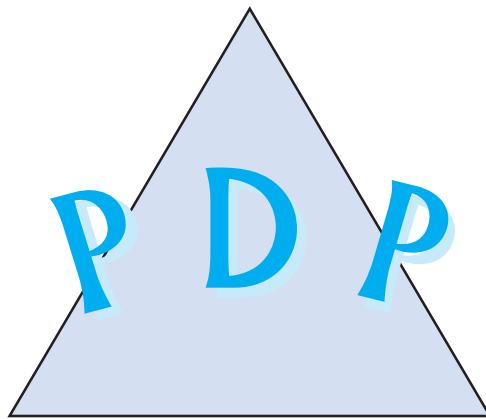


1998-1999



Professional Development Programme

Critical Events for Schools

Critical Events for Schools

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Foreword

Jenni Barr, Senior PDP Coordinator

My job in this introduction is to point you to the papers which follow, to tell you what's there, and to describe something of the group's activities across this year. Over the nine months of the project we have grappled with what disaster psychology is telling us and explored the implications and challenges posed for educational psychologists in Scotland when working with schools, children and their families.

The Professional Development Programme identifies an area to be studied, services nominate psychologists who wish to take part, and the group is then given considerable scope to plan the activities which will constitute the project.

In our case we were a big group – the largest to date under PDP – and within the group there was a range of experience and level of interest. Some were new to the area, but keen to grasp the implications for our practice as educational psychologists; some were service managers, with interests in strategic planning both at service and Council level. Three of the psychologists had been integrally involved in responding within the community of Dunblane following the shootings in the school in 1996. As part of this involvement they had received training in new approaches, and now they wished to evaluate these and to consider the benefits of such training in seeking to prepare psychological services – or a core of psychologists nationally – for further work in the area of disaster psychology.

It has sometimes been argued that the PDP timescale (May to April) is too short to allow for substantial development work, and that part of the group process involves a levelling of interest ('find the lowest common denominator and start from there'). This has not applied here. From the outset, the group has drawn on the different interests of members to create an agenda that has been lively, urgent and strongly focussed.

By August the group had an *Issues Paper* to debate, prepared by **Ian Liddle**, asking not only what is there in current disaster psychology that is of relevance for our practice, but, given the structure and remit of Psychological Services in Scotland, what roles might be feasible to adopt and what might stretch us beyond our capacity? This paper was also used to clarify tasks for the project. A revised version is offered here under the title, *Critical Events for Schools: Issues for Educational Psychologists*.

In September, ten members of the group took part in formal training on Critical Incidents Stress Management. This was followed in November by Level One training in EMDR (Eye

Movement Desensitisation and Reprocessing). Included in this report are full papers on both approaches, prepared respectively by **Alison Russell** and **Mike O'Connor**.

These two group members were already trained and experienced in the use of these techniques when helping those who have been traumatised. This has facilitated two significant developments. Firstly, with the group's involvement both in the training and in subsequently applying these approaches in day-to-day work, a wider dialogue has been developed around the uses and limits of such approaches in our practice as educational psychologists. Within this dialogue, those with more extensive experience have been able to develop specific questions which they were finding pressing:

- what are the implications and benefits of using CISM and EMDR in direct work with children?
- how can we protect children emotionally, and how do we assess who may be particularly vulnerable after a crisis?

Secondly, these two psychologists have been available to support those developing the skills for the first time. They facilitated the setting up of the training, and the EMDR training was offered to a wider group of educational psychologists than just those involved on the PDP project. This was a first for Scotland; and unique, too, internationally, in that there is now a core of psychologists trained to use EMDR at least to Level One, whose primary expertise lies in working with children. There are plans to continue meeting as a Special Interest Group within Scotland, and an extension of PDP funding into session 1999/2000 will assist the two experienced members to pursue formal accreditation as EMDR facilitators, and other members to undertake the further stages of training.

Along with the development of specific skills, the group took as a major focus the question of how best to support schools, children and families affected by critical events. While much of the literature draws on the lessons arising from major traumatic incidents, a key premise of the group has been that small-scale events can have just as much impact at the individual or school level. Indeed, the choice of title 'Critical Events *for* Schools', rather than 'Critical Events *in* Schools' reflects an awareness that an event need not have occurred physically within the walls of a school in order to impact significantly on its community. To probe this further, 820 schools in four areas were surveyed concerning their recent experience of critical events and the supports received and desired. The results reported here indicate that one in four schools are aware of having dealt with one or more critical event within the period surveyed, and - despite sampling very different types of area - common issues were reported across Councils. A full account is provided here, compiled by **Brenda Wallace** and **Stewart Biggar**.

The two computer disks inside the yellow folder contain the full staff development package, developed by **Ian Liddle, Alison MacDonald, Mike O'Connor, Alison Russell, Kate Watson** and **John Young**, and entitled *A Staff Development Package for Working with the Effects of Trauma*. The materials were trialled with a group of local authority psychologists in March 1999, and revised to take account of the feedback obtained. They are offered in both Mac and PC versions, available for easy download, editing and use. There are six sections, devised to be free-standing so that sections can be used singly or combined. These sections are as follows:

- Transitions, Change and Crises
- The Nature and Incidence of Critical Events for Schools
- Loss, Bereavement and Trauma: Grief and Crisis Reactions in Children
- School Readiness and Contingency Planning
- School Response to a Crisis
- Protection and Vulnerability.

Each section folder on the disk contains a key text folder, annotated or with separate notes to aid preparation and delivery. There are additional folders containing such material as overheads, exercises and handouts. The materials are pitched for use with professionals and/or schools. The thinking is that some tailoring would probably be desirable in order to articulate with a local audience, but all the basic content is there for those who may wish to make use of it for INSET delivery.

These materials are more extensive than could be included directly in the printed report. Nevertheless, there is content that would be of interest to the general reader too. To provide a general overview and guide, a synopsis of the content covered by each section of the Staff Development Pack is included in this report, together with a full description of all the materials contained on the disk.

Each section in the Development Pack and each chapter in this report includes its own comprehensive reference list and, where appropriate, bibliography. However, an additional set of lists of curricular materials has been prepared by **William Allison, Laurence Cairns, Christine Munro** and **Karen Telfer**, and these are included in the main report. From an extensive survey of available materials and writings, the compilers offer an accessible digest under the following separate headings:

- Scene-Setting and Awareness Raising
- Inservice Materials

- ❑ Guidelines for Working with Children
- ❑ Materials for Working with Children
- ❑ Activities for Children.
- ❑ Further Information
- ❑ Books for Young Children under 8 Years
- ❑ Books for Children 8-12 Years
- ❑ Books for Teenagers
- ❑ Books for Parents
- ❑ Books for Professionals.

A final section contains details of leaflets prepared for distribution as guides for parents, teachers, young children and teenagers, available for customising by adding a Council logo and details of local contact numbers and addresses. Colour versions of these leaflets can be obtained from the writers and downloaded after August 1999 from the PDP website at <http://www.scet.com/pdp/>

Beyond the activities listed here, individual group members have furthered their professional development by attending a wide range of conferences, including participating in a masterclass on *Trauma and Memory* with Bessel Van der Kolk, and attending a Loss and Bereavement conference based on the materials of *Winston's Wish* (referenced in full on p.51). There have been other developments. One member has been asked to represent Scottish educational psychologists at the Association of Child Psychologists and Psychiatrists' national networking meetings on the *Use of EMDR with Children*. Another has been invited to represent the British Psychological Society on a European *Task Force on Disaster and Crisis Psychology*, which also involves setting up a network of British 'correspondents' to offer ideas, comments and feedback. This summer three members of the group are due to speak – albeit arranged through contacts other than PDP – at important training events in Germany and in Italy. The contributors are supported in their planning by the work of the project.

I stand in some awe of this PDP group and its prolific activity. I could mention that the most time that any individual received from their service by way of workload reduction to participate in the project was twelve days spread across the year, and that for several even this has not proved possible.

If the dual aims of the Professional Development Project are to encourage development work for psychologists in important new areas and to facilitate joint working across services,

these aims have surely been achieved. Working with the group has always been fun and informative, and often thought provoking.

Perhaps a hallmark has been that this group never lost sight of the reason why it was meeting: to seek to understand and support as effectively as possible those whose lives have been assaulted by a critical event or traumatic experience.

Critical Events for Schools: Issues for Educational Psychologists

Ian Liddle

Introduction

The developing science of psychology covers most areas of human experience, from the psychology of birth to the psychology of ageing, from sleep to sport, and from individual therapy to organisational and community psychology.

Within the relatively well-established field of educational psychology, areas of specific expertise and specialist skill abound. Educational psychologists often need not only command of a whole range of generic skills and knowledge but in-depth involvement in at least one and possibly several specialist areas, in order to be able to respond effectively to the diverse and changing needs of children, families, schools and the communities in which they live and work.

The concept of disaster psychology is one which has emerged in North America and Northern Europe (particularly Scandinavia) over the last 20 years, as more has been learnt about the effects of large, unpredicted, catastrophic events, both natural and man-made, and as methodologies have been developed for responding to these. Some of these methodologies have been new, others are developments and adaptations of earlier psychological work on issues such as human deprivation, memory, perception and bereavement and loss. Additionally, there is a growing realisation that, as well as the possibility of people being exposed in unpredictable ways to large scale events at some point in their lives (calling for the mobilisation of massive resources), there are in the lives of children, schools and communities more numerous *smaller scale* critical events which call for similar psychological awareness and a sensitivity of response at an appropriate level.

In their work with families and children, educational psychologists have experience of the impact of bereavement, loss, separation and deprivation, and are aware of the consequences of those for children's mental health, socialisation skills and educational development. The growing awareness since the 1970s of the traumatic effects on children of physical and sexual abuse has also had a major impact on psychologists' work and has generated a new area of specialism.

Both in their day to day work and in more specialist areas, therefore, educational psychologists have been drawn increasingly into roles of awareness raising and responding

to critical events either affecting large numbers of people or individuals and families. In terms of large scale traumatic events, there has been involvement following the Lockerbie disaster (Robson 1989), the Glasgow school bus crash, the death of children and their families in house fires, and, latterly, in both the immediate and continuing response to the Dunblane tragedy. Smaller scale events occur on a very regular basis in psychologists' day to day work and in the experience of schools and local communities.

Given this level of involvement in a developing area of psychology, it is relevant to examine in more detail the parameters of such a role, or range of roles, and the rationale for including them within the skill repertoire of educational psychologists. As with many other developments which seem natural growth areas for psychological services, the whole area of critical incidents is one which appears very relevant in terms of psychological content, requisite skills and current involvement at various levels. It would, however, be a salutary exercise to consider which aspects of Critical incidents educational psychologists might realistically contribute to, which aspects might be less feasible or better dealt with in other ways, and what the implications of moving in this direction might be for other aspects of psychologists' practice. The purpose of this paper is to examine these issues.

Local Context

The wholesale reorganisation of local government in Scotland in 1996 affected psychological services in a number of ways. Most dramatically, it has produced a large number of small services, with the average establishment size now less than ten, where previously the modal service had more than twenty psychologists. The significance of this change for the present discussion is that in former time larger services were able to provide specialist input into regional emergency planning groups and incident assistance teams. In a number of authorities, including Strathclyde Region (Glasgow Division) and Central Region, one or more psychologists were linked to Emergency Planning Teams and roles for psychological services were mapped out to cover a variety of potential critical events. For new Councils emergency planning has not as yet had a high priority, and the size of psychological services in most authorities would militate against their participation in the same way. In fact, most Councils recognise that in the event of a medium to large-scale disaster there would have to be a strong reliance on shared expertise and a pooling of resources with neighbouring Councils.

There are two possible responses to these changed circumstances. Either educational psychologists can step back from involvement at this level of Council response to large scale critical events, or there can be an attempt to have at least a core or network of adequately trained educational psychologists, which can be mobilised to offer appropriate support

across geographical boundaries. The current initiative through the Professional Development Programme may be one means of securing this potential.

Training

This conjecture leads naturally on to the question of training. An educational psychologist takes several years to produce, including two years' postgraduate study plus one year's supervised induction in a psychological service. It is a common public assumption that educational psychologists emerge from training with identical sets of skills; in fact educational psychologists come from a variety of backgrounds and have very varied experiences of academic psychology, particularly at undergraduate level.

For the purposes of the present discussion, there might be an assumption that all psychologists would have as a prerequisite training in the following areas:

- ❑ interpersonal relationships
- ❑ developmental psychology
- ❑ therapeutic interventions
- ❑ counselling skills
- ❑ the psychology of systems
- ❑ abnormal psychology.

Since the 1970s, Training Courses for educational psychologists have moved away from a medical model and towards an emphasis on an *ecological* model of psychological thinking. This suggests that, from the above list, there is now more emphasis on the psychology of systems, developmental psychology and solution-focused approaches; interpersonal relationships would remain an important element, but there would be less emphasis on abnormal psychology and the more traditional therapeutic approaches, including counselling. This distinction is certainly not clear cut, as most psychologists in their practice very quickly encounter situations which require them to extend their knowledge base and range of skills.

The fallacy of believing that modern psychologists spend all of their time working at the 'systems' level is easily discounted (eg MacKay and Vassie,1998). Now, more than ever, there is a need for psychologists to respond flexibly to demands, and to respond at many different levels, including the individual level, family or class group, whole school and even community level. The demands of the job, combined with Continuing Professional Development opportunities, allow for a leavening of experience.

When we consider the potential for educational psychologists' involvement in critical incidents in the light of present training and practice, therefore, a number of questions arise. If we look at the psychological skills which might be applied at various stages during a critical event, we can classify these under the requirements for:

- immediate and short-term response
- medium term response
- longer term response.

It is probably in the latter two phases that more traditional psychological skills might be required, for example when carrying out longer-term counselling or therapy, or when identifying and treating Post Traumatic Stress Disorder (PTSD).

Immediate and Short-term Response

An ecological approach would have some benefits when addressing the issues and decision-making processes surrounding the immediate impact of, and response to a traumatic event. Knowledge of the organisational and human systems aspects of critical incidents is invaluable in gauging impact, in optimising communications and in the deployment of human and material resources.

Emphasis on an ecological approach sits well with such relevant activities as the offering of practical support at the early stages of a crisis; provision of factual information and the delivery of elements of Critical Incident Stress Management (CISM), including demobilisation, defusing and debriefing; the offering of psychological care for the victims and for professionals; consideration of leadership issues, and ensuring appropriate timescales and optimal settings for the interventions to take place (Nader and Pynoos, 1993). A fuller account of CISM is offered by **Alison Russell** later in this report.

The training which educational psychologists currently receive, and present practice within services blends well both practically and philosophically with intervention strategies such as CISM; it is therefore appropriate that the group of psychologists involved in the current PDP project have had the opportunity to acquire this set of skills. It is acknowledged that there have been recent criticisms of the benefits of some of the techniques involved (e.g. Paton 1997), many of these misplaced. One strong safeguard against some of the criticisms is appropriate and effective training. There remains, however, the question of how practice in such skills can be maintained in the longer term. Indeed, a further issue might be the extent to which the processes of defusing and debriefing would be carried out by educational psychologists themselves, or by trained school staff supported by the psychological service.

