When tragedy strikes
...in YOUR school
What will YOU do?

July 8-9, 1998
Pearl High School
Pearl, Mississippi

Participant’s Manual
Project Coordinator

Martha Garrett, Director of Guidance Services, Mississippi Department of Education, Jackson, Mississippi.

Workshop Facilitators

Larry W. Little, Assistant Superintendent for Curriculum and Instruction, Natchez-Adams School District, P.O. Box 1188, Natchez, MS 39121-1188

Peggy Caldwell, Counselor, Northeast Jones High School, Route 13, Box 15, Laurel, MS 39440.

Janie Rugg, Executive Director, Mississippi Counseling Association, P.O. Box 5565, Brandon, MS 39042.

Becky Rowan, Counselor, Pearl High School, 500 Pirate Cove, Pearl, MS 39208.

Cynthia Smith, Counselor, Natchez Middle School, 1221 Martin Luther King, Jr. Street, Natchez, MS 39120.

Speed, Dianne, Jones Junior College, Laurel, MS 39440.

Editorial Staff

© Larry W. Little, Turpin Creek Place, Route 4, Box 221, Natchez, Mississippi 30120-9104. Author.

Nancy F. Curtis, Chair, English Department, Warren Central High School, 1000 Highway 27, Vicksburg, MS 39180. Grammarian.

Mississippi Department of Education

Richard Boyd, Ed.D., Interim State Superintendent of Education
Richard Thompson, Ed.D., State Superintendent of Education (Effective July 1, 1998)
R. D. Harris, Deputy State Superintendent of Education
Walter Moore, Ed.D., Interim Associate Superintendent for Academic Education
Therrell Myers, Ed.D., Associate Superintendent for Vocational-Technical Education

The views expressed or implied in this publication do not necessarily represent nor reflect the official position of the Mississippi Department of Education, State of Mississippi, Jackson, Mississippi.

April 1998
Reprint July 1998
Table of Contents

Agenda .......................................................................................................................................5

Foreword ....................................................................................................................................7

Section 1 Defining a Crisis ................................................................................................9
  • What is a "crisis"? ................................................................................................................9
  • Stages of a Crisis .............................................................................................................13

Section 2 Developing a Safety and Crisis Management Plan .................................................19
  • Introduction ......................................................................................................................19
  • A Policy Statement .........................................................................................................21
  • Crisis Management Team ...............................................................................................23
  • Dissemination of Information .......................................................................................29

Section 3 Providing Crisis Counseling ....................................................................................35
  • Introduction ......................................................................................................................35
  • Prevention Counseling ..................................................................................................37
  • Intervention Counseling .................................................................................................43
  • Postvention Counseling ..................................................................................................54

Section 4 Post-Traumatic Stress Disorder ..............................................................................57

Section 5 Loss, Death, Grief, and Bereavement .....................................................................61
  • Loss and Reaction ............................................................................................................61
  • School-Associated Violent Deaths .................................................................................65
  • Suicide .............................................................................................................................68

Section 6 Readings ....................................................................................................................77

Section 7 Panel Discussion ......................................................................................................143

Section 8 Appendix ................................................................................................................145

Section 9 Bibliography/References ........................................................................................149
Figures

Figure 1 Stages of a Crisis ................................................................. 15
Figure 2 Victim's Emotional Responses to a Crisis ................................ 16
Figure 3 Overall Safety and Crisis Management Plan ......................... 19
Figure 4 SEMI Module on School Safety ........................................... 20
Figure 5 Sample Board Policy Statement ........................................... 22
Figure 6 Information for the "Telephone Tree" .................................... 27
Figure 7 Line of Responsibility for Contacting Personnel .................. 28
Figure 8 Guidelines for Handling the Media ........................................ 32
Figure 9 Crisis-Provoking Events ...................................................... 36
Figure 10 A Group Guidance Session on Crisis Management .............. 39
Figure 11 Crises Identified by Children ............................................. 40
Figure 12 Summary of Crisis Intervention Activities and Strategies ....... 44
Figure 13 Counseling Strategies .......................................................... 46
Figure 14 Five Components of "Psychological First Aid" ...................... 48-50
Figure 15 B.A.S.I.C. Personality Profile ............................................. 51
Figure 16 Validating Responses by Counselors ................................. 53
Figure 17 Post-Traumatic Stress Disorder .......................................... 58
Figure 18 Kübler-Ross' Model on Dying ............................................. 61
Figure 19 Stages of Grief ................................................................. 62
Figure 20 Developmental Sequence in Children's Perception of Death .... 63
Figure 21 Stages of Grieving and Possible Behaviors ......................... 64
Figure 22 School-Associated Violent Deaths (1992-1994) .................. 66
Figure 23 Suicide Tendencies Scale ................................................... 70-71
Figure 24 Jongsma's Short-Term Therapy Objectives (Sample) ......... 72
Figure 25 Coping with the Stigma of a Suicide ................................. 75

Activities

Activity 1 Events Which Can Lead to a Crisis Situation ........................ 11
Activity 2 Grouping Events/Situations Which Might Cause a Crisis ....... 12
Activity 3 Reflections ........................................................................ 18
Activity 4 Identifying Key Personnel in Your School District ............... 25
Activity 5 Reflections ........................................................................ 34
Activity 6 Group Guidance/Counseling Activities .............................. 42
Activity 7 Strategies You Can Use in a Crisis Situation ...................... 55
Activity 8 Reflections ........................................................................ 56
Activity 9 Suicide Knowledge Test ................................................... 76
Activity 10 Notes on Readings ......................................................... 78
Agenda

Day 1

9:00     **OVERVIEW**
         Welcome and Introductions
         Objectives of the Workshop

9:30     **SECTION 1 – Defining a Crisis**

10:00    Break

12:00    Lunch

1:30     **SECTION 2 – Developing a Safety and Crisis Management Plan**

2:30     Break

2:45     **SECTION 3 – Providing Crisis Counseling**

Day 2

8:00     **SECTION 4 – Post-Traumatic Stress Disorder**

8:30     **SECTION 5 – Loss, Death, Grief, and Bereavement**

9:45     Break

10:00    **SECTION 6 – Readings**

12:00    Lunch and Reassemble in Large Group

1:30     **SECTION 7 – Panel Discussion**

2:30     Explanation of CEU Credit
         Dismissal
Notes
Foreword

A school is supposed to be a place where students can learn in a safe and orderly environment. Unfortunately, the school environment oftentimes mirrors the community-at-large. One merely has to read the newspaper or watch the news on television to realize that there are elements in our society which are far from the idealized world we aspire.

Too often, events in the community-at-large spill over into the school environment. School officials and students are confronted with events which may result in a crisis situation for the individual, school, and/or community. The school district should become proactive in its quest to develop a comprehensive crisis management plan.

Decker (1997) states:

"...you cannot afford to commit an error when a crisis hits. Emotions run high and tolerance for poor judgment is low during a time of need and anguish. Being proactive and prepared to meet the challenge of a crisis is the first step in eliminating fatal errors."

Neither the superintendent nor the principal should be the only person involved during a crisis. An effective method of providing appropriate assistance is the formation of a school-based (or district-wide) intervention team. The name of the team -- e.g., Crisis Management Team -- is not as critical as its functions. Team members should include representation from the school (administrators, faculty and staff, school counselors and psychologists), health related professionals (mental health workers, social workers, and medical personnel), civil defense, law enforcement, and clergy. The team should develop proactive strategies for most contingencies so that it can respond effectively when a crisis occurs to assist students, parents, faculty and staff, and the community cope.
Objectives

The participant will:

1. define the concept "crisis."

2. list situational and maturational events which might result in a crisis situation.

3. assist in developing a crisis management plan.

4. formulate a proactive strategy to respond to conditions which might lead to a crisis situation.

5. develop intervention strategies to assist students and parents, teachers and staff, and the community at-large when a crisis-provoking event has occurred.
Section 1 – Defining a Crisis

What is a "crisis"?

There are many definitions of *crisis*, some formal and others informal. Oftentimes, it becomes necessary to redefine "crisis" in terms of any incident or situation, whether it is real or rumored, that is likely to have an impact within or outside the school.

*Webster's New World College Dictionary* (1996) describes a *crisis* as a "turning point in the course of anything; decisive or crucial time, stage, event, or state of affairs in which a decisive change is impending; a time of great danger or trouble, often one which threatens to result in unpleasant consequences; an emotionally significant event or radical change."

An individual's reaction to a specific event determines whether a crisis exists or not. We all deal with many problems and threats or potential threats on a daily basis. An event in and of itself is not evidence that there is a crisis. The individual's response to the event determines whether it will "trigger" a crisis; i.e., the individual perceives the event as important and threatening, and, secondly, believes that s/he is unable to deal with it. Often we deal with these events so easily and quickly that we hardly notice them. We have developed our particular set of coping mechanisms, those ways in which we typically resolve problems, maintain equilibrium, and thus protect and maintain our security.

The working definition of a crisis we will use in this training activity is

A crisis exists when there is the *perception* of an event or situation as being intolerable, exceeding the resources and coping mechanisms of the individual.
According to Slaikeu (1984), crises are often subdivided into those which are accidental or situational and those which are maturational or developmental.

Accidental or situational crises include events such as sudden death of a family member, a serious vehicle accident, devastation of the school by a tornado, or moving to another state and leaving friends and familiar places.

Maturational or developmental crises, which are more predictable on a group-wide basis, include the potential hazards of starting school, making transitions between schools (i.e., from elementary to middle/junior high school), and adjusting to the emotional and physical consequences of puberty.

Puryear (1979) discusses various events -- situational or maturational -- with which people find that they cannot cope. Sometimes the problem is too overwhelming, such as a death of a family member, classmate, or teacher. Other times several small problems over a short period of time have depleted the individual's ability to cope. Situations also induce crises if they involve new and unique problems for which appropriate coping mechanisms have not been developed.

Symbolic links to similar problems in the past which were not appropriately resolved have a delayed effect. For instance, following the death of a student, the teacher is unable to assist her students because she has experienced several painful deaths, and this instance stirs up repressed feelings about the loss of other important persons in her life. (Slaikeu, 1984)

Further evidence that an individual is in crisis comes from indications of the psychological disequilibrium associated with crisis reactions. Oftentimes, people feel as out of control of their emotions as they are of the practical effects of the hazardous event. If an individual who previously has been functioning adequately begins manifesting anxiety, helplessness, lowered self-esteem and depression, then additional evidence of an inability to cope is evident.
Activity 1

List of Events Which Can Lead to a Crisis Situation

DIRECTIONS: "Brainstorm" (by listing) crisis-provoking events.
Activity 2

Grouping Events/Situations Which Might Cause a Crisis

Directions: Share your ideas (from Activity 1) with your table-mates and compile a comprehensive list of crisis-provoking events by categorizing them under the specific headings listed below.

<table>
<thead>
<tr>
<th>Situational/Accidental</th>
<th>Maturational/Developmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crime</td>
<td>Violence/Terrorism</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural/Man-Made</td>
<td>Military Conflict</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Illness/Injury</td>
<td>Other/Crises of Modern Life</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexpected/Untimely Death</td>
<td>Transitions</td>
</tr>
</tbody>
</table>
Glass (1959) identified five stages of responses to a crisis, with specific characteristics manifested by the individual in each stage.

**Stages of a Crisis**

1. **Pre-Crisis Phase**
   - Individual is in a state of stability or equilibrium.

2. **Impact Phase**
   - Precipitating event creates great stress.
   - Tension increases rapidly.
   - Disturbing feelings come to the surface.
   - Some disorganization of behavior may be displayed.

3. **Recoil or Crisis Phase**
   - Shock is an early reaction.
   - Tension or anxiety is at very high levels.
   - Coping may be adaptive or maladaptive.
   - Period of confusion and disorganization is of varying severity.
   - Period of trial and error reorganization begins.

4. **Resolution or Adjustment Phase**
   - Regains control over emotions and works toward a solution.
   - Anxiety and tension decline to more manageable levels.
   - Works on healing which requires a great deal of sustained energy.

5. **Post-Crisis Phase**
   - Comes out of the crisis and resumes normal activities.
   - Approximately 25% of individuals (victims) do not resolve the crisis.
   - Unresolved crisis can lead to personality disorganization, depression (even suicide), confusion, or hysteria.
A tremendous amount of work has been done in the area of brain research within the past decade. One significant finding is that we have, in a sense, two minds, one that thinks and one that feels. Joseph LeDoux, a neuroscientist at the Center for Neural Science at New York University, was the first to discover the key role of the amygdala in the emotional brain. His research shows how the brain processes sensory signals. The sensory signal -- visual or hearing -- travels first to the thalamus, and then -- across a single synapse -- to the amygdala; a second signal from the thalamus is routed to the neocortex, the thinking brain. This branching process allows the amygdala to begin to respond before the neocortex. (Goleman, 1995)

Goleman (1995) further states:

These two minds, the emotional and the rational, operate in tight harmony for the most part, intertwining their very different ways of knowing to guide us through the world. Ordinarily there is a balance between emotional and rational minds, with emotion feeding into and informing the operations of the rational mind, and the rational mind refining and sometimes vetoing the inputs of the emotions. . . . In . . . most moments these minds are exquisitely coordinated; feelings are essential to thought, thought to feeling. But when passions surge the balance tips: it is the emotional mind that captures the upper hand, swamping the rational mind.

The amygdala "hijacks" the neocortical processes, triggering an emotional response. This emotional response causes the individual to "freeze" or respond "instinctively" to a specific event. For example, an individual walking across a street and seeing an on-coming vehicle, may be unable to move -- remaining "fixed" -- in the pathway of a speeding vehicle; another person's immediate reaction might be to jump out of the vehicle pathway. Each individual responds differently to a precipitating event. The individual who is unable to move from the vehicle's pathway is in a state of crisis. This crisis impacts not only the individual, but the driver and passengers in the vehicle and any bystanders. Oftentimes, the crisis lasts for a few seconds before rational thought makes the individual move to either side of the street, thus avoiding the oncoming vehicle.
Figure 1 depicts a dysfunctional situation when a person's emotions overwhelm rational thought resulting in a crisis situation. The "angle of disorganization" in the recoil stage is determined by the victim's perception of the injury -- emotional or physical. The outcome of a crisis can be either debilitation or growth. When "resolution" begins, the victim has begun to recover from the event or situation which instigated the crisis. The extent of recovery determines the degree of emotional injury. In some instances, the individual becomes more resolute and stronger than the pre-crisis level of functioning; in some instances the individual functions at a lower level of rationality. The goal is to return the individual to the pre-crisis level of functioning.

When the precipitating event, which results in a crisis situation, occurs the individual experiences an array of emotions. Initially, there is tremendous anxiety: "I can't believe this is happening to me!" This feeling of anxiety is oftentimes immediately followed by numbness.

Elisabeth Kübler-Ross, a world renowned psychiatrist on death and dying, states that an individual experiences the same emotions during a crisis as when confronted with death. Most classifications are based on her pioneering work. Stages of crisis and grieving are considered by many authors, who may name them differently. Epperson (1977) includes denial, anger, remorse, grief, and, finally, reconciliation.

These emotions are not linear; they occur and recur in the "muddled" thinking process. While the stages may overlap or appear in certain individuals in idiosyncratic ways, commonalities in types of behaviors do exist. Wheatley (1994) states that a crisis situation --

... is created by iterations in a non-linear system, information feeding back on itself and changing in the process. ... Very slight variances in the condition ... so small as to be indiscernible, amplify into unpredictable results when they are fed back on themselves. If the system in non-linear, iterations can take the system in any direction, away from anything we might expect.

Figure 2. Victim’s Emotional Responses to a Crisis

---

Puryear (1979) states that a "crisis is a state in which people have failed to resolve a problem, are in disequilibrium, and exhibit . . . the characteristics of a crisis -- symptoms of stress, attitude of panic or defeat, focus upon relief, and decreased efficiency." He says that an individual who exhibits these characteristics for over six weeks without any significant change is not in a crisis but a state of equilibrium, i.e., "surviving" at a lower level of functioning.

New research in "systems thinking" shows that everything a person does is interrelated (Senge, 1994). An event in an individual's life impacts more than that single individual. For example, if a student commits suicide, the hurt, loss, and search for meaning are felt by everyone directly or indirectly associated with the student: parents and siblings, extended family members, friends, classmates and schoolmates, teachers, neighbors and friends. The degree to which each reacts to the suicide is determined by the (1) coping skills which have developed over a lifetime and/or (2) relationship one had with the victim or associates of the victim.
Activity 3

Reflections

What have you learned in this session, and how will you apply it in your work?
Section 2 – Developing a Safety & Crisis Management Plan

Introduction

Decker (1997) states that the school and school district should develop a safety and crisis management plan. Both aspects of the plan are proactive, i.e., developing strategies which will reduce the type and number of incidences which might result in a crisis, intervening when a crisis situation occurs, and providing a postvention for those affected over a period of time as a result of the event. He has identified a ten-step approach for handling crises or tragic situation.

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Establish a district policy and a safety and crisis management mission statement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Appoint a district wide task force.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Survey surrounding school districts as well as the target school.</td>
</tr>
<tr>
<td>Step 4</td>
<td>Conduct assessment of building security.</td>
</tr>
<tr>
<td>Step 5</td>
<td>Identify current and proposed safety features.</td>
</tr>
<tr>
<td>Step 6</td>
<td>Identify, designate, and document the safety and crisis management team.</td>
</tr>
<tr>
<td>Step 7</td>
<td>Set goals and guidelines for developing building-level plans.</td>
</tr>
<tr>
<td>Step 8</td>
<td>Develop a “table of contents” for the building safety and crisis management team.</td>
</tr>
<tr>
<td>Step 9</td>
<td>Develop a safety and crisis management plan.</td>
</tr>
<tr>
<td>Step 10</td>
<td>Distribute the safety and crisis management plan.</td>
</tr>
</tbody>
</table>

In 1990, the School Executive Management Institute, Mississippi Department of Education, developed a training module for school administrators entitled School Safety and Emergency Preparedness: A Resource Guide. The training manual details procedures to address school safety and emergency procedures. Specifically, the sections in this training manual include the following topics: planning, security, life safety, medical emergencies, and death and suicide.
<table>
<thead>
<tr>
<th>Section</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td></td>
<td>• Overview of the Resource Guide</td>
</tr>
<tr>
<td></td>
<td>• Opening Activities: Case Studies (Bus Accident, Intruder with a Weapon, and a Student Suicide)</td>
</tr>
<tr>
<td>2</td>
<td>Planning for School Safety and Emergency Preparedness</td>
</tr>
<tr>
<td></td>
<td>• Communication</td>
</tr>
<tr>
<td></td>
<td>• Interagency Cooperation and Assistance</td>
</tr>
<tr>
<td></td>
<td>• Organization for School Safety and Emergency Preparedness</td>
</tr>
<tr>
<td></td>
<td>• Advocacy Review</td>
</tr>
<tr>
<td>3</td>
<td>School Safety and Security</td>
</tr>
<tr>
<td></td>
<td>• Campus Security and Safety Measures</td>
</tr>
<tr>
<td></td>
<td>• Weapons</td>
</tr>
<tr>
<td></td>
<td>• Drugs</td>
</tr>
<tr>
<td></td>
<td>• Gangs and Groups</td>
</tr>
<tr>
<td></td>
<td>• Transportation Safety</td>
</tr>
<tr>
<td>4</td>
<td>Life Safety</td>
</tr>
<tr>
<td></td>
<td>• Natural Disasters</td>
</tr>
<tr>
<td></td>
<td>• Fires</td>
</tr>
<tr>
<td></td>
<td>• Technological Disasters</td>
</tr>
<tr>
<td></td>
<td>• Bomb Incidents</td>
</tr>
<tr>
<td>5</td>
<td>Medical Emergencies and Epidemic/Health Hazards</td>
</tr>
<tr>
<td></td>
<td>• Medical Emergencies</td>
</tr>
<tr>
<td></td>
<td>• General Prevention Strategies</td>
</tr>
<tr>
<td></td>
<td>• Infectious and Communicable Diseases</td>
</tr>
<tr>
<td></td>
<td>• Social Ills</td>
</tr>
<tr>
<td></td>
<td>• Resources and Support Services</td>
</tr>
<tr>
<td>6</td>
<td>Death and Suicide</td>
</tr>
<tr>
<td></td>
<td>• Understanding Death and Suicide</td>
</tr>
<tr>
<td></td>
<td>• The School's Role</td>
</tr>
<tr>
<td></td>
<td>• Planning for Prevention</td>
</tr>
<tr>
<td></td>
<td>• Crisis Management and Postvention</td>
</tr>
<tr>
<td></td>
<td>• Identifying Resources</td>
</tr>
<tr>
<td></td>
<td>• Dealing with Non-Suicide Deaths</td>
</tr>
</tbody>
</table>

Robert H. Decker's publication, entitled When a Crisis Hits: Will Your School Be Ready?, addresses many of the issues included in the SEMI training module.
While the major thrust of the Counseling Institute is to assist school counselors and other members of the helping profession develop intervention strategies to be implemented when a tragedy occurs, several topics related to the overall safety and crisis management plan need to be reviewed.

A Policy Statement

One of the first priorities in developing a crisis management plan is to legitimize the school district's plan by getting the school board to establish a policy statement on safe schools. Such a statement by the school board sends a message to students, parents, staff, and community that the school district believes school safety is important so that consistent prevention and response measures are available if and when a tragedy occurs. (See Figure 5, page 22) District personnel, in turn, should develop administrative regulations to implement the board policy statement.

The administrative regulations should include the following elements:

1. Appointing a district-wide task force to develop a school safety and emergency preparedness plan.
3. Identifying existing safety procedures and making such procedures uniform district-wide.
4. Developing transportation safety guidelines.
5. Developing building-level safety and emergency preparedness plans.
6. Providing training for all personnel -- certified and classified.
7. Informing the public and, in particular, parents and students of all measures included in the school safety and emergency preparedness plan.

Each school district should develop its own statement based upon the uniqueness of the district. The size -- geographical area and number of students and staff -- will determine the specific implementation strategies outlined in the administrative regulations and crisis management plan.
Figure 5. Sample Policy Statement

Magnolia Public School District

School Safety and Emergency Management Plan

The Board of Trustees of the Magnolia Public School District is committed to the belief that students should be afforded a safe and orderly learning environment. This learning environment includes traveling to and from school; within all school facilities -- classroom, assembly, cafeteria, gymnasium; on the school grounds; and, while participating in and attending academic competitions, athletic events, extra-curricular activities, and field trips sponsored by the school.

Every effort shall be made to provide all reasonable precautions to protect the safety of all students, employees, visitors, and those present on district property or at school-sponsored events.

The Superintendent of Schools is directed to appoint a district-wide School Safety and Emergency Preparedness Committee, consisting of school personnel (administrators, teachers, and support staff); parents and community leaders; and, representatives from health providers, law enforcement, and civil defense. This committee shall have the responsibility of developing a School Safety and Emergency Management Plan that has prevention, intervention, and postvention components. The plan shall include but not be limited to the following:

1. Assessment of building and grounds security.
2. Current and proposed safety procedures.
3. List of agencies and contact persons who can provide assistance when a crisis situation occurs.
4. Working with the media.
5. Staff training.

The practice of safety shall be considered an aspect of the instructional program of the school district, and instruction shall be provided, as appropriate to subject areas and grade-levels, in accident and fire prevention, emergency procedures, and vehicular and pedestrian safety.

The plan shall be reviewed and updated annually prior to the beginning of the school year. The Superintendent of Schools, or designee, shall make a report to the Board, on an annual basis, regarding the implementation of the plan.
Crisis Management Team

Membership of the Team

In order to adequately address school safety and emergency preparedness, it is recommended that there should be three different teams. This recommendation, of course, is subject to modification based on the size -- geography and number of facilities -- of the school district.

There should be a district-wide crisis management team staffed with well-trained professionals representing the school district, public and parents, law enforcement personnel, and specific helping agencies such as mental health, hospital, civil defense, human services, and law enforcement. This team offers support to individual schools and has the responsibility of establishing basic procedures, coordinating community support people, working with the media, and making recommendations to the Board or Superintendent regarding policies and procedures. It also has the responsibility of informing individual schools about new developments through its contacts with other school districts.

A school-level crisis management team should develop a pre-planned response system to deal with the most common crisis situations and tragedies which might occur to any member of the student body or faculty. Each person on the staff should be trained in how to respond to a variety of incidents, e.g., bomb threat management; fire drill evacuation plan; tornado, hurricane, severe thunderstorm, or earthquake drill; school evacuation plan for dangerous situations; reporting system for missing or unaccounted for students or personnel; violence prevention drills for student safety; crime scene protection and weapon recovery; and, alternative notification procedures when the public address system is not working or there is electrical failure and bell alarm systems are not working. Everyone has a role of responsibility, and everyone should know his or her role in bringing the school back into balance.
The student level crisis management team provides on-going traditional counseling services to students, parents, and, as necessary, school personnel. This team is composed of district-wide and community personnel who are trained in counseling or psychotherapy, including school guidance counselors, mental health workers, social workers, psychologists, psychiatrists, and members of the clergy. These members of the helping profession are trained to help students with grief issues in their lives. (Refer to the list of events [Activity 2] which may lead to a crisis situation.)

Anticipating and planning for emergency situations enable school personnel to make all the decisions necessary to contain the crisis and channel the emotional reactions on the day of the event.

The first two teams involve the logistics necessary to address a crisis situation. The "individual" level addresses the need to provide crisis counseling to anyone -- students, parents, staff -- emotionally impacted by the incident.

