or idea for the individual
- Early responses require collaboration with first responders and others (police, fire-rescue, EMS, Red Cross, courts etc.)

Immediate Interventions

For children who are direct witnesses or victims

- Ensure physical health: Have medical personnel check if concern
- First and foremost: reunite with known caring adults (especially parents)
- If adults not available keep with teachers, friends and peers
- Move to safe place when possible, but in group or with family

Early Treatment an Intervention

- Psychotherapeutic interventions in the absence of structure and organization will not be effective.
- Provide real and concrete information about event, explain actions of authorities
- Provide basic necessities

Clinical Early Intervention Goals

- Help child/ren regain a sense of control and efficacy in the face of feeling overwhelmed and helpless
- Engaging child/ren and family
- Assessment of risk factors
- Monitoring and Follow-up

Psychotherapeutic Interventions

- Must facilitate developmentally-appropriate expression (e.g., drawing, play)
- Must focus on age-relevant categories/themes (i.e., basic schemata, e.g., safe-unsafe)
- Must not encourage premature closure/decisions or expose the child to information/affect overload

Key Elements of Early Intervention

- Engagement: Empathic, non directive inquiry (not what happened?, but how are you feeling)

- Support: Confer control in therapeutic contact (initiating drawings VS. 100 questions)
- Follow the child's lead

Key Elements of Early Intervention

- Somatic: Discern if physical concerns. Are they due real injury or toxic exposure requiring medical intervention or psychosomatic to psychological trauma
- Affect: Identify, label and link to ideation and somatic experience (noting differences from beginning to end of contact and with reports about pre-morbid functioning)
- Cognition: Assess quality and nature of thought processes and link to affective impact of event and associated ideas

Key Elements of Early Intervention

- Psycho-education: Explain the normal post-traumatic response (what to expect, what is normal and when additional support/intervention is needed)
- Follow-up: Arrange for series of contacts to assess symptoms and adaptive functioning

Early Interventions if Symptomatic

- Step 1: Slow Down (Take a time out; Calm your body; One thought at a time)
- Step 2: Orient Yourself (Bring your mind & body back to the present time/place)
- Step 3: Self Check (How much distress? How much control? The worst ever?)

Early Intervention: Collaboration

Early interventions require collaboration among:

- Medical personnel
- Mental health professionals
- Law Enforcement
- Firefighters
- EMS
- Courts
- Schools

Schools

- Schools are uniquely positioned to provide normalization and security to children.
- Schools provide an optimal location for discussion, peer and adult support.
- Requires that teachers and staff be prepared and able to engage
- Within classroom discussions are best
- Schools should remain open whenever possible

Schools

- In order for schools to support children who are having stress reactions, staff must have support and be aware of own responses to stress inducing event
- Organization among staff is essential to work with situations that may cause stress reactions

Appendix II- Linkage of Acute Mental Health Care to Existing Mental Health Programs
(from Betty Pfferbaum)

Given that the federal model is not intended to supplant other services and that it does not provide for treatment or services for those who develop psychiatric disorders, linkage to existing mental health programs is essential. Unfortunately, erosion of the public health and mental health infrastructure has diminished the ability of current programs to provide care under normal circumstances. The added burden of a terrorist incident will further tax existing systems.

Existing programs potentially provide a needed source of clinicians to assist in the planning process pre event, in disaster mental health training, and in service delivery and supervision post event.

Provider networks are needed to serve those with a range of responses. Interagency service agreements should be established prior to an attack and should encourage cooperative relationships among providers and provider groups. Planning should include information and decisions about how the network will function.

Referral to existing programs post event should be guided by the presence or risk of clinically significant psychopathology rather than by arbitrary requirements such as the number of individual sessions. Using support services as treatment in individuals with significant psychopathology, commonly in a group format, may not only fail to address their needs but may retraumatize them by exposing them to the traumatic experiences of others and to memories of their own experience they are not ready to face, especially if they have prominent avoidance and numbing. This does not mean that outreach, counseling, and supportive services are unimportant. Instead, it underscores the need for provider networks and increased attention to triage and referral in disaster mental health service planning and training.

A policy against record keeping in the federal model was established out of concern for confidentiality and about the ethics of entering clients into a mental health system without their own explicit intent to do so. Stigma associated with mental health care adds to the concern. Failure to maintain records, however, creates problems between disaster and traditional mental health providers and agencies, as traditional providers are required to maintain records.

Evaluation of disaster mental health and traditional services is greatly needed. While evaluation processes may increase the burden on disaster mental health programs initially, these programs are in an ideal position to conduct this work and will both advance the field and conserve resources in future incidents.

The American Psychological Association's (1997) review of the mental health response to the Oklahoma City bombing raised questions about the effectiveness of the school-based services because few children were referred, but absent an assessment of need, any conclusions must be tentative. For example, while less than 7% of the children in a study by Pfefferbaum and colleagues (1999) had sought counseling at seven weeks, more than 40% of those who lost an immediate family member, approximately 15% of those who lost another relative, and approximately 8% of those who lost a friend or acquaintance had sought counseling at the time

of the assessment. Hoven's (2002) study of children in New York City after the September 11 attacks revealed that two-thirds or more of those with probable PTSD had not sought counseling from school-based or other providers. Twenty percent of the children in the New York City study by Stuber and colleagues (2002) had received counseling, much of which occurred in schools. Future studies and programs established post incident should address service needs for children with various types and degrees of exposure.

Appendix III-Guidelines

A. One page informational summary on expectations following 9/11
B. Parent Guide for talking with children about 9/11
C. Parent Guide for talking with children about anthrax
D. Parent Guide for talking with your children about war
E. Teachers Guide for talking with students about war

A.

In the wake of our national tragedy, we join you in your concerns about how best to address the needs of our children. Seeing frightening or distressing events such as those shown on television or other media can take away a child's basic sense of safety and security, just as it does for adults. We all share in the terrible sense of loss. As adults, though, it is our job to try our best to support each other and our children and come together as individuals, families, communities and a nation to cope with these events.