Medium Term Response

Beyond the immediate impact of a critical event but still within the first few days or weeks, much of the support work involves dealing with the trauma itself. Victims of the event and the community at large require assistance in recognising in themselves and in others a wide range of behavioural, emotional and cognitive reactions. The offering of information and reassurance surrounding these reactions, in what Atle Dyregrov refers to as a 'psycho-educational process', is crucial in lessening the incidence of later, severe difficulties for those affected, such as PTSD and complicated grief reactions. Assembling, customising and communicating such information is a task for which educational psychologists are perhaps uniquely equipped (O'Hara et al 1994), and to this extent their potential contribution should not be overlooked in contexts *beyond* the educational field.

At this stage also, depending on the nature of the critical event, there is invariably a debate about the efficacy or otherwise of operating a screening procedure in an attempt to identify those most at risk of developing more serious problems. This approach fits well with a medical model of intervention and will often find favour with psychiatric and medical agencies in any crisis situation. Within an ecological model such measures would be likely to be perceived as being intrusive and perhaps counter-productive, adding fresh trauma to that already experienced. Educational psychologists would be more inclined towards a model of information-giving and careful monitoring, leaving responsibility with those most closely involved to identify, over the weeks and months that follow a disaster, those individuals who might require more specialist help. This community development model is the approach which, largely, has been adopted in Dunblane. The counter-argument is also worth noting: that it is unfair and perhaps unwise to expect those such as teachers and carers to be able to carry out such sensitive observations on others, when they themselves may have been deeply affected and possibly even disabled by the same event.

Longer Term Response

Different questions arise when we consider the issue of *longer term* therapeutic and counselling inputs following a critical event. It is unlikely, given current operational models of psychological services, the size of services and competing workload demands, that long term work can be undertaken in a routine or regular way by educational psychologists working in local Councils. In addition, the number of educational psychologists who would have the skills and experience to carry out counselling or related therapy work at this level would be a minority of the profession. It has not been feasible for the current PDP initiative to seek to change this situation. There may need to be arrangements within a local Council,

whereby those with requisite skills can be seconded or separately engaged to offer such a service. These individuals would build up unique expertise within educational psychology, but would in practice be operating in a fashion more closely aligned to clinical services.

There is one fairly specific area of trauma work, however, where there might be value in training educational psychologists. The relatively new technique of Eye Movement Desensitisation and Reprocessing (EMDR) appears to be successful in reducing the damaging effects of intrusive sensory images arising from experiences during traumatic events (Shapiro, 1995). Such images are particularly resistant to improvement via the common talk therapies (Regel 1999). **Mike O'Connor** offers a fuller analysis of EMDR in a separate paper in this report.

If the perceived benefits of EMDR were restricted to a narrow range of traumatic experiences, the payoff in training educational psychologists would be minimal. However two factors contradict this wisdom. First, there is growing evidence that the technique may have applicability for a wide range of presenting problems, such as cases of abuse and various kinds of learning difficulty. Second, there are indications that EMDR is more effective when someone already has an ongoing therapeutic relationship with the individual concerned and uses EMDR at appropriate points in the process, rather than when the process is carried out by a person who is less well known. Even in psychological services which are oriented heavily towards workload management, individual psychologists do have such ongoing casework relationships with a number of young people and their families. A significant proportion of these cases would potentially be candidates for EMDR at some point in the contact. Provided they meet minimum criteria for clinical experience, educational psychologists who submit to EMDR training should be in a position to apply the technique as part of their ongoing casework. It was seen as appropriate, therefore, for the Professional Development Programme to offer the opportunity for psychologists to acquire these skills, with a view to working both with critical incidents and in these wider contexts. There is enormous potential for developing this new technique especially for work with children, and here educational psychologists can be at the leading edge in terms both of practice and of training others.

Issues of Staff Development and Preparation

It is a central tenet of Crisis Psychology that although events can seldom be predicted or prevented from happening, the more thoroughly an institution can prepare, rehearse and anticipate various classes of event and the more carefully contingency plans can be made, the less damaging and enduring the effects of any actual event will be.

This is the essence of the seminal work by Yule and Gold (1993), entitled *Wise before the Event*, which offers schools coherent advice and a framework for planning for and responding to the critical events which can impinge upon them.

What is clear from this document and from the plethora of guidelines which have been developed in response (e.g. Moray 1993, Norfolk 1995, Stirling 1998) is that the framework provided can be used to make considered judgements about a school's response to a very wide range of situations. It allows the school itself to retain appropriate responsibility for organising the response and for calling in assistance from agencies and the community, as deemed necessary. It also lessens the risk of a panic response, which itself can lead to longer term damage.

It is also clear from the kinds of surveys carried out by Houghton (1996) and more recently by a group of Fife psychologists (Jack et al, 1998) that Critical incidents, *as perceived by schools themselves*, are not uncommon. Events which are serious enough in themselves to cause concern and potential disruption to at least a section of the school community are frequent enough to require attention and planning.

The fact that educational psychologists are invariably included in a fairly central role in such documentation is an indication:

- that both Councils and schools themselves expect that psychologists will be active participants at a range of levels when dealing with a crisis
- that psychologists may be expected by others to demonstrate high levels of the types of skill referred to above, including those of debriefing, psycho-educational interventions and EMDR.

An issue arising from these expectations is that because critical events are by their nature unpredictable, there would have to be the acceptance that formal arrangements concerning workload management, school visits and contracted work would almost certainly be compromised. Rapid response and crisis intervention do not equate with over-rigid timetabling.

Within educational psychology as a whole, one role which has expanded significantly in recent years has been the psychologist's staff development role in relation to schools. This has often consisted of interpreting and helping schools to implement national or Council

guidelines and policies, e.g. EPSEN, Early Intervention, Anti-bullying. Although, as indicated above, many authorities are now developing comprehensive guidelines for crisis management by schools, there remains a major task:

- ❑ to assist schools in developing their own, customised plan and to rehearse all aspects of the plan to the point of automaticity
- ❑ to devise and practice a wide range of possible scenarios
- ❑ to consider all aspects of 'care leadership' (Dyregrov, 1989)
- ❑ to develop the kind of school ethos which will minimise the impact of any event
- ❑ to make sure that before any event befalls the school, concepts such as loss, bereavement and death have found their way into discussion and into the formal curriculum at appropriate points and levels.

Although the vehicle for this progression would be staff development, and the content would be Critical incidents, the *key issues* would be preparation and anticipation.

A major task for the psychologists engaged in the PDP project has, therefore, been assembling, for the use of colleagues throughout Scotland:

- ❑ a bank of useful and useable materials which can be offered through staff development to schools and other establishments
- ❑ an initial database of reading materials for psychologists and teachers, and
- ❑ a database of appropriate curricular materials which schools can incorporate into their own programmes.

Conclusion

The final issue is one of assigning a priority level for the kinds of activities described here, within the broad range of the work of an educational psychologist. Schools' expectations that psychologists will be involved quickly when critical events occur does not sit well with the equally strong expectation of regular, time-tabled visiting patterns. Yet the literature suggests that management of critical incidents is most effective when the school itself, aided by the local professionals, retains control and responsibility for dealing with the situation.

Psychological services will have to be involved in their own contingency planning, and the issues that arise are best addressed at the level of each Council.

Critical Events for Schools: Issues for Educational Psychologists

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Critical Events for Schools: A Survey of Head Teachers in Four Scottish Councils

Brenda Wallace and Stewart Biggar

Introduction

There is a heightened awareness among the general public of the impact that critical or traumatic incidents can have on the physical, emotional and social well-being of individuals and communities. Large scale tragedies such as the Lockerbie plane disaster, Hillsborough, the fire on the oil platform Piper Alpha, the shootings in the primary school in Dunblane and in the secondary school in Littleton, Denver have all received wide coverage in the media.

In particular, the events in Dunblane have had a direct impact on schools in Scotland (and beyond) both in highlighting the effects of loss and bereavement on a school and wider community and in underlining the potential vulnerability experienced by school staff. Practical steps have been taken to address some of this at a national level, for example in implementing strategies for improvements in school security, and a number of Councils (such as Stirling and Fife) have developed guidelines to deal with crisis management.

It is only in the past ten years that the effects of trauma have been acknowledged as applicable to children. Until then it was assumed that any disturbances experienced by children were short lived. 'Post traumatic stress disorder can occur at any age, including childhood' (American Psychiatric Association 1994).

There is anecdotal evidence that a range of *smaller scale* incidents occur in schools, which may themselves have a significant impact on the school and its community. A survey of head teachers in Fife in 1997/98 concluded that each year a significant number of schools was dealing with one or more small-scale traumatic event (Jack et al, 1998). It was argued that this finding highlighted the need for the Education Service in Fife to plan an effective response for schools for coping with traumatic incidents.

Apart from this survey there is little information in Scotland on the frequency or extent to which schools are affected by these smaller scale incidents. As part of this project, therefore, it was decided to carry out a survey across four Councils with the aim of identifying the sorts of events that cause particular difficulties for schools, and the kinds of supports which are most appropriate and effective both at the time of the incident and in its aftermath. We were also interested in whether there appeared to be any urban / rural

differences.

The Survey

A questionnaire was sent to all educational establishments in Glasgow City, Dumfries & Galloway, North Lanarkshire and Renfrewshire during the period October 1998 - January 1999.

The questionnaire defined a critical incident as **“any event which has a stressful impact sufficient to overwhelm the usually effective coping skills of either an individual or a group”** (Mitchell and Everly, 1987).

The questionnaire asked Head Teachers the following questions:

- Please describe in just a few words any such events which have affected your school over the last two years.
- What forms of support has the school been able to access in managing these situations? We are interested in both direct support for the benefit of pupils or staff and indirect support in the form of consultation and advice to school managers.
- (In addition, head teachers were asked to mark **D** if this was a particularly difficult situation to deal with and also to mark **O** if the school has been affected in an ongoing way by the event.)
- What types of support would be desirable in these situations?

A copy of the questionnaire, and of a sample briefing note which could accompany its distribution, are provided as an appendix to this chapter. These may be adapted freely for local use.

Summary of the Findings

In total, 820 schools were surveyed, covering all sectors and age range (pre 5, primary, secondary and special) and representing a school population of 185,000. The return rate

across Councils from establishments was 40%, with the range spreading from 28% to 46% (Table 1).

None of the Councils involved in the survey had been involved in formal planning for the management of Critical Incidents and so the return rate was very positive, suggesting an awareness of the issues among school staff and an interest in managing such incidents more effectively.

Profile of Survey Returns (Table 1)

Council	Number Sent	Number of Returns	% Returns
City of Glasgow	402	167	42
Dumfries & Galloway	134	37	28
North Lanarkshire	194	89	46
Renfrewshire	90	38	42
Totals	820	331	40

Across the Councils, 23% of the establishments which responded had recent experience of a Critical Incident (Table 2). Apart from Dumfries & Galloway (where 13% of returns reported Critical Incidents), approximately one quarter of schools reported having experienced one or more Critical Incident during the past two years. Some schools also mentioned incidents that had occurred more than two years previously.

Profile of Returns reporting Critical Incidents (Table 2)

Council	Number Sent	Returns with Critical Incidents	% Returns
City of Glasgow	402	98	24
Dumfries & Galloway	134	17	13
North Lanarkshire	194	53	27
Renfrewshire	90	20	22
Totals	820	188	23

The information given by schools was retrospective and as such represents the head teacher's memory of events. It is, therefore, possible that the reported number of incidents is an underestimate. All incidents were reported by the schools as difficult to manage.

Across Councils, 34% of incidents were reported as ongoing – that is, one third of those events reported as having had an impact on the life of the school continue over time to require attention from the head teacher and school staff (Table 3). This suggests a continued need for access to appropriate support. The figure is consistent across Councils.

Profile of Incidents Reported as Ongoing (Table 3)

Councils	No. of Incidents	No. Ongoing	%age
City of Glasgow	150	49	33
Dumfries & Galloway	34	11	32
North Lanarkshire	83	31	37
Renfrewshire	38	14	37
Totals	305	104	34

The incidence rates given in Table 4 are based on a content analysis of the types of incident reported by heads teachers. Examples of the type of incident included in each category are given below.

Profile of Type of Incidents - Number Reported & Level of Incidence (Table 4)

	City of Glasgow	Dumfries & Gall.	North Lanarks.	Renfrews.	Total	%
Incidence						
Deaths/	53+	17+	47+	13+	130+	0.16
Illness/Accident						
Vandalism/	74	7	13	15	109	0.13
Assault/Threats						
System	24	10	23	8	65	0.08
Stressors						

The “+” sign after the reported number of deaths indicates schools who reported several deaths without specifying a number, suggesting that the level of incidence is still higher than that reported. Such responses occurred across all Councils and were counted as ‘1’.

The reported level of incidence of **Deaths / Illness / Accident** is higher than other types of incident, suggesting that the management of these types of event gives most concern to head teachers and school staff (Table 4).

While the category of **Deaths / Illness / Accident** is self explanatory, it is important to note the wide range of events which schools described: death following long / short term illness, sudden death, suicide, murder, coping with terminal illness, car crash, road accidents. These events may have happened to pupils, members of staff or others (parents, relatives / friends of staff, former colleagues) and some affected only individuals, while others affected also the wider school community.

Vandalism / Assault / Threats includes physical damage to the school building such as by fire, theft, flood or damage to staff property; physical attacks on pupils or staff and verbal abuse and/or threatening behaviour from pupils or parents; intruders in the school building; poison pen letters and complaints to senior management.

The category called **System Stressors** concerned a wide variety of events such as school rationalisation, staff on temporary contracts, media attention, auditors, HMI visits, issues from the events in Dunblane, drugs found on school premises, decant, loss of resources following fire, heating breakdown, roof blowing off, allegations against staff, disruptive pupils and child protection issues.

Schools reported that there seemed to be a general expectation that they should be able to deal effectively with whatever incident occurred. This inevitably leads to an increase in workload, both in practical, organisational terms and in the demands at a personal level, where staff members are giving emotional support to each other and to pupils and parents. An additional burden is placed on the head teacher as manager of the school.

Supports Accessed

The second question in the survey asked about the kind of supports that schools had been able to access. The detail of this by Council is provided in the appendix.

Across Councils very similar supports were sought. A content analysis divided them into three categories:

Council Supports: Included were the Directorate, Education Support Service, Personnel Department, Psychological Service, Staff Welfare Service, Staff Cover, INSET and Legal Services.

External Supports: Included were the School Chaplain, Social Work Department, Police, Medical Services, Trade Union and Voluntary Agencies.

Counselling Support (for head teachers, staff, pupils and parents): This included support for each other within the school, the use of colleagues, local schools, friends and relatives for support; as well as more formal counselling provided by the psychological service, staff welfare service or another agency outwith the school.

The separation of Council Supports and Counselling Support is artificial in that many schools request counselling support from the Psychological Service, where it was also seen as part of the support provided routinely by the Councils. **Counselling Support** was retained as a separate category in an attempt to identify the level of need for personal and individual support for school staff rather than the more practical requests made to authorities for staff cover, inset for whole staffs, pastoral visits by directorate etc.

