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The Impact of School Violence on School Personnel: Implications for Psychologists

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Each year, approximately 234,000 teachers in the United States are victims of school-related violence. After a violent incident, school-based mental health professionals, psychologists from the community, and administrators appropriately intervene to provide counseling and other services for students. Unfortunately, many school personnel who have been victimized do not receive adequate treatment after such incidents occur. In this article, the authors argue that psychologists, school personnel, and mental health counselors must be aware of the needs of teachers and administrators who have been affected by these events and must, therefore, provide counseling for them as well.

Keywords: crisis planning, crisis response, intervention, school violence, teacher victims

Violence in schools is a relatively rare yet traumatic problem that affects all members of the school community. School violence ranges from bullying to lethal rampages that swept the nation in the late 1990s. Among the following events, school personnel were killed at school or school-related functions. On November 21, 1991, 1 student and 1 teacher were shot and killed at Thomas Jefferson High School in East New York. On February 2, 1996, 2 students and a teacher were killed at a Moses Lake, Washington, junior high school. On March 24, 1998, 2 students shot and killed 4 students and a teacher at their middle school in Jonesboro, Arkansas. Another student killed his eighth-grade science teacher at a school dance in Edinboro, Pennsylvania, on April 24, 1998. And, on April 20, 1999, 2 students killed 12 students and 1 teacher before killing themselves at Columbine High School in Colorado. Unfortunately, the list of these incidents continues.

The purpose of this article is to highlight issues faced by school personnel who have been affected by school violence. The term *school personnel* is used here to refer to teachers, administrators, support staff, and school resource officers—in short, any adults who work in the schools. Throughout this article, *school violence* refers to any violent crime against one or more people that is perpetrated at school or a school-related function. This violence can be lethal (e.g., a school shooting), injurious (e.g., a stabbing), or potentially lethal (e.g., a hostage or barricade situation). Finally, the title *psychologist* refers to school psychologists, clinical psychologists, and counseling psychologists unless otherwise indicated. This article is organized around four primary themes. First, we examine the scope of school violence in general. Second, we explore the effects of school violence on school personnel. Third, we show that psychological services are delivered to students following an act of school violence but that such services are much less frequently offered to school personnel. Finally, we offer treatment recommendations for school-based and community-based psychologists who provide services to the school community following an act of school violence.

Scope of the Problem

Although lethal school violence attracts great attention from the public and the media, the prevalence is rather low. Indeed, less than 1% of youth homicides occur at schools (Cornell, 2006). However, according to the 2004 Indicators of School Crime and Safety report of the Bureau of Justice Statistics and the National Center for Education Statistics (DeVoe et al., 2004), from 1998 to 2002, teachers were the victims of roughly 234,000 crimes annually at school. These nonlethal crimes included, on average, 144,000 thefts and 90,000 violent crimes, such as rape, sexual assault, robbery, aggravated assault, and simple assault each year (DeVoe et al., 2004). This translates into an average of 32 thefts, 20 violent crimes, and 2 serious violent crimes per 1,000 teachers yearly. These data reflect all known reported crimes against teachers at schools, including victimization from students and external intruders.

During the 1999–2000 school year, approximately 9% of teachers were threatened by students, and 4% were physically attacked

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by students (DeVoe et al., 2004). According to Kondrasuk, Greene, Waggoner, Edwards, and Nayak-Rhodes (2005), "*teachers may be three times more likely to be victims of violent crimes at schools than are students* (21 incidents per 1,000 teachers versus 7 incidents per 1,000 students, respectively)" (p. 640).

Louis Harris and Associates conducted a survey of students, teachers, and law enforcement officers for the Metropolitan Life Insurance Company in which school violence was assessed (Binns & Markow, 1999). Their results show that within the year prior to the study 16% of public school teachers were the victims of violence at or near school. Of these victimized teachers, 90% reported that the perpetrator was a student, and 5% reported that the perpetrator was a parent. The survey did not ask the victimized teachers about their coping strategies, but it did reveal that 92% reported the incidents to the police.

Astor, Behre, Wallace, and Fravil (1998) reported the results of a survey regarding the victimization of school social workers. Of the 576 respondents, 35% reported being assaulted or threatened during the past year. The majority of assaults or threats were perpetrated by students (77%); however, 49% reported that the perpetrator was a parent. The consequences of these violent incidents included fearing for personal safety and taking precautionary measures, such as leaving money at home and avoiding the school after dark.