As a parent, listening to your child and understanding what your child feels are the first steps to help them. Identifying and naming their feelings helps children start to understand and cope with their feelings. It is particularly important to help them realize now what will keep them safe in their own lives and reassure them.

What Can You Expect?

Children communicate their upset feelings in many different ways. Over the next days and weeks, you may see the following reactions in your children:

- Questions of local safety and security
- Anger and thoughts about revenge
- Fighting with peers, parents, or other adults or not being able to get along
- Frequent nightmares or waking in the night
- Wanting to stay close by their parents
- Easily startled, jumpy, or uneasy
- Irritability, fussiness, difficult to soothe
- Using play to act out the events over and over
- Seeming more quiet, withdrawn, upset
- Tearfulness, sadness, talking about scared feelings or scary ideas
- Problems paying attention or behavior problems at home or at school
- Daydreaming or being distracted

How Can You Help?

For some children, going over the events with the adults they trust can help them feel less alone. Giving them time to talk about their questions and concerns can be very helpful. For other children, talking about what happened may be very hard. They may show their distress in other ways, such as upsetting behaviors. Recognizing your child's many different reactions can be the most important beginning to helping your child recover.

After a tragedy such as this, many children and adults will appear very distressed – often this is a "normal" reaction to an "abnormal" situation. But if you think your child is still having difficulties after several days and is having trouble in school, at home, or with peers, then help from someone who has experience working with children in such situations may be useful to you and your child. You can contact the National Center for Children Exposed to Violence (www.nccev.org) at 1-877-49-NCCEV (62238) or 203-785-7047 for help or to answer your questions.

B.

In the Aftermath of Crisis: Parents' Guide for Talking to their Children

Updated September 26, 2001

- ***Why should I talk about this with my children?***

In the wake of our national tragedy, we join you in your concerns about how best to address the needs of our children. The frightening or distressing events we have recently experienced and the ongoing threat of war can take away a child's basic sense of safety and security, just as it does for adults. We all share in the terrible sense of loss and ongoing worries about safety for ourselves and those we care about. As adults, though, it is our job to try our best to support each other and our children and come together as individuals, families, communities and a nation to cope with these events. Parents are the central sources of safety and security for their children. Children of different ages see what happens, understand it and react to it differently. As adults we must remember that we cannot assume that our children's worries are the same as our own. If you feel too anxious or overwhelmed, ask a relative or a friend to talk to your children and find someone you can talk to as well. When we as parents are able to listen to our children to understand their feelings and worries, we can help them make sense of them.

- ***What questions are children likely to have?***

  - ***What happened?***

Like adults, children are better able to deal with a situation if they feel they understand it. They want -- and need -- information just like adults. Begin by asking your children what they already understand about the situation. They have likely heard about it on TV, at school, or from their friends. Much of their information, though, may not be accurate. As they explain what they know about the situation, you can figure out what it is they don't already know or understand. Look for misunderstandings or frightening rumors. Tell the truth; do not mislead them.

The amount of details that children will find useful will depend on their age. The older the child is, the more details will likely be discussed. Provide the basic information in simple and direct terms and then ask for questions. Take your cues from your child in determining how much information to provide. Provide reassurance whenever possible and remind them that they are not at great risk of danger.

- ***How could something like this happen?***

Our government is working to figure out how to prevent something like this from happening again and to help the world become safer and more peaceful as soon as possible. But when children ask this question after a crisis, often they are really looking for reassurance that they are now safe. Take this question as an opportunity to reassure children of the steps we are all taking now to keep them safe. Terrorist acts such as this and ongoing concerns about the need for armed combat remind us all that we are never completely safe – but now is the time to reassure children that, in reality, they should feel safe in school, in their home, and in their community.

- ***What could I (or someone else) have done to prevent this?***

After a tragic event, we all wonder what we and others could have done to prevent this from happening. Even when it is obvious that there is nothing your children could have done to prevent or minimize the crisis, they may still feel helpless and wish they could change what happened, especially if they know someone who was injured or killed. Many more people are wondering who else might be at fault – they may be angry with the government, at adults they trust to protect them (including their parents), and others for failing to prevent this crisis. Let children know that this is a normal reaction; we all wish that there is something we could have done to prevent this tragedy. Perhaps the most important thing is to concentrate on what can be done now to help those most directly affected and to ensure safety in our communities.

- ***Whose fault is it?***

It is understandable that people would be angry at the individuals who commit acts of terrorism. But sometimes people are also angry at those people that are easier to find and blame – such as people who look like they might belong to the group that might have been responsible. Children should be told that although it is normal to feel angry, at this time it is important to remember that these acts of terrorism were committed by a small number of people who do not represent a particular race or ethnic group. The United States is a country that prides itself in having members of many different races and ethnic backgrounds. This is a time to join together as a country, not to search to blame members of our country. It is important to let children know that our government is taking action to defend our country against those who threaten us.

- ***What does this mean to me? How is this going to change my life?***

This is a question that we all struggle to answer not only for our children but also for ourselves. Especially in difficult times, children may act immaturely. Children are often very

concerned about themselves. When there is a tragic event, they may become even more concerned about what affects them personally. Adults who do not understand this may see this as being selfish or uncaring. It is important to make your children feel comfortable in asking questions and expressing their feelings. You are starting a conversation that you hope will continue for weeks and months as they begin to better understand and cope with the recent events. Expect your children to think more about themselves, at least at first. Once they feel that their needs are being met, they are more likely to think about helping others.

- ***What can I do to help?***

Once children start to feel safe and understand what is going on, many will want to try to help. While there may be little that they can do now to help the immediate victims of this crisis, there is a lot they can do to help. They can start by taking care of themselves – telling you when they are upset or worried, being honest and open. They can also offer help to other members of their community – their friends and classmates, their teacher, and other adults. Over time, they can think about how they, along with other members of their community, might be able to do something helpful for the victims and survivors.