Across Councils, schools often referred to 'self help' and 'mutual support', particularly when dealing with loss and bereavement. Although there were many positive comments about the more formal counselling services, difficulty in obtaining ready access to these supports at the point where they would be most valuable was highlighted.

Supports Required

The third question in the survey asked about the kinds of supports that schools would find helpful. A content analysis using the same categories as above was carried out.

Across sectors and across Councils, schools consistently reported the need for Council supports to be in place. The necessity for prompt access to all of the above services,

(whether these were internal to the Council or external) was emphasised. Many schools had experienced difficulty in securing support.

Significant features of desired support identified by head teachers were :

- ❑ the need for clear guidelines, an action plan or check lists to assist with making a response
- ❑ identification of practical support such as staff cover, panic buttons, mobile phones
- ❑ the need for staff training to ensure preparation and planning in advance of any event occurring
- ❑ access to personal support, as appropriate, and the availability of suitably trained counsellors for staff, pupils and parents.

Examples of comments made include:

“better / immediate access to trained counsellors”

“a team of experienced support staff, better still if they are known and trusted colleagues”

“the majority of situations described are staff intensive *time* to listen to people”

“provision of practical help and support on how staff can themselves support children and their families”

“advice on knowing what should be said to children”

“immediate response from management when seeking advice”

“an emergency help line”.

In relation to specialist provision, head teachers commented that death and illness had to be faced on a regular basis, which made the need for personal support for staff, pupils and their families and training in bereavement counselling more necessary for schools.

Councils had distributed copies to schools of *Wise before the Event* (Yule and Gold, 1993) and this was seen as very useful information, but head teachers considered that **all** of the above features were necessary, if support was to be effective.

Discussion

The survey was carried out as an information gathering exercise across four Councils in Scotland. The information is broadly similar to that obtained by the survey in Fife, reported by Jack et al in 1998, and supports a view that similar issues will face schools and local Councils throughout Scotland.

The only feature which differentiated the urban / rural dimension in this study was the reported incidence levels of **vandalism / assault / threats**: these were much higher in the urban setting, as might be expected given that overall crime rates are generally higher in cities. However, other aspects of the survey were broadly similar. Incidents affecting small schools will undoubtedly have a ripple effect to the wider community, though the *types* of support required appear to be no different.

There is an inevitable increase in workload associated with critical events, both in the number of practical tasks and in the emotional effects generated. Support is needed for both aspects, and the risk of long term adverse effects on staff and pupils can be reduced if appropriate support is available.

Responding to critical events is staff intensive. In recognition of this, some Councils had provided additional staffing on a short-term basis. This kind of practical support was greatly appreciated.

A wide range of events was reported, but there were significant similarities in the types of support required, whether the school was in an urban or more rural area. Many head teachers considered that it ought to be possible to be better prepared, even though such events are by their nature unexpected. The need for advance planning and preparation for critical events is now well documented (Houghton 1996, Yule and Gold 1993).

Conclusion

This survey has demonstrated that approximately one quarter of schools in four Councils across Scotland share the experience of having to deal with one or more critical incidents in a given two year period. Of these incidents, about one third are described as having ongoing effects. The responses to the survey indicated both a commitment to meet the challenge and a recognition that there are limits to what a school is able to do by itself. Responses called for having some form of procedural guidance, training for staff, and access - where appropriate - to counselling services for staff, pupils and parents.

It is hoped that the material from this survey will provide a firm information base of use to those Councils who wish to prepare a set of crisis management guidelines and to identify appropriate contingency supports.

Critical Events for Schools: A Survey of Head Teachers in Four Scottish Councils

References

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-1V). Washington DC: American Psychiatric Association.

Houghton K (1996) Critical Incidents Involving Schoolchildren—Research Update: The Response from School Psychological Services. *Education and Child Psychology*, 1996, 59-75.

Jack M, Munro S and Oliver L (1998) The Contribution of a Psychological Service in Planning for and Responding to Traumatic Incidents in Schools. *Educational Psychology in Scotland*, 4, 1, 1998.

Yule W and Gold A (1993) Wise before the Event: Coping with Crisis in Schools. London: Calouste Gulbenkian Foundation.

Acknowledgements

With thanks to colleagues in the City of Glasgow, Dumfries & Galloway, North Lanarkshire and Renfrewshire for their support in organising the distribution of the survey, and particular thanks to the head teachers who took the time to complete it.

Data for the four participating Council areas are listed in the appendices which follow.

CRITICAL INCIDENTS IN SCHOOLS

(A sample briefing paper which could be adapted to accompany the Survey)

During the 1980's and 1990's there have been many large-scale disasters or tragedies which have involved school children directly or indirectly. In Scotland, Lockerbie, Piper Alpha and more recently, Dunblane, readily come to mind. The research findings of Yule and Gold described the effects of traumatic experiences on children's educational progress and emotional development. Their findings are summarised in their book, 'Wise before the Event' (1993), a copy of which was distributed to schools throughout the UK.

Thankfully, tragedies involving the death of children such as occurred in Dunblane are relatively rare. However, as many teachers and psychologists know small-scale critical incidents affecting schools and schoolchildren are now uncommon. A survey of head teachers in Fife (Jack, Alexander and Oliver, 1996) found that traumatic events in schools are relatively frequent.

Head teachers were asked to complete a questionnaire that included the following question:

Over the past twelve months have there been any traumatic incidents in the school or community which have had a distressing impact on children or staff?

There was an extremely high response rate from the schools (87%). Of the schools that responded 40% reported that they had experienced one or more traumatic incident during the previous year. The majority of the incidents reported involved death or illness/accident of pupils, staff or members of the wider community. Other incidents were categorised as:

- Personal safety issues
- Threat to safety/well-being of the school community
- Physical damage to the school

During this school session a number of schools across Scotland have taken part in a similar exercise. The survey has taken place as part of the Professional Development Programme for Educational Psychologists in Scotland.

In recent months there have been several significant traumatic events affecting schools within the **XXXXXX** Council area. These events highlight a need to prepare guidelines for schools, pupils and parents as a means of mitigating the impact of traumatic experiences. As a first step in this process it will be essential to gather information directly from schools on the nature and prevalence of traumatic events within **XXXXXXXX**

This information can be gathered via a survey of all schools. Information from the survey will make a helpful contribution to the process of planning for and responding to traumatic incidents in schools.

References

Yule W and Gold A (1993) Wise before the Event: Coping with Crisis in Schools. London: Calouste Gulbenkian Foundation.

Jack M, Munro S and Oliver L (1998) The Contribution of a Psychological Service in Planning for and Responding to Traumatic Incidents in Schools. Educational Psychology in Scotland, 4, 1, 1998.

SURVEY OF CRITICAL EVENTS IN SCHOOLS

A critical event is any event which has a stressful impact sufficient to overwhelm the usually effective coping skills of either an individual or a group.

Critical incidents are typically sudden, powerful events which are outside the range of ordinary human experience. Because they are sudden and unusual, they can have a strong emotional effect even on well-trained, experienced people and can disrupt normally effective organisations.

About your school: Nursery / primary / secondary / special (please circle)

School Roll _____ Number of Staff _____

Please describe in just a few words any such events which have affected you school over the last two years.

What forms of support has the school been able to access in managing these situations? We are interested in both direct support for the benefit of pupils or staff and indirect support in the form of consultation and advice to school managers.

At the end of each description, please mark **D** if this was a particularly difficult situation to deal with.

Also, please mark **O** if the school has been affected in an ongoing way by the event.

What types of support would have been desirable in these situations?

Thank you for your assistance!

Critical Incidents Survey - Summary of Returns: CITY OF GLASGOW

School Population: 90,000

Profile of Survey Returns

Establishment	Number Sent	Returns with		Nil returns	Number of Returns	% Returns
		Critical Incidents				
Pre5/primary	325	73	53	126	39	
Secondary	31	13	6	19	48	
Special	46	12	10	22	48	
Totals	402	98	69	167	42	

24 % of establishments making a return have experienced a critical incident

Profile of Incidents Reported - Level of Incidence across Sectors

	Death/Illness/Accident		Vandalism/Assault/Threats		System Stressors	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	28+	0.09	45	0.14	19	0.06
Secondary	14+	0.45	9	0.29	4	0.13
Special	11+	0.24	20	0.43	1	0.02

Profile of Incidents Reported - Level of Incidence across Type of Incident

	no. reported	incidence
Death/Illness/Accident	53+	0.13
Vandalism/Assault/Threats	74	0.18
System Stressors	24	0.06

32% of incidents were reported as ongoing (total reported 151, 49 as ongoing)

What Forms of Support were Accessed ?

	Directorate /Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	43	0.13	14	0.04	17	0.05
Secondary	8	0.26	6	0.19	3	0.1
Special	13	0.28	4	0.09	3	0.07

What Types of Support would be Desirable?

	Directorate /Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	54	0.17	10	0.03	32	0.1
Secondary	10	0.32	3	0.1	4	0.13
Special	9	0.19	1	0.02	12	0.26

(This includes comments from nil returns)

Critical Incidents Survey - Summary of Returns: DUMFRIES AND GALLOWAY

School Population: 12,000

Profile of Survey Returns

Establishment	Number Sent	Returns with	Nil returns	Number of	% Returns
		Critical Incidents		Returns	
Pre5/Primary	116	14	18	32	28
Secondary	16	3	2	5	31
Special	2	0	0	0	0
Totals	134	17	20	37	28

13 % of establishments making a return have experienced a critical incident

Profile of Incidents Reported - Level of Incidence across Sectors

	Death/Illness/Accident		Vandalism/Assault/Threats		System Stressors	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	14+	0.12	5	0.04	10	0.09
Secondary	3	0.19	2	0.13	0	0
Special	0	0	0	0	0	0

Profile of Incidents Reported - Level of Incidence across Type of Incident

	no. reported	incidence
Death/Illness/Accident	17+	0.13
Vandalism/Assault/Threats	7	0.05
System Stressors	10	0.07

32 % of incidents were reported as ongoing (total reported 34, 11 as ongoing)

What Forms of Support were Accessed ?

	Directorate/Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	14	0.12	6	0.05	7	0.06
Secondary	0	0	1	0.06	4	0.25
Special	0	0	0	0	0	0

What Types of Support would be Desirable?

	Directorate/Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	16	0.14	2	0.12	9	0.08
Secondary	2	0.13	0	0	1	0.06
Special	0	0	0	0	0	0

(This includes comments from nil returns)

Critical Incidents Survey - Summary of Returns: NORTH LANARKSHIRE

School Population: 47,000

Profile of Survey Returns

Establishment	Number Sent	Returns with		Nil returns	Number of Returns	% Returns
		Critical Incidents				
Pre5/Primary	157	42	30		72	46
Secondary	26	7	4		11	42
Special	11	4	2		6	55
Totals	194	53	36		89	46

27 % of establishments making a return have experienced a critical incident

Profile of Incidents Reported - Level of Incidence across Sectors

	Death/Illness/Accident		Vandalism/Assault/Threats		System Stressors	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	31+	0.2	10	0.06	20	0.13
Secondary	7+	0.27	3	0.12	1	0.04
Special	9+	0.81	0	0	2	0.18

Profile of Incidents Reported - Level of Incidence across Type of Incident

	no. reported	incidence
Death/Illness/Accident	47+	0.24
Vandalism/Assault/Threats	13	0.07
System Stressors	23	0.12

37% of incidents were reported as ongoing (total reported 83, 31 as ongoing)

What Forms of Support were Accessed?

	Directorate /Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	29	0.18	13	0.08	10	0.06
Secondary	4	0.15	2	0.08	3	0.12
Special	3	0.27	0	0	3	0.27

What Types of Support would be Desirable?

	Directorate /Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	22	0.14	6	0.04	28	0.18
Secondary	5	0.19	1	0.04	4	0.15
Special	2	0.18	0	0	3	0.27

(This includes comments from nil returns)

Critical Incidents Survey - Summary of Returns: RENFREWSHIRE

School Population: 36,000

Profile of Survey Returns

Establishment	Number Sent	Returns with Critical Incidents	Nil returns	Number of Returns	% Returns
Pre5/Primary	71	16	15	31	44
Secondary	14	3	4	7	50
Special	5	1	0	1	20
Totals	90	20	18	38	42

22 % of establishments making a return have experienced a critical incident

Profile of Incidents Reported - Rate of Incidence across Sectors

	Death/Illness/Accident		Vandalism/Assault/Threats		System Stressors	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	8+	0.11	11	0.15	7	0.1
Secondary	5	0.36	4	0.29	0	0
Special	several		0	0	1	0.2

Profile of Incidents Reported - Level of Incidence across Type of Incident

	no. reported	incidence
Death/Illness/Accident	13 +	0.14 +
Vandalism/Assault/Threats	15	0.17
System Stressors	8	0.09

37 % of incidents were reported as ongoing (total reported 38, 14 as ongoing)

What Forms of Support were Accessed ?

	Directorate /Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	18	0.25	2	0.03	18	0.25
Secondary	4	0.29	1	0.07	2	0.14
Special	0	0	1	0.2	2	0.4

What Types of Support would be Desirable?

	Directorate /Council Supports		External		Counselling Support	
	no. reported	incid.	no. reported	incid.	no. reported	incid.
Pre5/Primary	28	0.39	3	0.04	15	0.2
Secondary	6	0.43	0	0	6	0.43
Special	1	0.2	0	0	1	0.2

(This includes comments from nil returns)

Critical Events for Schools: A Staff Development Package for Working with the Effects of Trauma.

Ian Liddle, Alison MacDonald, Mike O'Connor, Alison Russell, Kate Watson and John Young

Introduction

One of the major roles for educational psychologists working with critical events which impinge on schools is that of raising schools' awareness of the need to plan, to rehearse responses and to seek to provide the kind of environment in which crises, large and small, can be faced and addressed with confidence.

To this end a subgroup of the project team sought to design a Staff Development Package which could be used flexibly with schools, but which would be comprehensive in its provision of support materials. Its design would reflect a mixed methodology, allowing scope for ideas to emerge through discussion and role-play formats as well as through more standard presenting of information. It would also require to be adjustable, to take account of the size and previous experience of the audience.

Many of the elements of the package were felt to be suitable as stand-alone items of staff development, and for this reason the group decided to aim at a modular format, so that sections could be delivered individually or in various combinations. This would also allow scope to vary the length of presentation, which could range from two hours to several days.

The overall objective has been to provide a broad spectrum of materials familiar to educational psychologists, which schools can find useful both in planning preventative measures and in responding to their own critical events.

In devising the package, members became aware of a number of overlaps in the various sections. Often those working on different aspects of critical incidents would be referring to the same research findings or curricular materials. Since the package has been designed for flexible, modular delivery rather than for presentation as a unitary course (where every element must be worked through in a specific order), this was not seen to be problematic. It was, in fact, reassuring to members that others were quoting from the same sources.