Results of these studies clearly indicate that acts of school violence are committed not only against students. In fact, everyone in the school community is at risk for such victimization. Research has examined rates of both teacher (Binns & Markow, 1999) and school social worker victimization (Astor et al., 1998).

Effects of School Violence on Victims

Following a psychological trauma, victims experience both immediate and long-term consequences. Immediate reactions include physical, behavioral, emotional, and cognitive responses (U.S. Department of Health and Human Services, 2004). Physical responses may include faintness or dizziness, hot or cold bodily sensations, tightness in the throat, stomach, or chest, and nausea or gastrointestinal distress, to name just a few. Behavioral reactions may include sleep disturbance, hypervigilance, interpersonal conflicts, avoidance of reminders of the trauma, inability to express feelings, withdrawal, and increased substance abuse. A few common emotional responses to trauma include shock, anxiety or fear, psychological numbness, grief, and feelings of helplessness, hopelessness, and vulnerability. Finally, frequent cognitive reactions to trauma may include confusion or disorientation, poor concentration, complete or partial amnesia, flashbacks, self-criticisms, preoccupation with protecting loved ones, and questioning of spiritual beliefs.

After an act of school violence, victims are likely to experience a number of reactions to stress and trauma. The psychological effects of trauma on children and adolescents have been well documented (e.g., Brock, 1998; Shen & Sink, 2002). Children may experience sleep disturbances, nightmares, persistent thoughts of the event, a belief that another event will occur, and a number of other problems (Shen & Sink, 2002). Younger children may experience enuresis, thumb sucking, increased dependency, or reenactment of the traumatic event through play and other means (Flouri, 2005).

The psychological effects of school crime among teachers are also well known (Nims, 2000). Citing research conducted by Kadel and Follman (1993), Nims (2000) reported that teachers who experience violence at school often display symptoms of posttraumatic stress disorder (PTSD). Dworkin, Haney, and Teschow (1988) reported on the effects of urban teachers' victimizations. In their study, teachers reported being the victims of theft, minor and serious assaults, subtle and overt threats, and property destruction. It is not surprising, then, that research has shown that fear and heightened levels of stress that teachers feel lead to burnout and less effective work (Elliott, Hamburg, & Williams, 1998). In addition, Newman, Fox, Harding, Mehta, and Roth (2004) reported that teachers who worry about their safety are more likely to leave the teaching profession altogether. Ardis (2004) addressed school violence from a teacher's perspective. She described a pervasive fear among school employees following a school shooting. This fear is compounded by the ever-present thought that "our school could be the next one on the evening news and that our own students could be the ones running for their lives" (p. 133).

In a study of school shootings at West Paducah, Kentucky, and Jonesboro, Arkansas, Newman et al. (2004) found that teachers and administrators experienced multiple negative long-term consequences, including illness, divorce, burnout, and career change. These authors found that teachers, in particular, felt neglected following the shootings. These feelings were compounded by the fact that they were frequently expected to provide mental health services to students, but they were not qualified to do so.

There are both immediate and longer term consequences of exposure to traumatic events such as school violence. With respect to immediate effects, victims of school violence may experience acute stress disorder (ASD; Daniels, 2002). ASD is characterized by anxiety, dissociation, and other stress responses, which occur within 1 month of exposure to a traumatic event. Common symptoms of ASD include psychological numbing, feeling of being in a daze, derealization, depersonalization, and dissociative amnesia. The individual also may reexperience the event through recurrent images, flashbacks, thoughts, dreams, or other symptoms, and may therefore avoid events or situations that remind the person of the event. In the school setting this may be manifested by increased absenteeism (American Psychiatric Association, 2000).

Reactions to severe stress and trauma may also include longer term difficulties, such as symptoms of PTSD. Among the traumatic events listed in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; *DSM–IV–TR*; American Psychiatric Association, 2000), posttraumatic stress may result from situations in which the individual either witnessed or was directly involved with threat of death or serious injury or learned about a violent death or serious injury. In cases of targeted school violence, such as shootings or hostage events, students and school personnel are exposed to situations that meet these characteristics.

