Saltzman, W. R., Pynoos, R. S., Layne, C. M., Steinberg, A. M., & Aisenberg, E. (2001). Trauma-and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol. *Group Dynamics: Theory, Research, and Practice*, *5*(4), 291.

Screening for exposure with middle school students for PTSD. 7.1% met criteria and 26 aprticipated in the group. Associated with improvements in PTS and academic performance. Are we failing to meet an hidden need for treatment/counseling for like, 7% of our kiddos?

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: a randomized controlled trial. *Jama*, *290*(5), 603-611.

Claims to be first PTSD RCT for kiddos exposed to violence. This one is school-based. Sixth grade students. 10 session CBT for trauma. Early intervention and wait-list delayed intervention (two phase rollout 😊 ) Signif lower scores on PTS, depression, and dysfunction. No differences for problem bx, anxiousness, and learning.

Don’t forget—symptoms will likely go down over time regardless (spontaneous remission or regression to the mean) so be careful in interpretation. Mere expectation of improvement, demand characteristics, support, therapist-client alliance, effort justification, spontaneous remission, regression to the mean. (Beyerstein, 1997; Gaudiano & Herbert, 2008)

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., ... & Maguen, S. (2007). Five essential elements of immediate and mid–term mass trauma intervention: Empirical evidence. *Psychiatry: Interpersonal and Biological Processes*, *70*(4), 283-315.

“it is unlikely that there will be evidence in the near or mid–term future from clinical trials that cover the diversity of disaster and mass violence circumstances” (p. 284)

Connected with professionals to establish a consensus view on what are the important principles of interventions. These are:

1) a sense of safety, 2) calming, 3) a sense of self– and community efficacy, 4) connectedness, and 5) hope (Hobfoll et al 2007)

“The heterogeneity of traumatic events and their aftermath defies any specific guidelines, and there is a need for flexibility of interventions and adaptations to specific circumstances” (p. 284)

How does mass trauma operate?

1) pain, injury, destruction

2) grotesque elements

3) symbolic implications

4) personal relevance

These may be enhanced by a community which simply cannot support the level of trauma due to its severity due to depleted resources (economic and psychosocial).

When working with children and adolescents, there is a developmental course in the schematization of self–efficacy, efficacy of others (e.g., protective figures), and efficacy of social agencies in response to danger. Addressing such developmental interruptions and promoting normal and adaptive progression is an important component of post-disaster and mass casualty childhood interventions (Saltzman, Layne, Steinberg & Pynoos, 2006). Teaching children emotional regulation skills when faced by trauma reminders and enhancing problem–solving skills in regard to post–disaster adversities are especially important components of post–disaster interventions that have been shown to be effective (Goenjian et al., 1997, 2005). (PAGE 294)

Promoting social connectedness as an intervention seems to be important and salutary for children and adolescents in particular (but note—parents and family!) but there is similar danger for undermining rather than support.

“Despite the research gap between the natural positive influence of social support and the influence of intervention–created social support, there is enough experiential evidence post September 11th in New York (Simeon, Greenberg, Nelson, Schmeidler, & Hollander, 2005) and from WHO experience with refugees (van Ommeren, Saxena, & Saraceno, 2005) to make this a “best practices” suggestion, with a clear call for more careful research on the issue.” (Page 298)

Paine, C. K., & Schools, S. P. (2007). Hope and healing: Recovery from school violence. In *Public Entity Risk Institute Symposium for Confronting Violence in our Schools: Planning, Response, and Recovery, Fairfax, VA. Retrieved February*(Vol. 6, p. 2009).

Handling the intense and intrusive media was a formidable task.

Communication was especially difficult during the first few hours and days.

) The students’ delayed return to school required extensive planning with counseling support.

This is important-how can a school be a first site and a community-level-processor if the first policy change is to close the school and give kids time off? (but see how bailey case—dishman and lewis—staff needed to heal first and this gave them time.

Memorials and healing events?