The materials were developed by the subgroup in the period between August 1998 and March 1999. As well as sharing the contents with colleagues in the project and in the

writers' own services and inviting comments, the subgroup ran a two-day workshop in March 1999 for a volunteer group of colleagues from twelve different psychological services drawn from across Scotland. Materials and workshop scenarios were trialled and rehearsed. Written and verbal feedback was obtained at the end of each presentation session, and there was a plenary session at the end of each day. This valuable exercise enabled some adjustments and re-alignments to be made to the form of presentation, the balance of information giving and workshop exercises, and to the overall structure of the package. Participants also offered useful ideas for additional exercises, which were gratefully received. The appraisal of the package by the participants was very positive.

The final content of the *Staff Development Package for Working with the Effects of Trauma* can be described under the following six headings:

1. Transitions, Change and Crises
2. The Nature and Incidence of Critical Events for Schools
3. Loss, Bereavement and Trauma: Grief and Crisis Reactions in Children
4. School Readiness and Contingency Planning
5. School Response to a Crisis
6. Protection and Vulnerability.

Each section includes a set of aims, background literature, a script for delivering the material, associated OHPs, handouts, leaflets, factsheets, tasks, exercises and checklists, as relevant. The lists of references may be supplemented by the separate lists of texts (prepared by another subgroup of the project) for use by parents, teachers, children and teenagers, provided in the main report.

The accompanying disks contain the Staff Development Package. One is PC formatted, and the text is in Word 6. The other is Macintosh formatted and the text is in Word for Macintosh. A full version of all the materials can be downloaded in PDF format from the website at <http://www.scet.com/pdp/> from August 1999.

The disk contains a folder for each section, with subfolders for text, notes for presentation, handouts, exercises, overheads etc. Some readers may wish to access the text as a reference for their own information and for this reason the main text is presented in standard reader format, but for INSET use it could be printed in larger, bold type.

Space does not allow full presentation of these materials within this paper document, but the summaries which follows attempt to give an overview of the content of the package, and a clear indication of the materials provided on disk. The writers will be happy to receive feedback from users, as this Staff Development Package is likely to continue to be revised as it is tested in practice.

Section One - Transitions, Change and Crises

Kate Watson and Alison MacDonald

On Disk:

Folder 1: Text (10 pages)

Introduction

Learning to Deal with Change

Mental Health and Empowerment

The Promotion of Emotional and Psychological Health in Schools

Staff Responses to Pupils which Promote Emotional and Psychological Health

Young People and Trauma

Apparent Setbacks

References (7)

Bibliography (9)

Folder 2: 5 Exercises + Notes for Exercises

Folder 3: 4 OHPs

Summary – *Transitions, Change and Crises*

Aims:

- to raise awareness of the universal nature of change
- to emphasise that a plan to support young people in crisis is not a 'bolt on' approach, but must be embedded in a caring and supportive culture, observable and demonstrable in the everyday school ethos

- to stress that ways of coping with change are learnt and thus possible to be taught to young people
- to encourage participants to see their role in helping children and young people to have the necessary personal resources for dealing with changes, including crises
- to provide basic knowledge of responses to trauma and some skill development in how to handle children who have experienced a crisis.

Our methods of dealing with change can vary greatly from individual to individual and are often determined by our early experiences. Within the educational system, formally and informally, young people have the opportunity to develop their skills in coping with change (both expected and unexpected) including birth, death and divorce.

The emphasis of this section of the Staff Development Package is upon the importance of developing systems of support within schools which encourage young people to grow and develop good, sound coping skills which can help them deal with both the large and small traumas they will experience in life.

It can be used both to remind staff of the importance of life skills teaching and the development of a positive school ethos, as well as to provide explicit information on how to respond to children in crisis.

Communication is the foundation of coping skills and is necessary for young people to ensure they get help when they require it. School staff can help young people learn to identify and articulate their own feelings in order to understand their experiences and what they are going through. It is thus important to develop the young person's view of a teacher as a trusted adult to whom they can turn

Preparedness of any organisation, including educational establishments, increases the likelihood of an appropriate response in the event of a crisis. Whether or not an incident becomes a traumatic experience will depend to some extent upon teachers, and caring professionals' responses and the level of preparatory work that has been done to help the young person. School personnel can learn about reactions to critical incidents; stress responses and how to respond appropriately; how to co-ordinate effective intervention with other personnel and parents; when and how to use external resources, for example the school psychologist and therapists, to best effect.

Responses to critical incidents are as differing and unique as the individuals upon whom they impact. However there can be **identifiable patterns of responses**, and school personnel can and should be made aware of these. Whatever the behavioural changes, they are likely to be normal responses and reactions to abnormal circumstances. For example, suppressing one's thoughts and emotions, becoming upset by one's own reactions, feeling disorientated, experiencing emotional upset and physical symptoms can be very frightening both for the young persons affected and those around them, yet they can be very normal and identifiable in the usual pattern of recovery. As well as this, problems with decision making, problem solving and distinguishing between trivial and important information can lead people in crisis to behave in seemingly inappropriate ways.

Concerned professionals such as teachers often prefer to leave any discussions with young people in crisis to the 'caring professions' for fear of making things worse. However, the first line guidance role in which school staff are placed often means that it is advisable for staff to have **training** and advice on how to respond appropriately. Emotional withdrawal from a young person in crisis should be avoided and attempts should be made to integrate the young person into the ongoing classroom structure with caring, supportive and attentive school staff.

Section 2: The Nature and Incidence of Critical Events for Schools *Ian Liddle, Alison MacDonald and John Young*

On Disk:

Folder 1: Text (9 pages)
Aim
Looking at Definitions
Participants' Experience of a Critical Event
Other Evidence of Incidence
Why is Readiness for Critical Events Important?

References (12)

Folder 2: 2 Tasks

Folder 3: 7 OHPs

Summary – *The Nature and Incidence of Critical Events for Schools*

The aim of this section is to increase awareness of the typicality of critical incidents in the lives of school children and to highlight the need for preparation for large or small-scale incidents.

In recent years there has been a growing awareness of the impact of large-scale traumatic events and disasters on individuals, families and whole communities. Traumatic events affect schools in a number of ways. There have been major incidents affecting a whole school system, as well as events which affect the wider community of which the school is still a part. Not all trauma is associated with *major* incidents. Indeed, fortunately such events are still relatively rare. However incidents which are unexpected, sudden and distressing are fairly common and most schools can expect to have to deal with such events and their repercussions. These might include incidents such as the death of a pupil, teacher or parent, serious accident or injury, a fire, the disclosure of abuse, or witnessing a serious assault.

A staff development exercise elicits from participants their own concepts and experience of critical incidents, and compares these to national survey material. Research has identified seven major aspects of a child's functioning that might be affected by trauma and loss: cognitive, physical, emotional, behavioural, psychological, spiritual and practical. It is helpful to recognise the potential effects of trauma and loss on these seven aspects of adjustment, before implementing support strategies within the school setting.

Children often express distress in less direct ways than adults. They can also act out their emotional difficulty in ways which do not immediately evoke a sympathetic response in those around them. It is important, therefore, that we are aware before a critical incident occurs of possible signs of distress, particularly those which are not overt or obvious. Research indicates that adults tend to underestimate the extent to which children think about and are affected by critical events.

Schools are in a strong position to help militate against the worst effects of traumatic events on children and young people. Next to the family, the school is a primary care-giver for children.

Whether a school is directly affected by an incident or is part of the wider community in which an incident takes place, there is likely to be an impact on the school system itself. Schools can be precipitated into chaos by such events and the normal coping and support strategies and lines of communication can be disrupted. This secondary trauma can make it

even more difficult for a usually smooth running system to deal with an unusually challenging and/or distressing occurrence. All recent research points to the need for education departments and schools to have a policy and action plan in place to meet with traumatic events. This section points up the need for schools to address these issues.

Section 3: Loss, Bereavement and Trauma: Grief and Crisis Reactions in Children

Mike O'Connor

On Disk:

Folder 1: Text (24 pages)

Introduction

Different Types of Loss

Bereavement and Traumatic Bereavement

Grief and Mourning in Children

The Needs of Grieving Children

Children's Responses to Critical Incidents

Caring for Children in Crisis: the Role of Carers and Professionals

References (32)

Bibliography (2)

Folder 2: 6 Exercises

Folder 3: 20 OHPs

Folder 4: 5 Handouts

Summary – *Loss, Bereavement and Trauma: Grief and Crisis Reactions in Children*

By the time children reach school age they will have experienced a wide variety of changes in their lives. Feelings of loss often accompany change, and grief is a natural reaction to loss. In this sense children already know about loss and grief when they enter school for the first time. As they progress through school children, in increasing numbers, encounter the distress of parental separation and divorce. Twenty per cent will experience a parental divorce by the age of sixteen, and fifty per cent will experience loss through family break-up before adulthood. Some will have experienced bereavement through the death of a family

member. The reality is that thousands of children every week suffer loss. In the UK over 10,000 young people between the ages of ten and eighteen lose a parent each year through death alone. In any one year in the UK there are approximately 15,000 deaths of children and young people under the age of twenty.

Thankfully, tragedies involving the deaths of children such as occurred in Dunblane are relatively rare. Yet during the 1980's and 1990's in the UK there have been several large-scale disasters which have involved children directly or indirectly. As many teachers and psychologists know, small-scale critical incidents affecting schools are not uncommon (Houghton 1996). The death of a pupil through illness or accident can have a devastating effect on pupils and staff. The experience of being bullied is another example of a potentially traumatising event that can result in stress and grief reactions in children.

Many parents and teachers lack confidence in their ability to help children who have experienced loss and are uncertain about how best to help. In such circumstances there is a real risk that children's grief reactions will be overlooked, misunderstood, go unrecognised, or at worst, be denied.

Though the process of mourning for a perceived loss appears to be universal in human beings, the outward expression of grief is unique to each individual. Children do not mourn in the same way as adults. They mourn through their behaviours more than through words. While acknowledging the importance of individual grief responses, it remains possible to identify a range of common feelings and behaviour in children experiencing loss. These common features make it possible to develop some general strategies to meet the needs of grieving children.

The purpose of this paper with its related materials is to foster a greater awareness and understanding of the needs of children who have experienced loss or bereavement in those adults who have some responsibility for their care and education. It aims to do this by providing information and experiential exercises on the following topics:

- Different types of loss
- Bereavement and traumatic bereavement
- Grief and mourning in children
- The needs of grieving children
- Children's responses to critical incidents
- Caring for children in crisis and grief : the role of carers and professionals.

The expected outcome is that participants will become more confident in their ability to recognise and meet the needs of children in their care directly, and, where appropriate, to refer them for specialist help.

Section 4: School Readiness and Contingency Planning

Ian Liddle

On Disk:

Folder 1: Text (9 pages)

Aims

The Contingency Planning Process

School Readiness: Management, Organisation, Ethos, Curriculum

References (11)

Folder 2: 4 Tasks

Folder 3: 4 OHPs

Summary – *School Readiness and Contingency Planning*

There are two factors in school readiness: one has to do with straightforward planning of the mechanisms and systems to be put into place in the event of an incident; the other concerns the school's management and organisational ethos which will greatly influence its ability to respond effectively in such an event. This section of the Staff Development Package looks firstly at the contingency planning process, then at school factors.

Contingency Planning

The use of school crisis management groups is highlighted in most of the major texts and it is emphasised that these groups should be established in preparation for such events, not after the fact. There is a growing expectation that educational psychologists will have the skills and expertise both to advise a group on matters relating to Critical Incident Stress Management (CISM), and to offer hands-on support to a school in the event of such an incident.

It has to be recognised that on the day of any critical event, one or more of a crisis management group may not be available. Substitute personnel should always be considered, and should be involved actively in the planning and rehearsing.

It is well known that crises are better handled when there is a division of labour among members of the crisis management team. In a school situation, common roles assigned are: resource manager, care of staff, care of children, contact with parents and handling the media. A liaison role with the emergency services is also crucial, but may vary depending on the nature of the crisis. Finally, there is a need for someone to hold a 'maintenance' role, that is, to ensure that wherever there are aspects of normal school functioning that can continue, these are allowed to happen. After an incident the need to re-establish familiar school routines is important for many children.

An essential element in managing a crisis is the availability of reliable information. Whilst the most difficult aspect of this is information about the impact of the event itself, the situation can be helped enormously by having accurate school information – up-to-date class lists, registers and timetables; up to date home addresses and contact numbers; up-to-date contact lists for the emergency services, education management and other relevant Council services.

In order to be able to respond effectively and (in a sense) automatically to an incident, core groups should make a point of rehearsing situations which might conceivably happen within their locality.

Responses to critical events in schools are at their most effective if all members of the school, including pupils, are aware of the crisis management planning process.

Schools should also share their crisis management plans with parents, school boards and parent-teacher associations. Parent groups may be represented on the core group, and parent volunteers may be crucial in the event of an incident affecting the school.

School Readiness

It is often the case that schools find it hard to acknowledge children's suffering after a traumatic event. It is felt to be more important to be seen to be getting on with the business of teaching and learning, and the temptation to play down the emotional repercussions is high. Yet many researchers point out that the school can be a major source of healing and rehabilitation for children who have suffered loss or trauma.

The description usually given to the management consideration of these issues is called *Care Leadership*. The symbolic nature of the head teacher's involvement gives the lead to management staff, teaching staff, ancillary staff and pupils.

A major factor, which can influence the potential of schools to deal effectively with crises, is the curriculum. Curricular approaches which permit children to express their feelings and to raise issues of importance to them are an excellent vehicle for ongoing support when an incident does occur.

The Circle Time approach, variants of which are now fairly common at least in Scottish primary school classrooms, provides opportunities for children to raise genuine concerns, and can be used flexibly to explore the impact of traumatic events, large and small, in the lives of children.

Much of the literature stresses the need for concepts such as death, loss and bereavement to find a place in normal classroom discussion, so that children learn to appreciate the normality of these concepts.

This section allows for discussion of these issues, and references and sample materials offered by another subgroup are included

.

Section 5: School Response to a Crisis

Ian Liddle

On Disk:

Folder 1: Text (18 pages)

Aims

Obtaining Factual Information

Assemble Crisis Management Team

Decide Scale of Response

Contact Families

Call Staff Meeting

Inform Pupils in Small Groups

Debriefing Meeting for Staff

Debrief Pupils involved in the Trauma

Identify High Risk Pupils and Staff

Promote Discussion In Class

Identify Need for Group or Individual Treatment

Organise Treatment

Simulation Exercise: A School Response to a Critical Incident

References (8)

Folder 2: Simulation Exercise

Text

Additional Notes

Cut-out Messages

Folder 3: 6 OHPs

Summary – *School Response to a Crisis*

There are a number of documents which outline the steps a school might take when a critical incident does occur. The series of steps described in this section is an adaptation of the Yule and Gold guidelines offered in *Wise Before the Event* (1993).

The critical need to obtain accurate, factual information is emphasised, so that the crisis management team can make informed decisions.

In a school setting the needs of those most affected (or 'primary victims') often require to be dealt with separately, but the needs of three groups - staff, pupils and parents - almost inevitably have to be addressed.