Training

Developing a school safety and crisis management plan is the initial step. However, planning is of little consequence if no training follows. Training should include both knowledge and skill building and be on-going. It should cover such topics as security procedures, volatile situations, client assessment, behavioral and verbal clues, techniques for verbal defusing, self-defense, and follow-up staffing procedures. A critical component of training is not just talking about problems but gaining practice in solving them. There is no better way of doing this than through simulations and role-playing.
Activity 4

Identifying Key Personnel in Your School District

Directions: Take time to list key individuals within your school and community whom you think should serve on the school-level crisis management committee.

Administrators.

Other School Personnel.

- Teacher(s):
- School Counselor(s)/Psychologist(s):
- Certified Staff (Secretary, Custodian, Food Service):
- Transportation Coordinator/Supervisor:
- Other:

Community Personnel. Identify by name and job or job function.

- Area Crisis Response Management Team:
- Civil Defense:
- Clergy (trained in counseling/psychotherapy):
- Law Enforcement:
- Medical:
- Mental Health:
- Social Worker:
- Private Practice Personnel:
- Other:
The "Telephone" Tree

Communication is crucial during a crisis situation. The mechanism for contacting members of the faculty and members of the crisis management teams needs to be determined immediately. A "telephone tree" should be developed. It is recommended that the plan have a back-up system in the event individuals cannot be reached or are personally involved in the crisis event. All members of the crisis management teams and faculty members at each school should have a copy of the "telephone tree" so that they can assist in contacting personnel and serve as back-up personnel in contacting individuals. Copies of the "telephone tree" should be maintained at home and at work.

The list of names and telephone numbers should be updated at the beginning of each school year and as personnel change throughout the school year. The principal, or designee, should contact members of the school-level crisis management team and the superintendent. The superintendent should contact members of the school board, the media, and a contact for central office staff. At the elementary school level, grade-level chairpersons could serve as contact persons who, in turn, will contact teachers at their particular grade level; at the secondary school level, subject area chairpersons could serve in the same function; i.e., the English chairperson would have the responsibility of contacting all teachers of English. The school counselor, if one is assigned to the school, should contact members of the student-level crisis management team.
If a crisis situation develops after school hours -- at night, on the weekend or holiday, or during the summer -- there needs to be a mechanism whereby appropriate personnel can be contacted and the school can respond to the situation. Figure 7 graphically depicts such a "telephone tree" system.
Figure 7. Line of Responsibility for Contacting Personnel

Principal

- Superintendent and District-Wide Crisis Management Team
- School Board, Central Office Personnel and Media

School-Level Crisis Management Team (Contact)

- Crisis Management Team
- Faculty and Staff (Contact)
- Student-Level Management Team
- Faculty and Staff
Dissemination of Information

Essentially, there are three "publics" which must be considered in the dissemination of information: employees, parents and community, and the media. One person should be designated as the spokesperson for the school district. Oftentimes, this person is the principal at the school because s/he is more recognizable to the general public. In some school districts, the superintendent or the public information (relations) officer assumes this role.

Keep the Staff in the Information Loop

The school has a responsibility to keep its staff informed during a crisis situation as they are an extension of the school to the outside community. Evidence is overwhelming that more disinformation comes from employees than from the general public. The general public assumes that everyone employed by the school district is a valid source of information. Unfortunately, the employee often is not considered when facts regarding an incident are being released. It is critical to keep all employees informed of the facts regarding any crisis situation. The principal must emphasize the necessity of squelching rumors and maintaining only factual information.

The administration of a school should always maintain the lines of communication with the staff, students, and parents before a potential crisis-induced situation occurs. This stance might avert a possible crisis.
Communicating with Parents

Parents want to know that their child is safe. When an incident occurs at school or a school-sponsored event, parents besiege the school via telephone or vehicle asking the question: "Where is my child? Is s/he all right?" Immediately after the tornado hit Cathedral School, in Natchez, Mississippi, on February 26, 1998, all telephone lines, including cellular, were jammed, and streets to the school immediately became gridlocked, causing some parents to vacate their vehicle in the street and proceed to the school on foot. Fortunately, no one who required medical attention was seriously injured because the panic situation would have prevented emergency medical vehicles from getting to the school. Oakland Elementary School, Greenwood, South Carolina, was not as fortunate. On September 26, 1988, a gunman entered the school and started shooting, killing two and seriously wounding two other individuals. The street leading to the school was jammed with vacated vehicles; emergency medical vehicles were unable to get to the school.

Understandably, during a crisis parents become frightened, angry, and frustrated. They question the school's inability to protect their children.

Each community needs to develop a system to inform parents of the facts -- and prevent rumors -- regarding a crisis situation.

Addressing the Media

Wherever a crisis situation has occurred, principals have reported that facing the media was the most difficult aspect in handling a crisis. However, the media -- newsprint, radio, and TV -- should be used to disseminate factual information. The spokesperson for the school or school district should take a proactive position. S/He should contact the media when a "media
"generating" event occurs: this contact establishes the position that the school is cooperative and in control. Speaking with candor will create mutual respect between the school and the media.

There is a twofold responsibility: protecting those involved in the crisis, especially confidentiality of a minor, and responding to the community's concern.

No one is required to be interviewed by the media. The school has the legal right to restrict the press from interviewing faculty or staff on the school premises; faculty and staff have the right to refuse to give an interview at any time. Preferably, the staff should defer all questions to the school's spokesperson.

Prior to giving permission for the press to interview a student, parental permission must be obtained. The school has an ethical responsibility to protect students from over-zealous reporters.

The school has the right to determine who is allowed on school premises. A room should be set aside for the spokesperson to provide factual information to the press.

It is recommended that the school prepare a written statement about the specifics of the crisis situation. Consistent with the proactive approach, the school should choose aspects of the incident it wishes to emphasize about the incident.
Figure 8. Guidelines for Handling the Media

- Develop a written statement for dissemination
- Appoint a spokesperson (usually the principal)
- Keep the staff informed through one person designated to control rumors
- Be proactive with the media
  - Contact the media before they contact the school
  - Set geographic and time limits
  - Explain restrictions
  - Hold the press accountable
- Stress positive actions taken by the school
- Do not refuse to speak to the media
- Do not disclaim responsibility until all facts are known
- Announce new changes made after the incident has passed


Sometimes tragedies occur which attract the attention of the national media. Sometimes the media can become quite obtrusive -- by the sheer number of news agencies covering an incident and the methods used by some reporters. Morrissey (1998) reported that students at Heath High School in West Paducah, Kentucky, became quite disturbed by the media.

... students ... were quite disturbed by the media. The Dec. 1 shootings brought dozens of television satellite trucks and news reporters to the quiet town of Paducah. From CNN and Geraldo Rivera to People magazine and the scores of newspapers, the media were desperate to tell the story of what happened. Students began putting signs up in the windows that read: "Press Go Home!"

The Aftermath of a Crisis

Immediately after a crisis situation -- within the first three days -- the administration should have a debriefing session with its faculty and staff. While concern for students is
paramount, it should be recognized that the "care-givers" have become stressed and need time to express their emotions and concerns. Teachers should be asked to share their reactions regarding the events and provide suggestions for improvement. Peterson and Straub (1992) state that this is a time to

✓ Search for meaning in the event.
✓ Understand and accept their own emotional reactions.
✓ Increase their ability to cope with future adversities.

[so that they can]

✓ Promote maturity and growth in the students and the staff.
✓ Integrate the emotional investment of the students into a loyalty toward their school.
✓ Refine the [school safety and emergency] plan. (p. 59)

The crisis management teams should be debriefed also. During this time it would be appropriate to reconstruct actions taken by each team, reevaluate the school safety and emergency plan, and identify procedures, logistics and physical plant needs.
Activity 5

Reflections

What have you learned in this session, and how will you apply it in your work?
Section 3 – Providing Crisis Counseling

Introduction

Crisis situations are either the result of nature (e.g., tornado, hurricane, fire, earthquake) or are man-made. An individual's reaction to a crisis-provoking event differs when the event is the result of nature as opposed to one that results from an act of violence. Shelby and Tredinnick (1995), in their work with survivors of Hurricane Andrew, found that

...the nature of the stressor -- a natural disaster rather than a personal crisis or a work conflict -- enabled the clients to express their emotions easily.... That is, clients seemed to experience a shattered sense of the world as a meaningful place, yet their sense of people as basically benevolent seemed fairly intact. Relatively free from the shame and self-blame that often accompanies victimization from violent acts, our clients seemed particularly open to sharing their psychological experience of the disaster. (p. 492)

In today's society, homes, businesses, governmental agencies, schools, and health care providers are becoming increasingly responsible for managing crisis situations that occur in residential settings, schools, and the workplace. The dramatic rise in aggressive and acting out behaviors is a complex issue and is undoubtedly related to changing patterns and values in society. Regardless of the cause or causes, most authorities have accepted the fact that managing crisis situations is a fact of life and that selecting a system of crisis management is imperative for effective education and treatment.

An act of aggression or the sense of loss from an unexpected event impacts everyone connected with the event: the victim and family, friends, neighbors, and associates of both the victim and the perpetrator.

(The list of crisis-provoking events from Activity 2 [page 12] are listed on the next page.)
**Figure 9. Crisis-Provoking Events**

<table>
<thead>
<tr>
<th>Situational or Accidental</th>
<th>Maturational or Developmental</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crime</strong></td>
<td><strong>Violence/Terrorism</strong></td>
</tr>
<tr>
<td>Assault (mugging, rape)</td>
<td>Abduction, hostage, or</td>
</tr>
<tr>
<td>Abuse, battery</td>
<td>kidnapping</td>
</tr>
<tr>
<td>Incarceration/Release of</td>
<td>Stabbing, assault</td>
</tr>
<tr>
<td>offender</td>
<td>Sexual attack</td>
</tr>
<tr>
<td></td>
<td>Riot, gang fight</td>
</tr>
<tr>
<td><strong>Natural/Man-Made</strong></td>
<td>Homicide</td>
</tr>
<tr>
<td>Earthquake</td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td></td>
</tr>
<tr>
<td>Flood</td>
<td></td>
</tr>
<tr>
<td>Hurricane</td>
<td></td>
</tr>
<tr>
<td>Thunderstorm</td>
<td></td>
</tr>
<tr>
<td>Tornado</td>
<td></td>
</tr>
<tr>
<td>Nuclear</td>
<td></td>
</tr>
<tr>
<td>Vehicular</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Illness/Injury</strong></td>
<td></td>
</tr>
<tr>
<td>Dismemberment</td>
<td></td>
</tr>
<tr>
<td>Life threatening illness,</td>
<td></td>
</tr>
<tr>
<td>e.g., cancer, heart attack</td>
<td></td>
</tr>
<tr>
<td>Physical disability</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Unexpected/Untimely Death</strong></td>
<td></td>
</tr>
<tr>
<td>Fatal accident (vehicular,</td>
<td></td>
</tr>
<tr>
<td>recreational, etc.)</td>
<td></td>
</tr>
<tr>
<td>Fatal disease</td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Throughout life, individuals change. All changes, even seemingly simple ones, carry an emotional toll. Adjustment to change is either positive (healthy) or negative (unhealthy). Unmet
expectations and ensuing disappointments are fertile experiences for building appropriate coping skills. Given the opportunity, every event that occurs in an individual's life presents an occasion for growth.

Through the varied and many life experiences, beginning in childhood, individuals learn to understand, accept, and handle emotional reactions to a crisis. By adulthood, most individuals have a strong repertoire of coping skills upon which to rely. Students, on the other hand, have not had time to develop appropriate coping skills to recover from serious, crisis-provoking events in their lives. Both the home and school have the responsibility to guide them in their recovery.

The school guidance counselor is in a unique position to provide services to students at three levels: prevention counseling (developing attitudes and skills to ward off a crisis), intervention counseling (crisis counseling), and postvention counseling (attending to the needs of individuals after the initial shock has subsided but satisfactory coping skills have not been developed, i.e., post-traumatic stress disorder.)

Prevention Counseling

The divergent needs of students after World War II required information related to vocational decision-making and specialized psycho-social interventions beyond those which previously had been provided by teachers. School counseling -- primarily through the National Defense Act of 1958 -- was introduced as a specialized area to assist students with these needs. With the population explosion, these needs of students have changed or intensified over time.

Research has shown that the elementary school is a powerful socializing force in the development of the individual and that there is a critical need for elementary school counselors. For better or worse, nearly all members of our society carry the psychological imprints of their elementary school experiences throughout life. The school's failure to properly attend to the mental health needs of many elementary school students may manifest itself as adolescent disorders at the middle/junior high school level.
Schools need to initiate programs -- through developmental guidance activities and imbedded concepts in courses such as reading -- which focus on such issues as self-esteem, decision-making, moral development, conflict resolution, and problem-solving.

The counseling program must be an integral part of the total school program, and its orientation must be to primary prevention.

Effective school counseling programs are clearly based in human development theories in such domains as cognitive development (Jean Piaget), psycho-social development (Erik Erikson), moral development (Lawrence Kohlberg), and developmental tasks (Robert Havighurst). School counselors need to be well-grounded in these theoretical frameworks when developing various guidance activities for students at different grade-levels. A developmental guidance program is designed to help students cope with normal developmental tasks that characterize each developmental stage.

Borders and Drury (1992) state that

program content, goals, and interventions should reflect this theoretical foundation. The developmental program is proactive and preventive, helping students acquire the knowledge, skills, self-awareness, and attitudes necessary for successful mastery of normal developmental tasks. Developmental concepts are translated into specific outcomes for students; developmental principles are evident in the program plan (curriculum) and intervention strategies.... Developmentally based programs increase the visibility of the counseling program and ensure that more students are served. (p. 488)

School guidance centers on programs which are collaborative, comprehensive, and developmental. Counselors need to be actively engaged in all three components. They need to collaborate with parents and teachers through skill-building workshops, giving them the necessary knowledge so that they can understand the psycho-social issues students face and the skills to assist the them in making appropriate decisions. The guidance program should address the needs -- educational, career planning, and psycho-social -- of all its clients. Counselors
should develop guidance activities which provide for individual counseling, small group work, and skill-building workshops for students.

Allan and Anderson (1986) describe a classroom guidance activity entitled "Children and Crisis." The program consists of six phases covered during three 40-minute lessons. They implemented the activity in two second-grade, two fifth-grade, and two eighth-grade classes. A synopsis of the skill-building activity is given below.

**Figure 10. A Group Guidance Session on Crisis Management**

| First Lesson | ✓ Counselors introduced and presented exploratory stimulus questions.  
|             | ✓ Students defined ("brainstormed") the word "crisis" and described the kinds of crisis that affect children.  
|             | ✓ Students depicted a crisis experience by drawing.  
| Second Lesson | ✓ Students wrote a story about a crisis situation that had happened to them or to someone they knew or had heard about.  
|             | ✓ Students were asked to read their story or show their picture (from the first lesson) to the class.  
|             | (Second graders focused on the drawing activity, the eighth grade students focused on the writing sample, and the fifth graders participated in both activities.)  
| Third Lesson | ✓ Counselor focused activities on students' understanding of what constitutes a crisis and their actions during a crisis situation and six months later. (A lot of unfinished psychological needs became evident.)  
|             | ✓ Students were asked to identify what helps a child in a crisis, how they might help others, and how parents and teachers could help.  
|             | ✓ The facilitator summarized the main points of the discussion and asked the students what they had learned.  

The eight most cited crisis situations -- accidents, moving, illness, death, school, friends and peer pressure, family issues, and violence -- identified by the students in this activity are listed in Figure 11.
Allan and Anderson (1986) conclude their article by saying that "the counselor plays a key role in helping children during crises. To be effective in their role, counselors must be aware of the kinds of situations that elicit crisis reactions; the thoughts, feelings, and behaviors that become activated during a crisis (i.e., shock, denial, intense affect, bargaining, depression, withdrawal, and resolution); and action strategies for alleviating the crisis." (p. 149)

**Figure 11. Crises Identified by Children**

<table>
<thead>
<tr>
<th>Type of Crisis</th>
<th>Explanation (if needed)</th>
<th>Grade 2</th>
<th>Grade 5</th>
<th>Grade 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents</td>
<td>Very common with younger children; physical pain, cuts, bruises, broken leg, visits to the doctor.</td>
<td>22%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Moving</td>
<td>Hurt feelings about leaving friends, grandparents, special house; angry with parents; pain diminished as new friends were made.</td>
<td>9%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Illness</td>
<td>Severe illness and emergencies that led to hospitalization; sense of urgency.</td>
<td>19%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Death</td>
<td>Aware of feelings even though the death had been some years past; upset over adults not wanting to talk about someone who had died.</td>
<td>5%</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>School</td>
<td>Concerned about failing, learning something new, not doing homework causing a &quot;crisis.&quot; (Primarily eighth graders.)</td>
<td>7%</td>
<td>8%</td>
<td>25%</td>
</tr>
<tr>
<td>Friends</td>
<td>Focused on peer pressure; wrote about them although they did not discuss them openly. Stories revealed similar themes: common issue, deep struggle, resolution, and change of behavior.</td>
<td>17%</td>
<td>19%</td>
<td>22%</td>
</tr>
<tr>
<td>Family Issues</td>
<td>Major crisis at all grade-levels. Overwhelmed by hurt and angry feelings from parents' shouting, put downs, and physical abuse. Many students blamed themselves for their parents' difficulties.</td>
<td>8%</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>Violence</td>
<td>Concerned about violence in the world. Two main categories: physical violence (beatings, murder, suicide, child sexual abuse), and nuclear holocaust.</td>
<td>13%</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Allan, John, and Anderson, Eileen. (1986). Children and crisis: a classroom guidance approach. *Elementary School Guidance and Counseling, 21*(2), 143-149. [Figure adapted from content of the article.]
In order to be effective during a crisis situation, it is imperative that school counselors already have established rapport with students based on their knowledge and skill, availability and visibility, confidentiality (within guidelines), and willingness to be of service to their clients.

Keys, et. al. (1998) state that school counselors need to develop a collaborative relationship with community counselors to develop an effective prevention program. They go further in stating that comprehensive programs provide a continuum and continuity of services to support a full range of developmental needs, including physical, emotional, social, academic, and moral. Multifaceted programs (a) encompass interventions at the individual, family, community, and societal levels; (b) develop more than one type of skill and address more than one problem behavior; and (c) engage the key features of the contexts within which the individual is embedded (family, peers, work, and school). Integrated programs emphasize collaborative relationships among agencies and institutions to establish a non-fragmented service delivery system. (pp. 123-124)

They embrace Senge's "systems" concept that what happens to individual impacts everyone associated with that individual.

The problems facing children and families are complex and multi-causal, and these problems cannot be solved without addressing this larger context; there is no single or simple answer to such problems. If counselors are to help, they need to recognize that the environment surrounding their client is as much "the client" as the individual or family with whom they work directly. (p. 124)
Activity 6

Group Guidance/Counseling Activities

Directions: List group guidance/counseling activities you currently conduct at your school; specify grade-level for each activity.

<table>
<thead>
<tr>
<th>Grade-Level</th>
<th>Title (or focus) of the Guidance/Counseling Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Intervention Counseling

The school district should develop a multi-layered school safety and crisis management team. No single school should have the total responsibility of handling a crisis situation. Each crisis team -- district-level, school-level, and student-level -- should have specific responsibilities specified in the plan.

When a crisis-provoking situation occurs at a school, the principal has the duty to determine the extent of the incident and whether the crisis management teams should be contacted.

Prior to a crisis situation, the student-level crisis management team (refer to p. 24) should be identified and on stand-by. When the team leader receives notification (the importance of a "telephone tree" that is current and accurate cannot be overly emphasized) of a specific crisis situation, s/he should contact each member of the team, apprise them of the situation, and inform them of the meeting place and time with the administrator (building-level principal) in charge of the crisis intervention program. Guthrie (1992) states that -- during a specific crisis situation -- the leader of the student-level crisis management team

makes and receives calls to compile information with other team members. This kind of exchange of information serves two purposes: (a) it provides for a common base of knowledge about the crisis for all team members, and (b) it allows team members to come to school mentally prepared for the stressful day that awaited them. Early notification allows each team member to hit the ground running. (p. 74)

At the organizational meeting for the faculty and staff, the details of the incident should be discussed, rumors dismissed, strategy determined, and personnel deployed. The principal should be the individual who meets with the media.
The primary task of the student-level crisis management team is to restore some sense of control and dignity to the victims of the crisis; the school-level team's responsibility is to maintain order and restore the school to a level of normalcy as soon as possible.

The time of day and location of the crisis will determine the method and type of response. For example, if the crisis-provoking situation occurs on campus during the regular school day (e.g., a tornado or a killing), the staff must respond immediately, including the school counselor -- provided, of course, the school has a guidance counselor -- as an intervenor. Immediately, members of the student-level crisis management team will have to be contacted and briefed on the situation so that they, too, can assist individuals cope with their reaction to the crisis. If, on the other hand, the crisis-provoking situation occurs after school hours -- at night or during the weekend or holiday -- the crisis management teams may have more time to assess the situation, organize, and provide more coordinated intervention. It should be emphasized, however, that counseling intervention becomes more difficult the longer an individual has been in a state of crisis.

Logistically, an area -- guidance office area or classroom -- should be designated where counselors can assist students develop their coping skills. If classes are continuing to meet, it might be necessary for a counselor to speak to an entire class. Depending on the size of the campus and student enrollment, at least one counselor should be a "rover" who is continually

**Figure 12**

Summary of Crisis Intervention Activities and Strategies

1. Student-level team (counselors) contacted and assembled.
2. Faculty/staff organizational meeting; briefing on factual information; rumors dispelled.
3. Counseling room(s) designated for students and adults.
4. "Rover" scans the campus for possible referrals.
5. Classroom crisis intervention provided as needed.
6. Updated information provided to the team leader who disseminates it to members of the team.
7. List of students seen recorded and maintained for later reference.
8. List of "at-risk" students recorded for follow-up counseling.
9. Debriefing session at the end of the day to analyze performance and determine need for any subsequent follow-up.
checking with teachers for students who might need assistance. This person would accompany students to the counseling center where they can receive assistance.

According to Guthrie (1992) a record should be maintained of all students who received counseling. Each student should be classified in "one of three separate categories: (a) directly involved with the incident, (b) indirectly involved with the incident, or (c) affected through personal life history" (p. 75). This list, provided to the counselor (and principal), can provide vital information in the event any of the students exhibit post-traumatic syndrome disorders and need further counseling or psychotherapy.

Crisis counseling is extremely demanding and intense. Therefore, counselors need to have a "safe" room where they can vent any emotions they may be experiencing. Factual information can be provided at this time, as there might be information that would not be available for "general" knowledge.

At the end of the day, members of the student-level crisis management team need to meet so that they can reflect on the day, review the list of clients they have seen, apprise the counselor at the school of students who might need further counseling or psychotherapy, and determine whether the (entire) team will be needed the next few days.

Strategies

The crisis counseling approach used in a crisis situation is based on the individual counselor's theoretical frame of reference: basic or psychoanalytic approach, systems theory, adaptational theory, interpersonal theory, or a combination of these approaches. Succinctly stated, an integrational approach to these theoretical approaches emphasizes that behavioral responses to a crises associated with grief are normal, temporary, and amenable to alleviation through short-term intervention techniques (Gilliland and James, 1998). A crisis-provoking situation impacts
not only the individual, but those associated with the individual. The major reason why a specific event causes a crisis in an individual is that the individual has not developed appropriate coping skills. An individual cannot sustain a personal state of crisis for very long if s/he believes in him/herself; i.e., personal self-esteem (openness, trust, sharing, safety, empathy, genuineness).

The nature of the crisis-provoking event -- developmental or situational -- dictates, to a large degree, the victim's reactions. Developmental crises are considered normal, although each type is unique and must be assessed and handled differently. Situational crises -- nature- or man-made -- result from unexpected and extraordinary events over which one has little or no control; for example, tornado, automobile accident, kidnapping, sudden death, or violent acts such as those which have occurred recently on school campuses. "A situational crisis is random, sudden, shocking, intense, and catastrophic." (Gilliland and James, 1988, p. 15)

Slaikeu (1984) states that crisis counseling is a two-step process: providing immediate "psychological first aid," and a secondary-order intervention of crisis therapy. He identified five components of "psychological first aid" to crisis situations (pp. 87-88). He

---

**Figure 13. Counseling Strategies**

[Designed to prevent PTSD]

{Phrasing of questions and statements must be age-appropriate.}

**Phase 1 -- Informational Phase**
- What happened?
- Where were you?
- What role did you play?

**Phase 2 -- Idea Phase**
- What thoughts have you had?
- What ideas did you think of?

**Phase 3 -- Emotional Phase**
- How did you react at first?
- How are you reacting now?
- What impact has this had on you?
  (Allow and encourage emotional expression: crying, anger, fear, etc.)

**Phase 4 -- Meaning Phase**
- What repercussions has this had on your life?
- What symptoms are you experiencing?
- How has this affected your family? school? health? friends?