PTSD is characterized by four clusters of symptoms following exposure to an extremely traumatic event. The first set includes intense fear, a sense of helplessness, or horror, which are common reactions to lethal or potentially lethal school violence (Ardis, 2004; Nims, 2000). The second set of symptoms associated with PTSD is a persistent reexperiencing of the event through dreams, invasive memories, or "flashbacks" in which the person relives the physiological arousal of the event with accompanying intrusive

thoughts. Third, individuals experiencing PTSD persistently avoid stimuli associated with the traumatic event and feel a numbing of their general responsiveness. As with ASD, this may be manifest by absenteeism or even career change for school personnel (Daniels, 2002). Finally, individuals with PTSD experience persistent increased arousal such as sleep disturbance, irritability, difficulty concentrating, hypervigilance, or being easily startled. These symptoms may arise within 3 months of the event (acute reaction) and may persist for longer than 3 months (chronic reaction). Symptoms of PTSD may be delayed in their onset, sometimes not surfacing until 6 months or more after the violence at school.

The Need for Psychological Services for School Personnel

After a violent incident at school, multiple measures are taken to reassure, counsel, and provide other assistance for students. Among the documented services provided for students is critical incident stress debriefing (Daniels, 2002; Juhnke, 1997; Luna, 2000) and dealing with symptoms of PTSD that may develop over time (Brown, 1996; Daniels, 2002). These and other services are frequently provided by school psychologists, school counselors, or local mental health professionals who are brought into the school after a violent event (Brock, Sandoval, & Lewis, 2001; Daniels, 2002). Although the importance of these services cannot be understated, there is little in the literature to describe services that are offered to teachers and other school personnel following an act of school violence.

In one study of the impact of school violence on school personnel, Kondrasuk et al. (2005) surveyed school employees at all of the 824 educational institutions in the Portland, Oregon, metropolitan area. These organizations included preschools, K–12 schools, and institutions of higher education. Of particular interest, respondents were asked how they have responded to victimization. Although the preponderance of respondents were administrators (90% of the returned surveys), their results are important. Fifty-eight percent reported that they contacted the police, 39.5% contacted the school–employee response team, and 39.5% voluntarily engaged in counseling. In addition, 25% reported that they required the employee victim to go to counseling. Although these referrals for counseling are commendable, this suggests that three in five employee victims of school violence do not voluntarily seek counseling, and three in four schools do not require counseling for their employee victims.

In their study of the Paducah and Jonesboro school shootings, Newman et al. (2004) found that school administrators felt a need to get their schools back in session as soon as possible. There was a common perception that to wallow in the event unnecessarily prolonged the process of grieving and prevented the school community from moving forward. The negative consequences of this stance were that teachers often felt hurt, abandoned, and not validated (Newman et al., 2004). These reactions were expressed not only by teachers; one administrator indicated that he/she (the gender was not specified) was trying to keep the school running, deal with the criticism and anger of teachers, parents, and students, and resolve his/her own reactions to the trauma.

Daniels et al. (in press) presented results of a qualitative study regarding responses of school personnel who were involved in armed hostage or barricade events at three different schools. The purpose of that study was to ascertain common themes among school personnel who had been directly involved in the successful resolution of a potentially lethal situation. Using the consensual qualitative research methodology (Hill, Thompson, & Williams, 1997), the authors found that the most salient themes involved establishment of trusting relationships with all students and the importance of awareness, training, and communications in resolving hostage or barricade events. Most pertinent to the present article are the responses of two teachers whose classrooms had been held at gun- or knifepoint. One teacher, who was held at gunpoint by one of her students, expressed her anger at the legal system, which chose not to prosecute the barricader. After her students from that class graduated, the teacher quit her job because she no longer felt safe at school because she did not believe that the criminal justice system would protect her from criminal behavior in the schools.

In a second barricade event, the teacher reported that her colleagues minimized the seriousness of the situation (Daniels et al., in press). This teacher also indicated that she received little support from administration immediately after the incident. She felt that not only was she unsupported and dismissed but she was left to reassure parents afterward, a task she thought should have been assigned to someone who had not been traumatized. In addition, the teacher believed that support and mental health services should have been offered to her.