- ***How do I answer these questions? I don't want to make things worse, so should I say nothing instead?***

Often what children need most is someone who they trust who will listen to their questions, accept their feelings, and be there for them. Don't worry about knowing exactly the right thing to say – there is no answer that will make everything okay. Listen to their concerns and thoughts, answer their questions with simple, direct and honest responses, and provide appropriate reassurance and support. While we would all want to keep our children from ever having to hear about something like this, reality does not allow this. Silence won't protect them from what happened, only prevent them from understanding and coping with it. Remember that listening, answering, and reassuring should be at the level of the child's understanding.

- ***What if this discussion upsets them?***

During these discussions, children may show that they are upset – they may cry, get anxious or cranky, or show you in some other way that they are upset. Remember, it is really the events that are upsetting them, not the discussion. Talking about the events gives them a chance to show you how upset they really are. This is the first step to starting to cope and adjust. Feel free to pause the conversation to provide support and comfort to your children and ask if they wish to continue the discussion at another time. But make sure that they realize it is okay to show you when they are upset. Otherwise, they may try to hide their feelings and will then be left to deal with them alone.

- ***What if they don't ask any questions – should I bring it up? What if they don't seem to want to talk about it?***

When a major crisis of this nature occurs, it is a good idea to be ready to talk with your children. At first, older children may tell you that they don't want to or need to discuss it. In most cases it is not a good idea to force them to talk with you, but instead keep the door open for them to come back and discuss it later. Keep an invitation open, but wait until they accept. Often children find it easier to talk about what other children are saying or feeling instead of talking about themselves. Think about how your children dealt with prior crises in the past and consider trying now what helped them when they were upset or worried before.

- ***What if my child doesn't seem upset by the recent events?***

Many children may appear disinterested in the recent crisis and even irritated by the continued attention focused on these events. The size and scope of a child's world is smaller than that of an adult -- the crisis may simply not have affected them directly; they may be far more concerned about what affects their own life. Especially for young children, they may not yet understand, or even know, much of what has occurred or what it represents. They may be concerned, but afraid to ask questions or to share their feelings. Children find it difficult to hold strong emotions continually for a long period of time. They may visit their concerns briefly, but then turn to play or involve themselves in schoolwork before they allow themselves to feel overwhelmed. They may express their feelings indirectly through play or through changes in their behavior. For all of these reasons, it is easy for adults to underestimate children's reactions.

- ***How do I know if my child needs more help than I can provide? Where would I go for such help?***

When there is a tragedy of this size, it is important to remember that most children (and adults) are having "normal" reactions to a very abnormal situation – even if they seem very upset. But if your children continue to seem very upset for several days – especially if they are upset or worried about many things, or they are having (more) trouble in school, home or with their friends, then it is a good idea to speak with someone outside the family for advice. You may wish to speak with your children's teacher or school counseling services, pediatrician, mental health counselor or member of the clergy for advice. Please remember that you shouldn't wait until you think they NEED counseling – you should take advantage of counseling and support whenever you think it will be helpful.

- ***What if I have more questions? Where can I turn for answers?***

You may have many more questions or concerns. If you would like further information, please feel free to contact the National Center for Children Exposed to Violence (www.nccev.org) at 1-877-49-NCCEV (62238)

GUIDELINES

- What worries us as adults is probably very different from what worries our children.
- What children worry about will vary depending on their age.
- If you listen to your children's questions and observe their behavior you will have a better idea of what they are concerned about.
- Because children depend on the adults around them for safety and security, it is important for the adults to take care of themselves in order to take care of the children.

INFANTS

Infants depend totally on the adults who look after them. They sense the emotions of their caregivers and react accordingly. If the adult is calm and confident the child will feel secure; if on the other hand, the adult is anxious and overwhelmed, the infant will feel unprotected.

When adults are overtly anxious and distressed, infants may react. Infants may respond with fretful fussing, difficulty to be soothed, sleep and eating disturbances or may withdraw and seem lethargic and unresponsive.

Adults can help by remaining calm and maintaining ordinary routines of life.

TODDLERS

At this age children have begun to interact with a broader physical and social environment. They still depend on the adults that look after them and therefore will respond to the situation depending on how adults react. As with infants, if the adult is calm and confident the child will feel secure; if on the other hand, the adult is anxious and overwhelmed, the toddler will feel unprotected.

Common reactions include disturbances in eating, sleeping and toileting, increased tantrums, irritability and defiance. They may also become more passive and withdrawn. It is also very common for children to become clingier.

Adults can help by remaining calm and maintaining ordinary routines of life. At his age, children have access to television. Television can generate anxiety because of the repetitive and graphic images it projects. Exposure should be limited as much as possible.

PRESCHOOL CHILDREN

At this age children usually have become part of a social group beyond their family. Their language, play, social, and physical skills are more advanced. Through their play, talk and behavior, they show their ideas

of good and bad, their pride in all the things they can do with their bodies and their fears about possible injury.

Common reactions include disturbances in eating and sleeping, bed-wetting, increased tantrums, irritability and defiance. Changes in play may include more aggressive pretend play, play that re-enacts the frightening events or inability to play. Children can have difficulties separating from parents or caregivers; they can also make a big fuss about small injuries. Preschoolers may be very preoccupied with questions related to who did it and what will happen to them.

Adults can help by remaining calm and maintaining routines. Caregivers can become aware of the specific worries of each child by listening to their comments and questions and observing their play and other behavior. Once adults understand the child's worries they can answer questions, correct misunderstandings and reassure the child. Exposure to television should be limited. An adult should be present to monitor and protect the child from the overwhelming graphic images and to talk bout what they are watching.

SCHOOL-AGE CHILDREN

At this age children become more independent, they are more able to talk about their thoughts and feelings, they play with their friends and participate in groups. Ideas of what is fair and just become important and they can cope with difficulties with better skills. School-age children are more involved in learning, sports and recreational activities.