**Phase 5 -- Educational Phase**
- How have you coped with difficulties before?
- What are you doing to cope now?

**Phase 6 – Closure**
- Remind students of strengths.
- Reassure them that it will take time to heal.
- Reassure them that you (or someone) will be there.

states these components provide a conceptual framework to assist the counselor in asking questions, making statements, and taking action. (See Figure 14.)
## Figure 14. Five Components of "Psychological First Aid"

<table>
<thead>
<tr>
<th>Component</th>
<th>The Role of the Counselor</th>
<th>Do</th>
<th>Don't</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Make psychological contact</strong></td>
<td><strong>Behavior</strong></td>
<td><strong>Do</strong></td>
<td><strong>Don't</strong></td>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td></td>
<td>Invite client to talk.</td>
<td>Listen carefully.</td>
<td>Tell your &quot;own story&quot; yet.</td>
<td>Client to feel heard, understood, accepted, and supported.</td>
</tr>
<tr>
<td></td>
<td>Listen for facts and feelings.</td>
<td>Reflect feelings and facts.</td>
<td>Ignore either facts or feelings.</td>
<td>Intensity of emotional distress reduced.</td>
</tr>
<tr>
<td></td>
<td>Summarize/reflect facts and feelings.</td>
<td>Communicate acceptance.</td>
<td>Judge or take sides.</td>
<td>Problem-solving capabilities reactivated.</td>
</tr>
<tr>
<td></td>
<td>Make empathetic statements.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communicate concerns.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physically touch/hold.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bring &quot;calm control to an intense situation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Explore dimensions of the problem</strong></td>
<td><strong>Inquire about:</strong></td>
<td><strong>Ask open-ended questions.</strong></td>
<td><strong>Rely on yes/no questions.</strong></td>
<td><strong>Rank order:</strong></td>
</tr>
<tr>
<td></td>
<td>Immediate past.</td>
<td>Ask person to be concrete.</td>
<td>Allow continued abstractions.</td>
<td>(a) Immediate needs.</td>
</tr>
<tr>
<td></td>
<td>Precipitating event.</td>
<td>Assess lethality.</td>
<td>Ignore &quot;danger&quot; signs.</td>
<td>(b) Later needs.</td>
</tr>
<tr>
<td></td>
<td>Pre-crisis BASIC functioning (strengths and weaknesses);</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Present;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BASIC functioning now (strengths and weaknesses).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal (inner) resources.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social (outer) resources.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lethality.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Immediate future.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Impending decisions -- tonight, weekend, next several days or weeks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Component</td>
<td>The Role of the Counselor</td>
<td>Objective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------</td>
<td>-----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Examine possible solutions</td>
<td><strong>Behavior</strong>&lt;br&gt;Ask what client has attempted thus far. Explore what client can/could do now. Propose other alternatives:&lt;br&gt; - New client behavior;&lt;br&gt; - Redefinition of the problem;&lt;br&gt; - Outside (3rd party) assistance;&lt;br&gt; - Environmental change</td>
<td><strong>Do</strong>&lt;br&gt;Encourage &quot;brainstorming.&quot; Deal directly with blocks. Set priorities.</td>
<td><strong>Don't</strong>&lt;br&gt;Allow tunnel vision. Leave obstacles unexplored. Tolerate a jumble of needs.</td>
<td>Identify one or more solutions to immediate needs and later needs.</td>
</tr>
<tr>
<td>4. Assist in taking concrete action</td>
<td><strong>If</strong>&lt;br&gt;(a) Lethality is low, and (b) person is capable of acting on own behalf, then [behavior] ranges from active listening to giving advice.</td>
<td><strong>Take one step at a time.</strong>&lt;br&gt;Set specific short-term goals. Confront as necessary. Be directive, if and only if you must.</td>
<td><strong>Attempt to solve it all now.</strong>&lt;br&gt;Make binding long-term decisions. Be timid. Retreat from taking responsibility when necessary.</td>
<td>Implement immediate solutions intended to meet immediate needs.</td>
</tr>
</tbody>
</table>

**Facilitative Stance:** "We talk"; "You act"; and Contract for action is between helper and client.

**Directive Stance**<br>"We talk";<br>"I may act on your behalf"; and Contract for action might include family and other community resources.

[Continued on next page.]
<table>
<thead>
<tr>
<th>Component</th>
<th>The Role of the Counselor</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. Follow-up</strong></td>
<td>Behavior: Secure identifying information. Explore possible follow-up procedures. Set up contract for recontract.</td>
<td>Do: Make a contract for recontact. Evaluate action steps.</td>
</tr>
</tbody>
</table>

Slaikeu (1984) made use of an acrostic to describe an individual's personality profile: BASIC—behavioral, affective, somatic, interpersonal, and cognitive (pp. 118-120)

<table>
<thead>
<tr>
<th>Modality/System</th>
<th>Variables/Subsystems</th>
</tr>
</thead>
</table>
| **B**ehavioral  | Patterns of work, play, leisure, exercise, diet (eating and drinking habits), sexual behavior, sleeping habits, use of drugs and tobacco; presence of any of the following: suicidal, homicidal, or aggressive acts.  
|                 | Customary methods of coping with stress. |
| **A**ffective   | Feelings about any of above behaviors; presence of feelings such as anxiety, anger, joy, depression, etc.; appropriateness of affect to life circumstances. Determination of whether feelings are expressed or hidden. |
| **S**omatic     | General physical functioning, health.  
|                 | Presence or absence of tics, headaches, stomach difficulties, and any other somatic complaints; general state of relaxation/tension; sensitivity of vision, touch, taste, sight, hearing. |
| **I**nterpersonal | Nature of relationships with family, friends, neighbors, and co-workers; interpersonal strengths and difficulties; number of friends, frequency of contact with friends and acquaintances; role taken with various intimates (passive, independent, leader, co-equal); conflict resolution style (assertive, aggressive, withdrawn); basic interpersonal style (congenial, suspicious, manipulative, exploitive, submissive, dependent). |
| **C**ognitive   | Current day and night dreams; mental pictures about past or future; self image; life goals and reasons for their validity; religious beliefs; philosophy of life; presence of any of the following: catastrophizing, overgeneralizing, delusions, hallucinations, irrational self-talk, rationalizations, paranoid ideation; general (positive/negative) attitude towards life. |

Slaikeu (1984) stipulates that an initial assessment of an individual's BASIC profile is necessary to assess the impact of the crisis-provoking event on each area of functioning, understand the interrelatedness of each subsystem, determine the relative strength and weakness
of each subsystem, identify the "system" in which the individual lives, and evaluate the effectiveness of intervention counseling to determine whether pre-crisis functioning levels have been achieved (pp. 122-123).

There is an old saw that says: "You have only one opportunity to make a first impression." Establishing rapport at the very beginning of contact is extremely important to an effective counselor:client relationship. This goal is achieved by expressions of genuineness, establishing what Carl Rogers called "congruency," with the client, and ensuring that the client feels that something useful has been accomplished. Puryear (1979) states that the counselor needs to (1) take charge: "control the course of the session, maintain good communication, control the level and expression of hostility, prevent undue pressure or trauma for any individual, and control both the individual level and the general level of anxiety" (p. 63); (2) monitor and regulate the level of anxiety, realizing that some anxiety motivates the client to work on the problem (p. 67); and, (3) set the atmosphere, i.e., the general emotional tone, which includes the general feeling within the session including tension, good will, humor and hostility, and the mores of the client and "system" (p. 72).

All theoretical frameworks for counseling (e.g., psychoanalytic, person-centered, gestalt, REBT, TA, Adlerian, extentialism, cognitive-behavioral) are intended to change people: to make them think differently (cognition), to make them feel differently (affective), and to make them act differently (behavioral). Regardless of the counselor's psychotherapeutic training, which will manifest itself when working in crisis counseling, active listening is imperative. By listening, we are referring to giving full attention to the client, not only to what the individual says but to the tone, pitch and cadence of the person's voice and even body language. Oftentimes, the ability to listen is the skill that a counselor needs. The client is able to reach resolution simply by having had the opportunity to verbalize feelings of anxiety, hurt, disbelief, anger.
A second important aspect of active listening is to respond in ways that communicate to the client the counselor is accurately hearing both facts and emotional state. The counselor responds through reflection and restatement. Another aspect of listening is facilitative responding, eliciting coping mechanisms from the client. A fourth aspect of effective listening is by helping the client realize the full impact of the crisis situation, giving rational focus to the situation so that clients will move from their personal internal frame of reference and emotional bias (Gilliland and James, 1988, pp. 43-44).

In examining possible solutions, the goal is to get the victims to do as much for themselves as possible. Initially, the counselor should determine what the client has done and how effective were these measures. Then, the client should be encouraged to look at other alternatives and weigh the merit of each.

The next step in the process is to obtain commitment from the clients. Gilliland and James (1988) state that the counselor "is careful to obtain an honest, direct, and appropriate commitment from the client before terminating the crisis intervention session" (p. 28).
Postvention Counseling

The first level of intervention counseling takes place immediately after the crisis and involves from one to three sessions with the client. In most instances the first level of intervention is sufficient. In some instances, additional counseling is needed.

In some instances, further counseling will be sufficient in that the individual has returned to a pre-crisis functioning level; in other situations, it will become necessary to refer these individuals for mental health counseling, psychotherapy, or more extensive work.

Some individuals experience delayed reactions, often referred to as post-traumatic stress disorder. This type of stress can develop into a disorder where therapeutic counseling is needed beyond the scope and training of the school counselor.
Activity 7

Strategies You Use in a Crisis Situation

Directions: Please role play the scenarios listed below. Count off from 1-2-3 and rotate roles for each example. Role # 1 = Client/Student, Role # 2 = Counselor or Facilitator, and Role # 3 = Observer or Recorder. Specify age/grade level for developmental concerns.

1. Environmental Disaster

   Scenario: A student has experienced an environmental disaster, e.g., flood, tornado, fire, etc.

   1.1 What type of regressive behavior(s) did s/he exhibit?
   1.2 What did you do to help the student understand and/or cope with any anxieties s/he may have had as a result of this crisis-provoking situation?
   1.3 Do you feel that you handled this crisis situation in a satisfactory manner? Explain.

2. Transient Students

   Scenario: A student recently transferred into your school and was experiencing problems adjusting to his/her new school environment.

   2.1 What anxieties and/or fears did s/he exhibit?
   2.2 What steps did you take to help lessen the anxiety and fear?
   2.3 Do you feel that the strategies you used in helping the student adjust were successful? Explain.

3. Child Abuse/Neglect

   Scenario: You observed or had reported to you a student in your school suffering from child abuse/neglect.

   3.1 If so, what type of abuse/neglect was observed?
   3.2 What procedure did you follow to refer or report the abused/neglected child?
   3.3 Were there any intervention or treatment services provided? if so, what kind?

Activity 8

Reflections

What have you learned in this session, and how will you apply it in your work?
Section 4 – Post-Traumatic Stress Disorder

Any incident one experiences which is sudden, unexpected, unusual, or abnormal can result in emotional trauma and shock. The events -- situational and developmental -- listed in Figure 9 (p. 36) can result in trauma or shock. It is not normal for a person to be involved in a disaster or accident or have lives threatened; the effects of such incidents on the human mind and body can be quite dramatic and traumatic.

Parkinson (1993) states that

post-trauma stress is something that most will experience, but for different periods of time following the incident and in different intensity at the time or later. Some may be slightly distressed for a few hours or a few days and will then recover quite naturally and carry on with their lives. Others will suffer longer and if the symptoms persist and intensify for more than a month they are usually identified as suffering from Post-Traumatic Stress Disorder and will need treatment. (p. 25)

School guidance counselors, because of the focus and limitation of their training, are not in a position to attempt to cure individuals suffering from post-traumatic stress disorder. It is important, however, for the counselor to know when to refer a student for professional help.

Certain incidents more readily precipitate post-traumatic stress disorder. They include:

- The death of or serious harm to a close friend.
- The suicide of a friend or classmate.
- The inability to help in a situation when no one else is present to do so.
- Hostage situations.
- Witness to an act of violence.
- Particularly gruesome events.
- The panic and hysteria following a tragedy.
- Heavy media attention.
While experiencing a traumatic event, the individual might be able to control emotional and physical reactions, but other specific symptoms can occur once the incident is over. The disorder is the delayed response to an earlier crisis-provoking incident; it develops as a long-term reaction to the stress when the symptoms persist, intensify, and cause extreme distress and disruption in a person's regular, normal life.

### Figure 17. Post-Traumatic Stress Disorder

<table>
<thead>
<tr>
<th>General Symptoms</th>
<th>Symptoms Specific to Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recurrent and intrusive recollections of the event</td>
<td>• Distortion of time concerning the incident</td>
</tr>
<tr>
<td>• Nightmares</td>
<td>• Distortion of the sequence of events</td>
</tr>
<tr>
<td>• Numbing of emotions</td>
<td>• Retrospective identification of supposed premonitions</td>
</tr>
<tr>
<td>• Marked disinterest in activities</td>
<td>• Reenactment of traumatic events (usually not conscious)</td>
</tr>
<tr>
<td>• Feelings of detachment</td>
<td>• Repetitive play involving traumatic themes</td>
</tr>
<tr>
<td>• Hypervigilant or avoidance-behavior</td>
<td>• Pessimistic expectations of the future and life span</td>
</tr>
<tr>
<td>• Decline in cognitive performance</td>
<td>• Marked and enduring personality changes</td>
</tr>
<tr>
<td>• Startled reactions</td>
<td>• Greater memory of the event than that of adults</td>
</tr>
<tr>
<td>• Overwhelming and persistent guilt</td>
<td>• Fantasizing changes to &quot;undo&quot; the event</td>
</tr>
<tr>
<td>• Attacks of shallow breathlessness, heart palpitations, sweating, shaking</td>
<td></td>
</tr>
</tbody>
</table>


Post-trauma stress disorder has three symptoms: re-experiencing, avoidance, and arousal. An example of re-experiencing is the stress one experiences on the anniversary of the crisis-provoking event. Perhaps the most terrifying way of re-experiencing the symptoms is when they are not produced by any trigger, but "come out of the blue."

Avoidance is denial of feelings. For example, many men restrain themselves from expressing grief because it is not the "macho" thing to do. After a traumatic incident the denial of feelings
can be very strong, and those who use this defense mechanism usually will say that they do not need any help and that they are coping well.

Individuals who experienced a tornado become tense and more nervous than normal when they see a dark sky forming. This increased sense of awareness and arousal can result in the incapacity to cope with normal events and experiences.

School officials and counselors quite possibly can reduce the number of individuals who will ultimately experience post-traumatic stress disorder by conducting a defusing and a debriefing session. Gilliland and James (1988) warned that "what occurs during the immediate aftermath of the crisis event determines whether or not the crisis will become a disease reservoir that will be transformed into a chronic and long-term state" (p. 4).

Defusing, the ventilation of thoughts and emotions immediately following a crisis provoking event, allows students and staff to talk about the events immediately after the incident.

Debriefing is the process, which should occur between three days and a week after the crisis situation, when the individuals "process" everything that took place. "Debriefing-type interventions have been used with children involved in school-related traumatic events and have been beneficial in ameliorating the effects of the trauma and in hastening recovery" (Bell, 1995, p. 37). Individuals participating in a debriefing session are asked specific open-ended questions designed to take them from a cognitive level to an emotional level, then back to a cognitive level by the close of the debriefing, thereby becoming a major cathartic experience.

Re-experiencing the event, avoiding reminders, elation and arousal are typical symptoms of post-trauma stress. They may or may not be evident at the time of the crisis-provoking incident but can return months or years afterwards, sometimes with devastating effect of the individual, and often with those most closely associated with the individual (spouse, parents, family members, neighbors, friends.)
Notes
Section 5 -- Loss, Death, Grief, and Bereavement

Loss and Reaction

Loss comes in many forms: death of a loved one (illness, accident, homicide, suicide), separation and divorce, breakup of a close relationship, moving and loss of friends and neighbors, changing schools, quality of life, death of a pet. Some have a more profound impact than others; most, if not all, affect all those closely associated with the person or event, i.e., the "system." And, recovery from a major loss may require several years.

Elisabeth Kübler-Ross, in her definitive book *On Death and Dying* (1969), presented a five-stage model that outlines human reactions as they attempt to cope with their imminent death.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Brief Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Denial</td>
<td>Typical initial response: &quot;No, it cannot be me. There must be a mistake. This is a mistake.&quot; Healthy way of coping with painful and uncomfortable news.</td>
</tr>
<tr>
<td>2. Anger</td>
<td>Characterized by a &quot;why me?&quot; pattern. Cannot continue denial; exhibit hostility, rage, envy, resentment, anger. Difficult for family members to deal with people in this stage. Individuals should not take the anger personally.</td>
</tr>
<tr>
<td>3. Bargaining</td>
<td>Attempt to postpone death. Patient begins to bargain with physicians or with God for an extension of life, promising to be good and right wrongs. The care-givers should be sensitive.</td>
</tr>
<tr>
<td>4. Depression</td>
<td>Realization that death is imminent when physical signs become more evident. Two types of depression: (1) reactive: acceptance of irrevocable loss, and (2) preparatory: inner emotional preparation. Individuals should respond to the patient with love, caring, and empathy, using few or no words.</td>
</tr>
<tr>
<td>5. Acceptance</td>
<td>Reconciled to their loss and acceptant of their situation. This stage is characterized by a quiet, peaceful resignation. The individual becomes more inward; there is little need for conversation, large crowds, or frequent visitors. Love and support are shown by being present, sitting in silence, holding one's hand, responding to the patient's needs or requests.</td>
</tr>
</tbody>
</table>
The school should be aware of and sensitive to students who have family members that are experiencing prolonged illness, who have been involved in a tragic and life-threatening accident, or who are the victims of loss (theft, fire, death).

Petersen and Straub (1992) provide a chart (Fig. 19) depicting the stages of grief one experiences following a loss.

**Figure 19. Stages of Grief**

<table>
<thead>
<tr>
<th>Denial/Shock</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feeling of numbness</td>
<td>Two patterns observed especially in young people</td>
</tr>
<tr>
<td>• Belief or feeling that deceased will return</td>
<td><strong>Typical Depression</strong></td>
</tr>
<tr>
<td>• Insomnia/sleeplessness</td>
<td>• Lethargy</td>
</tr>
<tr>
<td>• Loss of appetite (people literally forget to eat)</td>
<td>• Decreased attention span</td>
</tr>
<tr>
<td>• Inconsistent behavior</td>
<td>• Frequent crying</td>
</tr>
<tr>
<td>• Persistent dreams or nightmares</td>
<td>• Unkept appearance</td>
</tr>
<tr>
<td>• Inability to concentrate</td>
<td>• Disinterested in activities</td>
</tr>
<tr>
<td>• Preoccupation without being able to identify with what</td>
<td>• Suicidal thoughts</td>
</tr>
<tr>
<td>• Confusion</td>
<td>• Withdrawal from friends</td>
</tr>
<tr>
<td></td>
<td>• Over eating or loss of appetite</td>
</tr>
<tr>
<td><strong>Fear</strong></td>
<td>• Self-deprecation</td>
</tr>
<tr>
<td>• Nightmares</td>
<td>• Over sleeping or inability to sleep</td>
</tr>
<tr>
<td>• Sleeplessness</td>
<td><strong>Masking Depression</strong></td>
</tr>
<tr>
<td>• Easily startled</td>
<td>• Substance abuse</td>
</tr>
<tr>
<td>• Anxiety and restlessness</td>
<td>• Consistent restlessness</td>
</tr>
<tr>
<td>• Verbal expressions of false bravado</td>
<td>• Consistent inappropriate joking</td>
</tr>
<tr>
<td>• Phobias</td>
<td>• Involvement in high-risk behaviors</td>
</tr>
<tr>
<td><strong>Anger</strong></td>
<td>• Gains reputation of &quot;party person&quot;</td>
</tr>
<tr>
<td>• Irritability</td>
<td>• Sexual promiscuity</td>
</tr>
<tr>
<td>• Provocative in fights</td>
<td>• Adoption of an &quot;I don't care&quot; attitude</td>
</tr>
<tr>
<td>• Sarcastic remarks</td>
<td><strong>Reorganization</strong></td>
</tr>
<tr>
<td>• Anti-social behavior</td>
<td>• Dreams of deceased becoming infrequent</td>
</tr>
<tr>
<td>• Vandalism</td>
<td>• Joy and laughter return</td>
</tr>
<tr>
<td>• Refusal to comply with rules</td>
<td>• Planning for future begins</td>
</tr>
<tr>
<td><strong>Guilt</strong></td>
<td>• Reinvestment in activities once dropped or forgotten</td>
</tr>
<tr>
<td>• Often masked by anger</td>
<td><strong>Depression</strong></td>
</tr>
<tr>
<td>• Self-destructive behavior</td>
<td>Two patterns observed especially in young people</td>
</tr>
<tr>
<td>• Apologetic attitude</td>
<td><strong>Typical Depression</strong></td>
</tr>
<tr>
<td>• Acting out in response to praise or compliments</td>
<td>• Lethargy</td>
</tr>
<tr>
<td></td>
<td>• Decreased attention span</td>
</tr>
<tr>
<td></td>
<td>• Frequent crying</td>
</tr>
<tr>
<td></td>
<td>• Unkept appearance</td>
</tr>
<tr>
<td></td>
<td>• Disinterested in activities</td>
</tr>
<tr>
<td></td>
<td>• Suicidal thoughts</td>
</tr>
<tr>
<td></td>
<td>• Withdrawal from friends</td>
</tr>
<tr>
<td></td>
<td>• Over eating or loss of appetite</td>
</tr>
<tr>
<td></td>
<td>• Self-deprecation</td>
</tr>
<tr>
<td></td>
<td>• Over sleeping or inability to sleep</td>
</tr>
<tr>
<td></td>
<td><strong>Masking Depression</strong></td>
</tr>
<tr>
<td></td>
<td>• Substance abuse</td>
</tr>
<tr>
<td></td>
<td>• Consistent restlessness</td>
</tr>
<tr>
<td></td>
<td>• Consistent inappropriate joking</td>
</tr>
<tr>
<td></td>
<td>• Involvement in high-risk behaviors</td>
</tr>
<tr>
<td></td>
<td>• Gains reputation of &quot;party person&quot;</td>
</tr>
<tr>
<td></td>
<td>• Sexual promiscuity</td>
</tr>
<tr>
<td></td>
<td>• Adoption of an &quot;I don't care&quot; attitude</td>
</tr>
</tbody>
</table>
The counselor's knowledge of Piaget's cognitive development theory, Kohlberg's moral development theory, and Erikson's psycho-social development theory will prove invaluable in understanding the child's grieving process and feelings of loss.

**Figure 20. Developmental Sequences in Children's Perception of Death**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Preoperational Stage (Ages 2 to 7)</td>
<td>egocentric conceptualization; magical thinking</td>
<td>extremely limited perception; little expression of sorrow</td>
<td>interested in word &quot;dead&quot; but ignorant of meaning</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>extremely limited and probably erroneous concept of &quot;dead&quot;</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>preoccupied with death ritual</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>calmness evident; death seen as happening to others, not self; death reversible</td>
<td>concept of death includes non-essential information</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td>understands word &quot;dead&quot; and events; defines by reference to biological essentials</td>
</tr>
<tr>
<td>7</td>
<td>Concrete Operations (Ages 7 to 11)</td>
<td>specific, concrete conceptualization</td>
<td>emotional reactions to concept of death; seemingly morbid interest in details</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>increasing accuracy in understanding concepts of death</td>
<td>faces death; interested in scientific aspects of death</td>
<td>death perceived as universal and not reversible.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Formal Thought (Ages 12 and above)</td>
<td>abstract, generalized conceptualization; understands that death is a natural phenomenon</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wisse (1990) states that the grieving process is the best way to deal with a major stress-producing situation such as death. Kaplan (1979) outlines the stages of grieving.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Possible Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness</td>
<td>Shock, little talking, blank expression, random physical activity.</td>
</tr>
<tr>
<td>Denial</td>
<td>Does not want to discuss the loss.</td>
</tr>
<tr>
<td></td>
<td>Does not want to think about the loss.</td>
</tr>
<tr>
<td></td>
<td>Keeps busy.</td>
</tr>
<tr>
<td></td>
<td>Becomes more of an achiever.</td>
</tr>
<tr>
<td></td>
<td>Does not feel sad or confused on the surface.</td>
</tr>
<tr>
<td></td>
<td>Refuses to have fun.</td>
</tr>
<tr>
<td></td>
<td>Makes less eye contact.</td>
</tr>
<tr>
<td></td>
<td>Idealizes the lost person or object.</td>
</tr>
<tr>
<td></td>
<td>Refuses to become involved with others.</td>
</tr>
<tr>
<td></td>
<td>Starts arguments with peers and teachers.</td>
</tr>
<tr>
<td>Bargaining</td>
<td>Thinks and behaves, &quot;as if...&quot; such as, &quot;If I do the best job at this activity that I can maybe this loss won't really be true or irreversible,&quot; or &quot;If I act the worst I possibly can, maybe the folks will get back together to help me.&quot;</td>
</tr>
<tr>
<td>Anger</td>
<td>Thinks, &quot;Why me? This is not fair!&quot;</td>
</tr>
<tr>
<td></td>
<td>Blames others unreasonably for own difficulties.</td>
</tr>
<tr>
<td></td>
<td>Feels resentment toward others, possibly even toward the lost other for whom s/he grieves for leaving the survivor in this predicament.</td>
</tr>
<tr>
<td></td>
<td>Acts in rude and uncooperative ways with others.</td>
</tr>
<tr>
<td></td>
<td>May experience anger with oneself and begin to appear unkempt and unclean.</td>
</tr>
<tr>
<td>Depression</td>
<td>Feels isolated and sad, empty.</td>
</tr>
<tr>
<td></td>
<td>Cries frequently, sometimes without apparent cause.</td>
</tr>
<tr>
<td></td>
<td>Becomes passive and listless, does little work.</td>
</tr>
<tr>
<td></td>
<td>Insomnia.</td>
</tr>
<tr>
<td></td>
<td>Silent and withdrawn or speaks incessantly about the loss.</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Person does not forget the lost person or relationship but is no longer angry, depressed, or preoccupied with it.</td>
</tr>
</tbody>
</table>

As stated previously, the specific counseling techniques the counselor uses is based on his/her philosophical training and the need of the child. Regardless of theoretical preference, *active listening* to the child's feelings is crucial to helping the grieving child reach resolution. Counselors should be readily accessible in a consultative role to teachers and parents who are working with grieving children.