Jaycox, L. H., Langley, A. K., & Dean, K. L. (2009). *Support for Students Exposed to Trauma: The SSET Program*. RAND Corporation. PO Box 2138, Santa Monica, CA 90407-2138.

Is curriculum based like many CBT and DBT programs, so that makes it part of the trend I guess?  
No data on efficacy?

Based on CBITS, which was founded on CBT. Ergo.

Jaycox, L. H., Langley, A., Dean, K. L., Stein, B. D., Wong, M., Sharma, P., ... & Kataoka, S. H. (2009). Making it easier for school staff to help traumatized students.

Small reductions in trauma symptoms (this is SSET) and maybe behavior. People are satisfied but results are small-to-inconclusive.

Crepeau-Hobson, F., & Summers, L. L. (2011). The crisis response to a school-based hostage event: A case study. *Journal of School Violence*, *10*(3), 281-298.

Bailey Colorado hostage case

Law enforcement led the response team to see the classroom to understand what had happened. Tough, but they appreciated it.

Flexibility of responder role in schools after the incident.

Need for f/u and long term interventions (screen and treat?)

“numbness wear off and real behaviors unravel” (p. 290)

NEED FOR EVALUATION OF THE RESPONSE

Turf wars with responders?

Need for opportunities for staff to debrief (not student-centric, but underlines the community-level aspect of this, and the benefit of seeking out community relationships as part of the healing process).

Dishman, M. L., Lewis, J. L., & Pepper, M. J. (2011). “A Student [Came] Down and Said ‘There’sa... Guy in the... English Classroom With a Gun’”: Recovering From Violent Invasion. *Journal of Cases in Educational Leadership*, *14*(1), 48-58.

(Bailey incident also)

Priority of healing staff before healing students ? (doctor heal thyself?)

Familiarity and security—return to normal

“Pass Program” – extra set of eyes at every door—is this wise? Well, it gave the community a way to help and feel needed.

Haravuori, H., Suomalainen, L., Berg, N., Kiviruusu, O., & Marttunen, M. (2011). Effects of media exposure on adolescents traumatized in a school shooting. *Journal of traumatic stress*, *24*(1), 70-77.

Association between higher level of exposure and media interviewing, and also interviewing and post-traumatic distress in adolescents. Independent effect when controlling for level of exposure, media following, and other background variables.

Nadeem, E., Jaycox, L. H., Kataoka, S. H., Langley, A. K., & Stein, B. D. (2011). Going to scale: Experiences implementing a school-based trauma intervention. *School psychology review*, *40*(4), 549.

CBITS again. Fuck this.

Crepeau-Hobson, F., Sievering, K. S., Armstrong, C., & Stonis, J. (2012). A coordinated mental health crisis response: Lessons learned from three Colorado school shootings. *Journal of School Violence*, *11*(3), 207-225.

“few accounts of responses to school based crises have been published to date and most provide very general information”

Colorado Crisis Response Team CRT

“one size fits all model is not efficacious”

Incident Command System structure gives everyone a job.

Mental health Incident Commander / Public Info Officer /

If MHIC is community ingroup, this can create problems when (s)he needs to process as well. But outsiders can exacerbate issues of community trauma

Key components:  
Reunification

Safe Haven (if off site, close proximity) Protected from media

NOVA Model:

3 elements: “safety and security, ventilation and validation, and prediction and preparation.” (214)

Mental Health Triage

(Screen and treat?) NO. this is to determine degree of exposure.

Debrief for providers

Long term follow up and intervention

Evaluation

Acosta, J., Barnes-Proby, D., Harris, R., Francois, T., Hickman, L. J., Jaycox, L. H., & Schultz, D. (2012). An examination of measures related to children’s exposure to violence for use by both practitioners and researchers. *Trauma, Violence, & Abuse*, *13*(4), 187-197.

Provides list and review of available measures for screening for violence induced trauma (but this is individual e.g. at home)

Salloum, A., & Overstreet, S. (2012). Grief and trauma intervention for children after disaster: Exploring coping skills versus trauma narration. *Behaviour research and therapy*, *50*(3), 169-179.