A crucial role in these situations, sadly, is the role of handling the media. Media intrusiveness often cuts across the team's planning and organising efforts, and it is better to have one person dedicated to the task of responding to media questions, preparing press releases and using the media positively.

The families of young people affected directly by a critical incident need to be contacted as early as possible, and given full and accurate information.

A staff meeting should be convened by the head teacher involving all staff (if possible) and groups of staff (if not). Both teaching staff and support staff should attend the meeting, which ensures that the same information is shared and that rumours do not circulate, causing additional distress. As well as factual information on the incident, psychoeducational information should be provided about the feelings and reactions people may have in the first few days.

Students should be told simply, clearly and honestly what has happened. This should take place in small groups with a teacher who knows them well. Any questions should be answered as straightforwardly as possible, and speculation about the causes of the crisis and its consequences should be avoided.

Closure of the school should, as a general rule, be avoided.

Appropriate debriefing processes should be carried out within optimum time-scales, and those children and staff requiring more intensive help should be identified. Treatment and monitoring processes should be put in place.

Workshops within this section will include simulations of critical events and involve participants in working through the stages of a crisis response.

Section 6: Protection and Vulnerability

Alison Russell

On Disk:

Folder 1: Text (12 pages)

Factors determining those at risk
The traumatic event itself
Factors within the individual
The recovery environment post-trauma
Targeting scarce resources

References (19)

Bibliography (5)

Folder 2: Notes for the Presentation (9 pages)

Folder 3: 3 Exercises

Folder 4: 2 Handouts

Folder 5: 20 OHPs

Summary - *What are the factors involved in determining which children will be most at risk following trauma or a critical event?*

Highly stressful traumatic events will have significant effects on those involved. For some these effects will be relatively short lived and they will recover without the need to seek professional help. Some will appear relatively unaffected and to function satisfactorily, though for them another traumatic event may prove sufficient to undermine this apparent ability to function. For others the effects will be major and long lasting and without help they will continue to experience a range of psychological symptoms which will have adverse effects on their lives. While for adults this is a serious enough problem in terms of their quality of life, it is of even greater significance for children whose personality development may be seriously disrupted following a trauma with which they are unable to deal.

Of those involved in a traumatic event the largest percentage will be able to deal with any disturbance they experience by using naturally pre-existing resources and current support networks. For this group recovery can be aided by some professional intervention, no matter how low key, although recovery does not depend upon it. Intervention, as brief and

simple as educating survivors to know how they may expect to react, can assist them in their recovery. For those who are more vulnerable to stressors, this recovery may require professional help.

Much has been written of the individual's capacity to survive adversity. Frequent denigration in the media of 'counselling' services has stressed the individual's drive toward self healing and the lack of need for professional help. No one would deny the ability of the human psyche to deal with distress and fear, but neither can one ignore the sizeable minority who will need to seek help.

In recent years there has been a good deal of research trying to determine why it is that some individuals seem better protected against the effects of trauma than others. Earliest investigations have tended to follow major events, since these are by their nature more readily identifiable and therefore easier to study. More recent work suggests that factors which seem to protect against long term psychological difficulties apply whether the events are small or large.

Some people are clearly more at risk than others. What are the factors involved? They fall, broadly, into three groups:

- The nature of the traumatic event itself.
- Individual factors which to a large extent pre-date any critical event and which affect the individual's personal resources.
- The recovery environment in which the individual exists post-event.

For those who have significant difficulties post-trauma, specialised help can be made available. But children can be adept at masking their difficulties and staff may themselves have difficulty recognising and dealing with the effects of trauma in children, especially if they themselves have been traumatised. Schools need an ethos of openness in communication in order that painful issues can be acknowledged, and they need a proactive monitoring system to identify those most in need. General screening, however, may not be the most appropriate approach.

This paper looks at a number of the issues involved and at some of the research evidence which identifies those issues. It looks briefly at the need to establish an effective system in schools which allows those children most at risk to be identified and appropriate specialist

help to be made available.

Lists of Curricular Materials

William Allison, Laurence Cairns, Christine Munro and Karen Telfer

Introduction

As with any body of knowledge or area of interest to the professional or lay-person, there is a wide and varied range of books focusing on the nature of critical events, loss and trauma. In putting forward this selection the emphasis has been on identifying both seminal works and practical guidelines readily accessible to most readers, especially those involved in the support or therapeutic services. The selection, therefore, includes works by major contributors in this field such as Kubler-Ross, Dyregrov, Heegard and Ward, but also fictional works appropriate to individuals of all ages who may be experiencing bereavement or trauma.

There are common themes in many of these texts: understanding bereavement and grief reactions; the role of family or school in helping an individual readjust following bereavement or trauma. Furthermore, most texts distinguish between crisis intervention and psychological treatment, the former being concerned with practicalities in the early days following a crisis, and the latter with follow-on strategies as delivered through most therapeutic interventions. In some form or other most texts provide information from natural settings that can be valuable not only to professionals but also to others (parents, school staff) involved with an individual or group affected by a critical event.

As with all recommended books lists, this selection cannot be seen as definitive. As we are becoming more aware of the nature of crisis or trauma and its effects, so there is an increasing literature available on this major psychological area.

The materials and references listed below have, therefore, been reduced deliberately in order to ease the time pressures on busy people, particularly at times of crisis. They provide a way into the topic.

Further reading material may be obtained from other sources such as the specialist mail order publishers and support agencies (details are included in the lists), bookshops, libraries and the Internet (Amazon website). Local libraries usually have a good selection of books for children who are dealing with loss and bereavement.

It is envisaged that this short selection should be useful to professionals, parents and children themselves. Most of these references, as well as being readily accessible, have been tried and tested and are highly regarded by those working in the field.

Finally, the group has put together sample leaflets which can be distributed at a time of crisis. There are separate leaflets for

- young children
- teenagers
- teachers
- parents.

Each has a space for a Council logo and for local contact addresses. The leaflets contain basic information and advice, details of local and national sources of support, and (on the leaflets for teenagers and parents) lists of appropriate and useful references.

Copies are available from the authors, and colour versions of the leaflets are displayed in this section. They can be printed with coloured graphics or in black and white, and customised for local use.

List One - Scene Setting and Awareness Raising

Bliss, T, Robinson, G & Maines, B (1995) Developing Circle Time. Lucky Duck Publishing

Bliss, T, Robinson, G & Maines, B (1995) Coming round to Circle Time. (Video) Lucky Duck Publishing

Bliss, T and Tetley, J (1993) Circle Time. Lucky Duck Publishing

Mosley, J (1993) Turn your School Round. Cambridge: LDA

Mosley, J (1996) Quality Circle Time in the Primary Classroom.
Cambridge: LDA

Mosley, J (1999) More Quality Time. Cambridge: LDA

Nelson, J, Lott, L and Glenn, H S (1993) Positive Discipline in the Classroom: How to use Class Meetings and other Positive Discipline Strategies. Prima Publishing

List Two - Inservice Materials

Chadwick, A (1994) Living with Grief in School: Guidance for Primary School Teachers and Staff. Kent: Family Reading Centre

Wagner, P (1993) Children & Bereavement, Death & Loss: What can the School do?
NAPCE

Winston's Wish, (1997) Positive Responses To Death: A Strategy For Schools. A Grief Support Programme For Children. Gloucestershire Royal Hospital GL1 3NN. Website: www.winstonswish.org.uk

List Three - Guidelines for Working with Children

Mallon, B (1998) Positive Strategies for Growth and Renewal. London: Jessica Kingsley

Smith, S C and Pennells, M (1996) Interventions with Bereaved Children. London: Jessica Kingsley

Smith, S C and Pennells, M (1994) The Forgotten Mourners. Guidelines for working with Bereaved Children. London: Jessica Kingsley

Steffes, D, Clegg, G and Dalzell, R (1997) When Someone Dies: Help for Young People coping with Grief. Richmond: Cruse

List Four - Materials for Working with Children

O'Rourke, K, and Worzbyt, J (1996) Support Groups for Children. Accelerated Development Publisher

Gersie, A (1992) Storymaking in Bereavement: Dragons in the Meadow. London: Jessica Kingsley

Heegard, M (1988) When Someone Very Special Dies. Woodland Press

Heegard, M (1988) When Someone has a Very Serious Illness. Woodland Press

Heegard, M (1988) When Something Terrible Happens. Woodland Press

Searle, Y and Streng, I (1996) The Grief Game. London: Jessica Kingsley

Turner, M (1998) Talking with Children and Young People about Death and Dying: A Workbook. London: Jessica Kingsley

Wells, R (1995) Helping Children Cope with Grief. Sheldon

List Five - Activities for Children

All About Me: Being Yourself (Groupwork Game) Barnardos Childcare Publications

Memory Store: Being Yourself Barnardos Childcare Publications

To Help Explore Feelings of Loss, Death and Grief (Activity Pack including Video) Child Bereavement Trust, Harleyford Estate, Henley Road, Marlow, Bucks, SL7 2DX

List Six - Further Information

For a fairly extensive annotated list of books relevant to *Children and Loss* contact:

Abbey Books 45,

BankView Road,

Derby,

DE22 1EL.

Tel: 01332 290021

Fax: 01221 290173

E-mail: abbooks@mcmail.com

A free catalogue is also available from:

Being Yourself,

73 Liverpool Road,

Deal,

Kent ,

CT14 7NN.

Being Yourself is an independent resource centre, offering a wide range of teaching and therapeutic aids for professionals and parents.

Phillips, K (1996) What do we tell the children? PARC, Sick Children's Hospital, Edinburgh

This is an excellent and comprehensive bibliography which will be a great help to many people in selecting suitable books for children. Books are categorised by age level and have a brief resume of content.

Ward, B and Associates (1989, 1993, 1996) Good Grief. Exploring Feelings, Loss and Death. Jessica Kingsley Publishers

These contain useful lists of resources, with booklists for students and educators, and separate consideration of the issues as they affect children under and over eleven years of age.

Jenny Mosley has a range of other publications on *Circle Time*. List available from:

Jenny Mosley Consultancies,

8 Westbourne Road,

Trowbridge,

Wiltshire,

BA14 0AJ.

The **Lucky Duck Publishing** company has a range of relevant material.

List Seven - Books for Young Children under 8 Years

Boulder, J (1992) Saying Goodbye. Boulder Publications

Brown, L K (1996) When Dinosaurs Die. Little Brown Publishers

Fassler, J (1983) My Grandpa Died Today. Human Sciences Press, New York

Varley, S (1985) Badger's Parting Gifts. Mulberry Books

Viorst, J (1972) The Tenth Good Thing About Barney. Collins

Wilhelm, H (1985) I'll Always Love You. Hodder

List Eight - Books for Children 8-12 Years

Levete, S (1998) When People Die. Aladdin Books

Little, J (1985) Mama's Going to Buy You a Mocking Bird. Harmondsworth: Penguin

Mellone, B and Ingpen, R (1983) Lifetimes. Dragons World Publishing

Morris, L and Perkins, G (1991) Remembering Mum. A and C Black

Smith, D B (1992) A Taste of Blackberries. Penguin

List Nine - Books for Teenagers

Blume, J (1984) Tiger Eyes. Piccolo

Gleitzman, M (1989) Two Weeks with the Queen. Pam Books

Grollman, E (1998) Straight Talk About Death for Teenagers. Beacon Press

Krementz, J (1988) How It Feels When a Parent Dies. Gollancz

Lloyd, C (1990) The Charlie Barber Treatment. Walker

Steffes, D (1997) When Someone Dies: Help for Young People Coping with Grief.
Cruse Publishers

Ure, J (1987) One Green Leaf. Bodley Head

List Ten - Books for Parents

Brooks, B (1996) The Scared Child: Helping Kids Overcome Traumatic Events. John
Wiley and Sons

Kubler Ross, E (1995) Living with Death and Dying. London: Souvenir

Monaghan, C (1995) Children and Trauma: A Parent Guide to Helping Children Heal.
Lexington Books

Osmont, K (1989) More than Surviving: Caring for Yourself while you Grieve.
Centering Corporation

List Eleven - Books for Professionals

- Black, D et al (1997)** Psychological Trauma: A Developmental Approach. Gaskell
- Dyregrov, A (1991)** Grief in Children: A Handbook for Adults. London: Jessica Kingsley
- Herbert, M (1996)** Supporting Bereaved and Dying Children and their Parents. BPS Books
- Johnson, K (1989)** Trauma in the Lives of Children. McMillan
- Saltar, A C (1995)** Transforming Trauma. Sage Publishers
- Smith, S C and Pennells, M (1996)** Interventions with Bereaved Children. London: Jessica Kingsley
- Tinker, R and Wilson, S (1999)** Through the Eyes of a Child: EMDR with Children. Norton and Co.
- Ward, B and Associates (1989)** Good Grief: Exploring Feelings of Loss and Death with Under 11's: A Holistic Approach London: Jessica Kingsley

IT HELPS TO

Talk about our feelings with someone we trust.

This might be our mum or dad, an aunt or uncle, our grandparents, a teacher or a friend.

Ask questions about things that we are not sure about or don't understand.

Remember all the good times before the terrible thing happened. It can be good to talk about these too.

Draw a picture, write a story, a letter or a poem.

This could be about the happy times before the terrible thing. It could also be about the terrible thing or how we feel about it.



REMEMBER.....



You are special. A lot of people care about you and want to help you.

It's important to think of the future as well as the past.

It's okay to enjoy the rest of your life.

WHERE TO FIND HELP...

Local Psychological Service

Local Social Work Department

Your Doctor

Your Clergy or Religious Leader

Childline 0800 - 1111

Local Council Logo

When Something



**A Guide for
Young Children**

Good things and bad things happen FEELINGS.....

to people all the time. It is easy to know what to do when good things happen and sometimes we know what to do when bad things happen.

But other times things happen which are so bad they are terrible, and we need help to know what to do. This leaflet has some ideas which might be helpful.

SOME TERRIBLE THINGS.....

Here are some examples of terrible things which can happen:

someone special dies



someone special has a very serious illness



their mum and dad split up

Such terrible things don't happen very often and usually they don't happen at the same time.

When something terrible happens we might feel:



Sad

We might cry. We might want to cry but not be able to or we might not want to cry. All of these feelings are normal.



Scared

We might be scared to be away from people we love or we might be scared that something else terrible might happen. Usually this does not happen.



Angry

We might wish the terrible thing had not happened and feel angry that it did. Sometimes we feel angry at people who are close to us for no reason at all.



Worried

We might worry that we did something to make the terrible thing happen. It is very important to remember that nothing we do or say or wish can make such terrible things happen. Also there is usually nothing we could have done or said to stop the terrible thing from happening. It's not our fault.



Mixed Up

Sometimes we don't know how we are feeling. It's like we feel nothing - just like our fingers go numb in the cold.

All of these feelings are normal.

EVERYONE IS DIFFERENT.....

Everybody feels things differently and we won't feel all of these feelings all of the time. One day we might feel sad, another we might feel worried, another day we might feel quite happy. This is okay. In a few weeks or months we will start to feel happy more of the time.