**School-Associated Violent Deaths**

Kachur, et. al. (1996) paint a disturbing picture of the incidents of violent deaths occurring on or near schools. In a two-year period, 105 school-associated violent deaths were identified. Students in secondary schools, students of minority racial and ethnic backgrounds, and students in urban school districts had higher levels of risk. The deaths occurred in communities of all sizes in 25 different states. Homicide was the predominant cause of death (80.9%), and firearms were responsible for a majority (77.1%) of the deaths. Most victims were students (72.4%). Approximately equal numbers of deaths occurred inside school buildings (29.5%), outdoors but on school property (35.3%), and at off-campus locations while the victim was in transit to or from school (35.2%). Of those occurring on school campuses, 43.8% occurred during classes or other activities and 43.8% occurred before or after official school activities.

The number of school-associated violent deaths was more common than previously estimated. Overall data show that school-associated incidents mirror that of the society in general.

School-associated deaths are tragic events that affect not only the individuals immediately involved but also the entire populations of the schools and communities where they occur. Each school-associated death becomes the focus of intense public attention, accompanied routinely by various suggestions to improve school safety.

The chart below depicts the characteristics of school-associated violent deaths.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of fatality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal (homicide)</td>
<td>85</td>
<td>(81.0%)</td>
</tr>
<tr>
<td>Self-inflicted (suicide)</td>
<td>20</td>
<td>(19.0%)</td>
</tr>
<tr>
<td>Time of fatal injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During school activities</td>
<td>46</td>
<td>(43.8%)</td>
</tr>
<tr>
<td>Classes</td>
<td>23</td>
<td>(21.9%)</td>
</tr>
<tr>
<td>Break periods</td>
<td>11</td>
<td>(10.5%)</td>
</tr>
<tr>
<td>After-school activities</td>
<td>12</td>
<td>(11.4%)</td>
</tr>
<tr>
<td>Before or after official activities</td>
<td>46</td>
<td>(43.8%)</td>
</tr>
<tr>
<td>Day with no classes or activities</td>
<td>8</td>
<td>(7.6%)</td>
</tr>
<tr>
<td>Unknown or other</td>
<td>5</td>
<td>(4.8%)</td>
</tr>
<tr>
<td>Location of fatal injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary school</td>
<td>31</td>
<td>(29.5%)</td>
</tr>
<tr>
<td>Secondary school</td>
<td>74</td>
<td>(70.5%)</td>
</tr>
<tr>
<td>On campus</td>
<td>68</td>
<td>(64.8%)</td>
</tr>
<tr>
<td>Classroom</td>
<td>10</td>
<td>(9.5%)</td>
</tr>
<tr>
<td>Hallway</td>
<td>9</td>
<td>(8.6%)</td>
</tr>
<tr>
<td>Other indoor location</td>
<td>12</td>
<td>(11.4%)</td>
</tr>
<tr>
<td>Parking area</td>
<td>11</td>
<td>(10.5%)</td>
</tr>
<tr>
<td>Other outdoor location</td>
<td>26</td>
<td>(24.8%)</td>
</tr>
<tr>
<td>Off campus</td>
<td>37</td>
<td>(35.2%)</td>
</tr>
<tr>
<td>Street/sidewalk</td>
<td>20</td>
<td>(19.0%)</td>
</tr>
<tr>
<td>In vehicle</td>
<td>13</td>
<td>(12.4%)</td>
</tr>
<tr>
<td>Private property</td>
<td>4</td>
<td>(3.8%)</td>
</tr>
<tr>
<td>Type of Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>63</td>
<td>(60.0%)</td>
</tr>
<tr>
<td>Suburban</td>
<td>32</td>
<td>(30.5%)</td>
</tr>
<tr>
<td>Rural</td>
<td>10</td>
<td>(9.5%)</td>
</tr>
<tr>
<td>Method of injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Firearm</td>
<td>81</td>
<td>(77.1%)</td>
</tr>
<tr>
<td>Knife or other blade</td>
<td>18</td>
<td>(17.1%)</td>
</tr>
<tr>
<td>Rope</td>
<td>5</td>
<td>(4.8%)</td>
</tr>
<tr>
<td>No weapon</td>
<td>1</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>Motive (more than one may apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal dispute</td>
<td>35</td>
<td>(33.3%)</td>
</tr>
<tr>
<td>Gang-related activities</td>
<td>33</td>
<td>(31.4%)</td>
</tr>
<tr>
<td>Random victim event</td>
<td>19</td>
<td>(18.2%)</td>
</tr>
<tr>
<td>Suicide</td>
<td>19</td>
<td>(18.2%)</td>
</tr>
<tr>
<td>Dispute over romantic relationship</td>
<td>12</td>
<td>(11.4%)</td>
</tr>
<tr>
<td>Robbery or attempted robbery</td>
<td>10</td>
<td>(9.5%)</td>
</tr>
<tr>
<td>Dispute over money or property</td>
<td>7</td>
<td>(6.7%)</td>
</tr>
<tr>
<td>Drug-related activities</td>
<td>6</td>
<td>(5.7%)</td>
</tr>
<tr>
<td>Unintentional</td>
<td>5</td>
<td>(4.8%)</td>
</tr>
</tbody>
</table>
The 105 confirmed cases included 85 deaths resulting from interpersonal violence (homicide) and 20 self-inflicted deaths (suicide). The victims ranged in age from four (4) to 62 years, with a median age of 16 years. Males contributed to 82.9% (n=87) of the deaths, and a majority of the victims were students, with a median grade level of 10. Twenty of the victims had a previous criminal record and a similar number were members of an organized gang. Racially, Black, non-Hispanic students had a 2:1 homicide rate (n=43 to 21) to White, non-Hispanics 20%). Individuals who died by suicide were more likely to have been White, non-Hispanic.

School-associated violent deaths accounted for less than one percent (1%) of the homicides and suicides among school-age children in the United States during 1992-1994. Although rare, these fatalities were more common than expected. As analogy, if the meteorologists predicts only 10% chance of rain, and it rains where you are, it is raining 100%! One only has to experience the death of a student or faculty member to realize the impact it has on the entire student body. When the death is tragic -- homicide, suicide or accident -- the impact is felt even greater.

What implications do the data have for school officials? Considering the epidemiologic features, efforts to prevent future school-associated fatalities should be targeted at males, at minority racial and ethnic groups, and at secondary school grades. Criminal activity, gang membership, and alcohol and other drug use are widely regarded as precursors of violent injury among young people. Finally, the nature of interpersonal disputes as a motive should be studied. Since fewer than one-third of the deaths actually occurred inside a school facility, the school needs to work collaboratively with law enforcement and judicial agencies to develop a comprehensive approach to preventing violence among young people.

Counselors should incorporate conflict resolution and self-esteem early in its group guidance activities and continually reinforce these concepts throughout the secondary school grades.
Suicide

Adolescent suicide is a phenomenon of epidemic proportions in this society. It is the second leading cause of death for this age group. Young women attempt suicide three times more frequently than young men; however, young men succeed four times more frequently largely because they use more lethal means such as firearms and hanging. Suicide "clustering" oftentimes occurs when one student commits suicide. In the 1980s, seven students in Plano, Texas, committed suicide as a result of "clustering."

The most widely recognized factors causing adolescent suicide are depression, drugs and alcohol abuse, academic and career pressure, breakup of the nuclear family, high mobility, and the loss of significant personal relationships.

Experts also cite youth itself as a contributing factor. A 16-year-old undergoing his/her first heartbreak or family or emotional crisis may not realize that, with time, feelings of despair and hopelessness will dissipate.

Most individuals who attempt or complete suicide are so sad or hopeless or angry that they simply can't stand it anymore. Depression, loneliness, anger, hopelessness, and stress can influence a person to consider suicide. High risk indicators include feelings of hopelessness, presence of a detailed suicide plan, history of previous attempts, chronically self-destructive lifestyle, severe loss or threat of loss, inability to accept help, family history of suicide, and paucity of resources. Suicide looks like a quick and easy solution, but it actually isn't all that quick and easy. As often as not, suicide is a complicated, messy business that creates as many problems as it solves. When people start thinking about ending their own life, they generally do not have all the facts.

Since school plays a major role in the lives of adolescents, educators are in a strategic position to identify and help the potential suicide as well as educate individuals about suicide and its ramifications.
Signs

It is crucial for teen-agers, as well as parents and teachers, to learn the signs that can warn of a person's vulnerability to suicide. These warnings are in four categories.

**Verbal Signs**

Direct statements: "I wish I were dead." "I'm going to end it all." "I wish I had never been born." "I wish I could go to sleep and never wake up."

Indirect statements: "No one cares whether I live or die." "Why is there so much unhappiness in this life?"

All of these and similar statements should be taken as red-alert distress signals.

**Behavioral Clues**

Any change in eating or sleeping habits or a change in energy level -- sudden agitation or sudden lethargy -- are signs of trouble. Teachers especially should be alert for a drop in the level of school performance. A teenager who is thinking of suicide might start giving away prized possessions or taking risks, such as driving recklessly. Previous attempts at suicide or making a will are serious signs.

**Situational Clues**

Behind most suicides is a loss -- a friend, self-esteem, parents' separation or divorce. Family strife, financial difficulties, end of a serious relationship, change of address, loss of job, serious injury, or mutilative surgery are situational clues.

**Syndromatic Clues**

Depression (most prevalent), disorientation (response to voices); defiance, dependence-dissatisfaction (helpless-hopeless), or inappropriate or excessive guilt are syndromatic clues.

Figure 23 presents the Suicidal Tendencies Scale developed by Crocitto and Barnes at the University of Central Florida. The counselor can use it to determine lethality; i.e., the extent to which the student is contemplating suicide.
**Figure 23. Suicidal Tendencies Scale**

Read each statement. Assess your client in each of the following categories. Place the appropriate score in the blank to the right of each statement. The statement applies if any of the conditions are met. If the question does not apply, consider it a zero (0). Add all the scores. Is your client a moderate, high, or very high suicide risk?

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. External behaviors</td>
<td>No change in communication, academic performance, dress, etc.</td>
<td>Moderate change.</td>
<td>Significant change.</td>
<td></td>
</tr>
<tr>
<td>C. Support System</td>
<td>Intact.</td>
<td>Alienated from some family or friends.</td>
<td>Socially unresponsive; alienated from most family or friends.</td>
<td></td>
</tr>
<tr>
<td>D. Significant relationships</td>
<td>Healthy relationships.</td>
<td>Moderate relationship problems.</td>
<td>Broken relationships.</td>
<td></td>
</tr>
<tr>
<td>E. Significant loss and/or change</td>
<td>None.</td>
<td>Recent death of a friend or pet; health, job, or financial problems.</td>
<td>Unresolved loss or death of loved one; loss of job; financial disaster; terminal illness.</td>
<td></td>
</tr>
<tr>
<td>F. Depression</td>
<td>Not evident.</td>
<td>Moderate; low in energy; not coping well.</td>
<td>Severe; apathetic and withdrawn or sudden rise in energy -- a &quot;happy depression.&quot;</td>
<td></td>
</tr>
<tr>
<td>G. Will to live</td>
<td>Has purpose/meaning for living.</td>
<td>Questions life, afraid of losing control; beginning to feel helpless or hopeless.</td>
<td>Consistent thoughts and feelings of helplessness and hopelessness.</td>
<td></td>
</tr>
<tr>
<td>H. Substance abuse; alcohol, drugs, food, etc.</td>
<td>None known.</td>
<td>Alcohol/drug use moderate; social use; overeats or undereats.</td>
<td>Alcohol/drug use heavy; addiction; bulimic, anorexic.</td>
<td></td>
</tr>
</tbody>
</table>

[Continued]
Jongsma, Peterson, and McInnis (1996) list six long-term goals regarding suicidal ideation.

1. Alleviate the suicidal impulses or ideation and return to the highest previous level of daily functioning.
2. Stabilize the suicidal crisis.
3. Place in an appropriate level of care to address the crucial crisis.
4. Reestablish a sense of hope for the client and his/her life.
5. Terminate the death wish and return to a zestful interest in social activities and relationships.
6. Cease the perilous lifestyle and resolve the emotional conflicts that underlie the suicidal pattern.
They provide a list of short-term objectives and therapeutic interventions. (Only a sampling from Jongsma, et. al. is provided so that there will be no copyright infringement).

**Figure 24. Short-Term Suicide Therapy Objectives (Sample)**

<table>
<thead>
<tr>
<th>Short-term Objectives</th>
<th>Therapeutic Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. State the strength of the suicidal feelings, the frequency of the thoughts, and the detail of the plans. (1, 2, 3, 11)</td>
<td>1. Assess the client's suicidal ideation, taking into account the extent of the ideation, the presence of primary and backup plans, past attempts, and family history. Then make an appropriate intervention or referral.</td>
</tr>
<tr>
<td>2. Report a decrease in the frequency and intensity of the suicidal ideation. (2, 3, 4)</td>
<td>2. Assess and monitor the client's suicide potential on an ongoing basis.</td>
</tr>
<tr>
<td>8. Identify feelings of sadness, anger, and hopelessness related to a conflicted relationship with the parents. (13, 15)</td>
<td>3. Notify the client's family and significant others of any severe suicidal ideation. Ask them to form a 24-hour suicide watch until the crisis subsides.</td>
</tr>
<tr>
<td>11. Arrange for the client to take the MMPI or BDI and evaluate the results as to depth of depression.</td>
<td>4. Explore the resources of emotional pain underlying the client's suicidal ideation and the dept of his/her hopelessness.</td>
</tr>
<tr>
<td>13. Probe the client's feelings of despair related to his/her family relationship.</td>
<td>15. Hold family therapy sessions to promote communication of the client's feelings of sadness, hurt, and anger.</td>
</tr>
</tbody>
</table>

What Actions to Take

If it is suspected or reported that a student is contemplating suicide, the counselor should:

1. Determine the seriousness of the threat. Ask the student directly, "Are you considering killing yourself (committing suicide)?" Remember, you will not be placing the thought in the student's head. Don't act appalled or offended by the response, remain calm and non-judgemental. Have the student tell you everything that has happened during the last few hours or days. This information should help to gain some understanding of factors contributing to the depression and suicidal feelings.

2. Throughout involvement with the student, the limits of confidentiality must be explained to the student and parents.

3. If the response is in the affirmative, determine lethality. A well-thought-out plan is a significant danger sign. Talk openly and directly, don't mince words. Commit the student to a contract that s/he won't attempt suicide without contacting you so that you can talk with him/her about such a serious action.

4. Remain with the student at all times or until s/he has been released to the custody of the parents.

5. Notify school personnel about the suicide behavior and/or potential for suicide attempt on a "need to know" basis, including the principal and school psychologist (if the school district employs one.)

6. Advise the student that you have a legal and moral obligation to notify his/her parents. Do so immediately. Ask them to come to the school so that all of you can talk about the situation. Communicate the school's concern, the seriousness of the situation, the youth's feelings, and the level of risk. Possible parental behavior include: shock, fear, guilt; denial, projection, intellectualization; minimizing and rationalizing; and, refusal to seek help. Information from the parents will dictate the subsequent steps to follow with respect to the student.

7. Determine whether the parents plan to seek medical (psychiatric) help. If possible, determine their ability to pay for such services or refer them to mental health which usually has a "sliding scale" for payment. Expect resistance because of guilt, denial, or lack of finances. Contact protective services for the parent. Obtain a release to speak with referral sources and establish a collaborative relationship with the family and protective services. Reinforce the importance of seeking treatment; affirm that it is the right decision.
8. Once the immediate crisis subsides, maintain contact with the student since many suicides occur after the onset of treatment or after the clinical symptoms begin to improve. Monitor the student's progress. A sudden recovery after severe depression may be a warning signal: it could mean that the decision has been made to end one's life (after everyone has been lulled into believing that the problem has been resolved.)

9. Maintain a detailed record of all action as a legal precaution indicating: (1) when the suicidal risk was recognized, (2) specific measures taken to deal with the risk, including time of contact with parents, principal, psychologist, referral agency personnel, etc., and (3) measures that have been carried out.

Knowledge of the dynamics of suicide should sensitize counselors to the causes and signs of suicide. There is agreement that the most effective means of keeping people from committing suicide is through education. Preventive suicide education is a continuous process which involves all aspects of society. Making the general public aware of the dynamics, dangers, cues, myths, and basic techniques for counseling and intervention is the primary goal of prevention.

Survivors of a Suicide

Counselors need to address the psychological needs of individuals who are the survivors of a suicide victim. Peers in whom the victim confided his/her intentions to commit suicide often experience guilt feelings. Parents and family members question themselves as to why they did not see the "warning signs." (It should be pointed out that these same guilt feelings are evident in individuals when there is violence perpetrated similar to that in Pearl, MS, Paducah, KY, Jonesboro, AR, Edinboro, PA, Springfield, OR, and Richmond, VA.)

Wisse (1990) lists four components of death that impose a particularly heavy burden on the survivors: (a) the stigma of suicide, (b) the specter that you yourself might suffer the same fate, (3) thoughts by day and dreams by night that are filled with disturbing images of blood and violence, and (4) the obsession of the survivor with the whos, the whys, the whats, and the ifs.
He states that "such obsessions and images clearly can become the well springs of disaster." (p. 356)

The stigma experienced by survivors of a suicide death include a sense of disgrace, failure, and social embarrassment. They fear that the community will blame them for the victim's suicide.

**Figure 25. Coping with the Social Stigma of a Suicide**

<table>
<thead>
<tr>
<th>Ways Survivors May Cope</th>
<th>Potential Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Silent treatment&quot;</td>
<td>Limits opportunities for</td>
</tr>
<tr>
<td>- keep suicide a secret</td>
<td>- catharsis</td>
</tr>
<tr>
<td>- cannot mention the suicide</td>
<td>- checking out distortions</td>
</tr>
<tr>
<td></td>
<td>- resolving guilt</td>
</tr>
<tr>
<td>Game playing</td>
<td>Takes up emotional energy</td>
</tr>
<tr>
<td>- &quot;It was an accident.&quot;</td>
<td></td>
</tr>
<tr>
<td>Escape</td>
<td>Denies necessary support system</td>
</tr>
<tr>
<td>- move away</td>
<td>Difficulties for child's relatives</td>
</tr>
</tbody>
</table>
Activity 9

Suicide Knowledge Test

Your understanding of suicide is your first line defense in preventing it. Check yourself out by answering "True" or "False" to the following statements.

_____ 1. Suicide accounts for very few deaths annually among the young.
_____ 2. Suicide in adolescence has doubled over the past ten years.
_____ 3. A leading cause of suicide among the young is hopelessness about the future.
_____ 4. About one-half of suicidal youngsters are involved in some form of drug or alcohol abuse shortly before their suicidal death.
_____ 5. Children never commit suicide.
_____ 6. Children, like adults, have well thought out plans, if they are seriously suicidal.
_____ 7. Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them.
_____ 8. Repeated statements such as "I would be better off dead" from a young person are usually made to get attention and should not be taken seriously.
_____ 9. Death by firearms is the most common method used by both sexes.
_____ 10. Suicide is represented proportionately among all levels of society.
_____ 11. The tendency toward suicide is inherited; i.e., it "runs in families."
_____ 12. The chances of suicide can be reduced by avoiding the subject.
_____ 13. Once suicidal, always suicidal.
_____ 14. Most suicides occur within about three months following the beginning of "improvement."
_____ 15. People who talk about committing suicide rarely attempt it.
_____ 16. Females attempt suicide more often than males.
_____ 17. Of any ten persons who commit suicide, eight have given definite warnings of their suicidal intentions.
_____ 18. There are over 500,000 depressed children in this country, and one-half of them have suicidal ideas.
_____ 19. Suicide happens without warning.
_____ 20. Suicidal individuals are mentally ill, and suicide is the act of a psychotic person.
Section 6 -- Readings

A Jigsaw Reading Assignment

Directions: Divide the readings among group members. Have participants reorganize themselves according to their reading assignment. Everyone at one table is to read and discuss the same article. Then, to piece the jigsaw together, participants are to return to their table group and report on their findings.

<table>
<thead>
<tr>
<th>Time</th>
<th>Article</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Cummingham, Bruce, and Hare, Jan. (1989). Essential elements of a teacher in-service program on child bereavement. ESGC, 23 (3), 175-192</td>
<td>93 - 100</td>
</tr>
</tbody>
</table>

[All articles reproduced with permission of copyright owner.]

<table>
<thead>
<tr>
<th>Time</th>
<th>Article</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Minutes</td>
<td>Individuals who read the same article share what they learned, their impressions about content, and how they can use the information in their guidance program.</td>
<td></td>
</tr>
<tr>
<td>60 Minutes</td>
<td>Participants return to their original table group and piece the jigsaw together by reporting on their &quot;collective&quot; knowledge of the topics (article).</td>
<td></td>
</tr>
</tbody>
</table>
Activity 10 - 1

NOTES

"Children and Environmental Disasters: The Counselor's Responsibility"

1. What are some of the short- and long-term effects of a natural disaster on children?

2. What actions should the counselor take as "an advocate for the child within the adult structure of the school"?

3. What are some classroom guidance activities the teacher can implement that will help students adjust to a disaster experience?

4. How useful do you think this program will be at your school? How would it be received? Would you have an opportunity to present it?
Activity 10 - 2

NOTES

"Essential Elements of a Teacher In-Service Program on Child Bereavement"

1. What is the general opinion teachers have regarding a child's bereavement?

2. How does a child's concept of death change as s/he matures? Why is it important to understand Piaget's developmental theory?

3. List and briefly explain each part of the in-service program.

4. Considering the violence at Pearl(MS), Paducah (KY), and Jonesboro (AR), how useful do you think this program will be at your school? How would it be received? Would you have an opportunity to present it?
Activity 10 - 3

NOTES

"The Grieving Child"

1. Explain the "grief cycle."

2. How can a counselor respond to a child who has experienced loss?

3. What services can a counselor provide parents and teachers so that they can respond appropriately to a child's grief?

4. How useful do you think that knowledge of the "grief cycle" would be to your teachers and parents? If you had the opportunity, would you present these concepts in an in-service program at your school?
Activity 10 - 4

NOTES

"Adolescent Suicide: Myths, Recognition, and Evaluation"

1. What are some myths associated with suicide?

2. How do you assess the degree of severity of suicidal ideation?

3. What are the symptoms of suicidal behavior?

4. What steps should a counselor take when working with a student who is considering suicide?

5. How useful do you think the information in this article would be to the faculty at your school? How would it be received? Would you have an opportunity to present a workshop on symptoms of suicide to the faculty?
Activity 10 - 5

NOTES

"Are You Thinking of Killing Yourself?: Confronting Student's Suicidal Thoughts"

1. Briefly describe the four fore-warning signs students give when considering suicide.

2. What are the questions the counselor should ask to assess the potential for suicide?

3. What is the value of a "contract?"

4. How useful do you think information from this article would be to your principals, faculty, and staff? How would it be received? Would you have an opportunity to present it?
Activity 10 - 6

NOTES

"Counselor Response to the Paducah [KY] Crisis"

1. Briefly summarize how a crisis intervention plan was developed. Who was involved?

2. What was the role of the crisis team?

3. What suggestions do you have as to how our state can organize itself regionally to provide an action response team to assist schools facing a crisis-provoking situation? How can counselors organize themselves to provide a student-level crisis counseling team?
Activity 10 - 7

NOTES

"Suicide Postvention: A New Disaster Plan -- What a School Should Know When Faced With a Suicide"

1. Briefly explain each component of a "suicide postvention 'disaster' plan."

2. How useful do you think this program would be at your school? How would it be received? Would you have an opportunity to present it?
Activity 10 - 8

NOTES

"Death of a Student: Implications for Secondary School Counselors"

1. What is the initial impact students experience regarding the death of a peer?

2. What are the long-term effects?

3. How do students express their grief?

4. What is the counselor's role in working with students who are experiencing grief over the death of a peer?

5. In view of the school violence at Pearl (MS), Paducah (KY), and Jonesboro (AR), how do you think you could use information from this article at your school? How would it be received? Would you have an opportunity to present it?
Children and environmental disasters: 
the counselor's responsibility
by Michael A. Crabbs, Counselor Educator 
University of Houston at Clear Lake City, Texas

The United Nations' sponsorship of the International Year of the Child in 1979 brought special recognition to this important population group. One result, was the reaffirmation by adults that the world is experienced differently by children. That is, the child's perception of the world is a function of current development in the behavioral, emotional, social, intellectual, and physical areas. Because this development is often influenced by age and experience, events that significantly influence an adult's life may have equal or greater impact on a child's life. As a result, when a negative life event occurs, children and adults seem to suffer quite differently from the prolonged and often indeterminable effects. Such is the case when children experience the effects of an environmental disaster.

Disaster, as defined by Webster's Seventh New Collegiate Dictionary (1976), is "an unforeseen mischance bringing with it destruction of life or property or utter defeat" (p. 237). Some authors (Benedek, 1979; Uroda, 1977) define disaster to include personal events -- parental divorce, death, illness, or injury. An environmental disaster, however, is limited to those events arising from the destructive forces of nature, often in combination with irresponsible acts by citizens. While these environmental disasters vary in nature and severity, statistics reveal that about a dozen disasters of major proportions and as many as 40 of smaller magnitude occur each year. In 1980 American cities such as Harrisburg, Kalamazoo, Mobile, Spokane, and Wichita Falls have had to cope with environmental disaster arising from tornados, hurricanes, floods, fires, or volcanic ash fallout. Children's reactions to the events may vary greatly. Responsive intervention by the elementary counselor may minimize immediate and long-range adjustment problems.