Common reactions at this age include a need to stay close to parents and an inability to participate in ordinary activities. They can become too preoccupied with the events and ideas about revenge and punishment. School-age children can, like younger kids, experience nightmares, find it difficult to go to bed or wake up in the middle of the night. They may also change their eating habits. They can begin to have difficulties at school and can become anxious and aggressive.

Adults can become aware of the specific worries of individual children by listening to their comments and questions, observing changes in their play and other behaviors. Attention should be given to answer questions with accurate information and relate it to the child's worries. Friends' ideas should be discussed and misinformation corrected. As with younger children, exposure to television news should be limited. An adult should be present to monitor and protect the child from the overwhelming graphic images and to talk about what they are watching.

ADOLESCENTS

Adolescents can feel out of control due to the many changes that are happening in their bodies. They struggle to become independent of their families and to define themselves. The world of peers and teachers becomes central. It is common for adolescents to have conflicts with parents, teachers and other authority figures. There is a tendency to deny or exaggerate what happens around them and to feel that nothing can harm them.

Common reactions may include too much preoccupation with what is happening; they can feel frightened and out of control and can easily feel completely helpless or imagine themselves as unrealistically strong and powerful. Adolescents can also become even more judgmental and critical of the adults around them and those dealing with the crisis situation. They may also act in ways that can put themselves and others in danger. When faced with tragic events, their usual sense that nothing can harm them is lost, making them feel very unsafe.

Adults can help by using the adolescents' ability to think and talk to discuss their thoughts, feelings and worries. Some teenagers may feel more comfortable talking in groups with their peers and or with teachers. Adults should be aware that drastic changes in adolescents' behaviors might indicate their distress. Forcing adolescents to talk about their feelings may cause more harm than good, and adults should make sure that adolescents have a variety of opportunities to talk to whom they want and when they are ready.

You may have many more questions or concerns. If you have concerns about your child contact your child' pediatrician, teacher or mental health professional. If you would like further information, please feel free to contact the National Center for Children Exposed to Violence (www.nccev.org) at 1-877-49-NCCEV (62238) or (203) 785-7047.

C.

NCCEV National Center for Children Exposed to Violence

Responding to Children's Questions and Concerns about Anthrax

Many parents and adults are concerned about the recent threats of bioterrorism by the spread of Anthrax through the mail system. First it is important to understand some of the basic facts about the Anthrax threat, and then it is essential that before we talk with our children, we are aware of our own fears about the threat. Children take their cues from their parents and important adults on how to respond to anxiety provoking situations. We must remember that, as adults, it is not only our job to protect our children, but also to help them feel as safe and secure in a sometimes-threatening world.

1. What is known about the current Anthrax situation?

1. As of November first, there are fewer than 20 total cases of Anthrax and most of them have been non-fatal. Only one child has been diagnosed with Anthrax. While the idea of the fact that someone is trying to harm us by causing a fatal illness is unfathomable the threat of Anthrax to the average citizen continues to be infinitesimally small especially when compared to the rates of automobile fatalities, accidental injuries in the home, etc.
2. Anthrax infections have been limited to New York City, Northern New Jersey, Boca Raton, Florida and the Washington D.C. metropolitan area. All contaminated letters have been mailed to media personnel or political leaders.
3. The vast majority of infections have occurred in people who are known to have direct contact with mail in which Anthrax spores were concealed.

4. Even the most dangerous form of Anthrax infection (inhaled form) is treatable when caught early on and new early and rapid detection methods have recently been developed.

The threat from Anthrax infection has greatly diminished and the efforts towards insuring our security seem to have been effective.

2. My children aren't talking about Anthrax, how do I introduce the subject?

It is important to remember that children differ greatly depending on their age and developmental level. Some children may be hearing about Anthrax on the news or at school, while other children may not be aware of the threat at all. If your children haven't mentioned that they are concerned about the Anthrax scares, then perhaps they are not.

Younger children, especially, may not be aware of the Anthrax threat. It is more likely that younger children will respond to their parent's and other adults' worries than they are to the news. You may ask older children (approximately 4th grade and up) about their thoughts about the news. It is often easier for children to discuss their ideas and feelings when they are asked about their classmates and friends (e.g. what are the kids at school saying about…?). If they don't raise concerns about Anthrax and are not demonstrating behavioral changes (See: In the Aftermath of Terrorism: A Summary) then there is no reason for you to introduce the subject. Remember the goal of the Anthrax mail is to induce fear, not to infect and kill large numbers of people. Fear often overwhelms reason, but try to think rationally when dealing with your children. It is essential to recognize and then separate fear from the when talking to our children.

Try to take your cues from your child about what is worrying them. Don't assume that you know what your child's fears and concerns are without first talking to them. If your child is worried about Anthrax, ask them what they know about it and then tell them the facts. It is important to reassure children that they probably are very safe from the threat of Anthrax. Instilling unnecessary fear and anxiety in your children is not helpful and will not help to protect them from any potential threat.

Telling your children the facts about Anthrax in an age appropriate manner and letting them know that there is little to worry about should help relieve their anxiety and fear. However, if you are fearful and anxious, regardless of what you say, your children will be more affected by your mood than by your words. If you are feeling anxious then try to have someone else talk with your children.

And finally, be thoughtful about where your children are getting their information. If children are watching the news or reading about terrorism scares in the media, parents should guide them in this process. One may even consider turning off the news if it seems to cause more worry. If your children are going to watch the news, watch it with them and use it as an opportunity to engage in some family discussion.

3. **We live in one of the areas mentioned and my kids are talking about it all the time usually by joking, what do I tell them?**

   Again, the risks of many dangerous things are much greater than Anthrax, for instance, getting hit by a car or being in a car accident. There are things that one does to be safe that minimizes the risk such as looking both ways when crossing the street and using cross walks. Although unnecessary, if you are worried about Anthrax through the mail, you may want to take some precautions such as asking your children to let you go through the mail first. Do not open any suspicious looking letters and report any highly unusual mail to your post office or local law enforcement personnel. Although this level of concern is not warranted, if you want to minimize your and your family's risk you can wear latex gloves when handling the mail and wipe envelopes lightly with a bleach solution. This will kill any Anthrax that has contaminated the external surface of any mail. But remember, the risk of Anthrax to you and your family is incredibly small.