BOOKLIST (Check with local library)

- J.Blume(1984) Tiger eyes.
Piccolo
- C.Lloyd(1990) The Charlie Barber
Treatment.
Walker
- J.Ure(1987) One Green Leaf.
Bodley Head
- J.Krementz(1998) How it feels when a
parent dies.
Gollancz
- J.D.Morgan(1990) The Dying & Bereaved
Teenager .
Charles Press
- E.A.Grollman(1998) Straight talk about Death
for Teenagers .
Beacon Press
- E.Houghton(1995) Dealing with Death.
Wayland



WHERE TO FIND HELP...

Local Psychological Service

Local Social Work Department

Your Doctor

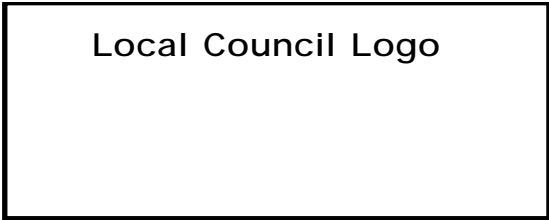
Your Chaplain or Religious
Leader

ORGANISATIONS

Local CRUSE Office

Samaritans 0345 90 90 90

Childline 0800 - 1111



**A Guide for
Teenagers**

WHEN SOMETHING TERRIBLE HAPPENS

We may from time to time have bad experiences such as a sudden death in the family, witness an accident or be involved in one.

Examples

- ◇ A parent dies suddenly
- ◇ Parents divorce / separate
- ◇ You are involved in a car crash
- ◇ Someone in your school is killed

All of which may make us feel very sad, unsettled and worried.

YOUR FEELINGS

To feel sad is OK

To shed tears is OK

You may

- ◇ be in a state of shock
- ◇ feel helpless
- ◇ have sleep or eating problems
- ◇ have difficulty talking about your feelings
- ◇ have difficulty talking about the accident.

FRIENDS AND FAMILY

You may

- ◇ feel that you do not care about your friends or family or
- ◇ that they do not care about you.

AT SCHOOL

You may

- ◇ lose interest in school or struggle in class
- ◇ be frightened or worried about going to school
- ◇ want to withdraw from everything.

WHAT CAN YOU DO?

When you are feeling ready to talk, talk to someone you choose ...

- ◇ a parent
- ◇ a friend
- ◇ a teacher
- ◇ a relative
- ◇ school psychologist
- ◇ social worker

GOING OVER THE EVENT

As the images intrude more and more into your thoughts, there is a need to

- ◇ talk about it
- ◇ share these thoughts and worries with someone

You may find you dream about the event.

Sharing with others who have had a similar experience can help.

Privacy. You may find it necessary at times to be alone, to be just with your family and close friends.

Don't worry. These are all ways in which you can begin to feel better.

SOME DO'S AND DON'Ts

Do share your experience and feelings with someone else.

Do ask for support and help whenever you need, especially from your friends, family and teachers.

Do allow time to sleep, eat, rest, think, and be with your close family and friends.

Do make sure that your teacher knows what is happening.

Don't bottle up your feelings.

Don't expect your feelings and memories to go away quickly. It may take some time to sort these out and before you feel that you are coping well with them.

TIME - HOW LONG?

It can take months but you will be able to cope again.

Try to talk about what happened but don't feel that you have to unless you are ready.



BOOKLIST

- S.Varley(1985) Badger's Parting Gift
Picture lions
- S.Levete(1998) When People Die.
Aladdin Books
- L.K.Brown(1996) When Dinosaurs Die.
Little Brown
- J.Viorst(1972) The Tenth Good Thing
About Barney
Collins
- H.Wilhelm(1985) I'll always Love You
Hodder
- J.J.Boulder(1992) Saying Goodbye
Boulder Publishing
- J.Little(1985) Mama's Going To Buy You
A Mocking Bird
Harmondsworth Penguin

(Check with your local library)



WHERE TO FIND HELP...

Local Psychological Service

Local Social Work Department

Your Doctor

Your Clergy or Religious Leader

If you need further help/advice, the following groups are there to give support.

* The Compassionate Friends
53 North Street
Bristol
BS3 1EN
Tel: 0117-953-9639

* CRUSE
Baltic Chambers
50 Wellington St
Glasgow
G2 6BH
Tel: 0141-248--2199

Local Council Logo

When Something

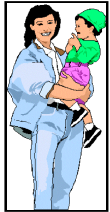


**A Guide for
Parents**

WHEN SOMETHING TERRIBLE HAPPENS

Children vary markedly in their reactions. Many show obvious outward distress, some hardly appear to react at all, at least on the surface. Sometimes children don't know how to react because they don't understand what has happened.

The following advice is to help you, as parents, understand and support your child in coping with a stressful event.



Although children of varying ages do have differences in their reactions, there are common factors.

You should:

- * Share information at children's level of understanding.
- * Give time, attention and listen.
- * Allow children to participate in rituals.

EMOTIONAL REACTIONS to a stressful event

Fear	Anxiety
Guilt	Sadness
Anger	Denial
Withdrawal	Regression

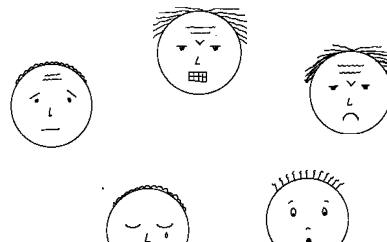
- The above are all normal reactions. The way in which children make sense of death and grief is related to their stage of development.

4-7 years: Death is still seen as reversible. Children may see a terrible event as a punishment or believe it was 'their fault'.

Reactions can include nightmares, sleeping and/or eating disturbances, violent play

7-11 years: This is a difficult transition period. Children want to see death as reversible but are beginning to understand it as final. Death may still be viewed as punishment. Behaviour may include immature reactions or outwardly difficult behaviour.

11-18 years: Young people at this stage usually have an adult concept of death. Reactions may include anger, depression and non-compliance



WAYS TO HELP

How you react as a parent can make a difference to how your child reacts. Parents are, after all, role models to their children.

- ◇ Maintain usual routine as far as possible.
- ◇ Be honest. Answer questions as truthfully as you can, and try to find brief and simple answers that they can understand.
- ◇ Listen. Try to understand what children are saying and, just as importantly, what they are not saying.
- ◇ Don't wait until children start to cry before giving a hug. Physical contact is extremely important at this time and sometimes says a lot more than words.
- ◇ Talk in a language they can understand. Don't use terms like 'gone to sleep', 'resting', 'gone away' to explain death. This can cause further confusion and anxiety.
- ◇ Allow children to be silent, but don't discourage expressions of emotion. Let them know it's O.K. to cry.
- ◇ Don't force children to take part in anything if they don't want to.
- ◇ Let children know it's OK to laugh and have fun as well as to grieve.

Local Council Logo

W h e n S o m e t h i n g



Terrible

H a p p e n s

**HELPING PUPILS WITH
BEREAVEMENT**

Some Guidance for Teachers

INTRODUCTION

As adults we have more than likely faced bereavement and loss at some stage in our lives. Consequently we appreciate how shocking and upsetting a death can be, especially when the deceased is someone familiar and loved. Pupils vary in their concept of death where for example very young and or immature pupils have a poor grasp of the notion that death is a permanent state. In any event a pupil will need time to come to terms with their loss.

COMMON GRIEF REACTIONS

Teachers typically observe a range of reactions in pupils. They may be in denial and acting as if nothing has happened. There could be displays of agitation, hyperactivity, increased aggression with peers and unruliness. Alternatively, the pupil could present as excessively passive and almost zombie-like. Sleep disturbances, including nightmares, insomnia, fear of darkness are not uncommon. There may be an exaggerated sense of danger or worries about leaving other family members. Self blame and denigration can follow to the extent that the pupil illogically takes on some responsibility for the death.



THINGS THAT HELP IN THE IMMEDIATE AFTERMATH

Comfort from family members, teachers and others with whom a pupil has a positive relationship is a major help in itself. It is essential that they get honest information about the circumstances in plain everyday language, allowing the pupil to ask questions. Historically, children might have been precluded from the grieving process - in order to spare their feelings. They need to be included along with other family members and the wider community and this can include attending the funeral service.

IN SCHOOL

Liaison with the family is important in order to support the pupil and to learn how the wider family is managing, and whether there are any factors around that could have particular repercussions for the pupil in school. The pupil may draw special comfort from the perception and the school and home are in good communication and at one. In most instances, an early return to school is best and ideally should be planned in consultation with the headteacher and family.

Returning to school and facing people will be hard for many pupils. It helps to be aware that some may be harbouring irrational worries about the wellbeing of surviving family members and be

reluctant to separate from them. It is very possible that the pupil may regress to an earlier stage of development and under perform in class. Allowance needs to be made for the fact that concentration may be disturbed and poorer retention of information. Patience and gentle encouragement to engage in normal work and school routines is recommended.

School is a predictable and safe place in the minds of most pupils and as a teacher you have many inherent skills that place you in an ideal position to support your pupil. If a pupil is indicating that they would like to talk and share feelings - try and make the time. With a busy class to look after it may not be possible to take time there and then, but perhaps you could appoint a time free from distractions. Allow emotional expression where pupils know it is ok to cry. Allow the pupil's peers to be involved in supporting them. Circle Time can provide such an opportunity.

HOW LONG DOES THE GRIEVING LAST

This will vary but in general the acute grief phase may last for up to three months before subsiding and perhaps beyond two years for the grief process to come to closure. However, given time and understanding, children can resolve the loss.

CISM or Critical Incident Stress Management: an integrated crisis intervention approach.

Alison Russell

This paper aims to introduce the reader to the components of the crisis intervention used extensively following critical events, known as Critical Incident Stress Management or CISM. It will look briefly at recent controversy over the effects of its use in a broader range of situations than those for which it was specifically developed. The issue of using debriefing with children who have experienced trauma will be examined.

The main aims are to:

- Outline the development of CISM
- Describe the component parts of CISM
- Discuss in some detail the process of Critical Incident Stress Debriefing (CISD)
- Highlight the recent controversy about the use of CISD
- Examine some issues raised in using psychological debriefing with children.

In the course of our lives approximately 60% of men and 50% of women over a lifetime will experience a number of critical events (Freeman 1999). Critical events are not necessarily high profile, large-scale events, and the degree to which any given individual will experience a life event as 'critical' may be determined by previous life experiences, and earlier trauma.

Critical events may include such experiences as loss of a meaningful relationship through separation or death, major and/or life threatening illness, loss of job or business, rape, assault, burglary - in fact any event that is outwith the range of normal day to day experiences and which threatens to overwhelm, or does overwhelm the individual's normal coping mechanisms.

For children the range of events which may be classified as 'critical' can be far wider. Events, which for adults will be manageable, may far more readily overwhelm the coping mechanisms of children because of their undeveloped ego and immature sense of security. Then such apparently commonplace events as change of school, loss of a friend through separation, loss of a pet, the birth of a new baby, admission to hospital, may become 'critical'. This is not to argue that to experience such events is to be unable to cope with the outcome. Rather that children may need to make use of a range of supports, both internal

and external, to ensure that they can deal with them and continue to develop in an emotionally healthy way.

In fact, of the percentage reckoned to experience at least one critical event in a lifetime, two thirds of these are likely to deal with the emotional impact of the event successfully and to require no professional help. The remaining third may continue to experience post-trauma reactions to such a degree such that they will need to seek help or will experience a loss of quality of life.

Individuals with supportive social networks and good pre-existing personal resources are able to access a range of supports, both emotional and practical, and are more likely to cope with the effects of critical incidents than those who do not have such resources. However, the presence of these resources will not always protect individuals from the effects of overwhelming stressful events.

The recognition of the importance of providing psychological support following critical incidents and traumatic events at work has led to the development of an integrated crisis intervention approach whose purpose is to reduce, where possible, the harmful aspects of traumatic stress. This approach is known as *Critical Incident Stress Management* or CISM.

CISM will include:

- Pre-incident information
- Pre-incident stress education
- Post-incident stress education
- Support services
- Counselling and other long-term interventions
- CISD – (debriefing, defusing, demobilization)
- Follow-up and monitoring.

Probably the most well known aspect of CISM is *Critical Incident Stress Debriefing*. Much has been written about the effectiveness of CISD in mitigating the effects of post traumatic stress. CISD has been found to be a valuable tool when it is used by trained personnel, experienced in working with the client group to whom the process is to be applied. Its use in situations for which it was not designed or where it is used without the necessary follow up has led to criticism of the method as a whole.

Critical Incident Stress Debriefing, developed initially by Mitchell in 1983, is a form of psychological debriefing designed to mitigate the harmful effects of work-related trauma. In its original form it was developed for use with emergency personnel who had experienced trauma in the course of their work. Over time, it has been adapted and applied, in a range of situations, sometimes more effectively than others. The process has been adopted for use by the military, high-risk businesses and industry. More recent applications to *individual* rather than group trauma situations and for victims of trauma rather than *personnel* involved in trauma in the course of their work have led to controversy over its effectiveness, and a range of research investigations has yielded apparently conflicting results.

Brewin (1999), studying the value of debriefing with victims of violent crime, found no significant differences between the experimental and control groups. He concedes that the results may have been influenced by the self selected sample who took part. Robinson and Mitchell (1993) in one of the few systematic evaluations of the effectiveness of debriefing found that many subjects found debriefing helpful in reducing stress levels. Everly & Mitchell (1997) reviewed only research consistent with the 'Mitchell Model' formulations of CISM or CISD. Their findings all reported positive outcomes. Studies by Kennedy et al (1996) and Hythen & Hasle (1989) concluded psychological debriefing did not influence psychological morbidity, while yet others (eg Griffiths & Watts 1992) suggest that psychological debriefing may exacerbate difficulties over time.

The practice of using debriefing techniques in isolation rather than as part of a comprehensive intervention, and the failure to monitor outcome may be two factors affecting these results. Other variables affecting outcome may be that CISD is being used too soon, or that to use a *group* process for *individuals* may be to lose a valuable element of the process. Beverly Raphael argues that CISD may be viewed more positively than is merited by research findings because it meets a number of needs:

“the needs of those not directly affected to overcome their sense of helplessness and the guilt of surviving, to make restitution, and to experience and master vicariously the traumatic encounter with death; the needs of those directly affected to speak of what has happened, understand it, and gain control; and the symbolic need for workers and management to assist those who suffer and to show concern.”

(Raphael, 1995, p.1480)

Despite the current debate, CISD is the most widely used group technique for the prevention of work-related post-traumatic stress disorder amongst high-risk emergency workers.

CISD is a seven-stage process, based on crisis intervention and education intervention theory. Together with defusing, it is designed to prevent the development of PTSD, and to allow early identification of those who will require further follow-up.