The emotional and behavioral reaction of children is often a function of the type, magnitude, and duration of the environmental disaster, coupled with the manner in which the child was prepared for the crisis. Following a highly traumatic event with little warning, children may exhibit a range of emotions and behaviors that do not differ radically from established coping patterns. When, however, the threat of an environmental disaster approaches more slowly (e.g., river water rising gradually over a period of hours), children who are not properly prepared exhibit atypical behavior because of uncertainty, anxiety, and apprehension. Although a child's reaction may be intense, emotional and behavioral responses "are quite normal and do not represent mental illness" (Kafrissen & Heffron, 1975, p. 161).
Children's responses to environmental crises may be quite normal and may even enhance their ability to mobilize resources for the impending threat. The elementary counselor, however, should be able to recognize maladaptive responses and undertake appropriate interventions before these responses lead to school- or family-related problems. Because few children assume responsibility for their own basic needs following a disaster (i.e., parents or adult volunteers usually provide food, clothing, shelter, and safety), the needs for belonging, love, information, and understanding become paramount. When these needs continue unfulfilled and are combined with the intense emotional and behavioral responses to the disaster, the short- and long-term effect are readily identified.

**Short-Term Effects**

The majority of initial problems are identified in children within hours of the disaster experience and may continue until appropriate attention is provided. Research (Block, Silber, & Perry, 1956) indicated that one child in two will manifest maladaptive emotional responses immediately following a disaster. These children exhibit regressive behavior such as enuresis, are afraid to remain alone, and are easily upset by conditions that remind them of those that existed before the disaster. Many children return to earlier fears of going to sleep and experience insomnia as well as other sleep disturbances (i.e., dreams or nightmares). In addition, crying, vomiting, expressions of fear of death, separation, or further trauma arise from children's experience with real or imagined stimuli following the disaster. Finally, young disaster victims may manifest behaviors characterized by docility, lack of responsiveness, inhibition of activity, and absence of emotion. As is evidenced, children manifest a complete range of responses that are typical of the "disaster syndrome" that Wallace described (1956).

**Long-Term Effects**

Children, while being very resilient, may not be able to adjust to their disaster experience immediately. While initial reactions to the crisis may continue for an indeterminate period time, other behaviors and emotions may occur months or years from the event. Of particular importance for school counselors is the finding (Terr, 1979) of many of these long-term effects in the school. It is not uncommon for children who are victims of an environmental disaster to exhibit increases in fighting or crying in school, school phobia, recurrent daydreaming, and cognitive errors. The passage of time may reveal compulsive reenactment of talk about the event, personality changes, chronic anxiety, traumatic dreams, and inappropriate and uncontrolled fear of further disasters.

**ROLE OF THE COUNSELOR**

Elementary counselors are constantly being challenged to provide a full range of counseling, coordinating, and consulting services to students, parents, and educators. Following an environmental disaster,
the counselor is frequently the only person in the school whose function is to meet the developmental needs of children. While the principal and faculty are busy returning the school to the normal focus on learning, the counselor is charged with serving as "an advocate for the child within the adult structure of the school and community" (American School Counselor Association, 1978, p. 202).

Although the environmental disaster challenges the resources of the community, the schools are usually seen as an area of support. Oftentimes emergency shelters are set up in school gymnasiums or cafeterias, and as quickly as possible schools reopen to go about the business of educating today's youth. As a result, much of the intervention the counselor contemplates can be implemented within a familiar environment. The effective counselor, relying on skills in coordination and consulting, will draw on these guidelines when working with children from a disaster-stricken community. Some guidelines for disaster work are:

**Maintain Focus and Do not Become Overwhelmed**

While the entire community may represent a group with which to work, the elementary counselor should respond to the demonstrated needs of students within the schools. Priority can be given to those student identified by teachers, parents, or peers who exhibit atypical behaviors or emotions. Later activities can be directed toward the remaining school population.

**Encourage the Young Victim**

While a disaster may immobilize it victims, children should be encouraged to participate in the day-to-day learning activities of the classroom. By returning one aspect of the victim's life to normal, the counselor enhances the child's ability to manage the upheaval and emotional reactions triggered by the disaster.

**Support From Adults**

Research (Benedek, 1979) has indicated that children respond favorably to open and honest communication from adults. The counselor's role is to involve the teaching staff and other adult school workers in providing this much needed emotional support while serving as a stabilizing force.

**Confront the Crisis**

It is important for adults and children to acknowledge that something disastrous has happened. To adapt to the disaster experience, victims must deal effectively with its reality (Kafrissen & Heffron, 1975). The counselor can assist young children in ventilating their inner feelings and adjusting to the loss.
Honest Appraisal

Many children will want to know when their lives will return to normal. The counselor's task in these situations is to provide emphatic responses, but not false assurance. In many instances, the child's world will never be the same, and statements to the contrary instill false hope in the victims. An honest appraisal of the situation, along with a sincere offer to help, will enable the counselor to best meet the needs of these children.

Develop Support Systems

An environmental disaster usually results in a large scale disruption to the social aspects of children's lives. Victims are likely to have increased feelings of alienation, isolation, and depersonalization, as well as guilt about what they may have done to precipitate the disaster. By developing peer support systems, matching victims with non-victims, the counselor has to take appropriate steps to mediate these feelings. Through this effort to reestablish social ties, children are encouraged to build friendships that will carry them through the crisis.

Consult With Teachers

The counselor should be active in organizing the school's response to the environmental disaster. Capitalizing on classroom guidance activities, the counselor can assist teachers in leading group discussions and other activities. Spontaneous ideas, questions, and discussion may be encouraged, or a structure can be designed to facilitate the desired interaction. The counselor can also serve as a resource to the teacher by providing information, materials, and activities that the teacher can implement within the classroom (for more ideas see the following section). In any event, the teacher/counselor relationship should be consistent with the consulting dimension on the elementary counselor's role.

CLASSROOM GUIDANCE ACTIVITIES

To provide a positive school response to a disaster, the counselor can consult with teachers regarding classroom needs. As appropriate and with the assistance of the teacher, the counselor may conduct classroom guidance activities that focus on the results of the environmental disaster. Because the counselor will have several classes with which to work, the teacher is encouraged to model the counselor's skills and procedures in implementing classroom guidance activities with a disaster focus. As a result, elementary counselors are encouraged to develop or adapt materials or activities and make them available to the classroom teacher. Ideas for activities to help children adjust to a disaster experience follow.
Unfinished Sentences

The child can be provided with an opportunity to express concerns, fears, and emotions through the use of unfinished sentences. This activity can be completed in individual worksheet format or by typically oriented small group discussion. Examples of unfinished sentences might include:

- During the flood (tornado, fire etc.) I was scared when ________.
- When I lost my __________ I felt __________.
- If I could change what happened to my family that day, I would ________.
- When it rains (the wind blows, or the fireplace crackles), I think about ________.

Student Art Work

The use of art work based on the children's experiences with the disaster or their current feelings about it can serve as an outlet for pent-up emotions. The children would be invited to share their work with the class and describe what they have constructed. It is important that the counselor, teacher, or class focus on what is expressed rather than the quality of the art work. Ideas for art projects are:

- Draw a picture of what happened to you during the disaster.
- Draw a picture of the favorite toy you lost during the flood.
- Picture yourself during the flood and then today.

Graffiti Board

A class project related to the disaster can be developed through the use of a large piece of butcher paper. The paper would be labeled with an appropriate heading. "The Houston flood of September 19, 1979," and each child would have an opportunity to draw a picture of something meaningful from the experience. The graffiti board would then be hung appropriately in the classroom. Children would have an opportunity to share with their classmates the experience that they depicted.

Magic Box

Using a covered shoe box, the counselor or teacher might describe the magic properties of this box: Anything will materialize in the box if you wish hard enough for it. Students are then handed the box and invited to describe the most important lost item and where it is at this moment.

Music Lessons

The counselor or teacher can take a favorite song that the class enjoys singing and change the words so that it reflects the experiences and feelings of the students who experienced the flood.
Community Resource

Invite a community resource person into the school or classroom who would represent the fire, weather, or disaster relief departments of the city. Ideally, the counselor or teacher would select someone who would feel comfortable answering the students' question about the disaster as well as sharing his or her personal views and experiences.

CONCLUSION

Elementary School counseling programs have changed greatly in the last few years. Trained guidance and counseling professionals have extended the focus of education to meet the needs of students in the affective as well as cognitive domains. This article establishes yet another service area within which the counselor has a major role. Helping children to understand and accept their experience with an environmental disaster is a challenge that cannot be cast aside. While the counselor's response is reactive in nature, an understanding of the impact on children of environmental disaster is important. In addition, familiarity with the literature of the field as well as operational considerations enables the counselor to take an active stance.

REFERENCES


[Reproduced with permission of copyright owner, the American School Counselor Association.]
Essential elements of a teacher in-service program on child bereavement

by Bruce Cunningham and Jan Hare
Assistant Professors, Department of Human Development,
Family Living and Community Educational Services,
University of Wisconsin--Stout.

As many school counselors can testify, it is distressing and painful for young children to experience the death of sibling, parent, or, more frequently, a grandparent. The loss of other much loved figures such as family, friends, pets, or a classmate may also cause a child to grieve. Symptoms of bereavement are not left at home and are well documented by educators in the classroom (Evans, 1982; Fredlund, 1977; Rosenthal 1977; Terkelson, 1978; Ryerson, 1977). Typically, children ages 3 to 9 years experience a disruption of habit patterns and they may also experience depression, psychosomatic disorders, adjustment disorder, and conduct disorders (Nagera, 1970; Rando, 1984; Raphael, 1983).

The bereaved child faces a threefold task of (a) coming to terms with death, (b) grieving, and (c) resuming the appropriate progression toward development of personality (Furman, 1984). School counselors and teachers who are sensitive and skilled can help children accomplish these task. Unfortunately, many teachers feel neither comfortable nor adequately trained to offer support to bereaved children (Brennan, 1983; Mosley, 1976; Pratt, Hare, & Wright, 1987). Consequently, teachers are not able to help young children resolve grief in a healthy manner and may inadvertently complicate the grieving process through such behaviors as omissions, refusals to answer questions, diverting techniques, and negative nonverbal messages. This lack of help may lead the child to a diminished capacity to understand what has happened and a corresponding increase in grieving symptoms.

Experimental efforts (Hare & Cunningham, 1988; Molnar-Stickels, 1985) suggested that with some training in child bereavement, teachers can become more effective in assisting the child with the grieving process. Furthermore, school counselors seem to be likely candidates to provide this training because of their expertise in helping children with personal socio-emotional concerns. The remainder of this article builds on previous training efforts and describes the essential elements of a bereavement in-service program for teachers. Particular attention is paid to the existing knowledge and misconceptions teachers of young children possess regarding child bereavement. The important issues of increasing teachers' comfort in communicating about death and supplementing a knowledge base with exercises designed to build skills in helping children cope with grief are also discussed.

IN-SERVICE FORMAT

The minimum amount of time for this in-service program is 4 hours. The program has been conducted as a single 4-hour session (Hare &
Cunningham, 1988) and can be offered during a pre-school conference day or other in-service day. The content of the in-service program can also be adapted to four 1-hour after school sessions because each of the following sections take approximately 1 hour: (a) awareness of children's bereavement behaviors, (b) awareness of children's perceptions of death, (c) awareness of personal attitudes toward death, and (d) exercises in dealing with bereaved children's concerns. The fifth section of the in-service program, which consists of a list of resources, can be distributed to the participants. Optimal group size for the exercises and discussions is approximately 25 participants.

TEACHERS' KNOWLEDGE AND CONCERNS REGARDING CHILD BEREAVEMENT

An effective child bereavement in-service program must first take into account the existing knowledge and immediate concerns of the teachers. Results of a pilot bereavement training program (Hare and Cunningham, 1988) suggest the following general impressions regarding teachers' knowledge of childhood grief and bereavement:

1. Teachers recognize that children experience feelings of loss, but they are unaware of the range of behaviors that children may manifest in response to the death of a significant person in their lives. Teachers are concerned about recognizing the behaviors in bereaved children that may indicate that professional help is warranted.

2. Teachers have misconceptions about the expected duration of children's grief. Several expressed the belief that children "should be over it within a few weeks," when the grieving process may, in fact, be much longer.

3. Teachers understand that age influences children's understanding about death, but teachers are less aware that children's previous experiences with death can also have a major influence on their conceptual awareness.

4. Teachers are unclear about their role in helping a grieving child. Many expressed the belief that it was necessary to reposed in some way that would be helpful to an individual grieving child or a classroom of bereaved children, but they were concerned about possible disapproval by the parents.

5. Teachers have limited awareness of currently available resources that would enable them to incorporate information on death and grief in the classroom. Teachers greatly appreciated being informed of curricular and community resources that deal with these topics.
ELEMENTS OF CHILD BEREAVEMENT IN-SERVICE PROGRAM

Awareness of Children's Bereavement Behaviors

Because teachers seem to have concerns and misconceptions about children's grieving behaviors, school counselors should address this as the first element in a bereavement training program. Teachers need to understand the typical range and likely duration of symptom in bereaved children. It is essential for teachers to understand that grief is very much an individual matter and that each child will experience a grieving process that is "normal" for him or her. Teachers should also be made aware of the factors that influence bereavement in each child. These factors may include the degree of attachment the child has to the deceased, the suddenness of the death, the child's previous experiences with death, the amount of assistance in grieving the child has received at home, and, finally, the individual differences among children. While keeping this perspective in mind, teachers also need to know the type, intensity, and duration of behaviors that indicate that professional help is warranted.

Teachers seem most curious about children's responses to bereavement, and nearly all will be able to cite examples of these behaviors by bereaved children that they have had in their classrooms. Beginning the in-service program with this information in a discussion format will allow those teachers who are less familiar with children's grieving behaviors to become more knowledgeable. The school counselor can guide this discussion to increase the teachers' awareness of children's bereavement behaviors.

Awareness of Children's Perceptions of Death

A second element of bereavement training program should involve the school counselor educating teachers about children's developmental knowledge of death. Familiarity with young children's preoperational (2 to 6 years of age) and concrete operational (6 to 12 years of age) conceptualizations as based on the work of Childers and Wimmer (1971), Furman (1984), Nagy (1948), and Wass and Corr (1984) is essential for assisting young children in grieving. According to this Piagetian perspective, young children think in qualitatively different ways than adults. Rather than reasoning deductively or inductively, young children tend to reason intuitively, moving from particular to seemingly unrelated particular. For example, the frequently used explanation that death is "just like going to sleep" may make sense to an adult, yet may be interpreted literally by young children. Consequently, this well-intentioned explanation may lead to subsequent bedtime fears (Hare & Skinner, 1988).

Most teachers have familiarity with the characteristics of preoperational and concrete operational thinking. A didactic presentation that applies these modes of thinking to the concept of death can increase teachers' awareness of how young children conceptualize death. Teachers are often willing to share and discuss personal experiences that illuminate young children's understanding of death.
This approach of lecture and discussion has produced significant gains in knowledge of grief with teachers of young children (Hare & Cunningham, 1988).

**Awareness of Personal Attitudes Toward Death**

A third element of bereavement program should involve experiences that help teachers achieve some understanding of their own thoughts, feelings, and attitudes toward death. Although young children may be distressed by death because it is a new experience, familiarity seldom makes it less distressing for adults. In a death-denying culture such as the United States, many adults have not sorted out their personal understanding of death. This is an important consideration because a teacher's attitude toward death will affect the communication between teacher and child.

School counselors must also examine their own thoughts, feelings, and attitudes toward death before assisting teachers with this same task. Methods for achieving this goal should include attending a workshop on bereavement, grieving, or death education; reading current books such as Gordon and Klass (1979), Grollman (1967, 1976), Hare and Courier (1987), and Kübler-Ross (1983), and special editions of journals (Carroll, 1977); and discussing personal attitudes toward death and dying with other professionals.

School counselors can devise many exercises to help teachers clarify their own attitudes toward death (Nelson, 1977). The Leming Death Fear Scale (1979-1980; Leming & Dickerson, 1985) has also been used for this purpose (Hare & Cunningham, 1988; Hare & Skinner, 1988). This 26-item questionnaire asks individuals to give their first opinions or impressions to statements about their own death. Responses are recorded on a Likert-type rating scale. These statements are grouped into eight areas of (a) fear of dependency on others while dying, (b) fear of pain, (c) fear of indignity, (d) fear of isolation/separation/loneliness, (e) fear of afterlife, (f) fear of the finality of death, (g) fear of leaving loved ones, and (h) fear of the fate of the body. Subsequent discussion can focus on the areas that provoked the most and least fear, on reasons why some areas produced more concern than others, and on ways in which religious beliefs affect death fears.

**Exercises in Dealing with Bereaved Children's Concerns**

A fourth element of a bereavement in-service program involves exercises, such as role playing, that give teachers practice in dealing with common situations they will encounter with bereaved children. This element is essential to an in-service program because quasi-experimental studies of the effects of bereavement programs found that knowledge about bereavement alone may not be enough to induce teachers to assist bereaved children (Hare & Cunningham, 1988). A particularly useful exercise is one in which teachers generate responses to children's common questions and comments regarding death such as those compiled below (Hare & Skinner, 1988).
Expressions of Feeling:

"Why does God want to take my Mom?"
"It's not fair. I need her to be with me."
"My heart is broken."
"I hate God."
"Sometimes I just feel so sad."
"There's just something missing all the time. I just feel like something is missing."
"Why do I cry when I think of him?"
"Does Daddy miss him?"
"It makes me sad to think about his dying the way he did."
"Do we miss him?"

Concern for the Body and Life After Death:

"Where is she now?"
"What happens to her in the grave? Does she keep her glasses?"
"Where does Grandpa go when he's buried?"
"Is dying and the end forever?"
"Where is he now? Will we see him again?"

Concern About Cause of Death:

"Why did she die?"
"What did they do in the ambulance?"
"Does everyone die who goes to the hospital?"
"Does cancer grow in you or do you catch it like a cold?"
"Will I ever get cancer?"

Teachers can work together in small groups of two to four teachers to respond to these comments, and can share and discuss their responses with the whole group. A general format for responding to young children's questions about death includes five steps: (a) reflecting, a Rogerian technique, what the child is really asking, or asking a question to clarify the child's concerns; (b) keeping in mind the developmental understanding the child has regarding death; (c) responding in a timely fashion rather than delaying or diverting the question or comment; (d) giving an honest response that will increase the child's understanding about death without increasing fears or fantasies; and (e) providing emotional support to the child. This process is demonstrated in the following two examples.

Example 1:

Child: "I hate God."
Teacher: "When we lose someone we love, we usually feel angry. Are you feeling angry with God because your mother died in that accident?"
Child: "Yes, I am."
Teacher: "It's OK to be angry. If you let yourself feel angry, then after some time the anger will go away."
Child: "But maybe I'll be punished for being angry with God."
Teacher: "I think God is big enough to handle your anger. God will probably understand your anger that you have lost your mother."

Example 2:

Child: "Where is he now?"
Teacher: "His body is at the funeral home, but the rest of your grandfather--the part of him that you love, the grandfather that took you fishing and made you laugh and fixed you bicycle, is in your memory. As long as you remember him, he will still be with you."
Child: "Will we see him again?"
Teacher: "Do you believe you will see him again?"
Child: "Yes, when I die I'll see him in heaven."
Teacher: "Yes, many people believe they will see all the people they loved when they go to heaven. When a person dies, we usually think a lot about him. It's important to keep those special memories."

School counselors can also use the small-group format for other exercises such as preparing a class for the return of a bereaved child, writing a letter to parents of a class with bereaved children, discussing death with non-bereaved children, and generating teaching strategies about death education for young children (Nelson, 1977).

**Awareness of Curricular and Community Resources**

A final element in a bereavement in-service program involves providing teachers with a list of curricular and community resources. Teachers have a limited awareness of these types of resources and indicate a desire to know more about the topics of child bereavement, grieving, and death education (Hare and Cunningham, 1988).

An excellent source of resources for incorporating death education into the curriculum is Wass, Corr, Pacholski, and Forfar (1985). This annotated bibliography contains an extensive list of age-appropriate children's literature, films, videotapes, and other resources. Special editions of journals, such as Carroll (1977) can also be of use to teachers.

School counselors should make teachers aware of community resources and services, which may be helpful to bereaved families. These resources should include the names of counselors and psychologists in the community who are trained in children's loss issues. In addition, such a list would include names of local hospices and grief support groups for children and adults. School counselors can compile such a list by contacting hospices, hospitals, and community mental health organizations in their own communities.
EVALUATING THE IN-SERVICE PROGRAM

School counselors can collect feedback from the teachers to evaluate the effectiveness of the inservice program. At the minimum, this feedback should cover the format, and each of the five elements of the in-service program. An open-ended response form asking teachers to indicate what they found most helpful about each section and what improvements could be made in each section is recommended. The overall effectiveness of the in-service program can be assessed by requesting this feedback at the conclusion of the in-service program and several months later, after which teachers may have had the opportunity to use the information.

SUMMARY

In summary, studies (Brennan, 1983; Mosley, 1976; Pratt, Hare, & Wright, 1987) suggested that most teachers of young children have little or no training in assisting children cope with bereavement. Results of quasi-experimental studies (Hare & Cunningham, 1988; Hare & Skinner, 1988); Molnar-Stickels, 1985) indicated that brief in-service programs or workshops can be an efficient and effective way to increase teachers' knowledge and skill in assisting young children with the tasks of coming to terms with death. After examining their own attitudes toward death, school counselors can conduct in-service programs for teachers that include (a) awareness of children's bereavement behaviors, (b) awareness of children's perceptions of death, (c) awareness of personal attitudes toward death, (d) exercises in dealing with bereaved children's concerns, and (e) awareness of curricular and community resources. Gathering feedback from the teachers can help the school counselor evaluate the effectiveness of the in-service program.

REFERENCES


[Reproduced with permission of copyright owner, the American School Counselor Association.]
The grieving child

by Rebecca M. Hawener, Assistant Professor, Early Childhood Education, and Wallace Phillips, Counselor Educator, University of North Carolina, Greensboro

A six-year old boy edged toward his teacher and said, "My Daddy died." With some hesitation and obvious discomfort, the teacher replied, "Oh."

Looking away and speaking to no one in particular, the grieving child murmured, "Now we won't have all that smoke in the house anymore."

The anxious teacher could only muster another feeble, "Oh."

This brief passage (Hawener, 1972a) illustrates the critical need for teachers and counselors to prepare themselves as helpers to grieving children. Perhaps the most poignant and traumatic grief accompanies loss through death, but divorce, separation, and other such situations occur which leave children as well as adults with a profound sense of incomprehensible loss -- grief. Once such a loss occurs, the personal coping process begins in an attempt to understand, accept, and fill the void caused by the event. The young boy used the lack of smoke in the house to help him begin to comprehend the event; the teacher used avoidance to deal with the young boy's personal loss.

Children acquire their understanding of death and the means of coping with it from the significant adults in their lives. While adults accept death as a biological process, children view death differently, unless they have experienced the death of a significant person in their lives. Until about the age of four, death for children is a word with little or no meaning; from about five to seven, death is a reversible process; after the age of seven, death begins to be viewed as an irreversible process caused by a "bad thing." Not until about the age of nine is death viewed as a biological event (Ilg & Ames, 1955).

The critical factor which determines how well children cope with death is the quality of their interaction with adults. And, in turn, the quality of help adults can offer children is related to the learning they acquired as children. Thus it is vital that adults understand children's developmental capacities and gear their talks with children to the appropriate level.

Separation and divorce, like death, are grief-producing events; unlike death, they usually do not mean the permanent absence of a loved one. For children, separation and divorce create a kind of "suspended animation" -- life is not the same, yet there are residual hopes that the parents will return and restore the family to its previous norms (Pitcher, 1969). In this situation, the grieving process is prolonged by the elements of uncertainty, hope, and intermittent contacts with the absent parent.
For many adults, including teachers and counselors, death and divorce are anxiety-producing subjects (Hawener, 1974b). They find themselves either unable to discuss death (or divorce) with children, as in the case of the boy's teacher, or resort to nice stories to explain away the event. If teachers and counselors are to be helpful to children, it is essential that they re-examine and come to terms with their own values and beliefs regarding death and divorce.

THE GRIEF CYCLE

Lindeman (1944) studied the patterns of grieving among family survivors of the victims of the Boston Coconut Grove holocaust. He identified stages in the management of grief very similar to the grief reaction patterns that Kübler-Ross, 1969) found in persons with terminal illnesses. She observed that, regardless of cause, grief progresses through identifiable stages of denial and isolation, anger, bargaining, depression, acceptance.

Initially, symptoms of somatic illness frequently appear -- a loss of appetite, decreased vigor, and social aloofness. Preoccupation with some aspect of the deceased's life is common; for the young boy, the father's smoking took on special significance as he spoke of his father's death.

Guilt

Guilt usually plays an important role in grieving. Expressions of not having done enough while the person was alive or self-incrimination for failing to commit a saving act are frequently made by grieving adults. Similar guilt feelings are often present in young children in both death and divorce situations, but are related to children's thinking that their actions caused the person to die or that because of some defect in them their parents separated and divorced. Teachers and counselors working with the grieving child should provide supportive assurance that the child was not the cause of the situation.

With divorce, children need to understand that the divorce is between the parents and that although the parents no longer live together, their love for the child is still there (Grollman, 1969). Death- and divorce-associated guilt often exist in young children because children are at an egocentric stage of development, when they believe they cause events around them to happen. These children need the assurance that "scary, mad wishes don't make things come true" (Rogers, 1972).