4. **My child is acting more worried and irritable, but is not saying anything about Anthrax, what should I do?**

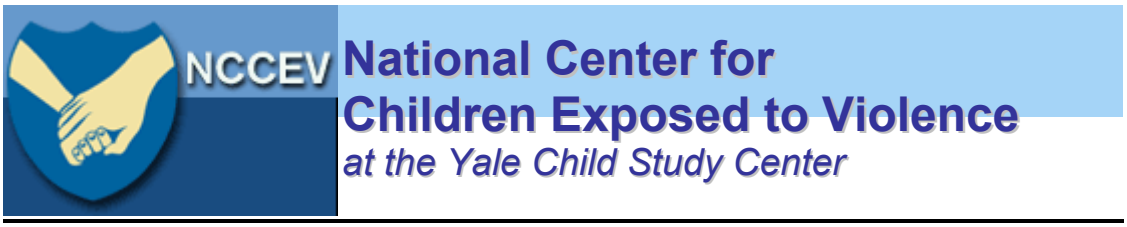
   It is hard to know if children who are responding in this way are reacting specifically to Anthrax fears or to the general anxiety in the adults and peers around them. If you notice some concerning or unusual behaviors in your children, you can point out these behaviors and ask them if they have any ideas about what they are about. If they are unable to answer the question, you may ask them if they have been listening to the news or if they have been worried about anything that is going on in the world. If they respond with a yes, then starting a conversation about what their fears and concerns are would be a good place to start. If they have specific concerns about the threats of Anthrax or other forms of terrorism, then find out what their understanding of these issues is, and then correct any erroneous assumptions or ideas they may have. If your children indicate that they have concerns and fears, you can provide them with some basic information and do your best to reassure them. However, do not overwhelm your children with more information or too many details beyond what they are asking. Consider who your child is-- you know him or her better than anyone else. Think about what your child can handle and what level of information would be most appropriate.

   Remember that the Anthrax scare may be a way of talking about other worries that your child is either unaware of or unable to talk about. Be careful to allow for other issues to come up that might not be related to Anthrax. Creating an open, trusting atmosphere where your child can come to you and talk about their fears and concerns is the goal. As a parent or significant adult, children will look to you for guidance and cues on how to respond to potentially scary things in the world around them. Show your children, by your example, how to be appropriately concerned, but not to let fear and unnecessary anxiety overwhelm you. And finally, remember that if you are having a hard time, you should seek out assistance and support for yourself. If we give into the terror, then we will not be able to help our children.

5. **What if I've tried all these things, but I still have serious worries and concerns about how my child is coping?**

If you have serious concerns about your child's behavior and do not feel able to help, do not worry alone. Contact your pediatrician or qualified child mental health care provider.

D.



Parents' Guide for Talking to their Children about War

Why should I talk about this with my children?

With increasing news about war and with talk about the threats of terrorism, children, their parents and caregivers may feel uncertain and robbed of a basic sense of safety and security. We all share concerns about the horrors and dangers of war and terrorism. However, as adults and parents, it is our job to help our children and each other cope as best as we can with concerns that will confront us as individuals, families, communities and as a nation.

Your calm ability to listen to your children's concerns is one of the most powerful ways of helping them to learn, understand and feel safe and secure in the most important part of their world---their families.

When using these guidelines what should I keep in mind?

- Children whose family members or friends are directly involved in the war or are in the military will be more directly impacted.
- Ongoing threats of terrorism may add to children's distress related to the war and war may heighten concerns about terrorism.
- Children who have experienced trauma and loss or have longstanding emotional problems are most vulnerable during periods of new threats.
- Reactions will vary from child to child depending upon a variety of factors including their personality, age, developmental level and personal history.

- Not all children will appear to be affected by news of the war. For some children, especially younger ones, it is not helpful to "force the issue" if it does not appear to have an impact.

- When thinking about how to talk to your children, take your lead from them in terms of what they need and what they are thinking and feeling.

- Helping children deal with a difficult event is hard work—parents should seek help and support from other adults when needed.

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What reactions may I notice in my child?

There is no one way in which children express worries and fears at times of greater stress. Here are some examples of how children communicate their upset feelings:

- Irritability or difficulty in being calmed and soothed.
- Tearfulness, sadness, talking about scary ideas or scary feelings
- Anger directed towards specific communities or ethnic groups
- Fighting with peers, parents or other adults or not being able to get along
- Changes in sleep patterns, nightmares or waking in the night
- Wanting to stay close to their parents' or refusing to go to school
- Physical complaints such as stomach-aches, headaches or changes in toileting habits

How can I help my children?

For some children, talking about their concerns with the adults they trust can help them feel less alone. Giving them time to ask questions can be very helpful. For some children, talking might be very hard. Recognizing your children's many different reactions can be the most important beginning to helping your children.

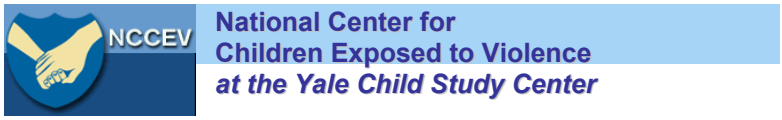
General guidelines

Television and Information

- Watching too much television coverage of war, violence and terrorism, especially graphic images, can be harmful to children of all ages. Monitor and limit the amount of news coverage they watch.
- Pre-school and younger school-age children will be especially worried the more war news they see and hear.
- If your school-age and older child is interested in watching news about the war, watch with them when you can so that you can talk about what you have seen and heard.

Talking about the daily events

- Do not assume that you know what your children are thinking and feeling
- Create a safe and comfortable environment to talk to them.
- Take cues from them in terms of how much they want to discuss what is going on in the world.
- It is important that routine and structure are maintained in children's lives and that they continue to enjoy life, with their friends and family.