Stages of CISD

Introduction to introduce CISD team members to the process and expectations

Fact to allow participants to describe the event one by one from their own perspective, on a factual level

Thought to describe cognitive reactions to the event

Reaction to identify individual emotional reactions

Symptom to identify individual symptoms of distress and to begin to move back from the personal emotional level to a cognitive level

Teaching to give information on stress management, normal reactions and coping mechanisms

Re-entry to clarify outstanding uncertainties, prepare to finish – and to give additional information

Debriefing is not psychotherapy but a structured group meeting that allows participants to discuss their experiences, thoughts and feelings about a distressing event in a safe, controlled setting. One of the very important messages CISD also gives is confirmation that, although each individual will have their own experience of an event, they are not alone.

Defusing

A shortened form of debriefing called *defusing* may also form part of the overall CISM process. Defusing will usually take place very shortly after a traumatic event, will generally be shorter than CISD (one hour, compared to two to three for debriefing) and will usually be a three stage process. These three stages are: *introduction, exploration (fact, thought and emotion) and information.*

Demobilization

Demobilization, also referred to in CISM, is a short, factual session, held immediately after the major incident is finished and before personnel return to normal duties. It is designed to assess the need for more intervention, to provide stress management information and to assess the well-being of personnel.

CISD and defusing appear to derive their effectiveness from several sources. They offer the chance to verbalise trauma, to reconstruct verbally and express specific fears and regrets; to prevent distortion of memory, to vent emotion, to re-establish control, to offer the opportunity for peer support, for normalization and for identification of those who may need further help.

Although, originally, CISD was developed specifically for the prevention of PTSD among high-risk and emergency personnel, it has been modified more recently for use in mass disasters and in community responses. Further adaptation for use in individual trauma situations (eg motor vehicle accidents, assaults) has led to a questioning of its value. Research findings suggest that it may not in fact be helpful in these situations and may even be unhelpful. Practitioners in this area of work stress the need for CISD to be used both with caution and as part of an overall comprehensive intervention package. While there is an active debate questioning its effectiveness and, therefore, some suggestion that it may not always be an appropriate intervention, there is equally strong agreement that to do nothing following a critical event is not an option.

Children & CISD

CISD, in its original form, was designed for use with adults. Early beliefs that children were little affected by trauma (Garmezy and Rutter's review of the literature suggested as much in 1985) have been challenged and there is now considerable evidence to show that the impact of trauma on children is at least as great as that on adults.

Recent recognition of the impact of traumatic events on children has resulted in a tendency to apply to children the model of debriefing developed for use with adults. This form of the intervention does not take into account whether the debriefing process is appropriate for children, both in terms of their roles in critical events, and in terms of their developmental or maturational level.

CISD was initially developed for use with workers who had responsibilities in an incident. Only rarely (for example, if children were youth leaders or monitors) would children find themselves in such a role. Yet some of the functions clearly identified in the CISD process would argue for its use (or the use of something similar) with children, provided a number of other factors are taken into account.

Children may, by nature of the stage in their emotional development, take on responsibility for tasks or actions, which they are not easily able to conceptualise, acknowledge or communicate. They may experience a range of reactions following a critical incident similar to those experienced by adults. They may need reassurance about the appropriateness of

their responses. They may need to understand why they are feeling and reacting as they are, and to feel their experiences can be understood, accepted and contained by trusted adults. Like adults, they may need additional information about the incident and a chance to dispel myths (although it is equally important to take account of the stage in a child's understanding of the role of fantasy and of their emotional need for fantasy in the mastery of a threatening situation).

Account needs to be taken of the child's ability to engage in the debriefing process (their cognitive, emotional and verbal skills) and of the fact that the emotional immaturity of young children may mean they have as yet underdeveloped defence mechanisms or ego strength. The very young child is not used to or adapted to the group process, unlike the adolescent for whom the peer group is of considerable significance. For children, debriefing requires to be part of an overall *psychological first aid* intervention, in which they can be given necessary and age appropriate information about what has occurred. For the young child this should be carried out in the presence of a parent (or carer) who will be able to contain and secure the child's emotional response. A related issue here is that attention needs to be paid to the fact that the adults may themselves be secondarily traumatised by such information and require adequate preparation, if they are to avoid reacting in ways which will inhibit and hinder rather than encourage the child's progress.

As with all debriefings, care needs to be taken that any groupings are homogeneous. This is essential in order to avoid further secondary traumatisation of children who may be thought to have had similar experiences but may in fact have only limited knowledge of what occurred (for example, because of their location during the event).

Both Wraith (1995) and Pynoos (1992) have written extensively of the need for caution in the use of debriefing with children. At the same time they stress that, appropriately used, it can be of considerable value.

Wraith describes stage one in the debriefing process as the *First Aid* stage, primarily establishing safety, orientation to the event, and the opportunity for emotional release and 'the engagement of support'.

Stage two is a more cognitive process, aimed at developing a child's understanding of their own and other's reactions, and where there is an opportunity to establish coping strategies. As with adults, it also gives the debriefers the opportunity to observe and note who may require further intervention, support or longer-term help.

Pynoos (1992) has described the aims of debriefing as follows:

- To dispel cognitive confusions and encourage active coping through bolstering the child's ego and reality testing functions
- To help the child to anticipate, understand and manage everyday reminders
- To help children to distinguish between current life stressors and past trauma, and so to decrease the impact of a trauma on the present experience
- To legitimise children's feelings and reactions and assist in the maintenance of self-esteem
- To prepare children to deal with the return of unresolved feelings
- To monitor coping skills.

Debriefing with adults requires to be led and managed by individuals trained in the debriefing process and who have skills in group work. Debriefing with children needs these same skills, together with a sound knowledge of children's development overall and an awareness of how children communicate their feelings and manifest emotional difficulties. Debriefers require, in addition, to have knowledge and ease in working with family and group dynamics. They require a sound knowledge of how to communicate with children and of the techniques sometimes required to tap into children's unconscious thoughts and feelings. Children often use drawing and play to communicate, sometimes far more readily than they will use words. Skill and experience in working with children is therefore essential when using the debriefing process with this population.

Debriefing with children, while similar in its use with adults, may require it to be moderated and adapted. Sessions may need to be shorter, stages may need to be repeated.

Such a process clearly demands a qualified and experienced child worker. Many who find themselves asked to respond (for example to a request from a school when a critical incident has taken place) may feel insufficiently qualified to offer such intervention with children, though happy, if trained, to provide debriefing for staff. Many workers, feeling insufficiently skilled, may avoid the question of children's need for debriefing. Yet this intervention can undoubtedly help prevent the development, in some, of Post Traumatic Stress Disorder or other more damaging emotional disorder in children, post trauma.

CISM is an integrated approach, of which CISD is only one part. There are a number of other elements involved.

Pre-Incident Information

Although by definition critical incidents cannot be planned for, we can be prepared. All authorities and many agencies now have emergency contingency plans. It is essential that these include a 'who does what' – and for agencies such as schools to have details of lines of communication, decision making and so on (Yule and Gold's *Wise before the Event* (1993) deals very well with this).

Pre-incident planning can also include the establishment of a system which allows staff to be aware of significant information which may highlight those children who are likely to be most vulnerable in the event of a critical incident.

Stress Education

Stress responses can be helpful and enhance performance in many situations, but too much stress may in the long term be harmful to the body and stress management therefore can provide an important part of maintaining health.

Traumatic stress responses may overwhelm the individual and leave a person feeling helpless or out of control and can include perceptual distortions, physiological and physical changes that can be alarming. Individuals suffering from Post Traumatic Stress Reaction (PTSR) need information in order to normalise and understand their responses and to help reduce the feelings of helplessness experienced.

Support Services

Following a critical incident, many will need to seek practical help and/or support. Typically, following such an event, those affected find it hard to organise and manage simple aspects of their lives. Provision of a range of practical support services is invaluable in the early stage.

Long-Term Follow-Up

Pre-education, immediate and short-term interventions are designed to help mitigate the effects of trauma. They will be effective for a very large percentage of the individuals involved. Some will go on to develop further pathological responses requiring long-term intervention and follow-up that may include counselling, therapy (play, family, cognitive, behavioural, talking therapies) as well as such techniques as Eye Movement Desensitisation and Reprocessing (EMDR). Recent research into PTSD has highlighted the effectiveness of

therapies that can by-pass declarative memory and deal more rapidly with the somatic and sensory memories of trauma (Van der Kolk 1999). EMDR is one such approach and is now the most widely used, effective and well-researched intervention for use with sufferers of PTSD.

An example of the use of Psychological First Aid in a Local Council setting to illustrate some the elements of CISM.

The Psychological Service responded to a request for help following a critical event.

The incident took place within a local nursery school, which offers half time or full time places to 160 pre-school children who range in age from 3-5 years.

The Council operates a policy of integration for children with a range of special needs (e.g. severe physical disability, learning difficulties). Amongst those attending are children with life threatening conditions.

The critical incident which took place and gave rise to the need for response occurred when one child, with severe physical disability and major respiratory difficulties experienced breathing problems. For thirty minutes staff helped him to continue to breathe and prevent him from choking. Four staff members, including the headteacher, senior nursery nurse, and two supervisory assistants were involved. All coped well, reacting calmly and appropriately during the emergency. The incident took place away from the nursery floor and, although others in the nursery were aware of it (and the tension which surrounded it), it was not witnessed by other staff or children.

Following the incident, the nursery head contacted the Head of Education Services who in turn contacted Psychological Service. Staff members involved were clearly very distressed by what had happened. The psychologist available at the time, not known to the staff, offered to visit to talk with them but this offer was not taken up.

On returning to work three days later the nursery's link psychologist (the writer) contacted the nursery head, offering to provide debriefing and appropriate psycho-educative information. The offer was taken up.

The writer and the nursery staff met for approximately two hours, four days after the incident. Staff were offered information on PTSR and on ways of dealing with stress reactions. They were given the opportunity to share their experiences, feelings and thoughts if they wished.

All chose to talk. All reported finding comfort in sharing their experience, in the 'normalising' they felt. They reported immediate reactions to the incident, which included fear, anger, distress and feelings of uselessness. They reported, too, an increase in alcohol consumption, loss of concentration, difficulty in sleeping, increase in psychosomatic symptoms such as skin irritation and irritable bowel syndrome over the days following the incident.

The session ended with information about the need to be alert to persistent stress reactions, to the effects of further stressors or other pre-existing stressors, as well as information about where to seek further help if it was needed.

A phone contact the following day confirmed staff were feeling calmer and more reassured. They reported having spoken to one another more about events following the meeting and feeling happier to know that what they were experiencing were common reactions.

The writer was asked to return two weeks later to the nursery to offer a training session for all staff on the areas of traumatic stress, PTSD and stress management. Staff subsequently indicated that they had found the intervention helpful. None of the staff involved in the incident reported ongoing difficulties. The timing of the intervention and the fact that the writer was well known to staff may have been significant factors in its apparent effectiveness.

Conclusion

While there continues to be great debate about almost all aspects of intervention post-trauma, one conclusion remains clear. It is no longer acceptable to do nothing. What precisely we do to greatest effect, is still to be established.

Critical Incident Stress Management

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EMDR: A Specific Intervention for the Treatment of Trauma

Mike O'Connor

The purpose of this paper is to introduce the reader to the relatively new and innovative therapeutic methodology known as EMDR, *Eye Movement Desensitisation and Reprocessing*.

To understand the methodology and how EMDR works requires some understanding of the nature of trauma and traumatic memory. This paper will touch on these topics and refer to key texts providing detailed information for those who wish to follow up specific areas of interest.

The main aims of the paper are to

- discuss EMDR in the context of trauma
- describe the origins of EMDR
- outline the components of EMDR and basic treatment effects
- discuss the underlying theory of EMDR
- describe current training requirements.

Trauma and EMDR

Throughout history human beings have been exposed to terrible events. Art and literature record the remarkable capacity of humans to survive trauma and to adapt to dramatic changes in their circumstances. "Enduring, recovering from, and succumbing to trauma are all aspects of the human condition" (deVries, 1996, p398). Yet, scientific enquiry to identify the factors that determine whether a person survives or succumbs to trauma is a relatively recent endeavour. In the U.S. the psychosocial impact of traumatised veterans returning from the Vietnam War provided the impetus for the systematic investigation of the effects of trauma. Around the same time, in countries across the world, the exposure of the prevalence of sexual abuse of children brought public attention to the long-term impact of trauma.

In 1980, the American Psychiatric Association (APA) legitimised the suffering of Vietnam veterans by providing the label of Post-Traumatic Stress Disorder (PTSD) to describe their experience (DSM III, 1980). According to deVries (op cit) this legitimising of suffering confirms the relationship between individual trauma and society's responsibility for the care

of its members. He writes, "A medical label justifies and operationalizes social intervention and resource allocation" (p.407). In 1987, the APA revised the definition of PTSD and specifically recognised the condition in children (DSM III-R, American Psychiatric Association, 1987).

The recognition of PTSD as a formal diagnosis in psychiatric classification resulted in a massive allocation of resources in the U.S. to investigate the way people react to overwhelming experiences and to provide effective treatments. The most common forms of treatment include cognitive, behavioural, psychodynamic and psychopharmacological approaches. The development of EMDR has proved to be an effective treatment for PTSD in adults and children and this success has resulted in a world-wide interest in its application to a wide range of psychological problems.

To suggest that those affected by trauma might require some form of treatment is a controversial issue that arouses strong emotions and fierce debate. Such reactions have been evident in the aftermath of Dunblane as elsewhere. According to MacFarlane and Van der Kolk:

"Society's reactions to traumatised people are rarely the results of objective and rational assessments. Rather they are the results of conservative impulses in the service of maintaining the belief that the world is essentially just, that 'good' people are in charge of their lives, and that bad things only happen to 'bad' people".

(1996, p.28)

The effects of trauma touch on the fundamental social issue of individual versus societal responsibility. It is hardly surprising that participants in the debate rarely remain emotionally neutral. Trauma and its aftermath raise many complex issues including those of moral and financial responsibility. Do people have the right to expect support and financial compensation when they are severely traumatised? Should they be expected to live with their suffering?

The emotion generated by these issues frequently clouds our existing knowledge about how the majority of those affected by trauma could be helped. There is abundant evidence to show that the presence or absence of *social support* is the crucial factor in determining the fate of those exposed to trauma (MacFarlane and Van der Kolk, op cit). In particular, for children the family is usually a very effective protection against traumatisation (Werner,

1989). Adults also rely on family, friends and colleagues to provide protection in the face of trauma. It is now widely accepted that in the aftermath of disaster the provision and restoration of social support should be the primary objective of any intervention programme. There is clear evidence from research findings around the world that, for the majority, post-trauma reactions are short-lived.

In the aftermath of the tragedy in Dunblane in March 1996 a small number of psychologists were trained to use EMDR. Experience gained by these individuals in their work with traumatised children and adults convinced them that EMDR was relevant to the work of educational psychologists. Teachers and social workers often consult educational psychologists after traumatic events. Sometimes, there is an expectation that psychologists will provide some form of counselling or therapeutic intervention to mitigate the impact of the trauma. Generally, this is not necessary and other forms of intervention are more appropriate, such as information and education. Yet, there are occasions when direct therapeutic interventions *are* appropriate. Small-scale traumas affecting children occur regularly. Children are exposed to intrafamilial, interpersonal and community violence, serious accidents and life-threatening illnesses. These experiences have the potential to overwhelm the coping resources of those involved. EMDR is a treatment option that psychologists can use in their work with children, provided they have undergone the required training and have the skills to work in a therapeutic role.