In summary, one study of armed hostage and barricade events in schools revealed that teachers often do not feel safe or supported following these potentially lethal situations (Daniels et al., in press). Moreover, Kondrasuk et al. (2005) reported that 60% of their respondents did not voluntarily seek counseling, and 75% of school districts did not require counseling for teacher victims following an act of school violence. Newman et al. (2004) found numerous negative effects of school shootings on teachers and other school personnel that were not adequately attended to. Because many teachers do not receive the appropriate support from the criminal justice system, colleagues, or the school system, psychologists, counselors, and administrators must be aware of the potential impact of school violence on school personnel and offer their support or referrals to other mental health professionals who may be able to work with them.

Recommendations

School violence affects all members of the school community. As such, psychologists must be aware of everyone affected by a violent situation and offer services and resources to all. There are three broad areas that psychologists need to consider when their communities are faced with the aftermath of an act of school violence. These are an increased awareness of the need for mental health services for school personnel as well as students, clinical considerations related to both immediate and longer term care, and therapist self-care. Because there is no literature directly related to treating school personnel as victims of school violence, the following considerations are presented for working with adult trauma victims.

Clinical Considerations

Psychologists and mental health professionals have a tremendous opportunity to play a vital role in the recovery of school-related trauma victims. Psychologists employed in professional settings where the framework is in place for dealing with traumatic events should obtain training related to trauma interventions, understand their roles during and after a school crisis, and work to ensure they are ready to fulfill crisis-related responsibilities. If they are in work settings where no framework is in place to develop a response plan, they need to develop partnerships with area leaders in business, faith communities, and schools. The National Association of School Psychologists (NASP) has developed a crisis planning and intervention training program for school-based mental health professionals. The PREPaRE curriculum (National Association of School Psychologists, n.d.) is designed to address both short- and long-term preparation, prevention, response, and recovery, and includes information about addressing the psychological needs of students and school personnel following a crisis.

Effective school crisis response plans need to address immediate response, short-term response, and long-term response. Many resources are available for developing or revising plans for dealing with mental health issues following an act of school violence (e.g., Barton, 2000; Brock et al., 2001; Furlong, Felix, Sharkey, & Larson, 2005; Knox & Roberts, 2005). The Web site of the NASP (http://www.nasponline.org) has many useful resources for school violence prevention and intervention, such as documents related to talking with children about violence, bullying, and threat assessment. The following section details clinical considerations for psychologists and other mental health providers responding to school violence-related crises. The discussion is centered on lethal or potentially lethal acts of school violence, such as school shootings, bombings, armed intruders, and hostage and barricade events.

Immediate Response

In the moments and hours following an act of lethal or potentially lethal school violence, it is imperative that the psychologist be a calm, nonanxious presence for the victims. This is not a time for processing but is rather a time for empathetic action. Being an active listener is helpful at this time. Supportive responses may include questions that help the client identify personal strengths and resources and previous coping strategies (Steele, 2004). Psychologists and other first responders should also work to lower victims' emotional distress. The goal is to acknowledge, comfort, and soothe emotions. Actions should be discussed that can be implemented that day, the following day, or within the week. Clients' strengths and resources should also be assessed and utilized.

In the training manual for mental health workers responding to mass trauma, the U.S. Department of Health and Human Services (2004) outlined four components to crisis intervention. These include promoting safety and security; identifying current priority needs, problems, and possible solutions; assessing current level of functioning and coping; and providing reassurance, normalization, psychoeducation, and practical assistance. In addition, there are several intervention models that are prevalent in the literature for working with individuals immediately after a traumatic experience. Three of those—psychological debriefing, psychological first aid, and crisis counseling—are briefly described. Despite their wide use, not all have been empirically supported.

Psychological debriefing. Perhaps the most common service provided to victims of trauma has been psychological debriefing. Psychological debriefing is a group counseling approach in which members receive information about the crisis response, share their experiences, explore different coping strategies, and provide information about additional resources (Brock & Jimerson, 2004). Although this is a common intervention, is there any evidence of its effectiveness? In a review of 25 empirical investigations of psychological debriefing, Arendt and Elklit (2001) found little support for it in preventing subsequent psychological disorders. Moreover, the literature failed to support psychological debriefing in the lessening of traumatic stress. Raphael, Meldrum, and McFarlane (1995) suggested that psychological debriefing continues to be a common practice, despite the lack of empirical support, because the strategy offers psychologists and clients many face-valid needs following a trauma. Given this lack of empirical support, psychological debriefing cannot be recommended as an intervention following a school crisis.