Hostility

Hostile reactions resulting from the survivor's feelings of anger at being left and separated from the love one are often a part of the grief cycle. Such reactions often cause the child to misbehave in school, and the consequent punishment may lead to more persistent hostility. These
children are frequently perceived as intentionally doing all they can to isolate themselves and to hurt those who are trying to help and understand them.

**Change**

Children's patterns of interests and activities change with the onset of grief. The child may try to maintain old patterns, yet not be able to do so. It is as though the reasons for former activities were lost along with the loved one. For the child who has lost a parent through death, activities that would please the parent become meaningless; demonstrating good behavior to bring divorced parents together goes unnoticed by those who care. At this point, the grieving child needs a supportive adult to give encouragement and to help discover new reasons for doing.

**Delay**

Because death is a feared phenomenon relegated to the old, children are often shielded and their grieving is aborted by well-meaning adults. In school-aged children, grieving may be delayed and grief symptoms appear weeks or even months after the death occurred. Children who have been told the deceased has gone on a vacation or is sleeping may delay grieving even longer. The same supportive relationship with an understanding, secure adult is important regardless of when the grieving process begins.

**HELPING CHILDREN HANDLE GRIEF**

Recognizing and helping children work through their grief is a vital counseling function. Unresolved childhood grief is indicated in the histories of a large number of juvenile delinquents (Moriarty, 1967). While the relationships are not clear, the evidence is convincing enough to warrant counseling intervention as a preventive measure.

The grieving child needs a secure friend who will listen, answer questions, and help work through feelings of loss and allay guilt/anxiety. The privacy, time, and professional objectivity school counselors offer their clients should make them uniquely suited to provide the required relationship. However, who does it is not as important as how is done (Hawener, 1974b). A teacher, a parent, or other family member who has established rapport and assumed significance in the child's life can help, with the counselor giving support as a consultant.

**Counseling Techniques**

The quality of help provided for grieving children in school will depend on the quality of established home/school relations and the awareness of this particular need created among teachers. Counselors should be readily accessible to teachers and parents who are working with grieving children. Usually, a brief contact with parents or teachers indicating that the counselors stands ready to help when needed will suffice.
Specific counseling techniques will vary according to the counselor's style and the child's unique needs. The authors' experience has taught us that the *listening and communicating understanding* of the child's feelings are the crucial element in helping the grieving child. With some elementary-age children, play media and methods such as the "mutual storytelling technique" (Gardner, 1971) have been effective; with older children, it is usually possible to deal directly with the verbal content the child brings to the counseling interview.

A close working relationship with the family should be established throughout the child's grief cycle. Approaching the family at these times requires great tact and discretion; often the adults' grief is such that a close working relationship cannot be established. However, it is essential that the family members responsible for the child's welfare be contacted when symptoms of grieving are interfering with the child's educational progress; hopefully, a collaborative relationship with parents can be developed in the child's interest.

Many children who have experienced the death of a loved one develop intense fears associated with that death. A common fear is that the surviving family members will be lost in the same way, or that the child himself will die. At such times the child needs to be reassured that such things do not happen (Joseph, 1974). Fear reduction is often indicated as the first step in helping the grieving child.

The funeral process may cause concern and confusion for children. For example, one small boy could not understand how the person went to heaven since the body was securely locked in a casket and vault. Funeral services and religious or ethnic customs regarding the deceased should be appropriately dealt with according to the child's capacity and need to understand.

**CONCLUSION**

Lamers (1969) offers in six points to guide the helping process with grieving children:

1. Remember attitudes are more important than words.
2. Talk before the need arises.
3. Begin at the child's level.
4. Let the child talk.
5. Try to answer all questions.
6. Make yourself available to the child.

Counselors who wish to help grieving children should begin by clarifying their own attitudes, values, opinions, and beliefs regarding death and divorce. An abundance of literature is available (see the bibliography at the end of this article) and numerous university courses and workshops are now being offered to those who wish to upgrade their competence in this critical counseling area. Knowing what to expect and being willing to listen are the primary requirements for
helping the grieving child; fulfilling these requirements does not seem to be an unreasonable expectation for person in the helping profession.

REFERENCES


BIBLIOGRAPHY


[Reproduced with permission of copyright owner the American School Counselor Association.]
Notes

Adolescent Suicide: Myths, Recognition, and Evaluation

Nancy K. Martin, doctoral student, and
Paul N. Dixon, Chairman, Department of Educational Psychology,
Special Education, and Institutional Technology
Texas Tech University, Lubbock

In the United States suicide is reported by some as the third leading cause of death among adolescents, exceeded only by accidents and homicides (Finch & Poznanski, 1971; Grollman, 1971; Holinger & Offer, 1981; Tishler, McKeny, & Morgan, 1981). Others report the incidence has exceeded homicides and risen to the number two position (Wellman, 1984). Yet, these statistics probably underestimate the frequency of suicide because of misreporting of accidents and underreporting as the result of cultural taboos related to the act.

These underestimates represent but one of several other myths about suicide. Despite the discrepancy in figures, there can be little doubt that suicide among young people is an occurrence that merits the attention of all who come in contact with adolescents. The purpose of this article is to describe the nature of the suicidal adolescent and what to do once he or she has been identified.

Another misconception concerning suicide is that a person who attempts suicide and fails is safe from future attempts. In reality, four out of five people who kill themselves have made previous attempts; 12% of those who attempt suicide will do so again and succeed within 2 years (Grollman, 1971). Once an individual crosses the invisible boundary between contemplation and action, it becomes easier to make repeat attempts (Garfinkel, Froese, & Hood, 1982; Grollman, 1971; Hawton, 1982; Klagsbrun, 1981).

Another myth is that most people commit suicide during the winter months when the weather is dark and dreary. The opposite is true. Suicide is more prevalent in the spring, with the peak in April, when it is 120% above the average for the rest of the year (Grollman, 1971). One explanation given for this is that the bright, colorful spring months act as a constant reminder of a perceived hopeless situation. The suicide rate is also high during the Christmas season because of the emphasized dichotomy between the depressed person's low, alienated feelings and the high feelings generally associated with the so-called "happy season" (Grollman, 1971; Klagsbrun, 1981).

Similarly, many people associate death with darkness and thus assume that the majority of suicides occur late at night (Klagsbrun, 1981). The time of day most frequently chosen by adolescents, however, is between 3:00 p.m. and 6:00 p.m., when others are home and usually readily available for rescue (Klagsbrun, 1981).

The infamous suicide note has caused a great deal of misunderstanding as well. Contrary to popular belief, only about 15% of
Perhaps the most dangerous myth is that those who talk about suicide are not seriously considering it. One should always assume that any reference to suicide is a serious one (Farberow, 1967).

DEGREES OF SEVERITY AND CHARACTERISTICS OF EACH

Among adolescent manifesting suicidal tendencies, there are various degrees of severity. Suicidal ideation can be divided into three ascending categories: passive suicide, suicidal gestures, and impulsive suicide. Passively suicidal individuals can be described as those who experience unconscious self-destructive impulses; they eat, drink, and smoke excessively. Reminiscent of Freud's death-instinct, they drive recklessly and work long hours. They also engage in life-shortening activities and take too many chances. As Grollman (1971) explained, "Installment-plan suicides may be less obvious, but are just deadly" (p. 10). The passively suicidal do not consciously contemplate suicide. They simply arrange their lives so that circumstances will do it for them.

The second category of suicidal ideation involves those who are insincere about suicide and endeavor to punish or manipulate others by simulating and attempting (Arieti & Bemporad, 1978). Individuals who cut their wrists or impulsively threaten their own life are generally considered to be acting out a suicidal gesture rather than making a sincere attempt. Certainly no suicidal gesture should go unnoticed because it may recur as a true attempt if its importance is neglected by family and peers, thus confirming suspicions that no one cares.

Suicide is usually not impulsive yet the act often is. Teenagers impulsively attempting suicide represent the largest group of adolescents manifesting self-destructive behavior (Finch & Poznanski, 1971). The adolescent who makes impulsive attempts is only occasionally successful in suicide. These teenagers are most often vengeful and angry and try to punish those who interfere with their lives. Like other adolescents, they too attempt independence; however, they are inept at managing independent undertakings. Following an attempt at suicide, they will deny both serious motive and the existence of typical emotional problems such as depression. (Finch & Poznanski, 1971).

SYMPTOMS OF SUICIDAL BEHAVIOR

Suicidal teenagers are typically characterized by depression, ambivalence, stress, and social isolation. In addition, an adolescent's sex and marital status have emerged as possible predictors of suicide.

Depression is a major factor in the underlying dynamics of the adolescent suicidal personality. Litman & Wold (1974) reported from their 10-year study that 95% of their participants drawn from a suicide prevention center suffered from some type of depression. As adolescents...
with low esteem compare themselves to their happy, well-adjusted peers, they become more acutely aware of their problems. This dichotomy makes them feel even more depressed and of less worth.

Depressive feelings alone are not useful predictors. Everyone gets depressed; these are normal feelings. When coupled with the deterioration of relationships with peers and family, however, depression should be considered relevant (Hersh, 1975).

Depression is more easily identified in adults than adolescents because of the natural mood swings experienced by those in the adolescent age group. As explained earlier, however, there are signs to consider because depression may manifest itself in a variety of ways. There are also behavioral equivalents of depression such as truancy, disobedience, and self-destructive behavior (Finch & Poznanski, 1971; Grueling & DeBlassie, 1980; Grollman, 1971).

Unlike most depressed adults, depressed adolescents are often confused about their self-identity. Anger is also frequently displayed and openly expressed whereas depressive feelings tend to be overshadowed, the opposite of what is seen in their adult counterparts. Depression is sometimes masked by more dramatic symptoms such as alcoholism, drug abuse, unstable personal relationships, antisocial acts, confusion, and social withdrawal and isolation (Litman & Wold, 1974).

Ambivalence generally characterizes those contemplating suicide. Of those considering suicide, 80% communicate this ambivalence to others in some fashion (Grollman, 1971). A clue may be subtle as breaking a date by saying, "I won't be here Saturday night," or as clear as stating overtly the intention to commit suicide.

Suicidal individuals typically feel great stress that is perceived as unresolvable. They often believe they are controlled by their environment (Grollman, 1971). This stress and lack of control often lead to insomnia, fatigue, and loss of appetite, libido, and concentration (Finch & Poznanski, 1971). Therefore, a severe decrease in weight, grades, social activity, or any combination of these should be cause for concern. Other serious clues to suicidal behavior include talking about giving away prized possessions or actually giving them away and active tensions with the family of origin, especially if there is evidence that psychological or physical abuse exists in that family (Hersh, 1975).

Hawton (1982) and Hersh (1975) suggested that as many as 25% of suicidal adolescents experience an increase of social isolation before their suicide attempts. Arieti and Bemporad (1978) explained that social isolation is the primary variable differentiating true suicide intent from a suicide gesture. When suicidal individuals have someone to turn to for help or an opportunity to vent their anger, suicide may be avoided. The greatest danger of suicide occurs with social isolation. Increased alienation can be described as feelings of isolation from family, friends, and significant others. Evidence supports the idea that adolescents suffering from this type of alienation constitute a high-risk group (Grueling & DeBlassie, 1980).
Research also reveals a significant difference in the adolescent suicide rate according to marital status (Hawton, 1982; Holinger & Offer, 1981). Although there is a high incidence of suicide among single adolescents, it is higher among married teenagers, and highest among those who are divorced, suggesting a relationship between marriage and stress, depression, and alienation from peers.

ADDITIONAL FACTORS

Although more women than men attempt suicide, men consistently outnumber women in successful completion of the act (Hawton, 1982; Hersh, 1975; Holinger & Offer, 1981). Violent self-injury is more prevalent among boys than girls (Finch & Poznanski, 1971; Hawton, 1982; Hersh, 1975). The difference in the methods chosen may be the result of culturally established differences in male and female responses to stress (Hersh, 1975), or may be determined by individual's access to drugs, firearms, or other harmful materials (Finch & Poznanski, 1971). Women are more likely to choose self-poisoning than wounding or mutilating themselves (Hawton, 1982); this often provides greater opportunity for successful intervention. Men, on the other hand, tend to use a more violent method such as hanging or shooting (Hersh, 1975; Holinger & Offer, 1981).

The methods most commonly chosen by those who complete suicide are firearms and explosives, followed by hanging and poisoning (Garfinkel, Froese, & Hood, 1982; Holinger & Offer, 1981). Of those who attempt suicide, however, drug overdose is the leading method chosen (Garfinkel, Froese, & Hood, 1982).

PROFILE OF A TYPICAL SUICIDAL ADOLESCENT

The "typical" suicidal adolescent is a White, Anglo-Saxon, Protestant female, approximately 15 years of age. Her parents are divorced and her mother works full time. Last year she was an "A-B" student, but this year she has experienced failure in school. She has missed a significant amount of school this year primarily due to colds and flu, but has been caught truant twice. Her weight has dropped dramatically and she has no real appetite. She feels tired much of the time but has trouble sleeping. Having a few or no friends, she has recently increased her social isolation by breaking up with her boyfriend of 2 months and does not feel she can communicate with either parent. Her mother manifested symptoms of depression, attempted suicide a year ago, and seems indifferent toward her daughter. They quarreled just before the girl's drug overdose. Suffering from low self-esteem and libido, she is oriented to time, place, and person; she seems lethargic and depressed (Tishler, McKenny, & Morgan, 1981).
CRISIS SITUATIONS

McBrien (1983) explained, "The goal is to intervene before students reach the stage in their crisis or depression that prompts the overt cry for help" (p. 76). When confronted with a crisis situation, however, one is not afforded the luxury of making well-thought-out decisions. Conditions, often chaotic and disorganized, require immediate action. Everyone in daily contact with teenagers, therefore, has a responsibility to educate themselves before the overt cry for help presents itself.

The initial establishment of a relationship with the adolescent is essential. One should offer support, hope, and help while simultaneously assuming the role of authority and exemplifying an air of confident professionalism (Farberow, 1967). It is important at this point to obtain identifying information, names, and phone numbers of significant family members or friends.

The primary objective is to keep the adolescent alive. It is necessary, then, to use experience and research findings as criteria for assessing the potential for suicide. Three areas have been helpful in providing a framework for the evaluation of intent: age and sex, the suicide plan, and the level of stress being experienced by the victim (Farberow, 1967).

EVALUATION

When evidence of suicide ideation is present but threat of the act is not imminent, three elements of the suicide plan should be investigated: specificity of details, lethality of the proposed method, and availability of means (Farberow, 1967). A well-considered, detailed plan indicates a significantly higher level of suicide intent than does an impulsive suicide attempt. The lethality and availability of the method chosen are also important facts to ascertain. This information will help in determining whether the suicide is imminent and allow for the development of a framework for time.

The level of stress should be evaluated from the perspective of the student, not the perspective of society. An event may be highly stress provoking for one individual and not for another. Those with inadequate coping skills may find that many situations induce stress. Once potential for the suicide has been ascertained, a counselor can begin to formulate ideas concerning the services available and the best referral possible for the client (Farberow, 1967).

Although the most reliable information is collected during the interview, the counselor may use a supplementary scale to gather information. One such scale is Beck's Suicidal Intent Scale (Hawton & Catalan, 1982), which focuses on circumstances surrounding the suicide attempt; that is, evidence of premeditation, time of attempt, and location of attempt. The scale derives pertinent retrospective data from the client and relevant observers such as the family and police.
The scale is divided into two parts. The first section deals with overt behavior preceding, during, and after the attempt. Three factors need to be considered when using this section: (a) the evidence may be ambiguous, fragmented, or come from unreliable sources; (b) it is possible for an individual to deliberately fabricate all the circumstances suggesting high suicidal intent; and (c) the individual may deny all such circumstances (Beck, Schuyler, & Herman, 1974).

Second, the scale deals with the concept of introspective data. This type of information can be the most valuable; unfortunately, it is usually difficult to obtain. Ideally the counselor would elicit a response from the client such as, "I want die," or "I wasn't sure about dying, so I left it to chance." Because of the questionable reliability or the second section, many do not use it. Those who are suicidal may exaggerate, attempt to conceal information, or simply have difficulty recalling the specific information. Depending on the suicide method chosen by the client, he or she may be unable to cooperate with the interviewer.

**IMPLICATION FOR COUNSELORS**

Although the responsibility of identifying suicidal teenagers logically falls within the counselor's realm of responsibilities (McBrien, 1983), classroom teachers have more opportunities to identify such teens (Wellman, 1984). Educating parents and students is also encouraged because they are likely to come in contact with those who have suicidal tendencies. Steele's (1983a) booklet, *Preventing Teen Suicide*, outlines a series of six workshops designed for parents and school personnel; a videocassette, *Teenage Suicide: What to Do* (Steele, 1983b) is also available.

The classroom teacher -- often the first to recognize the suicidal adolescent -- should immediately refer the student to the school counselor (Wellman, 1984). The counselor should then conduct an evaluation interview and conclude it by obtaining the student's signature on a contract to live. McBrien (1983) reported that this method has proven effective and cited Morgan as stating that anything less than a full commitment is considered a risk. The student should be informed of the counselor's right to warn others of the potential suicide. Parents, teachers, the principal, and school psychologist should be informed. It is important for the counselor to be supportive, empathic, and understanding.

Although the counselor should be available to the student, the primary therapeutic responsibility belongs to the school psychologist (or other mental health professional of the family's choosing). Although suicidal thoughts last only a few hours at the most, they will recur if more acceptable coping skills are not learned (Grueling and DeBlassie, 1980). The school counselor is generally not able to commit to the intense level of therapy necessary because of other demands on his or her time. The school psychologist should consult with the counselor so that he or she is well informed of the client's progress.
SUMMARY

Adolescent suicide has reached alarming proportions in the United States. It is unknown exactly how high the rate is partly because of misreporting and underreporting, a reflection of cultural taboos.

Whereas some teenagers do not consciously plan their suicides, others flirt with the act to gain attention. The majority of teenager attempting suicide do so impulsively.

Depression, ambivalence, social isolation, and stress typically characterize suicidal adolescents. Although more girls than boys attempt suicide, more boys succeed. Boys manifesting these tendencies constitute a high-risk group.

Crisis situation require counselors or parents to take on a role of authority while offering support, hope, and help to the teenage. Once a suicidal teenager is identified, it is imperative to assess the seriousness of his or her intent. Considerations should include how detailed the suicide plan is as well as how difficult it would be for the adolescent to obtain the firearm or drug necessary to carry out the plan.

Most information needed for this assessment is gathered during an interview with the client, but a supplementary scale may be used. The school counselor's responsibilities include being informed on the subject of adolescent suicide, arranging workshops to educate others, and offering immediate support and evaluation of the teenager. The primary therapeutic responsibilities, however, belong to the school psychologist or other mental health professional of the family's choice.

REFERENCES


[Reproduced with permission of copyright owner, the American School Counselor Association.]
Are you thinking of killing yourself?: confronting students' suicidal thoughts

Robert J. McBrien
Director, Counseling Services
Salisbury State College
Salisbury, Maryland

STUDIES OF SUICIDE

"Are you thinking of killing yourself?" is a question that counselors are now asking students more than 5 years ago. Morgan (1981) cited that there are as many 100,000 suicides each year. Crumley (1979) reported that suicide ranked third as the cause of death among 15- to 19-year-old adolescents. [Editorial Note: Today, suicide is ranked second as the cause of death among teenagers.]

School counselors are perhaps the only school professionals with training in suicide prevention. In schools where personnel are concerned with suicide prevention, the tasks of identifying and intervening with potentially suicidal students logically fall within the duties of the counselor. The need for this service should increase. Crumley (1979) reported that by 1975, the suicide rate of the 15-19 age group had increased 124% in 10 years. Tishler, McKenry, and Morgan (1981) stated that the subject of adolescent suicide is fast becoming a major concern of parents, teachers, mental health practitioners, and others who are in contact with adolescents.

Tishler et al. (1981) studied 108 adolescents (average age of 15) who attempted suicide. The criterion for the label suicide attempt was treatment for a suicide attempt in a children's hospital emergency room. The majority of the adolescents were depressed. Over half (52%) identified parental problems as the reason for their attempt, while problems with the opposite sex and school problems were the next two reasons cited. There were 22% who were exposed to recent suicidal behavior in a family member, and 20% had experienced a recent death of a friend or relative.

The findings of this study show a pattern of events that has been associated with suicide attempts. Tishler et al. (1981) offered support to the concept that adolescent suicide is a developmental problem resulting from three stages: (1) a previous history of problems; (2) an increase of problems associated with adolescence; and (3) an intense period of problems -- usually a recent change of an ending or any meaningful social relationship.

Crumley (1979) reviewed the cases of 40 adolescent patients (average age of 15.8) from his private practice. All had attempted suicide. The findings were similar to those in the Tishler et al. (1981) study. Depression was found in 82% of this group. Family discord was evident, with 32%
being children of divorce. Experiences with death were present. A suicide had occurred in the families of 10%, while 5% had family members attempt suicide and [one] 1 patient lost a friend through suicide.

The danger signs of adolescent suicide, based on studies with suicide attempters, have been identified. If persons working with adolescents are trained to recognize the suicidal danger signals, only them, as Tishler et al. (1981) suggested, could the adolescent suicidal rate be reduced.

There is concern that the number of children and adolescents experiencing the problems identified as danger signals of suicide is increasing and that counselors are missing many opportunities for early intervention. There is no way to estimate how many students in a given school, on a given day, might be involved with thoughts of suicide. An estimate could be obtained from other related sources. Since Morgan (1981) found that there were 100,000 suicides in a year and Tishler et al. (1981) estimated 50-150 attempts for each completed suicide, the number in a particular school is probably large.

The focus of this article, however, is on students who experience suicidal thinking. Burns (1981) stated the magnitude of the problem when he cited Beck's finding that 33% of the patients identified as moderately depressed admitted to having thoughts of suicide.

This article offers systematic counseling strategies, principally developed at the Center for Cognitive Therapy (Beck, Bush, Shaw, & Emery, 1979), that permit counselors to identify and evaluate for seriousness of intent those students who are experiencing suicidal thoughts. Although these counseling techniques can be used with more overtly suicidal students, the goal is to intervene before students reach the stage in their crisis or depression that prompts the overt cries for help. Such cries for help might include statements about suicide, self-injury, overdosing on vitamin C and other nonlethal acts, and serious attempts requiring medical treatment.

PREVENTION STRATEGIES

Morgan (1981) reviewed Schniedman's four broad areas identified as forewarnings of suicide:

1. verbal statements such as, "I want to die";
2. behavioral clues, the most serious being previous attempts or writing a will;
3. situational clues, with family and relationship clues, with family and relationship problems being most common; and
4. syndromatic clues, with the three developmental stages of the syndrome being (a) history of previous problems, (b) additional problems associated with adolescence, and (c) a recent intense period of problems with significant social relationships (studies with adolescent attempters showed that depression and loss were common among this group).
This article discusses verbal statements and situational clues. Review of recent literature (Crumley, 1979; Morgan, 1981; Tishler et al., 1981) and the present author's 10 years of counseling experience with youths prompt the belief that intervention in these two areas offers the best opportunity for suicide prevention.

**Verbal Statements**

Verbal statements about suicide serve as evidence that suicidal thinking is operating. The statements to listen for are the indirect, subtle *whispers for help*. Experienced practitioners are familiar with overt statements that signal suicidal intent, including "I want to die," "How many aspirin will it take to kill someone?", and "After I'm dead, they'll be sorry."

Because whispers for help are subtle, counselors need to use active listening skills to identify them. Examples of extremely subtle statements include "It isn't worth it," "I don't care to face tomorrow," "My life is empty," and "It's hopeless."

Last year, a statement heard more often than the examples listed above was "I have these weird thoughts." After hearing this, the counselor should ask the student to explain what is meant by *weird*. Frequently, the term is related to fantasies and thoughts of suicide. As one student described, "I can see myself going out to my garden and shooting myself."

By using the active listening skills so basic to normal daily work, counselors have the opportunity to identify the danger signals of adolescent suicide. The themes to listen for are statements about helplessness, hopelessness, and death (Beck et al., 1979).

**Situational Clues**

Situational clues form an area in which counselors have the opportunity for the earliest possible intervention. Evidence supporting this viewpoint is the strong relationship among depression, the inability to cope with a recent crisis involving loss, and suicide attempts. When situational factors exist, such as those described by Morgan (1981), Tishler et al. (1981), and Crumley (1979), counselors are expected to be aware that a student is experiencing depression and loss and needs help. Morgan (1981) stated that any of the four types of forewarnings should be taken seriously. He recommends that the counselor "address the issue with the client in the most direct, forthright manner possible" (p.285).

School counselors have opportunities to be informed of drastic changes in the life situations of students. When hearing of a life crisis, it
would be an effective prevention strategy to invite the student to a conference, with the goals of providing support during a difficult time and probing for suicidal thinking. The theme to explore is coping with loss.

Any loss in an adolescent's life can be viewed by the young person as too much to bear. Adults who observe such events as failing a course, being cut from the [athletic, debate] team, being fired from a part-time job, or having an application to a particular college denied may judge the event as a minimal loss, soon to be overcome. Counselors using active listening skills, especially empathy, have the ability to identify the student's private view of the loss. It is this skill that provides counselors with opportunities for early intervention.

They key to a suicide prevention program based on situational clues is the network of concerned school personnel who keep the school counselors informed of students who experience the life crises known to be danger signals. One approach to establishing such a network is for the counseling staff to offer an inservice workshop on suicide prevention to the faculty and staff in their building.

