Supporting children’s recovery from crisis - How we can do it better

David J Schonfeld, MD, FAAP
Director, National Center For School Crisis And Bereavement
Children’s Hospital Los Angeles

schonfel@usc.edu
Outline

• National Center for School Crisis and Bereavement
• Limitations in reliance on medical model for school crisis recovery
• Common adjustment reactions after crisis events
• Trauma and grief
• Timeline for recovery
• Professional self-care
• Coalition to Support Grieving Students
• (Public communication in a crisis)
• ((Exercise, drills, and other prevention interventions))
National Center for School Crisis and Bereavement
www.schoolcrisiscenter.org

Initial Funding: September 11th Children’s Fund & National Philanthropic Trust
Current Support: New York Life Foundation

• Promote appreciation of role schools can serve to support students, staff, and families at times of crisis and loss
• Enhance training in professional education programs
• Serve as resource for information, training materials, consultation and technical assistance – provided at no cost to the school
Through a transdisciplinary team of medical, mental health, and school professionals, the NCSCB provides:

- Confidential on-site/remote technical assistance and consultation for school leadership and professionals
- Practical, timely advice via 24/7 toll-free number and email
- Ongoing support in the immediate aftermath of a crisis and throughout the long-term recovery period
- Educational resources and crisis management tools
- School staff training and community presentations; professional development for range of professional audiences
What do we do when we consult?

- Help meet needs, both short- and long-term
- Advise on models of crisis mental health services, staffing, training, policies, etc.
- Offer staff support
- Prepare them to address educational impact and academic supports
- Suicide postvention
- Commemoration and memorialization
Limitations of applying medical model to public health crisis

• A school response to a crisis is not the same as a clinical approach applied to every child in the school

• Need to shift from exclusively a medical model (i.e., screening, evaluation, diagnosis, referral, and treatment for individual students with mental illness) toward a system of universal support as primary response – focusing on building resilience rather than delivering treatment
Effects of the Word Trade Center Attack on NYC Public School Students

Applied Research and Consulting, LLC, Columbia University Mailman School of Public Health, NY State Psychiatric Institute

• Students grades 4-12
• 1 of 4 surveyed 6 months after 9-11 met criteria for one or more probable psychiatric disorders: PTSD (11%), major depressive disorder (8%), separation anxiety disorder (12%), panic attacks (9%), agoraphobia (15%)
• Estimated that 250,000 students required counseling
• 87% reported at least 1 trauma symptom 6 months later
Psychological First Aid

- Provide broadly to those impacted
- Supportive services to promote normative coping and accelerate natural healing process
- All adults should understand likely reactions and how to help children cope
Anyone that interacts with children can be a potential source of assistance and support – if unprepared, they can be a source of further distress.
Common Adjustment Reactions to a Crisis

- Fears & Anxiety; School Avoidance
- Sleep problems; Change in Appetite
- Difficulties with Concentration & Academic Performance
- Sadness & Depression; Anger & Irritability
- Alcohol & Other Substance Use
- Physical Symptoms
- Post-traumatic symptoms/PTSD
- Grief
- Guilt
Grief vs. Trauma

• Trauma and grief often co-occur in lives of children; professional fields have far less overlap

• Reactions after death of close family member/friend viewed in mental health field as normative reactions → do not generally need treatment

• Reactions after traumatic event viewed as symptoms → require treatment
Co-occurrence of trauma and grief

- Those caring for children who have experienced both trauma and loss should attend to impact of both.

- It should not be assumed that every time loss and trauma co-occur, the predominant reactions relate to trauma, nor that consideration of bereavement is less crucial or time-sensitive than trauma.

- Interventions designed for treatment of trauma may not be optimal for supporting grieving children.
Crises are not generally isolated events

• Reactions may be due to a wide range of other stressors associated with the crisis
• Yet, we treat crisis events as singular, isolated events in terms of funding
• A crisis often awakens feelings related to a pre-existing or even past crisis
Adjustment Over Time in Crisis

A = baseline functioning
B = event
C = vulnerable state
D = usual coping mechanisms fail
E = helplessness, hopelessness
F = improved functioning
G = continued impairment
H = return to baseline
I = post-traumatic growth
Importance of professional self-care

• Recognize it is distressing to be with children who are in distress
• It’s important professionals appreciate and address impact of supporting children are grieving, traumatized, or otherwise distressed
• Create a culture where:
  – it is ok to be upset
  – members normalize asking for help and model willingness to accept assistance
Compassion Fatigue & Burnout

• Exposure to trauma and suffering of others can lead to compassion fatigue
  – Empathy: understanding and taking perspective of another
  – Compassion: requires empathy but includes wanting to help and/or desiring to relieve suffering – “to bear or suffer together”