Psychological first aid. Parker, Everly, Barnett, and Links (2006) described psychological first aid as the provision of support and facilitation of resources immediately following a trauma. For example, individuals who are visibly in psychological crisis, as exhibited by shaking, screaming, or disorientation, may need medical treatment. Likewise, individuals who appear to be emotionally shut down or dissociating may also need immediate attention. For these people, psychologists can be supportive through comforting, providing concrete information about what will next occur, listening and validating feelings, and normalizing their stress response (U.S. Department of Health and Human Services, 2004). Until systematic research has been conducted, psychological first aid needs to be viewed with prudence, as there are no controlled studies as to its effectiveness (Parker et al., 2006).

Crisis counseling. Crisis counseling may occur in one session or across multiple sessions. Taking an ecological perspective of crisis response, Collins and Collins (2005) indicated that the goals of single-session crisis intervention should include supportively and empathically joining with the client, assessing and immediately intervening to create a safe environment, stabilizing and deescalating, and managing immediate needs. Additional goals of single-session crisis counseling include exploring and assessing the magnitude of the crisis event and crisis reaction, examining alternatives and developing options, assisting the client to mobilize personal and social resources and connect with other community resources, anticipating future difficulties, and arranging for a follow-up meeting. Longer term crisis counseling will be described in greater detail below.

Short-Term Response

Before offering any psychological services, it is important to keep in mind that not everyone will want or need counseling following a violent act at school. Following the events of 9/11, reports surfaced in the news that some victims' families felt hounded by mental health practitioners who meant well but insisted that they needed services. With this in mind, within a week or two of the school violence, psychologists may begin to implement group opportunities for school personnel who were trauma-

tized and who desire help. These groups may include teachers, administrators, or other school staff and may have already been facilitated if relations among individuals were positive prior to the crisis. However, if relations were strained before the crisis, the psychologist may need to address some of these animosities before healing work can begin. Another potential barrier to be aware of is the notion by some victims that they were "more traumatized" than others (Newman et al., 2004). In their study of two school shootings, Newman and colleagues (2004) found that victims who had been closer to the trauma felt that other staff members who had not "touched a child" following the shootings should not have been as negatively affected by the events as they were. This division led to deep resentment between the "front line" teachers and those who were not directly involved with the shootings. Psychologists need to be aware of these potential animosities and remain neutral as they work with both types of victims.

Information provided to victims of school violence is often helpful and comforting in the short term. It gives people whose world has been altered by an unexpected, tragic event an increasing sense of knowledge. In many ways, knowledge is power. This often has a calming effect on people and allows them to access the more rational and creative parts of themselves, thereby increasing the resources available to them to navigate through this difficult time.

Long-Term Response

In the months following the initial school crisis, individuals who received services immediately following the incident and in the short term may need continued treatment for lingering problems associated with their reactions. This is often a time when the community and the school are trying to heal. It is also a time when divisions arise among members of the community (Newman et al., 2004). Many of the people will have already been given the resources they needed to work through the impact of the experience and may be not only surviving but thriving. Others may still be struggling with the symptoms previously described. These people may have experienced events following the school violence that have compounded the recovery process. For example, some individuals who were victimized may have had their experiences discounted or invalidated by others who were less traumatized (Daniels et al., in press; Newman et al., 2004). The support and resources needed for these individuals will likely be longer lasting and multifaceted.

Longer term crisis counseling attempts to attain the following five goals (Collins & Collins, 2005): (a) stabilize the client's affect, (b) replace negative behavioral coping strategies with positive strategies, (c) reframe the client's core beliefs that have been threatened to highlight the survivor aspects of the individual's experiences, (d) continue development along a normal path, and (e) restore the client's healthy and adaptive ecosystem (social and community associations). Shelby and Tredinnick (1995) argued for the additional goal of improving the survivor's precrisis level of functioning by focusing on preexisting strengths and attempting to extend and embellish those strengths.