School personnel will probably be supportive of a workshop on suicide prevention. In recent years, the public has read in general journals that suicide among the 15-24 age group increased in epidemic proportions over a 5-year period (Naglin, 1977), that in 1978, 2,000 between 10 and 19 killed themselves, and that this number is twice that of 1968 (Langone, 1981). In the same article, Langone quoted authorities who stated that suicide attempts outnumber completions by a ratio of 50 to 1 and that 33% of the children who were sent to outpatient clinics had suicidal thoughts.

In another article appearing in the Sunday supplement of a major newspaper, Jerome (1979) stated that the number of suicides in the 10-14 age group has increased 32% since 1968 and is the third-ranked cause of death in the 15-24 age group. Such articles have the effect of consciousness raising in the general public. Counselors can develop support for a prevention program in their school by calling the attention of faculty and staff to similar articles, television documentaries, or programs offered by local mental health groups.

An excellent 16mm teaching film, "Adolescent Suicide," (available from [American Counseling Association's] Order Services Department, 5999 Stevenson Avenue, Alexandria, VA 22304) would provide the desired consciousness raising. The film offers vignettes with expert commentary and teaches viewers about danger signals. The vignettes portray several of the life crises, including parental problems, death, the breakup of a love relationship, and trouble with the law.

After viewing the film, participants in a workshop might add to the list of situational events. The collective experiences of a group of veteran faculty and staff will be able to generate a list of crises associated with the students' age group, the developmental tasks associated with the age group, and situational events. The collective experiences of a group of veteran faculty and staff will be able to generate a list of crises associated with the students' age group, the developmental tasks associated with the
age group, and situational events involving loss. Other activities for the workshop involve discussing the signs of depression and defining loss.

**The Assessment Interview**

When a student is invited to a conference with the counselor because it is known that life crisis has occurred, the focus of the interview is on the student's coping with the problem. When the counselor learns that the student is experiencing depression and feelings of helplessness or hopelessness, "Are you thinking of Killing yourself?" is the question that must be asked.

A myth persists that if you get someone to talk about suicide, it will "plant the idea" in his or her head, and if the person does commit suicide, it is your fault. This myth is false. The contrary is more accurate. Beck et al. (1979) learned that when they discussed the topic of suicide, their patients expressed feelings of relief. This has also been the experience of the present author.

A calm, informed counselor completing an assessment of suicidal risk seems to signal to the student that it is acceptable to process frightening thoughts of suicide. Furthermore, the student can feel safe and secure in discussing personal problems with someone who cares, listens, and is willing to deal with a discussion of death. The assessment of suicidal risk permits the student to view the suicidal thoughts more objectively and the counselor to gather data to use in planning the appropriate intervention.

How should counselors confront a student who has suicidal thoughts? It might be helpful to say, "It sounds as if you are having a rough time of it -- do you ever think about killing yourself?" Most often, students readily admit to having thoughts of suicide or clearly state that they are not thinking of suicide. A few do not respond to the question, and the counselor should probably assume that suicidal thoughts may be experienced in the near future or perhaps have already been experienced. When the counselor has information that the student is involved with suicidal thoughts, the assessment of risk (sometimes termed lethality) begins.

The interview that will determine the seriousness of the student's intent to commit suicide begins with an evaluation developed from Beck's Scale for Suicide Ideation (Beck et al., 1979). Beck hypothesized that a continuum. The questions identify and clarify the student's thinking in four areas: attitude toward dying; attitude toward living; the characteristics of suicidal thoughts related to an attempt; and actual plans (Beck et al., 1979).

The key to the interview is the calm, confident manner in which the counselor conducts it. How is it possible to calmly interview someone who wants to commit suicide? A good analogy is interviewing a client who is planning a trip. The counselor could find out about the trip by asking the following questions in a calm, direct, and confident manner: "How will you travel?" "How badly do you want to go?" "Will you miss anyone?" "How long have you been planning this trip?"
When a student admits to having thoughts about suicide, the work of the counselor is to evaluate the seriousness of the threat and to decide whether to refer the student to local mental health resources, to begin continual counseling, or to classify the student as non-suicidal.

**Ten Critical Questions**

Assessing the potential for suicide requires that the counselor quickly identify the probability of an attempt. Translating the analogy of interviewing someone who is about to take a trip into suicidal risk assessment, the counselor should calmly and with matter-of-fact voice tones ask the following ten questions, which are from the work of researchers at the Center for Cognitive Therapy (Beck et al., 1979). This approach differs from other approaches to the assessment of suicidal risk because the focus is on the cognition of the student. By drawing out the private self-talk of the client, it may be possible to intervene at an early point along the suicidal thinking, verbal clues, gesture, and attempt continuum.

1. *How will you do it?* Depending on the vagueness or specificity of the plan, counselors can determine a low (no plan) to high (use of a quick method such as a gun or jumping) risk factor.

2. *How much do you want to die?* The cognitive therapists (Beck et al., 1979) asked their patients to place their wish to die on a 3-point continuum, with 1 representing little desire to die, 2 a moderate desire, and 3 a great desire.

3. *How much do you want to live?* This question forces the student to think about living. The student can at least begin to focus on reasons for living.

   Again, a 3-point scale is used, with 1 representing little desire to live, 2 a moderate desire, and 3 a great desire. Cognitive therapists have said that when depression is present, the person's thinking is distorted (Burns, 1981). These cognitive distortions include the all-or-nothing thoughts about death that prompt suicidal actions.

4. *How often do you have these thoughts?* The counselor needs to know whether the student rarely thinks of suicide (low risk) or is constantly thinking about it (high risk).

5. *When you are thinking of suicide, how long do the thoughts stay with you?* The counselor needs to know whether the thoughts are under control. Reports that the thoughts are almost out of control (running away) are indications of high risk.

   Further questioning includes inquiries to determine whether the student can turn off the thoughts, perhaps switching to others less threatening, or can counter with thoughts of reasons for living (Burns, 1981). Evidence of fears of loss of control of the impulse to commit suicide indicates a referral for psychiatric evaluation.
6. Is there anyone or anything to stop you? This looks for the student's support system or lifeline. When a support system is lacking, it is necessary for the counselor to temporarily become the lifeline until resource persons are identified or the life crisis prompting suicidal thoughts is resolved.

Efforts should be made to involve a person who has significant relationship with the student in the monitoring of the student during the time of the crisis. These efforts are made with cooperation of the client. If the student is uncooperative and, in the judgment of the counselor, there is a serious threat of a suicide attempt, the counselor is ethically permitted to notify the family. The student is advised if this step is taken.

7. Have you ever attempted suicide? Another myth about suicide is that once an attempt has been made, the person will not try again. A history of suicidal thinking, gestures, or attempts represents high risk, and referral to mental health resources is needed. The student with a history of suicidal behavior requires ongoing therapy.

8. Do you have a plan? If the student has made final plans, such as choosing a specific time, giving personal possessions to friends, writing a note, or saying "good-bye," the risk is very high and referral action is required. Few plans, vague plans, or no plans lower the risk factor.

9. On a scale from 1 to 10, what is the probability that you will kill yourself? The student's answer to this question will offer a clear signal to take referral action or not. Again, the explanation of the cognitive therapist is that this type of question confronts the all-or-nothing thinking that suicidal persons are experiencing.

10. What has happened that makes life not worth living? This question begins the investigation of the events that have precipitated so much stress in the student's life, so that the feelings of depression, helplessness, and hopelessness are overwhelming. Counselors probe for loss in the student's life and identify the sources of stress. This question is a bridge between the evaluation of the risk of suicide and the continuation of counseling. When the decision is to refer the student, there is no need to use this question.

These ten questions serve as the data base for the decision to start the referral process for the high-risk student or to continue counseling the low-risk student. There is no cutoff score to rely on; it requires clinical judgment based on the training and experience of the counselor, especially empathy and active listening skills.

Counselors should trust their active listening skills. When a counselor feels confident that he or she can work with a student, that the student is low in risk and has the motivation to learn how to cope with the problem, he or she should continue to counsel that student. When the counselor is fearful or feels uncertain as to whether the student is high in risk or not cooperative, the counselor should refer. A good motto is: "When in doubt, refer!"
If the decision is to refer, the counselor should inform the student of the decision and begin taking the steps for the referral right away. In most cases, the student is a minor, and the procedure will involve school authorities and parents in the effort to send the student to local mental health of psychiatric services.

If the decision is to continue counseling, Morgan (1981) stressed that regular contact be maintained. A directive counseling approach is recommended because this approach offers support to the student during the crisis. Without letting go of the relationship-building skills in nondirective counseling, a counselor can introduce the systematic procedures for helping students change that were learned in behavioral and cognitive counseling.

**The Contract**

Using a counseling contract increases the counselor's involvement with the student (Morgan, 1981). This approach has proven to have positive results. When an agreement to continue counseling is reached, it is important to develop a commitment to counseling with the student.

The use of a no-suicide contract is recommended. Suicidal thinking can be impulsive, and it is important that the student has control over such impulses. The no-suicidal contract offers the control that the student needs. Drye, Goulding, and Goulding (1973) reported that during a 5-year span, about 600 patients known to them have made no-suicide decisions. During the time these patients were on contract to no commit suicide, none did. These authors offered no demographic data regarding the 600 patients, and it is not known what results these researchers have had with adolescents. The present author's experience using no-suicide contracts with young adult 18 to 22 has been positive. Drye et al. (1973) also concluded that the no-suicide contract is effective. They report that the technique can be used by helping people with a wide range of training (nonprofessional to professional) and experience (no experience to much experience).

Twiname (1981), in support of Drye et al.'s approach, offered the verbal contract developed by them as follows:

_No matter what happens, I will not kill myself accidently nor on purpose, at any time._ (p. 11)

This statement can be typed on an index card on the counselor's desk. When a counselor is aware that a client has suicidal thoughts, he or she should first ask the ten questions discussed earlier, and when it is agreed that the client should continue counseling, the counselor should hand the card to the student with the request that the statement be made.
Requesting the student to state the no-suicide contract provides another opportunity to evaluate both the risk of suicide and the commitment to counseling. Twiname (1981) stated, "The client who is able to make this statement confidently and with congruent behavior is considered safe..." (p. 11). Morgan (1981) alerted counselors to any modification by the client. Modifications such as "Well, I'll try" or "I won't promise but I'll make every effort" are indicators of suicidal risk.

Recently, this author used the contract technique with a student the day after her suicidal gesture of cutting her wrist. When she finished making the contract, she said it made her feel better to have the contract. Another student admitted that [verbally] stating the contract removed a heavy burden.

The supportive counseling that follows is scheduled regularly, with the student having permission to contact the counselor if more time is needed. In most cases, appointments are weekly, sometimes more frequently. On occasion, it might help to schedule daily 15-minute sessions. With students experiencing suicidal thoughts, it is recommended that the counselor's home phone number be given, with the best times that the counselor may be reached.

The goals for counseling are to provide the student with the opportunity to talk about the problem, to learn how to cope with the stress that accompanies a life crisis, and to develop a plan for coping with the demands of each day. Since counseling takes place in school, goal setting usually focuses on coping with academics and the daily routine of school. Short-term goals are recommended. Daily planning permits the student to succeed with coping.

Counselors and students can collaborate on such goals as establishing daily schedules of activities, time budgeting, planning for the weekend, and concentrating on studies. Information regarding systematic approaches to counseling suicidal clients is found in Morgan (1981). Counselors working with students who experience depression along with the suicidal thoughts may find that systematic planning of meaningful activities will help the student overcome that depression (McBrien, 1981).

REFERENCES


[Reproduced with permission of copyright owner, the American School Counselor Association]
Notes

Counselors respond to Paducah [KY] crisis

by Mary Morrissey
Special to Counseling Today

After a 14-year old boy opened fire on his classmates with a .22-caliber pistol as they concluded their daily informal prayers at Heath High School in West Paducah, Ky., counselors and other mental health professionals rushed in to help the small Kentucky community cope with its grief.

Monday, Dec. 1, [1997] was a day that began like any other for the students and teachers at Heath High School, but it will be remembered as the day on which police say Michael Carneal, a freshman at Heath, calmly inserted ear plugs, drew a handgun from his backpack and fired into a group of students in the school's front lobby. He fired 11 shots, killing three students, partially paralyzing two more and wounding three others.

Developing a crisis plan

Administrators dismissed classes for the Heath elementary, middle and high schools following the Monday morning shootings. By that afternoon, a team of mental health professionals from the Kentucky Community Crisis Response Board had arrived at the McCracken County school to develop a crisis response plan. Part of the plan included the decision to hold school the next day so that the school could grieve together.

"It's in the students' and the faculty's best interest to go back to school the next day and the reason for that is obvious," said Renelle Grubbs, executive director of the Kentucky Community Crisis Response Board. "They are a community that is suffering and they need to be able to do that together and they need the opportunity to talk about what they are experiencing."

Grubbs and other members of the crisis team met with school administrators until 9:00 p.m. that first night developing the plan for the next few days. They discussed what resources could be provided for the teachers, students and parents. With local and national media descending on the town, they also developed a plan for keeping the media from interfering with the healing process.

Helping the students grieve

As the students arrived at school Tuesday morning, a group began to assemble spontaneously at the site where the shootings occurred just 24 hours before. Some prayed, some cried and some lit candles.
Pam Gabbard, an elementary school counselor in neighboring Ballard County trained in crisis counseling, volunteered her services at Heath. One of Gabbard's primary responsibilities throughout the two days she spent at Heath was to make herself visible in this front foyer. "When I would see students who seemed to be in a lot of stress, I would approach them, talk with them and work with them," she said, and noted the students were very open to talking with the counselors.

While Gabbard kept watch in the lobby, other counselors worked in the "drop in rooms" set up throughout the school for the students to go and talk with counselors at any time throughout the day. These group debriefings were facilitated by a member of the state crisis team and a local school counselor or psychologist. A number of ministers from the Paducah community also volunteered and were paired with the crisis workers. To identify and give support to the students who were closest to the victims, these pairs also followed the class schedules of the eight students who were shot.

"One of the things that's classic to trauma -- whether it's in a school or anywhere -- is that it tends to bring up every unresolved issue or grief an individual has," said Grubbs. "I call it Pandora's box."

Angela Wilkins, and ACA member since 1973 and a member of the Kentucky Community Crisis Response Board, was among those who provided counseling at Heath. Citing confidentiality, she declined to discuss the kinds of things she heard most from the students other than to say that "they said the kinds of things you would expect."

But perhaps one of the things that Wilkins and others didn't expect to hear from the students, particularly so soon after the tragedy, was words of forgiveness. Paducah is very much considered part of the Bible Belt and those strong religious beliefs were evident in the students.

In describing the mood of the students Wilkins said: "Shock and sadness prevailed -- anger was amazingly absent." By Tuesday afternoon, several students placed signs outside the school that read: "We forgive you Michael [Carneal]." The boy's older sister, who is projected to be the class valedictorian, was embraced by the students when she returned to school two days after the shootings.

"These students were an inspiration to me," said Wilkins. "They gave me a renewed faith in young people and they showed just what belief in God can get you through. They were incredible. We were just the facilitators; they got themselves through this."

Gabbard was equally impressed with the students' ability to focus on healing rather than hatred. In addition to providing crisis counseling at Heath, she facilitated a debriefing at her school where many of the students have friends and family at Heath. She hasn't heard one word of anger directed toward Carneal.

"Everyone is worried about him, concerned about him and praying for him," she said. "It's amazing to me."
"Press Go Home!"

Although the students didn't express anger toward Carneal, they were quite disturbed by the media. The Dec. 1 shootings brought dozens of television satellite trucks and news reporters to the quiet town of Paducah. From CNN and Gerald Rivera to People magazine and scores of newspapers, the media were desperate to tell the story of what happened. Students began putting signs up in the windows that read: "Press Go Home!"

"Trying to get the kids back to normal conditions with 20 satellite dishes parked behind the school was not easy," said Wilkins. "The media has a very important role in society. But I think there needs to be a real healthy discussion between the media and the people who work in crisis situations in terms of what is helpful and what is sensationalism. Trying to grab any child who will talk to them and put [him or her] on camera is the worst thing they can do."

The crisis response team is accustomed to the media's reaction to traumatic events and dedicated a good deal of time developing a management plan that serve everyone's needs, said Grubbs. The team and the school administrators decided to allow the media to set up outside the middle school across the street where an appointed spokesperson would provide frequent updates throughout the day. After the students went home, the camera crews were allowed in the high school.

"I think many times we find the media can retraumatize," said Grubbs. "The way we had it set up, we were able to protect the children and the school community from the media and still get the story out so families would understand that their children were getting helped.

Role of crisis team

When a tragedy of this magnitude occurs, the community is confused and immobilized. It's the job of the crisis response team to get everyone back on their feet as quickly as possible. The crisis team needs a comprehensive response plan and trained professionals of different disciplines working in unison to provide all the necessary services. The team at Heath had both and by Tuesday afternoon Grubbs could begin to see a marked change in the school's mood.

"What was noticeable was we had students and faculty saying how glad they were that they had a chance to come together," she said. "They recognized the value of having the opportuniy to grieve together, to have a safe place to do it in and to be given permission to grieve. The normalizing began to take hold and people got to be more comfortable with the fact that they were hurting terribly."

Indeed, a large part of what crisis response team does is normalize the feelings of those who are grieving. Most people are uncomfortable with grief and will try to distant themselves from it. Oftentimes, trauma survivors need to be told that it is OK to grieve. Knowing this, the crisis
response team at Heath educated the community on the physical, cognitive and emotional reactions to what had happened.

"We give them permission to feel awful, to feel confused, to not be able to stop crying, to not want to talk to anyone," said Grubbs. "We stress that we are about helping people manage the long-term effects of critical incident stress and that we are responding to normal people who have experienced abnormal events."

The students and faculty at Heath High School weren't the only ones who benefited from the work of the crisis response team. Counselors met with the emergency personnel who responded to the shootings and the janitors who had to clean up the students' blood in the foyer. The team also held a special meeting in the school gymnasium for parents and other community members. They gave tips to parents on helping their children in the months ahead and distributed educational material on the grieving process.

"Our emphasis is to ensure that every population and subpopulation that was impacted receives support," said Grubbs. "We perceive our role as helping the community tease out what's going on now, what they anticipate is going to happen and what is the most helpful way of supporting people through those natural responses."

Before leaving Heath on Wednesday, Dec. 3, the team sat down with the school's administration to identify community resources that may be needed, such as counseling services of special support groups. They also warned the administration that anniversaries -- whether the first of each month or every Dec. 1 -- may trigger memories of other events.

"We responded to the actual crisis, but obviously the grieving process will go on for some time there," said Grubbs. "This is only the beginning for them. The grieving didn't end when we left and it didn't end after the funeral."

**A commitment to counseling**

In an era when local school boards and state legislatures everywhere are tightening their belts, Kentucky is somewhat of an aberration. The Kentucky Community Crisis Response Board was established in 1996 when, after two tragedies with multiple deaths, the mental health and emergency services communities came together and asked the state to develop a planned response to community crises. Nearly 200 volunteer crisis responders throughout Kentucky have been trained since the board's formation. A standing agency that responds to all types of community crises, Grubbs said it is the only one of its kind in the nation.
At the local level, Wilkins credited the McCracken County School District for investing heavily in counseling without any mandate to do so. The state's school reform legislation of 1990 withdrew the mandate to have counselors for grades K-12 but, eight years later, McCracken County has counselors in every elementary, middle and secondary school.

"This is a district that made a commitment with its tax dollars to have a counselor in all schools and I think that's real important," she said.

Alan Warford, the counselor at Heath High School, declined a request for an interview saying he didn't want to jeopardize his counseling relationship with the students he continues to see as a result of the shootings.

**Understanding why**

Wilkins lived near Paducah years ago. Like everyone else, she was shocked that something like this would happen at Heath High School, a rural school of approximately 600 students in grades 9-12. It is a community where there are no strangers and where your neighbors are your friends. And it is a community that now must struggle with one question: Why?

According to reports, Carneal, the son of an attorney, hung out with self-professed atheists and sometimes heckled the prayer group, but he had no serious past discipline problems.

Carneal suggested to police that he was influenced by a scene in the movie *The Basketball Diaries,* in which a boy dreams of gunning down his classmates. Reportedly, he also warned friends the week before that "something big's going to happen."

Carneal allegedly carried into school a .22-caliber semiautomatic handgun with three spare clips of ammunition, two .22-caliber rifles and two shotguns. He apparently wrapped the rifles and shotguns in blankets and told curious classmates they were props for a science project.

Asked afterward by sheriff's detectives why he shot his classmates, the 14-year-old gunman told them he didn't know.

Carneal is being charged as an adult with three first-degree murders and five attempted murders. If convicted, Carneal faces up to life in prison without parole for 25 years on each of the murder counts. The attempted murder charges carry a possible sentence of 10 to 20 years in prison. He is not eligible for the death penalty. Kentucky law requires defendants to be at least 16 to be eligible for execution.

Mary Morrissey is a former editor of Counseling Today. She lives in Boulder, Colorado.

[Reproduced with permission of the American Counseling Association.]
Suicide postvention: a new disaster plan -- what a school should do when faced with a suicide

Peterann M. Siehl
Assistant Professor of Guidance and Counseling
Bowling Green State University
Bowling Green, Ohio

How many schools have suffered from fire? And yet, plans for fire drills are known and practiced by almost every school in the United States. Compare this with the number of schools that have plans in effect for coping with student suicide, and the results are striking. Suicide is the second leading cause of death today in the adolescent population, second only to accidents, and still few suicide plans for coping with the event of suicide are in effect in schools across the United States. Gone are the days of the single procedure; now, depending on what part of the country you live in, drills and written procedures exist for fires, tornadoes, earthquakes, and floods. These disasters may be one-in-a-lifetime situations, or disasters that may never occur -- and yet procedures must be established so all concerned will know what to do in the event that one of these disasters does indeed occur. Preventive planning can save time and lives and alleviate much confusion.

Another type of disaster that can occur in today's school systems is that of suicide. Are you a new school counselor anxiously awaiting your first crisis case? Are you a veteran counselor still leery of dealing with suicidal clients? Are you aware that the adolescent suicide rate in the United States has more than doubled in the past decade and is still rising (Langone, 1981; Lee, 1978; McBrien, 1983; Morgan, 1981; Motto, 1978; Ray & Johnson, 1983)? The statistics become even more alarming when we realize that many of the suicides are never recorded as suicides but are listed as accidents. With these thoughts in mind, it is probable that every counselor will at some time in his or her career come into contact with a client who will talk about, attempt, or commit suicide.

What can a counselor do to be prepared for this most difficult task of dealing with the suicidal client? Many workshops, articles, and conferences are available for counselors to upgrade their skills and improve their knowledge on the topics of dealing with the warning signs of and counseling strategies for the troubled or suicidal adolescent (Wellman, 1984). This article goes one step beyond the prevention and intervention vein of working with suicidal youth and presents a plan of action that could be taken when all other measures fail and counselors are faced with the actual crisis of a suicide. Postvention strategies need to be developed, distributed, and understood by all school personnel to provide an effective means of working with a death by suicide and its aftermath.
Just as schools have procedures for fire drills, tornadoes, and bomb threats, so should a procedure for a suicide be developed and readily available in the case of this type of disaster. All of the disasters mentioned affect the lives of the entire school population, with every minute important in helping to save a life. A planned procedure for dealing with a suicide can help save lives and improve the emotional environment of the school if carried out in an orderly manner. Confusion due to an absence of formal procedures can delay important postvention activities.

The counselor can be instrumental in developing the postvention plan. Each counselor knows his or her own school system, the community resources that are available, and other mental health workers who could be of vital importance.

Recognizing that each school and community is unique and possesses its own special resources, it is hoped that the following suggestions will be used as guidelines for each system to develop a plan that will be most appropriate for each school.

1. **TEAM DEVELOPMENT**

It is important to develop a "team" that will be able to handle this emotional crisis (Barrett, 1985; Capuzzi, 1986; Dayton City Public Schools, 1990; Hempfield High School, 1989; Pocono Mountain Board of School Directors, 1988). The team concept is used today in drug counseling and other specialized counseling areas in which experts are needed to aid counselors in efficiently handling large numbers of students. I suggest that teachers be asked to volunteer to serve on a special suicide task force and that these teachers as be given special inservice training by counselors or area resource specialists on dealing with suicide and its aftermath. The team would be composed of counselors, area resource person, volunteer teachers with special training, school psychologists, and other personnel designated in advance by the postvention plan (Butler & Statz, 1986; Fuimura, Weis, & Cochran, 1985; Hart & Keidel, 1979; Konet, 1986; Quakertown Community School District, 1984; Wall & Viers, 1985).

2. **INSERVICE PROGRAMS**

School counselors, area resource persons, or other team members should present inservice workshops to the entire school staff in order that all teachers feel comfortable with discussing the issue of suicide with the students. Special workshops for small groups of students and all support staff, inclusive of bus drivers, janitors, and cafeteria workers, should also be planned to discuss the topic of suicide. Its causes, warning signs, and sources of help, in an attempt to prevent student suicide. It is also important to let the student population know that the staff is willing to discuss these sensitive issues when necessary.
3. FACULTY CONTACT

The day a suicide occurs (usually after school hours or on weekends), the principal should initiate a chain phone call to inform all faculty members of the tragedy and to schedule an early morning [faculty and staff] meeting for the following day. The phone call and morning meeting reduce the risk of faculty arriving at school uninformed. The purpose of the meeting is threefold: (a) to be sure faculty members are informed of the incident, (b) to ensure that faculty members know the facts surrounding the incident so they can dispel rumors and horror stories that may crop up during the day, and (c) to announce the special schedule and events of the day (Barrett, 1985; Hempfield High School, 1989; Shipman, 1987). Team members and planned resource persons should also be contacted so they can plan to assist at the school the following day. Substitutes also need to be scheduled for team members who will be out of their classrooms during the crisis phase of the school day. An end-of-the-day meeting should be held to evaluate and discuss the day's procedures as well as further concerns for the days to come. Mental health personnel should be available during this meeting for those teachers who need to work through their grief and loss due to the suicide.

