

PRACTICE-BASED RESOURCES AND REFERENCES

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Although in general the authors use the term "Queer and Trans people" to describe this populations, The authors may use different acronyms for this population throughout the chapter as it relates to the research reviewed, i.e., the populations discussed in the literature cited may not include all Queer and Trans people, but rather only certain identities from the population, e.g., LGBT, LGB, etc.

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Although in general the authors use the term "Queer and Trans people" to describe this populations, The authors may use different acronyms for this population throughout the chapter as it relates to the research reviewed, i.e., the populations discussed in the literature cited may not include all Queer and Trans people, but rather only certain identities from the population, e.g., LGBT, LGB, etc.

SECTION IV: COMMUNITY VIOLENCE, MASS VIOLENCE, CRISIS, AND LARGE-SCALE DISASTER

CHAPTER 19

Historical Trauma and Trauma-Affected Communities

MATTHEW J. WALSH, REVEREND PAUL T. ABERNATHY AND LISA LÓPEZ LEVERS

CHAPTER OVERVIEW

This chapter focuses on the importance of understanding historical trauma and how its legacy influences communities that have been affected by trauma. One major purpose of this chapter is to explore the lived experiences of individuals and communities exposed to trauma, in ways that can lead to trauma-informed interventions, especially among those affected by historical trauma. One such research-based strategy is highlighted and discussed in detail.

trauma. One such research-based strategy is highlighted and discussed in detail.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Understand the impact of trauma on communities;
2. Develop insight about the effects of historical trauma;
3. Re-imagine community development from a trauma-informed framework to produce a bio-behavioral change at the micro-community level;
4. Describe a new framework through which to understand trauma as a communally experienced, multigenerational, and layered phenomenon;
5. Understand how to design a salient community-engaged/community-embedded research strategy from a bio-ecological perspective; and,
6. Identify elements of a context-sensitive model for sustainable integrated healthcare in low-resource communities.

INTRODUCTION

Trauma affects individuals living in communities around the world. While urban areas have higher densities of populations, more people living in poverty, and more communities with higher crime rates, people living in suburban and rural areas also experience trauma. The reality, however, is that historically marginalized groups of people and lower-resourced communities have experienced historical trauma as well as more frequent incidences of traumatic events. The purpose of this chapter is to explore the lived experience of trauma from an individual and community or collective perspective. To frame our discussion, we explore the following topics: First, we describe the phenomena of historical trauma, the developmental impact it can leave on subsequent generations, and the intersection with low resource communities; second, we explore developmental aspects of trauma, including complex trauma and Adverse Childhood Experiences (ACEs); third, we expand on the idea of community trauma, highlighting ecological influences, and presenting the idea of trauma-affected communities; and, finally, we offer a salient example of a research-based, trauma-informed response to community trauma from the *Neighborhood Resilience Project*. This is followed by a brief conclusion and an online list of practice-based resources.

THE LIVED EXPERIENCE OF TRAUMA

The lived experience of trauma can be elusive and profound, not just for the individual who has experienced the event or events, but also for the community. The lived experience of trauma can affect the individual and the community in a variety of ways that are not always completely understood to the individual and the community. Trauma can have an impact on the body; the environment; identity formation; interpretations of the past, present, and future; and our relationships with others. [Herman \(1992/1997\)](#) states that traumatic events “violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis” (p. 51). Such existential crisis reverberates in the words of one community resident who participated in an inquiry about community-based violence ([Walsh, 2015](#)):

My mom went to jail. ... My grandmother would beat me because I reminded her of my mom ... because she did not want me, I felt like I was not worthy. ... I was the lost girl, the girl that wasn’t worthy.