What if I feel overwhelmed?

- In difficult and stressful times, children look to their parents and other significant adults in their lives to know how to cope.
- If you feel overwhelmed or upset, your children are likely to be sensitive to this. Infants and very young children also react strongly to changes in their parents' mood and emotional state.
- If you feel upset and overwhelmed by your own fears and concerns, don't struggle alone. Get the help and support you need from a trusted friend, professional or clergy.

What questions are children likely to have?

❖ *Are we safe and can we be attacked?*

When children ask questions about safety, often they are really looking for reassurance that their immediate world of family, friends, and other important figures in their lives are safe now. The amount of details about safety and security in the broader world that children will find useful will depend on their age. Should these questions emerge, ask first for your children's ideas so that you can respond to the details of their concerns. It is impossible for us, as adults, to predict the length or impact of war, but we can tell children of our hopes that the war will end quickly and that, here at home, parents, caregivers, teachers, and other adults including our national leaders are doing everything possible to keep them safe.

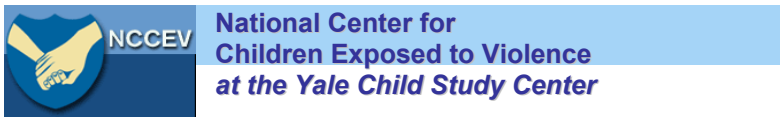
❖ *Whose fault is it?*

Many adults have very strong feelings about our country going to war. Parents should respond honestly to questions about their views of the war that their children may ask. Whatever the political views, parents can also remind their children that while it is normal to feel angry in a time of war, it is important to remember that we are not fighting a war with a particular race or

ethnic group. The United States is a country that prides itself in having members of many different races and ethnic backgrounds.

- ***What does this mean to me? How is this going to change my life?***

During stressful times, children may become even more concerned about what affects them personally than usual. Expect your children to think more about themselves, at least at first. Once they feel that their needs are being met, they are more likely to think about helping others. Teenagers may also be struggling with ideas such as being drafted or volunteering. Using available facts and carefully listening to them and engaging them in meaningful conversation may help them make sense of some of those questions.



- ***How can I help?***

Some children may want to express personal opinions about the war or to find ways of helping the country at this time of crisis. They can start by taking care of themselves – telling you what's on their minds, about their views, their fears and their hopes. They can also offer help by listening to the views and feelings of other members of their community – their friends and classmates, their teacher, and other adults. Over time, they can think about how they, along with other members of their community, might be able to do something helpful for our armed forces and their families as well as for the Iraqi children and families who will also suffer the effects of war.

As a parent, how do I answer these questions? I don't want to make things worse, so should I say nothing instead?

Often what children need most is someone whom they trust who will listen to their questions, accept their feelings, and be there for them. Don't worry about knowing exactly the right thing to say – *there is no answer that will make everything okay*. Silence won't protect them from what is happening, but silence will prevent them from understanding and coping with it. Remember that listening, answering, and reassuring should be at the children's own level.

What if this discussion upsets them?

It is important to remember that war is upsetting. While not always easy, talking is an important means of sharing your feelings and learning how to cope and adjust with loss. It is okay if your children get upset when talking about scary or disturbing things. As a parent, you can then reassure them and help them to feel safe and secure. Make sure your children realize it is okay to show you when they are upset. Otherwise, they may try to hide their feelings and will then be left to deal with them alone.

What if they don't ask any questions – should I bring it up? What if they don't seem to want to talk about it?

When upsetting things happen, it is a good idea to be ready to talk with your children. At first, older children may tell you that they don't want to or need to discuss it. It is often easier to begin discussions by asking your children what their friends and classmates are thinking, feeling and saying about the war. In most cases it is not a good idea to force your children to talk with you, but instead keep the door open for them to come back and discuss the war and concerns about it later.

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What if my children don't seem upset by events around the war?

Many children may appear disinterested and even irritated by the continued attention focused on the war. The size and scope of a child's world is smaller than that of an adult -- the situation may simply not have affected them directly and they appropriately may be far more concerned about their own life. Young children may not understand, or even know, much about what has happened or what it means. Other children may be concerned, but afraid to ask questions or to share their feelings. Children may visit their concerns briefly, but then turn to play or involve themselves in schoolwork rather then letting themselves feel overwhelmed. Paying attention to changes in behavior and mood as well as asking about children's ideas are the first steps to recognizing whether and when they may have concerns about the war.

How do I know if my children need more help than I can provide? Where would I go for such help?

War evokes a range of upsetting but "normal" reactions. If your children continue to seem to be particularly or unusually upset for several days – especially if they are upset or worried about many things, or if they are having trouble in school, home or with their friends -- then it is a good idea to speak with someone outside the family for advice. You may wish to speak with your children's teacher or school counseling services, pediatrician, or a mental health counselor for advice. Remember, you don't need to wait until your children show signs of being very troubled. Seek advice whenever you think it might be helpful.

What if I have more questions? Where can I turn for answers?

You may have many more questions or concerns. If you are concerned about your children, please contact a trusted professional in your community. If you would like further information, you may also contact the National Center for Children Exposed to Violence through our website at www.nccev.org or by calling 1-877-49-NCCEV (62238).

DEVELOPMENTAL GUIDELINES

- What worries us as adults is probably very different from what worries our children.
- What children worry about will vary depending on their age.
- If you listen to your children's questions and observe their behavior, you will have a better idea of what they are concerned about.
- Because children depend on the adults around them for safety and security, it is important for the adults to take care of themselves in order to take care of the children.

Infants

Infants depend totally on the adults who look after them. They sense the emotions of their caregivers and react accordingly. If the adult is calm and confident, the child will feel secure; if on the other hand, the adult is anxious and overwhelmed, the infant will feel unprotected.