Grief and Trauma Intervention (GTI)

Imrpovements in distress related symptoms and social support. (cohen’s D small for social support relative to PTSD, but I’ll take it).

Maintained up to 12 motnhs

Trauma narrative processing?

Cross, A. B., Jaycox, L. H., Hickman, L. J., Schultz, D., Barnes‐Proby, D., Kofner, A., & Setodji, C. (2013). Predictors of study retention from a multisite study of interventions for children and families exposed to violence. *Journal of Community Psychology*, *41*(6), 743-757.

Retention rates typically low, making ITT a pain in the ass. Retention is better if assigned to tx group ( go figure), child experienced more trauma. (Parents stick around if their kids need help and are getting it. Go figure).

Hickman, L. J., Setodji, C. M., Jaycox, L. H., Kofner, A., Schultz, D., Barnes-Proby, D., & Harris, R. (2013). Assessing programs designed to improve outcomes for children exposed to violence: Results from nine randomized controlled trials. *Journal of experimental criminology*, *9*(3), 301-331.

“The National Safe Start Promising Approaches for Children Exposed to Violence”

No measurable impact in ITT at 6 or 12 months pose baseline. TOT associated with improvement in cooperation and assertion. No site-to-site variability. Fuck this.

Openshaw, L. L. (2013). Group interventions in rural schools to assist with a community trauma. *Contemporary Rural Social Work*, *5*, 110-124.

Works best when schools have crisis plans in place.

Here’s a cool typology: Primary (prevention) Secondary (intervention: taken during the crisis) Tertiary (taken post crisis: debriefing, support groups, short term counseling, referral to Community Based Services)

Ramirez, M., Harland, K., Frederick, M., Shepherd, R., Wong, M., & Cavanaugh, J. E. (2013). Listen protect connect for traumatized schoolchildren: a pilot study of psychological first aid. *BMC psychology*, *1*(1), 26.

LPC: first aid by non-mental-health professionals. Quasi-experimental wow N= 20. Reduced symptoms but jeez. Demonstrated potential let’s say. Key feature is non-mental-health professionals and “first aid” aspect.

Dyb, G., Jensen, T., Glad, K. A., Nygaard, E., & Thoresen, S. (2014). Early outreach to survivors of the shootings in Norway on the 22nd of July 2011. *European journal of psychotraumatology*, *5*(1), 23523.

The plan worked. 70-80% of the kids got help, and this was the ones who needed it the most. Yikes Norway, good job.

Turunen, T., Haravuori, H., Pihlajamäki, J. J., Marttunen, M., & Punamäki, R. L. (2014). Framework of the outreach after a school shooting and the students’ perceptions of the provided support. *European journal of psychotraumatology*, *5*(1), 23079.

“importance of enhancing the natural networks” + additional support to those in greatest need.

Wow “media coverage with psychoeducative and calming content.”

Open door policy at the trauma affected school.

Reinforced youthwork and student welfare

Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D., & Jaycox, L. (2015). Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *Journal of consulting and clinical psychology*, *83*(5), 853.

Immediate or delayed intervention: better with PTS and anxiety, depression.

Ten group sessions, 2-3 individual sessions, 1-3 parent education sessions.

Psychoeducation, relaxation training, cognitive restructuring, social problem soliving, positive activities, and trauma focused intervention strategies (gradual approaches to anxiety provoking situations) and trauma narrative (what IS THIS?)

Grolnick, W. S., Schonfeld, D. J., Schreiber, M., Cohen, J., Cole, V., Jaycox, L., ... & Wong, M. (2018). Improving adjustment and resilience in children following a disaster: Addressing research challenges. *American Psychologist*.

Essentially a recap of the research problems following disaster: obtaining consent, designing rigorous studies, and obtaining funding quickly enough to conduct the study.

To date, no RCTs on psychological First Aid (but of course, LPC pilot study 5 years earlier was QE)

Causal research challenges. Wowzer this’ll be one to add to the collection for later citations.