4. CRISIS CENTERS

Special centers, staffed by counselors, school psychologists, area mental health workers, and specially trained team members, should be setup throughout the school (Barrett, 1985; Shipman, 1987; Souderton Area School District, 1986). The centers should be easily accessible and private for those students who might need special counseling throughout the day and for several days after the suicide. Team members can also be placed in certain classrooms to help teachers who feel uncomfortable with the early morning activities.

5. INDIVIDUAL CLASSROOM PROCEDURES

Faculty members should have a checklist of activities for the first class session of the day, similar to checklists used to describe the opening and closing procedures of school.

Each teacher should announce the death of the student and the known facts of the death to his or her first class of the day. Time should be allowed for grief reactions in the classrooms and discussions if necessary, but the teacher should then return to the regular education schedule as soon as possible. Students should be allowed to express their grief and discuss openly their feelings, fears, and concerns that surround the event. Teachers must know the location of special crisis centers to which they can send extremely upset students throughout the day for special counseling or help in dealing with this tragedy. Students should be made aware of the special counseling locations set up for the day and allowed to use the counseling services as needed. Funeral arrangements should be explained, and students should be informed that they will be allowed to attend the funeral if they have a note from the home.

Teachers should keep their eyes and ears open for those students who may react in an extremely upset manner. Students who appear extremely
upset should be escorted to the counseling center, and the counselors should be notified so parents can be contacted. Some students may become so upset that they need to be sent home to spend time with family members. It is important for faculty members to be sensitive to the feeling of each student during this time because it is impossible to judge which students might have the strongest reactions. Teachers should try to return to the regular classroom agenda as soon as possible while allowing individual students the grief time that is necessary. It is very important to deal with the suicide in a gentle manner, but it is also important not to glamorize or turn the student who took his or her life into a hero.

6. DAYS FOLLOWING SUICIDE

Teachers should remain on the lookout for students who might show signs of depression related to the recent suicide. These students should be referred for counseling, and the parents should be contacted and invited to a special meeting to help them understand and help their child cope with his or her feelings. Warning signs that could suggest further difficulty for their child might be discussed, as well as sources of help.

7. HOME VISITATION

The principal, counselor, or favorite teacher should make a home visit to the family of the deceased within 24 hours of the death. This visit is not only for the expression of sympathy but also to explain the school's procedure in dealing with the death, to seek advice in what the family expects from the school, and to discuss possible plans for a memorial service or special event to be held in memory of the deceased. A second visit should occur, within an appropriate time frame, to return personal locker items and to lend support to the survivors. This second visit is handled best by a teacher who was close to the student or by the guidance counselor.

8. SPECIAL EVENTS OR MEMORIAL SERVICES

These items can be planned by the school or planned in response to the request of a parent. The events or services should be in memory of the loss of the student, but a point should be made that there are much better solutions to problems than suicide and that there are people to help when problems seem insurmountable. Planned events or services help students draw closure to the death and tragedy that has occurred and help them to begin to go on with their work and lives. Some sources would argue this step and would consider a memorial service a glorification of suicide (Garfinkel, Crosby, Herbert, Matus, Pfeifer, & SHERAS, 1988). I believe a memorial service or special event helps with closure and promotes healthy feelings with friends, families, and significant others in the life of the deceased child.
9. MEDIA COVERAGE

It is extremely important to have honest, accurate coverage of the incident reported to the media. One school official should be responsible for all media coverage. This coverage should be checked and cleared with the family to avoid any problems in the community. The student's school activities should be reported, but the student should not be made into a hero or outstanding individual if this was not the case. The school's sympathy should be reported, but the idea should also be conveyed that a life was cut short that could have been saved if the individual had reached out for help.

10. LENGTH OF TIME FOR CONCERN

It is necessary for teachers and counselors to be alert for months after a suicide. Some students will deal with the loss and grief immediately, while others will let it fester and grow within themselves for months. The aftermath of suicide will often continue for up to 2 years. It is important that "high-risk" students be carefully monitored for at least 6 months, with less intense, but continual, concern for 1 to 2 years thereafter.

Suicide is on the rise, and it is unfortunate that school systems need to plan in advance for this type of disaster, but they must! Postvention taken seriously can aid the students, staff, administration, and community in dealing with such a tragedy. Suicide postvention, when carefully dealt with and openly planned for, can help to prevent further tragedies in the aftermath of suicide.

REFERENCE


[Reproduced with permission of copyright owner, the American School Counselor Association.]
Death of a student: implications for secondary school counselors

Judson Swihart  
Director, International Family Center, Manhattan, Kansas
Benjamin Silliman  
Assistant Professor, College of Human Ecology, Louisiana Tech University, Ruston, Louisiana
Joan McNeil  
Associate Professor (ret.), Kansas State University, Manhattan, Kansas

It may only be a matter of time for any high school counselor before he or she is confronted with the issue of how to respond when a student dies of illness, accident, or suicide. In a recent survey of college students by one of the authors (McNeil, 1987), 63% of the sample of 190 students reported experiencing the death of a peer during high school years. Despite their developmental capacity to comprehend the meaning of death (Kastenbaum, 1986), teens typically have few opportunities to discuss death and coping with informed adults (Gordon, 1986). Rituals (funerals) social support (meals, personal contact), and informal discussion of death are often oriented toward adults, leaving peers as the forgotten victims of a teen's death (McNeil, Silliman, & Swihart, 1990). When a student dies, high school counselors will likely be expected to respond therapeutically or educationally on at least three levels: (a) help to individuals, (b) support of peer groups (among teachers and students), and (c) guidance of the student body as a whole. In addition, counselors may be asked, formally or informally, to help grieving and healing in community groups (churches, parent groups) and the community as a whole.

Little or no research on the short-term or long-term impact of peer death on high school students has been conducted (McNeil, 1986) and relatively few support programs in schools have been reported (Calvin & Smith, 1986; Ribar & Berman, 1987; Zinner, 1987). Suicide (Crespi, 1990; Martin & Dixon, 1986; Perrone, 1987) and death of parents (Gray, 1988) have been discussed by several authors, but effects of peer death from disease have rarely been studied. The current study addressed three issues believed critical to understanding and enabling students' adjustment to a peer's death: (a) short-term and long-term impact of adolescent death on peers, (b) types of grieving behaviors peers used to adjust, and (c) procedures that promote adjustment implemented by a school system. Findings in these areas formed the basic recommendations to the school staff listed at the end of this article.

METHOD

A case study approach, developed by two of the authors, was used to gather quantitative and qualitative data in a small, rural, midwestern high school 18 months after the death from leukemia of a popular 16-year-old male student (hereafter referred to as "Bill"). Questions in the instrument were derived from existing literature on adolescents and death (Corr & McNeil, 1986). Findings from this study are most appropriately generalized to small, rural schools. Although participation in the study was voluntary, researchers collected 94 usable questionnaires from a high
school of 140 students. Most non-participants were students who did not know Bill. In addition, qualitative data were gathered from opened-ended responses of students, comments of teaching and administrative staff, and comments of Bill's family. These data are integrated with quantitative responses below.

RESULTS

Initial Emotional Impact

Students surveyed described themselves as significantly influenced by the death of their peer, which corroborated observations made by Kastenbaum (1986). Of the respondents, 96% reported some emotional impact at the time of death, and 4% reported the death had no immediate impact. Students report initial feelings as "very sad" (67%), "shocked" (45%), "angry" (42%), and "numb" (34%). These responses are to be expected in light of those described in previous studies (Martin, Martin, Barrett-Kruse, & Waterstreet, 1988; Raphael, 1983). Although most (83%) of the students reported that during the first week following their peer's death they thought about him, many (39%) of the students reported thinking about Bill's death four or more times per day. These responses were confirmed by interviews with teachers and administrators who described the students during the first week: "shock, some frustrations, unusual anger.... The teachers had a tough time getting the students to do anything in class.... They just sat there."

Long-Term Effects

Eighteen months after the peer's death, about half (52%) of the students still in high school reported they will thought of him "once in a while," and an additional 15% reported they still thought of Bill "frequently." About half (53%) of the students reported they thought of him on special days such as his birthday or athletic events. These results parallel those of Balk (1981), who found that one third to one half of his sample of sibling-bereaved adolescents reported intensive emotions during interviews conducted an average of 23.6 months past death. Gray (1988) reported a similar pattern of prolonged adjustment in high school students who requested continued participation in support groups after 12 weeks.

During data collection 18 months after Bill's death, researchers observed that the student body was solemn. Several students cried; others declined to participate. Later, several distressed students talked with the principal and school counselor.
A majority of the students (64%) felt they had permanently changed because of their peer's death, and an even higher percentage (89%) reported permanent change. Reported changes included appreciating friends more, thinking more about dying, wondering what happens after death, and worrying about death more.

Teachers and administrators also described Bill's classmates as changed over the long term: "Students were more thoughtful, quiet, serious ....Students seemed moodier.... [The death] changed the atmosphere of the whole class -- [They were] more subdued; his class never had real leadership -- they just wanted to get done and out of school.... They were just 'skimming the surface.'"

**Types of Grieving Behaviors**

On open-ended questionnaire items, students reported 19 different grieving behaviors used in attempts to adjust to the loss. Grieving behaviors included attending school assemblies, attending the funeral, purchasing a plaque, physical release by playing excessively hard in sports, crying, talking with friends and family, writing down feelings, trying not to think, visiting the cemetery, and dedicating their yearbook to Bill.

The major categories of grieving responses identified as helpful by students were "talking it out" (44%), "thinking about it alone" (19%), "exchanging self-comforting explanations" (13%), and "physical release via activity or crying" (8%). A total of 89% of the respondents talked with friends. Overall, there emerged two categories of student grief responses: those who wanted more time to talk (especially to peers) and those who wanted the school system to get on with life and not bring up the topic. These patterns are consistent with earlier findings (Balk, 1983, Fleming & Adolph, 1986). This dichotomy may reflect the seeking withdrawal conflict and behavior conflict of adolescents in grief (Fleming & Adolph, 1986). Both groups seemed to be trying to adjust to pain; some by working it through and others by avoiding it. The first group included primarily close friends of the deceased peer. The second group, largely not close friends of the deceased, expressed some feeling that "too much was made of the death." That group may also have included those afraid to confront and discuss death.

In general, students perceived little support from their families, as reported by Gordon (1986). Qualitative questionnaire responses reflected the egocentrism of adolescence (Elkind, 1981) in which parents were assumed to be uninterested and unsupportive if they had not known the deceased friend. In other cases, students found parents uncomfortable, as reported by Gordon (1986): "Parents and teachers generally do not handle the subject well, but teens do not know that until they participate in a death-related experience." Interestingly, teachers in this study had similar roles in the students' support systems as parents had in Gray's (1988) study of teens whose parent died (i.e., close friends of the deceased).
Many teachers were unable to offer support because they were working through their own grief. Students reporting the best adjustment to the crisis seemed to be among those using an array of grieving responses rather than trying to adjust through only one activity.

**IMPLICATIONS**

**School Counselor Responses**

When an adolescent dies, the school counselor may be effective in counseling individual students, but an even more extensive approach may be initiated by treating the entire school as a system. In such a model, grieving and coping include, yet transcend, the sum of individual responses. Individual reactions can only be understood in the context of interaction in an intimate network, present, past, or both. Personal and group responses to facts and feelings about the death (i.e., denial, blaming, or facing issues together) will inevitably influence both the future functioning of the group and the adjustment of individuals. The systems model views these coping processes and consequences as outcome of group rules and dynamics (i.e., openness in talking about death).

The school administration in this case study turned to the school counselor for assistance in designing a response. This plan considered potential student and faculty reaction as well as their prior training and experience with death. The school system made available to students and faculty a wide variety of activities that allowed time and places for "processing" grief. From this experience, several valuable issues emerged.

**Issues to Consider in Counseling and Planning**

1. A large percentage of students will be affected by the loss of a peer. Close friends of the teen who died will likely experience grief more intensely and longer than the student body in general. These students may require special attention from counselors, teachers, and administrators, but may also comfort those within their subsystem. Small schools may be relatively more affected, because a larger percentage of a given class may have lost a close friend. Others not close to the peer who died may nevertheless be reminded of previous grief experiences or current feelings of alienation. Their responses may not make sense in the immediate or known context, but may be signals that additional support is needed.

2. The first week after the death, students may be "numb" and not feel like producing academic work in the classroom. Teachers need not turn class sessions into group therapy or recreation times, but may scale down expectations in response to change energy levels, as indicated by Gray (1988).
3. Teachers, dealing with their own grief, may not know what responses to offer or may try to do too much. Both preventive and proactive responses by school systems should enable teachers to work through grief and offer the grace of listening. Students rarely expect perfect answers or controlled indifference (McNeil, 1986), but find teachers most helpful as emphatic listeners.

4. Not all students will grieve or respond in the same manner. Some will want to relieve the hurt by discussion, others by avoiding the issue. These reactions are typical (Gordon, 1986; Kastenbaum, 1986) and should be affirmed by counselors. In any group, implicit or explicit rules (expectations about crying, talking) may restrict the form or range of expression allowed to members. Obviously, prohibitions on sympathetic suicide or active revenge are necessary limits to grieving. Groups whose rules allow young men to shed tears or young women to express non-destructive anger will promote healthy adjustment to loss. For many people, small groups may offer psychologically safer contexts in which to share a variety of feelings and thoughts.

5. Students often release initial frustration and emotional energy through physical activity (McNeil, 1986). Schools may find extended hours for these activities therapeutic for students.

6. Adolescents seem highly aware of in- and out-group membership. The closest friends or class of the deceased may "draw in" and exclude other students or adults from expressions of grief or memorials (meetings, plaque). Counselors can defuse these potentially volatile coalitions by bringing a variety of students together in small groups to share feelings. Nevertheless, certain activities may be reserved for those in the same grade to meet special needs.

7. Study respondents indicated a need for unstructured discussion time. Because school is a major social environment for teens, institutional denial of a student's death or attempts to overcompensate and structure all grief expression may cut off normal, informal exchange of ideas and feelings. Healing in all types of systems takes place via open communication and support. By contrast, repression of losses tends to lead to dysfunction.

8. School counselors form a vital link between teens' peer and school systems and their family systems. Such a link is used to its maximum when counselors inform all parents of the loss, offer support, and suggest listening and affirmation skills that, in this case, teens found the most helpful family response. A school staff's expression of loss and sympathy to the family of the deceased should not be forgotten as a model and complement to efforts with peers. Similarly, many students reported support from a pastor or fellowship of Christian athletes. Counselors who link with these helpers present a more unified support network and reduce work overload on themselves.

9. Every system is characterized by certain relationship roles. School personnel should recognize that students come to identify and value peers or the roles they play in small or large group functions. After a death,
peers may not allow another student to replace roles fulfilled by the lost member (e.g., group leader, skeptic, romantic, clown). Although the group may eventually acknowledge replacement(s), adults' attempts to force such system changes may result in intense resistance.

10. Individual and group responses to loss may remain intense for extended periods. School systems should provide opportunity for death education or follow-up discussion for those who want to participate.

The response of the school counselor in the school system is not the only factor in adjustment to peer death. It may, however, be a significant influence on student and staff grieving, mutual support, maturing and togetherness in the face of death.

REFERENCES


[Reproduced with permission of copyright owner, the American School Counselor Association.]
Section 7 – A Panel Discussion

This workshop has merely touched the surface of the process necessary to develop a school safety and emergency preparedness plan. Individuals who have experienced crises first-hand will share their reflections on incidences which occurred in their school district. Participants will be afforded an opportunity to ask questions, share concerns, and express beliefs.

Questions
Jean Piaget: Cognitive Development Theory

Piaget's cognitive stages presuppose a maturation process in the sense that development is a continuation and is based on previous growth. The mental operations are sequential and successive. The stages are hierarchical, and they form an order of increasingly sophisticated and integrated mental operations. Hereditary or environmental factors may speed up or slow down cognitive development, but they do not change the stages or the sequence.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 18 Months</td>
<td>Sensorimotor Intelligence</td>
<td>Infants experience the environment through the senses of taste, smell, touch, sight, and hearing. Newborns &quot;taste&quot; all objects that can be put in their mouths. They call attention to their needs and wants by crying. Infants avoid things that are distasteful, smell odious, give pain, or sound or appear frightening. They are dependent but display a desire for independence. They tend to be largely self-centered, concerned mainly with their own interests and feelings. Their awareness of others is generally limited to significant adults.</td>
</tr>
<tr>
<td>1½ - 8 Years</td>
<td>Preoperatory</td>
<td>Symbolical functioning (speech, language, play, gestural systems, [e.g., postponed imitation], developing mental develop. Thought is possible; speech develops. Walking and following a pattern develops. The sensorimotor level must be elaborated again and again. They become more aware of others as they develop friendships with age-mates and adults other than their parents. They begin to be aware of how they affect other people, and they widen the range of people upon whom they depend.</td>
</tr>
<tr>
<td>7 - 12 Years</td>
<td>Concrete Operations</td>
<td>Begin to perform elementary logical operations and expand upon their sole dependence upon perceptual judgements. They notice inconsistencies between thought and action. They still accept the ethics and rules of parents and other authorities. Process development develops over these years include seriation and classification. Elementary schooling begins. During this span to years the individual begins to depend on peers for feedback regarding behavior and beliefs.</td>
</tr>
<tr>
<td>12 + Years</td>
<td>Propositional or Formal Operations</td>
<td>Begins to use more abstract hypothetico-deductive reasoning; perform logic and can control variables in experimentation. Wants to know &quot;why&quot; something happens and questions &quot;why&quot; authorities require them to do specific things. Transcience also marks a major shift as seeking independence come prior any goal, resulting in conflict with adults who would prefer to retain their influence. The classic &quot;identity crisis&quot; begins and expands during adolescence. Feedback from a range of significant others, including parents, friends, and heroes, and feedback from TV and other media may also influence the view of self. Begins to think of self as a member of a larger community. More mature relations based on sexual attraction emerges as the capacity for intimacy develops.</td>
</tr>
</tbody>
</table>
# Erik Erikson: Psycho-Social Development Theory

<table>
<thead>
<tr>
<th>Stage</th>
<th>Ages</th>
<th>Basic Conflict</th>
<th>Important Event</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Oral-Sensory</td>
<td>Birth to 12-18 Months</td>
<td>Trust vs Mistrust</td>
<td>Feeding</td>
<td>The infant must form a first loving, trusting relationship with the caregiver, or develop a sense of mistrust.</td>
</tr>
<tr>
<td>2. Muscular- Anal</td>
<td>18 Months to 3 Years</td>
<td>Autonomy vs Shame/Doubt</td>
<td>Toilet Training</td>
<td>The child's energies are directed toward the development of physical skills, including walking, grasping, and rectal sphincter control. The child learns control but may develop shame and doubt if not handled well.</td>
</tr>
<tr>
<td>3. Locomotor</td>
<td>3-6 Years</td>
<td>Initiative vs Guilt</td>
<td>Independence</td>
<td>The child continues to become more assertive and to take more initiative, but may be too forceful, leading to guilt feelings.</td>
</tr>
<tr>
<td>4. Latency</td>
<td>6-12 Years</td>
<td>Industry vs Inferiority</td>
<td>School</td>
<td>The child must deal with demands to learn new skills or risk a sense of inferiority, failure, and incompetence.</td>
</tr>
<tr>
<td>5. Adolescence</td>
<td>12-18 Years</td>
<td>Identity vs Role Confusion</td>
<td>Peer Relationships</td>
<td>The teenager must achieve a sense of identity in occupation, sex roles, politics, and religion.</td>
</tr>
<tr>
<td>6. Young Adulthood</td>
<td>19-40 Years</td>
<td>Intimacy vs Isolation</td>
<td>Love Relationships</td>
<td>The young adult must develop intimate relationships or suffer feelings of isolation.</td>
</tr>
<tr>
<td>7. Middle Adulthood</td>
<td>40-65 Years</td>
<td>Generativity vs Stagnation</td>
<td>Parenting</td>
<td>Each adult must find some way to satisfy and support the next generation.</td>
</tr>
<tr>
<td>8. Maturity</td>
<td>65 to Death</td>
<td>Ego Integrity vs Despair</td>
<td>Reflection on acceptance of one's life</td>
<td>The culmination is a sense of oneself as one is and of feeling fulfilled.</td>
</tr>
</tbody>
</table>
# Lawrence Kohlberg: Moral Development Theory

<table>
<thead>
<tr>
<th>Stage</th>
<th>Level</th>
<th>Concept of what is Right</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level A -- Preconventional Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>The Stage of Punishment and Obedience</td>
<td>Right is literal obedience to rules and authority, avoiding punishment, and not doing physical harm. Actions are judged in terms of physical consequences rather than of psychological interest of others.</td>
</tr>
<tr>
<td>2</td>
<td>The Stage of Individual Instrumental Purpose and Exchange</td>
<td>Right is serving one's own or other's needs and making fair deals in terms of concrete exchanges. The person separates own interests and points of view from those of authorities and others.</td>
</tr>
<tr>
<td><strong>Level B -- Conventional Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The Stage of Mutual Interpersonal Relationships and Conformity</td>
<td>The right is playing a good (nice) role, being concerned about the other people and their feelings, keeping loyalty and trust with partners, and being motivated to follow rules and expectations. Is aware of shared feelings, agreements, and expectations, which take primacy over individual interests.</td>
</tr>
<tr>
<td>4</td>
<td>The State of Social Systems and Conscience Maintenance</td>
<td>The right is doing one's duty in society, upholding the social order, and maintaining the welfare of society or the group. Differentiates societal point of view from interpersonal agreement or motives. Takes the viewpoint of the system, which defines roles and rules.</td>
</tr>
<tr>
<td><strong>Levels B/C -- Transitional Level</strong></td>
<td></td>
<td>Choice is personal and subjective.</td>
</tr>
<tr>
<td><strong>Level C -- Postconventional and Principled Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The Stage of Prior Rights and Social Contract or Utility</td>
<td>The right is upholding the basic rights, values and legal contracts of a society, even when they conflict with concrete rules and laws of the group. Considers the moral and legal points of view, recognizes they conflict, and finds it difficult to integrate them.</td>
</tr>
<tr>
<td>6</td>
<td>The Stage of Universal Ethical Principles</td>
<td>This stage assumes guidance by universal ethical principles that all humanity should follow. Recognizes the nature of morality as an end, not means.</td>
</tr>
</tbody>
</table>
Robert J. Havighurst: Developmental Tasks Theory

Havighurst has identified six periods in human development: (1) infancy and early childhood, (2) middle childhood, (3) adolescence, (4) early adulthood, (5) middle age, and (6) late maturity. Developmental tasks are defined as "the tasks the individual must learn" for purposes of "healthy and satisfactory growth in our society." For our purposes, only the first three periods are presented here.

- **Infancy and Early Childhood**
  1. Learning to walk
  2. Learning to take solid foods
  3. Learning to talk
  4. Learning to control the elimination of body wastes
  5. Learning sex differences and sexual modesty
  6. Achieving physiological stability
  7. Forming simple concepts of social and physical reality
  8. Learning to relate oneself emotionally to parents, siblings, and other people
  9. Learning to distinguish right and wrong and developing a conscience

- **Middle Childhood**
  1. Learning physical skills necessary for ordinary games
  2. Building wholesome attitudes toward oneself as a growing organism
  3. Learning to get along with age-mates
  4. Learning an appropriate masculine or feminine social role
  5. Developing fundamental skills in reading, writing, and calculating
  6. Developing concepts necessary for everyday living
  7. Developing conscience, morality, and a scale of values
  8. Achieving personal independence
  9. Developing attitudes toward social groups and institutions

- **Adolescence**
  1. Achieving new and more mature relations with age-mates of both sexes
  2. Achieving a masculine or feminine social role
  3. Accepting one’s physique and using the body effectively
  4. Achieving emotional independence of parents and other adults
  5. Achieving assurance of economic independence
  6. Selecting and preparing for an occupation
  7. Preparing for marriage and family life
  8. Developing intellectual skills and concepts necessary for civic competence
  9. Desiring and achieving socially responsible behavior
  10. Acquiring a set of values and an ethical system as a guide to behavior.
Section 8 -- Bibliography/References

The following books, periodicals, newspaper/newsletter articles, etc., were used or referenced in the development of this workshop.

Books


Periodicals, Newspapers, Pamphlets, Workshop Handouts

[Note: Some references, when appropriate, are listed under more than one category.]

Abuse, Emotional, Physical, and Sexual; Date Violence

Special Issue: Child Abuse – Issues and Interventions


**At-Risk**


**Bibliography/References**

**Bibliotherapy**


**Blended Families**


**Brief Counseling**


Bullying


Conflict Resolution

<table>
<thead>
<tr>
<th>Special Issues on Conflict Resolution</th>
</tr>
</thead>
</table>


---

**Crisis Prevention, Intervention, and Postvention**

<table>
<thead>
<tr>
<th>Special Issues on Preventive and Developmental Counseling</th>
</tr>
</thead>
</table>


Dying and Death


Bibliography/References

**Depression**


**Environmental Disasters**


**Homeless**


**Incarceration**


**Latch-Key**

Bibliography/References

Mobility


Phobia


Post-Traumatic Stress Disorder


Runaways


Separation and Divorce


Bibliography/References


**Stress**


Suicide


**Transitions**


Bibliography/References

Violence

<table>
<thead>
<tr>
<th>Special Section: Focus on School Violence</th>
</tr>
</thead>
</table>


War

Other Categories