When adults are overtly anxious and distressed, infants may react. Infants may respond with fretful fussing, difficulty being soothed, or sleep and eating disturbances, or they may withdraw and seem lethargic and unresponsive.

Adults can help by remaining calm and maintaining ordinary routines of life.

Toddlers

At this age children have begun to interact with a broader physical and social environment. They still depend on the adults that look after them and therefore will respond to the situation depending on how adults react. As with infants, if the adult is calm and confident, the child will feel secure; if on the other hand, the adult is anxious and overwhelmed, the toddler will feel unprotected.

Common reactions include disturbances in eating, sleeping and toileting, increased tantrums, irritability and defiance. They may also become more passive and withdrawn. It is also very common for children to become more clingy.

Adults can help by remaining calm and maintaining ordinary routines of life. At this age, children have access to television. Television can generate anxiety because of the repetitive and graphic images it projects. Exposure should be limited as much as possible.

Preschool Children

At this age, children usually have become part of a social group beyond their family. Their language, play, social, and physical skills are more advanced. Through their play, talk and behavior, they show their ideas of good and bad, their pride in all the things they can do with their bodies and their fears about possible injury.

Common reactions include disturbances in eating and sleeping, bed-wetting, increased tantrums, irritability and defiance. Changes in play and drawings may include more aggression, fighting, or re-enactments of the frightening events. Some children may show their upset through their inability to take part in play and other activities that usually give them pleasure. Children can have difficulties separating from parents or caregivers; they can also make a big fuss about small injuries. Preschoolers may be very preoccupied with questions related to who did it and what will happen to them.

Adults can help by remaining calm and maintaining routines. Caregivers can become aware of the specific worries of individual children by listening to their comments and questions and observing their play and other behavior. Once adults understand children's worries, they can answer questions, correct misunderstandings and offer reassurance. Exposure to television should be limited. An adult should be present to monitor and protect children from the overwhelming graphic images and to talk about what they are watching.

School-age Children

At this age, children become more independent; they are more able to talk about their thoughts and feelings, play with friends and participate in groups. Ideas of what is fair and just become important and they can cope with difficulties with better skills. School-age children are more involved in learning, sports and recreational activities.

Common reactions at this age include a need to stay close to parents and an inability to participate in ordinary activities. They can become too preoccupied with the events and ideas about revenge and punishment. School-age children can, like younger kids, experience nightmares, find it difficult to go to bed or wake up in the middle of the night. They may also change their eating habits. They can begin to have difficulties at school and can become anxious and aggressive.

Adults can become aware of the specific worries of individual children by listening to their comments and questions, or by observing changes in their play and other behaviors. Attention

should be given to answer questions with accurate information and relate it to the children's worries. Friends' ideas should be discussed and misinformation corrected. As with younger children, exposure to television news should be limited. An adult should be present to monitor and protect children from the overwhelming graphic images and to talk about what they are watching.

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Adolescents

Adolescents can feel out of control due to the many changes that are happening in their bodies. They struggle to become independent of their families and to define themselves. The world of peers and teachers becomes central. It is common for adolescents to have conflicts with parents, teachers and other authority figures. There is a tendency to deny or exaggerate what happens around them and to feel that nothing can harm them.

Common reactions may include a preoccupation with what is happening; they can feel frightened and out of control and may feel completely helpless or imagine themselves as unrealistically strong and powerful. Adolescents can also become even more judgmental and critical of the adults around them and those dealing with the crisis situation. They may also act in ways that can put themselves and others in danger, such as increased experimentation with alcohol and drugs, reckless driving or other behaviors, which may serve an attempt to avoid feeling vulnerable and small. When faced with tragic events, adolescents' usual sense that nothing can harm them is lost, making them feel very unsafe.

Adults can help by using the adolescents' more advanced ability to think and talk to discuss their thoughts, feelings and worries. Some teenagers may feel more comfortable talking in groups with their peers and/or with teachers. Adults should be aware that drastic changes in adolescents' behaviors might indicate distress. Forcing adolescents to talk about their feelings may cause more harm than good; instead, adults should make sure that adolescents have a variety of opportunities to talk to whom they want and when they are ready.

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In the Setting of War:
Teachers' Guide for Talking to Your Students

Purpose:

These guidelines address teachers' questions and concerns arising from the recent onset of war. They offer teachers assistance in the following areas: 1) How to identify and address signs of adjustment difficulties in your students and 2) How to facilitate conversations about the war in classrooms with your students.

While looking through these guidelines, it is important to keep in mind:

- Children whose family members or friends are involved in armed conflict or in military service may be more directly impacted.
- Children who experienced a recent loss or trauma, even if not related to war, may be more directly impacted by the war as well.
- lated to the war and the recent war may heighten children's concerns about terrorism.
- Teachers, parents, and students may benefit from thoughtful discussions about the war and the effects it is having on them.
- vary from child to child.
- In order to be able to help their students, teachers themselves need to be supported.

What should we expect to see in our students during wartime?

- During war, children may experience a recurrence of some of the feelings associated with a prior loss or tragedy. Children with continuing distress related to 9/11 or other crises may be particularly impacted.

- During war, children may have heightened concern about their personal safety, either related to the risk of terrorist events or representing a more general sense of increased anxiety.

- Reactions of children and adults may vary widely.

- Some signs of children's distress to look for include the sudden appearance or noticeable change of:

  - Depressed or irritable mood
  - Oppositional and defiant attitude
  - Attentional or other behavioral problems
  - Difficulties with classmates and peer group
  - Social isolation or withdrawal
  - Dramatic changes in academic performance
  - Physical complaints
  - Changes in appetite
  - Sleep disturbances

- The extent and nature of these potential difficulties may be related to many factors, including:

  - Age and developmental level
  - Personal history (e.g., prior trauma, loss, or emotional difficulties)
  - Support from peers, parents, and school staff

- Some children who are not directly impacted by the war may not be interested in discussing the events and may prefer to remain focused on the typical concerns of childhood.

- It is important to find ways within the school to recognize the events without imposing personal emotions or expectations on either students or staff.