Group counseling. In addition to individual treatments, trauma survivors also may receive various forms of group counseling. R. B. Weinberg (1990) described a method of conducting large-group counseling for students following school-related trauma. The most common group interventions for trauma survivors include support groups, cognitive–behavior groups (CBT), and psychodynamic groups (H. Weinberg, Nuttman-Shwartz, & Gilmore, 2005). The purpose and benefit of support groups for trauma victims is to restore members' sense of belonging in the community. In CBT groups, group members help each other identify any cognitive distortions that may have developed following the trauma (H. Weinberg et al., 2005). Members of psychodynamic groups explore the impact of the traumatic event on their internal psychodynamic processes. Although trauma survivors report feeling better after group counseling, there is little documented empirical support for client improvement (H. Weinberg et al., 2005); therefore, further research is needed.

Anniversary dates and legal proceedings. As with any experience of trauma or loss, anniversary dates are often difficult for survivors. Often schools and local communities have some form of memorial on the 1-year anniversary of the event (Newman et al., 2004). During anniversaries, psychologists may need to anticipate and address the resurfacing of emotions and reactions that the client believed were resolved. Another potential difficulty for the therapist to be aware of is the often drawn-out legal proceedings following an act of targeted school violence (Daniels et al., in press; Newman et al., 2004). Individuals often report that the legal maneuverings continue to bring up memories and feelings that they are trying to work through. The legal process also may result in anger and resentment if the punishment for the perpetrator(s) is not deemed harsh enough by survivors (Daniels et al., in press; Newman et al., 2004). Finally, there is some indication that the legal process may fuel already strained relations among members of the community who hold differing views about the appropriate punishment for the perpetrators (Newman et al., 2004). At this time, the psychologist needs to put his or her biases about the case aside, remaining neutral so that she or he can process clients' negative emotions.

Therapist Self-Care

Because mental health professionals who intervene following an act of targeted school violence are often members of the affected school community as well as the larger community, they may be at risk of both their own emotional reactions and those of their clients. This may be especially true for school-based mental health professionals who may have known the perpetrator(s) and the victims. These professionals may need to recognize issues suggestive of possible impairment and seek treatment for themselves.

Vicarious trauma occurs when psychologists and other mental health professionals develop trauma reactions secondary to exposure to clients' traumatic experiences (Trippany, White Kress, & Wilcoxon, 2004). This is not an uncommon occurrence. Vicarious trauma affects all areas of a psychologist's life. Some psychologists working with traumatized school personnel may experience physical, emotional, and behavioral symptoms, work-related issues, and interpersonal problems. Others may experience a decrease in concern and empathy for their clients, all of which may lead to a reduced quality of care.

Constructivist self-development theory (Trippany et al., 2004) suggests that people construct their realities through the development of cognitive schemas and perceptions. These facilitate humans' understanding of life experiences. People are constantly

constructing and reconstructing their world, integrating new pieces of information and experiences as they occur. One proposition of constructivist self-development theory that is relevant to the present discussion is that distorted schemas develop as a way of protecting the individual from experiences that are perceived to be traumatic. These distortions may negatively affect psychologists across multiple life domains (Trippany et al., 2004). This may be expressed through having heightened safety needs, feeling increasingly vulnerable to self-doubt, feeling that trust is damaged, questioning one's own abilities, experiencing feelings of emptiness and withdrawal, and having a tendency to overcontrol.

Knowing about vicarious trauma can help psychologists work to prevent it. Psychologists' awareness of their own reactions to the school violence incident and their reactions to their clients' traumatization may allow them to engage self-care strategies (Trippany et al., 2004). There are some concrete ways to prevent or minimize the impact of vicarious trauma. These include limiting one's caseload, actively participating in peer supervision, seeking psychotherapy, obtaining education and training, using personal coping strategies, and relying on one's spirituality.