When individual, family and community supports are severely disrupted, outside help needs to be mobilised. For a number of people caught up in the Dunblane tragedy specific treatment interventions were necessary. EMDR is one of these and its role in helping those affected should be viewed in the context of the continuum of support provided.

The development of EMDR and its application to a range of psychological problems has also aroused controversy not least because it challenges the efficacy of other more traditional therapies. Very few people outside the field of psychology and psychiatry know EMDR. However, its subject matter - trauma - is familiar to a much wider audience. Trauma and its effects have been central to the development of EMDR. There can be no denying the public awareness of the concept of trauma, awareness developed through regular exposure to natural catastrophe and man-made disasters via our newspapers and televisions. Terms such as 'critical incident', 'traumatic stress' and 'post-traumatic stress disorder' (PTSD) are rapidly becoming familiar to us all.

The development of EMDR owes much to the traumatic experiences of its originator, Francine Shapiro, an American psychologist. Its empirical validation as an effective therapeutic procedure is based mainly on evidence obtained from a series of studies on trauma victims experiencing PTSD. Shapiro's personal insights and intuitions resulted in the development of the EMDR methodology that, in turn, re-invigorated the debate and scientific investigation into the effects of overwhelming stress on the body and human psyche.

Origins and Development

According to Shapiro (1995) the discovery of EMDR in 1987 owed more to chance than scientific investigation. Yet, from her account of her life during the previous decade it is clear that her accidental discovery of EMDR was made against a background of dedicated and systematic enquiry into the connection between physical and psychological health. The diagnosis of her cancer in 1979 provided the motivation for her to find out as much as was known about mind/body interactions and psychological methods for enhancing physical and mental well-being.

Her initial discovery of EMDR occurred when she was walking through the park one day in May 1987. While walking she became aware that some disturbing thoughts going through her mind suddenly disappeared. She also noticed that when she brought these thoughts back to mind they seemed less upsetting than before. Fascinated by the apparent change in the affect linked to these thoughts she began to pay close attention to what was happening.

"I noticed that when disturbing thoughts came into my mind my eyes spontaneously started moving very rapidly back and forth in an upward diagonal. Again the thoughts disappeared, and when I brought them back to mind, their negative charge was greatly reduced. At that point I started making eye movements deliberately while concentrating on a variety of disturbing thoughts and memories, and I found that these thoughts also disappeared and lost their charge. My excitement grew as I began to realise the potential benefits of this effect" (Shapiro, 1995, p.2).

From these chance observations Shapiro went on to investigate the process systematically and found that the initial effects she had observed continued to occur. An account of the first controlled study appeared in the *Journal of Traumatic Stress* (Shapiro, 1989). Twenty-two subjects suffering from PTSD symptoms reported that the EMDR procedure was successful in reducing or eliminating distressing intrusive thoughts stemming from traumatic events.

Shapiro acknowledges that many of the components of EMDR were derived from case studies from the field of biochemistry and psychotherapy, including cognitive, behavioural and psychodynamic therapies. Its development and continued refinement are the result of clinical observation and empirical research. A recent review of the status of EMDR (Spector and Read, in press) reports, currently there are 15 controlled studies published in the literature on the use of EMDR with PTSD, all since 1989. This is more than any other treatment of PTSD. The research base of EMDR is substantial given that it has been around for less than a decade. Spector and Read conclude that "There is now abundant evidence that.....EMDR is a therapeutically effective treatment for PTSD".

In recent years there have been increasing reports of the use of EMDR in other areas, including with those who have an attention deficit disorder, panic disorder, phobia or learning difficulty. Case reports include the use of EMDR with children in all of these areas. Tinker and Wilson (1999) have published an account of their use of EMDR with children and adolescents. Clinical evidence on its effectiveness with traumatised children is well documented, but to date there are no published reports of controlled empirical studies.

What is EMDR ?

Assumptions

A basic assumption underlying the EMDR methodology is the belief in the internal health of the individual. According to Shapiro (1995) everyone has within them the inherent ability to overcome the effects of traumatic experiences.

Goals

The stated goal of EMDR is consistent with this view of the healing process. Shapiro describes her method as a "clinician-assisted healing process" whose goal is to relieve suffering and to assist individuals affected by past or present trauma to mobilise their own inherent capacity for self-healing (Shapiro, 1994).

Components of EMDR and the standard procedure

The EMDR method consists of an eight-phase treatment designed to be integrated into a comprehensive plan for the treatment of trauma. The basic components of the treatment phases are:

client history, preparation, assessment, desensitisation, installation, body scan, closure, re-evaluation.

This is the standard EMDR procedure and a standard protocol guides the overall treatment of the client. During the treatment process clients are asked to use eye movements or other forms of bilateral stimulation such as sound or touch, the effect of which is to enable them to process disturbing thoughts and experiences until they are no longer distressed by them. The length of sessions and overall treatment will depend on many factors, including the nature of the trauma and the client's previous history. Clinical reports indicate that EMDR is most effective when used by experienced clinicians incorporating it into an existing therapeutic approach.

Briefly, the technique involves clients focusing on four main aspects of the trauma while tracking the therapist's fingers across their visual field in repeated sets of rapid left to right eye movements. First, clients choose a visual image or another aspect of the memory, which for them represents the worst part of the trauma. Second, they bring to mind any negative thoughts or beliefs about themselves associated with the event. Third, any emotions aroused by the memory. Fourth, clients are then asked to focus on any physical sensations evoked by the memory. The emphasis is on *present* images, thoughts, feelings and sensations experienced by the clients while they think of a *past* memory.

Following these initial steps clients are then invited to make positive self-assessments relating to their involvement in the traumatic event. The purpose is to assist them make more objective and rational assessments of their experience than was possible at the time of the trauma. After each set of eye movements clients are asked to report what they are experiencing.

There are variations in the procedure that take into account individual client needs. Some clients do not have a visual image of their trauma but they may have, for example, an auditory memory of the event on which they can focus. For many the pain of remembering is such that they are, understandably, reluctant to describe their experience in words. Others may have no verbal memory of their experience to recall. The reasons for this are to do with the way traumatic memories are stored in the brain. Human beings do not require language to be traumatised, a point best understood when visualising pictures of pre-verbal children caught-up in war situations or natural disasters.

Basic treatment effects

Although the pattern of responses varies from individual to individual some consistent effects occur. Commonly, clients report changes in their selected image, cognitions, feelings and physical sensations. The effects can be very rapid and there is often an obvious reduction in levels of psychological and physical distress even within a single ninety-minute session. A case study illustrates basic treatment effects.

Case A

The client is a man in his late forties referred by the Police four weeks after a RTA. He was the driver of the car in which his wife was killed. There was no other vehicle involved and the accident was the result of a blow-out of a tyre. Initial assessment revealed that along with the distress associated with the loss of his wife the client was experiencing a re-enactment of the accident, including recurring intrusive thoughts, images and physical pain in his arms and legs. The most distressing aspect for him was his self-perception of responsibility for the death of his wife.

He chose as the target memory the visual image of his wife slumped in the back of the car. His negative cognition was his sense of self-blame, 'it was my fault'. The emotions associated with the event were fear and anxiety. Physical sensations evoked by the memory were pains in his limbs.

After some sets of eye movements there was a shift to other memories linked to the trauma, a common occurrence in EMDR. Further sets, over a fifteen-minute period, resulted in a change in the client's perception of the entire event. He was able to bring to mind the visual images of his wife without experiencing an overwhelming sense of fear and anxiety. Instead, he described his sadness and sense of loss. His cognitions had altered and he began to talk about his wife's death as 'an accident' and to recall details from the police report (an objective account of the event). His limb pain had disappeared entirely and he described the pain he had felt immediately after the accident, the results of his desperate attempts to control the car.

On follow-up one week later the client reported that there had been no recurrence of the symptoms previously experienced.

This case is an example of a successful use of EMDR with a client who had experienced a single trauma event. He had no prior history of trauma or psychological problems. It is important to note that the EMDR addressed the traumatic aspect of his experience and not his grief. EMDR enables clients to process stored dysfunctional memories rapidly ('it was my fault') but does not take away cognitions and emotions which are appropriate and functional. Thus, the client continued to mourn the loss of his wife. The circumstances of

her death could have caused him to become fixated on the trauma and complicated the grieving process.

Individuals affected by trauma cannot always articulate their distress in a coherent manner to fit the format of a therapeutic technique! Often, they are unable to verbalise their distress. EMDR methodology is flexible and is particularly suited to helping clients resolve trauma that is expressed via somatic symptoms and avoidance behaviour. Indeed, Shapiro advocates that client and therapist talk as little as possible during sessions. Her view is that talk interrupts the natural flow of information processing which takes place during EMDR.

The next case study is an example of EMDR with very little verbal interaction between child and therapist.

Case B

A boy, age 8, was referred for EMDR by a psychologist who had been providing weekly individual therapy for two years. The psychologist was pleased with his progress but was concerned that he was unable to come to terms with certain aspects of his traumatic experience that had occurred two years earlier. His behaviour at home and school indicated that he was still traumatised and re-living his past experience. A specific concern of the parents was that their son did not feel safe. Two years before he had been severely injured in a shooting incident in his school. He was shot by a gunman and witnessed the murder of many of his friends and classmates.

After careful preparation of the boy and his parents six sessions of EMDR were provided over a period of ten weeks. The treatment goal was clear to everyone involved - to enable him to process the memory of his appalling experience and to help him perceive this as a past memory. Briefly, the boy was able to recall his experience in graphic detail and to express these memories through a series of drawings instead of words. The therapist had suggested this to the boy, anticipating that he might have difficulty putting his recollections into words. After each set of eye movements the boy made a drawing. There was almost no talking during sessions. The therapist gave directions to the client as part of the EMDR procedure and sought clarification on details of the drawings.

After the first session there was an unmistakable change in the boy's physical appearance, behaviour and attitude. His parents were delighted and relieved to see their son less fearful and anxious. By the end of the sixth session the boy told the therapist that he felt safe. One year later he confirmed that he still felt safe.

For reasons of brevity it is not possible to give a full account of the changes in the lives of these two clients following the successful application of EMDR. Hopefully, the information provided gives a flavour of the EMDR method and its use.

Theory: How Does EMDR Work?

The development of EMDR has contributed to our understanding of how the brain processes and stores information. For over a hundred years it has been known that human beings respond to a perceived threat at a biological and psychological level (Van der Kolk and Saporta, 1993). At present there is no definitive explanation of how EMDR works. Explanations have been constructed on a post-hoc basis to explain the effects.

"Theories that explain why EMDR works have arisen after the fact and have not yet been confirmed. However, the lack of definitive explanation of the underlying mechanisms of EMDR in no way detracts from the demonstrated effectiveness of the method. At the very least, these theories are clinically useful because they have helped us to improve the methodology."

(Shapiro, 1995, p 309).

The recent neuropsychological studies of Van der Kolk and colleagues (1996) lend support to the view that EMDR has a biological as well as a psychological effect.

Shapiro proposes what she calls an *Accelerated Information Processing* model to explain the rapid and consistent treatment effects. Using this model we can think of the brain as an *Information Processing System*, organising and storing experiences as memories that 'make sense' (Flavell, Miller & Miller, 1993). Memory refers to a number of processes that the brain uses to enable it to perceive a stimulus, encode elements of it and then store these for later recall.

A hypothesis put forward to explain EMDR is that when a traumatic event occurs the information processing system becomes blocked or unbalanced. The consequence is that the memory of the trauma is stored in the brain in its original form with all the images, thoughts, emotions and sensations intact. There is evidence to suggest that different types of memory are dependent on different brain structures and that traumatic memory is encoded in a different way from non-traumatic memory (Siegel, 1997). Traumatic events have the potential to overwhelm the normal coping strategies of the individual. When this happens the individual is capable of processing only part of their experience at a 'conscious'

level (*explicit or declarative memory*). The need to diminish the emotional impact of the trauma may lead to a focusing of attention away from the traumatic elements of the experience. However, memory processing still takes place though the individual may not be aware of this (*implicit or procedural memory*) and therefore may have no conscious awareness of the information that is stored. These memories are likely to be inaccessible to verbal recall because they reside in a part of the brain that is not readily accessed by language. These are memories that are primarily perceptual in form, sound, touch, taste, smell and vivid visual imagery. They might later be experienced as 'flashbacks'.

Shapiro (1995) hypothesises that EMDR enables clients to access and reprocess traumatic memories; the eye-movements or other forms of left-right stimulation unlock the client's information processing system allowing the dysfunctional memories to be reprocessed and brought to an 'adaptive resolution' (p 44). As dysfunctional information is processed, more accurate and positive self-assessments appear and can be integrated into the belief system of the client. Only the dysfunctional material is discarded. Useful knowledge is retained for future learning. For example, anxiety is useful in certain circumstances; it can alert us to danger and help to keep us safe.

There is some evidence to suggest that the eye-movements perform a similar function to those that occur during a stage of sleep known as REM (Rapid Eye Movement). REM sleep is known to perform a vital information processing function (Winson, 1993).

Training Requirements

EMDR is a therapeutic technique that can elicit very powerful reactions from clients. For this reason it is essential that EMDR is used only by properly trained and experienced clinicians. The EMDR Institute and the EMDR International Network (EMDRIA) regulate and oversee training world-wide. The EMDR Association (UK and Northern Ireland) also provides training. EMDR practitioners who have been accredited by the Institute conduct training courses. Two levels of training are offered both of which include a didactic component as well as supervised practise.

Level I training covers the fundamental aspects of EMDR regarding trauma as well as issues and guidelines concerning client safety.

Level II training focuses on the application of more specific EMDR protocols for particular problems. Neither level of training focuses on the use of EMDR with children . A specialist

training on the use of EMDR with children is offered and will shortly become mandatory for those working with children.

EMDR

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Post Script

Jenni Barr

These papers detail what, for many of us, has been a new involvement in an area that some years ago would not necessarily have been seen as the domain of an educational psychologist. The research literature is growing all the time. We are conscious that what is outlined here is not the final word on the topic, but an attempt to address at the present time issues of relevance for educational psychologists and the schools, children and families whom we support.

Some ten years ago Kelvin Robson wrote about the experience of assisting after the tragedy in Lockerbie (referenced on p.16). One of the clear lessons then was that amongst the victims of a major event there should be numbered those who are brought in to help – few would emerge unscathed.

Ten years on we are perhaps more optimistic, indeed much of the content of the papers presented here deals with the very practical steps which can assist in restoring emotional health for those - any of those - affected by a critical event. However, the reminder is salutary. Those of us who work within the helping professions are not immune. Our own resources, the effects of previous experiences, the strength of current supports (both personal and professional) will all have a bearing on how a critical event or series of critical events impacts upon us. We may even fail to notice, though others undoubtedly will.

As we look with schools at ways of developing a *care ethos*, we would do well to look also at our own services for assurance that the structures and supports that we set in place are similarly built 'with care'.

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