• Warnings about compassion fatigue imply that compassion is necessarily tiring

• Compassionate approaches can be gratifying and bring meaning to the work
Supporting those most in need can be gratifying

• Realistic objectives of purpose of interactions
• Have skills and resources to provide meaningful assistance
• Are aware of and have sufficient support to deal with personal impact of work
• Especially difficult in austere environment and when you have other challenges
Trauma and loss are common; training is not

• 1 out of 20 children experience the death of a parent
• 9 out of 10 experience the death of a close relative or friend by the time they complete high school
• <10% of educators receive any training on how to support grieving children — the main factor limiting their ability and willingness to provide support
Training is important prior to an event

• Training has not been a priority in teacher preparation coursework nor in professional development
• Often sought only in the aftermath of event
• Just in time training is not in time
• The recommendations we suggest need to be broadly relevant and applied in all communities
Supporting Organizational Members

[Logos of various organizations and coalitions related to education, health, and support services, including Actively Moving Forward, AESA, AMLE, ASDC, BE STRONG, Boys & Girls Clubs of America, CASEL, Childcare Aware of America, Committee for Children, COPS, EKR Foundation, Education for All Coalition, Eluna, Education Foundation, Guardian Lane, Healgrief.org, HFA, Hospice Foundation of America, NACG, National Alliance for Children's Grief, NAIS, National PTA, SDBP, Society for Developmental & Behavioral Pediatrics, Teach Everything Coalition, Voices of September 11th, Worldmaker International, and Save the Children.]
Children's Grief Awareness Day is November 17
This offers guidance to educators on how to recognize Grief Awareness Day in their school.
www.grievingstudents.org

Order Free Materials (download)

After a loved one dies—
How children grieve and how parents and other adults can support them.
Public communication during a crisis

• Communication about a crisis should not be a source of further crisis

• Two basic reasons for public communications in setting of crisis: Reassure or provide information to direct people to take actions to decrease risk

• Use language that is direct and simple to understand (avoid jargon)

• Provide accurate and timely information, but avoid undue speculation
Public communication principles continued

• There will be many sources of information and they won’t agree
• Misinformation often travels faster than accurate information and is usually more interesting and compelling
• Those who are ill informed often come up with explanations convincing to those who are ill informed
• People decide what information is correct mainly by trust – often base trust on interpersonal factors
• People often pick up on how we present ourselves more than what we say
General principles continued

- People don’t learn well when stressed; they will be stressed during a crisis. People don’t explain things well when stressed – have material scripted prior.
- Goal: help people *feel* they understand and know what to do.
Avoid fear-based approaches

• We don’t need to craft message that tell people to get scared – they can do that on their own

• Excess fear can lead to:
  – Sense of fatalism
  – Discrediting risks if one risk felt to be false or exaggerated
  – Reactive risk-taking and counter-phobic behavior
Our behavior should be directed by human behavior in crisis situations

• While we would hope people in crisis rise to the occasion, most are in distress and not at their best
• Those impacted by crisis often react to feeling out of control by trying to exert more control – people will have very different views about what should be done and feel strongly about those views
• People don’t generally do what you want them to do, they do what they want/need to do – try not to ask them to choose
Early intervention and prevention initiatives

• Children’s stories, coloring books and parent guidance often quickly developed in immediate aftermath and widely disseminated without evidence base – and without attempt to collect evidence to guide future use

• Materials are developed and promoted for prevention efforts without evaluation for efficacy
Exercises and drills (e.g., active shooter drills in schools)

• Occurring in almost all schools
• Lack evidence of efficacy – researchers have begun to question efficacy of some popular training approaches
• We must be cautious about potential unintended consequences
• Growing evidence of a significant potential of psychological risks and other unintended consequences, especially when children are deceived or high-intensity drills
Some children report they want this training

• Some students feel empowered by exercises
• They may underestimate how others with different personalities, coping studies, personal histories of prior trauma or anxiety/stress, and other individual vulnerabilities may respond
• May feel comforted because it provides illusion of control – prevention efforts are only effective if they actually decrease risk of harm
• Such efforts could result in increased guilt if individual is not able to respond in idealized fashion in real event
Additional considerations

• Unique needs of young children; children who suffered traumatic events/losses or pre-existing anxiety; those with physical, intellectual and NDD rarely considered in exercise planning

• We need research identifying children most likely to experience negative impacts and successful accommodations to mitigate additional burden on vulnerable children

• Must also consider needs of adults
Summary recommendations

• Research is needed to evaluate the goals, efficacy, and potential unintended consequences of crisis preparedness activities involving children

• Strategies likely to cause significant distress or unintended consequences (e.g., high-intensity live exercises) should be evaluated carefully before implemented, especially in absence of evidence of efficacy