School Crisis Response Plans

In addition to the treatment recommendations already described, the authors urge members of school crisis response teams to anticipate some of these issues as they develop crisis response plans. Effective school violence prevention planning includes team members from various backgrounds, such as school psychologists, counselors, and social workers, psychologists from the community, administrators, teachers, parents, and community and religious leaders (Barton, 2000; Brock et al., 2001; D'Andrea, 2004). Members of crisis planning teams must advocate for inclusion of crisis counseling, resources, and referral services for students as well as teachers and other school staff in the crisis response plan. The plan should include a current list of local psychologists and mental health providers (updated yearly) who are qualified to provide crisis and postcrisis mental health services. This plan should include school psychologists from the district and surrounding districts who have been trained in school crisis response. In rural areas, there may not be local service providers; therefore, alternative resources should be included, such as psychologists from neighboring communities (Hargrove, 1986).

Again, the NASP Web site (http://www.nasponline.org) provides many helpful resources for developing crisis response plans. Some of these resources are written for parents and teachers (e.g., managing strong emotions following trauma; helping children with special needs cope with trauma), and others are written for school-based mental health professionals and administrators (e.g., dealing with death in the school; culturally competent crisis response resources). The NASP PREPaRE curriculum (National Association of School Psychologists, n.d.) also offers essential training for professionals developing a school crisis response plan.

In a recent study of crisis prevention and intervention, Nickerson and Zhe (2004) found that practicing school psychologists were used predominantly in school crisis prevention and intervention strategies. These respondents indicated that they are least used in the development and evaluation of crisis response activities. Allen et al. (2002) surveyed practicing school counselors to determine their level of preparation for handling crises. Approximately 64% of their sample indicated that they had received some exposure to crisis intervention in graduate school. Thus, more than one third of school counselors have had no training or experience in handling crises.

When developing school crisis plans, it must be acknowledged that there are times when dual relationships cannot be avoided. In a study of rural psychologists, Schank and Skovholt (1997) found that multiple relationships between psychologists and clients are common. Moleski and Kiselica (2005) pointed out that not all dual relationships are destructive, and if handled well, they may even be therapeutic. If there are no other service providers available, it is imperative that local psychologists establish clear boundaries before beginning the therapeutic relationship, discuss potential risks and benefits of dual relationships, consult with other professionals if problems arise, document the dual relationship in case notes, and seek supervision (Moleski & Kiselica, 2005). The psychologist who finds him- or herself geographically isolated from other mental health professionals must develop an action plan before a school crisis occurs for working with all victims.

Summary and Conclusions

As has been evidenced throughout this article, teachers and other school personnel often have unmet psychological needs following violent acts at schools (e.g., Astor et al., 1998; Daniels et al., in press; Kondrasuk et al., 2005; Newman et al., 2004). Of the numerous results of school violence, one is that many teachers and school personnel do not feel safe at school (Dworkin et al., 1988; Nims, 2000), and if they have been victimized, frequently they do not receive counseling or any other support services to help them cope with their reactions. Newman et al. (2004) argued that teachers and administrators must not be ignored following an act of school violence. Psychologists and other mental health professionals responding to school violence must not overlook the psychological needs of teachers and other school staff who were also victims of the tragedy.

We strongly recommend that in their efforts to provide assistance to the student body, psychologists not overlook opportunities to provide aid to teachers and other school staff who have been traumatized. School-based mental health professionals who work side-by-side with teachers must work to avoid, or limit, the impact of dual relationships. Moreover, if these professionals also have been traumatized, they need to take measures to assure their own mental health so that they do not inadvertently do harm to their clients.

It is proposed that in their work with adult victims of school violence, psychologists and mental health professionals attend to several pertinent clinical issues. These may include immediate crisis counseling and longer term treatment for potential PTSD and other trauma-related complications.

In this article, we have described the often unmet needs for psychological services of teachers and other school staff following an act of school violence. It has been shown that the impact of school violence is far-reaching, from the students to the school administration and staff. Although school districts make efforts to provide students with mental health services, it has also been shown that teachers and other school personnel may not receive the support they need following mass trauma. Three areas of focus have been presented for psychologists and other mental health

professionals working in schools and communities in the aftermath of an act of school violence. These include (a) increased awareness of the scope of the problem of school violence and the need for provision of psychological services to all potential victims, including students, faculty, staff, and administrators; (b) the effects of school violence on school personnel who were victimized; and (c) treatment considerations for working with school violence victims immediately after the crisis, in the short term, and in the long term. We hope that school-based mental health professionals, community psychologists, and administrators will see to the psychological needs of teachers and other school personnel following future acts of school violence.

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