- Children do not always demonstrate their feelings directly and we should pay special attention to signs of concern or distress.

- Heightened media coverage of the war and associated events (such as terrorist threats or acts) may increase reactions in children. Parents should monitor and supervise their television watching, and especially for younger children, consider limiting the amount of television exposure.

- The use of live television in classroom settings should be actively discouraged. If appropriate, media coverage can be videotaped and previewed prior to its viewing in class by students.

How can discussion about the war be helpful to children?

- Group discussions facilitated by trusted and knowledgeable adults, such as within classrooms, can be a safe environment where children can ask questions that are personally relevant and come to understand what has happened and what is likely to happen.

- Discussion allows children to explore how they are feeling, and to think about what might help them feel better. Peers can often provide each other with helpful ways to deal with feelings related to the war.

- Children may have similar needs as adults in times of crisis, but they often meet those needs in very different ways. It is important to find out from your students what concerns they have and how they might feel their needs could be met.

What should teachers keep in mind when conducting these discussions?

- Different groups of children and adults will have different needs and wishes.

- Teachers must remember that children who are either directly impacted by the war (e.g., those who have friends of family members who are involved in armed conflict or in military service) or who have experienced prior traumatic experiences (e.g., 9/11) may have difficulty with discussions about the war. Teachers should not assume that their students could discuss an ongoing war with the same level of objectivity that they might be able to discuss a past historical event.

- Students (and their families) may not wish to disclose to the school that family members are involved in the war or in military service. Teachers should conduct all classroom discussions assuming that some of their students may be personally impacted. While it is helpful to identify children with relevant experiences, it is not necessary nor appropriate to pursue their identification to the extent it interferes with the rights of children and families to maintain privacy.

- Teachers should be careful not to impose their own political beliefs on students.

- Both students and staff may have very different perspectives on the appropriateness of war. These differences of opinion should be respected and attempts should not be made to either actively promote or discredit one viewpoint. Tolerance for differences of opinion should be promoted. Children (and adults) may have different ways of demonstrating their love

and concern for their country and may not wish to participate in any one particular patriotic display and should not be forced or coerced to do so.

- Discussion of community assets, strengths and values can be very important in helping to foster children's hope for the future.

- Children may find it comforting if they can figure out ways they can help others at this time. Adults should encourage children to think about how they might be helpful and allow the children to decide what will be most meaningful for them. Although adults can offer suggestions of activities, they should resist the desire of telling students what they should do to provide assistance to others. Activities that promote active student involvement in delivering services (as opposed to solely fund-raising) may be more meaningful to students and therefore more helpful.

- Such activities may occur in concert with activities aimed at helping students understand and adjust to the war.

- It is important to remember that those children who are grieving their own personal losses (unrelated to the war) may resent what they perceive as excessive attention to losses related to the war.

- Students (and staff) may be inclined in times of war to become less tolerant of cultural and ethnic diversity and may view those who are different from them with more suspicion and even frank hostility. It is important to actively challenge these tendencies and to work to promote increased support for individuals of foreign descent. Teachers need to actively work to create an environment within their classrooms and throughout the school where all students feel safe. While children should feel comfortable expressing their views, hostile comments need to be challenged and should not be ignored.

How do you go about planning school activities?

- Begin by initiating conversations with students in groups, such as in classrooms or in after-school groups.

- It is important to involve students in the planning process, but equally as important for us as adults to provide guidance, structure and support to children.

- Consider the children's ages and developmental levels when planning activities.

- If you have a School Crisis Response Team you should use it as a resource when planning your school's response.

- Schools that are affiliated with military bases may benefit form additional services and should collaborate with support staff at the military base to the extent possible.

How can teachers handle this sensitively?

- Activities within an individual classroom may impact other students and staff as well as children's families at home.

- Parents and caregivers should be informed about discussions and activities that are planned.

- School discussions and activities often help to initiate discussions at home where children may be most comfortable talking about the war and their associated feelings.

- Parents should be invited to share with school personnel any concerns or relevant family experiences including:

    - Direct impact on family and friends.
    - Earlier or recent trauma or losses
    - Involvement of family members in other high-risk professions (e.g., police, firefighters, EMS).

- Open discussion communicates to children that adults are available for further discussion and support.

- Any discussions that teachers have with children in the classroom should be conducted as if there were students who were directly impacted by the war or any associated events, even if you are not aware of any – some children and their families may choose to keep their experiences and concerns private.

- Teachers should look for signs of distress in students, such as agitation, acting-out, or other unexpected behaviors.

If you are aware of any children who are directly impacted by the war efforts or who have suffered personal losses (such as related to 9/11) it is important to talk to them and their caregivers, if possible prior to the start of classroom discussions. Students should be reassured that no one will disclose their personal experiences and that there is no obligation for them to share their personal experiences or feelings. We need to remember that many children and their families choose not to disclose personal losses or experiences and make our best efforts to respect their privacy.

What should I do if I find this work difficult?

- Some teachers and staff may find it difficult to discuss the war, especially if they are dealing with concerns about their own family members of friends or if they have experienced personal losses.

- This is difficult work for all of us and we need to think about what our own feelings are in relation to the events.

- Remember that children look to us, as adults, for guidance and support during difficult times. We need to think about how our own reactions may impact the children.

- Providing an opportunity for faculty and staff to talk about their own reactions prior to talking with students may be useful to them personally and will better prepare them to meet the children's needs.

- Children's questions may sometimes catch us off guard and make us confront issues we would rather not think about.

- Adults should seek out support from other adults and colleagues when needed.

- Having a plan to address these concerns in advance will help make the task easier.

- If the task seems overwhelming to you, share it with a colleague, or invite someone else into your classroom to conduct discussions with your students.

Where can I find additional information?

If you have additional concerns please contact a trusted medical or mental health professional in your community. You may also obtain additional information on the impact of violence and trauma on children on the website of the National Center for Children Exposed to Violence at **www.nccev.org**.