Trauma can alter the very existence and meaning that an individual gives to their life ([Frankl, 2006](#); [Janoff-Bulman, 1992](#)). These existential influences can hinder an individual’s ability to trust, hope, and care for themselves or for others, resulting in a “disconnect” between an individual’s perceived sense of self, as well as relationships with others ([Herman, 1992/1997](#)). Trauma can attack the core of an individual’s normal living and coping mechanisms and cause the individual to retreat into the self or to become isolated from others. From a resident of the *Neighborhood Resilience Project*, [Walsh \(2015\)](#) states that trauma can

others. For many residents from [Walsh's \(2015\)](#) community-based study, trauma informs their understanding of the world and how they interact with their environment, as well as how the environment affects them developmentally. Identity formation and the ability to reach or recognize an individual's potential are based in large part on the meaning-making relationship with the community and the environment. If an individual feels that they have no potential or feel trapped in a prescribed socioeconomic status (SES) or role, their sense of self can become stagnant or distressed. Likewise, if they view the community as distressed, that person may view the self as distressed and stagnant. Within the broader discussion of lived trauma in this section, we examine the relevance of historical trauma, the developmental effects of trauma, the role of attachment and the environment, the importance of the ACE study, and community trauma in the following subsections.

Historical Trauma

Historical trauma theory provides a context for understanding community trauma and illuminates potential barriers to treatment. As introduced in Chapter 1, "An Introduction to Counseling Survivors of Trauma: Beginning to Understand the Historical and Psychosocial Implications of Trauma, Stress, Crisis, and Disaster," historical trauma theory tries to understand *how* and *why* certain populations have a greater likelihood of disease and other disparities. It also is important to understand the confluence of historical trauma, racism, poverty, and other forms of oppression. According to David and Derthick:

Despite its pervasiveness and harmful impacts, however, it seems as though many of us still do not have a clear understanding of oppression, its many manifestations, and its consequences. Many of us may have heard of racism, sexism, and even heterosexism or homophobia ... but do not see the need to address them—believing that such "isms" are not legitimate concerns and are just products of some people's ideological movement toward "political correctness"—thereby failing to understand that "isms" are oppressive and are therefore harmful. Even among those of us who are familiar with specific "isms" and agree that they are social ills that need to be addressed, many seem to not see that the core commonality between these various forms of "isms" is that they are problematic precisely because they are oppressive. ([David & Derthick, 2017](#), p. 2)

[Sotero \(2006\)](#) has described historical trauma theory as a relatively new concept in public health that aims to assess the higher prevalence of disease among populations exposed to long-term traumatic experiences (e.g., racism, slavery, genocide) across generations. [J. C. Alexander \(2004\)](#) examined the construct of cultural trauma as a constructivist concept. He asserted that events are not inherently traumatic; rather, it is the beliefs of individuals and societal groups that make them such ([J. C. Alexander, 2004](#)). Although some events are considered to be nefarious, universally, in short, Alexander posits that it is not so much the events, *per se*, but their meanings, which disturb and shock the social consciousness.

The process of cultural trauma, according to [Eyerman \(2002\)](#), has evolved from the reconstruction and reconceptualization of collective memory and identity. [Estrada \(2009\)](#) has pointed out that it is precisely the intergenerational stress, in response to atrocious and traumatic social and historical events, that is at the core of historical trauma theory. This applies to many groups of indigenous and oppressed peoples around the world, for instance, colonized Africans across the continent of Africa, African Americans and other previously enslaved peoples of the African diaspora, Native American and First Nations people of North America, colonized indigenous peoples throughout South America, Aboriginal people of Australia and New Zealand, and various populations throughout Asia, among others ([Walk Free Foundation, 2018](#)). [Wilkerson \(2020\)](#) eloquently identifies the existence of racism in the United States as a caste system, outlining the eight pillars of caste systems that can be found universally. The concept of historical trauma, or collective trauma, implies that the experience involves generational transmission across a group of people who have established a cohesive identity or a sense of group affinity ([de Mendelssohn, 2008](#); [Evans-Campbell, 2008](#)).

As research into generational trauma is still a relatively recent phenomenon, there remains work to be done in refining definitions, explaining modes of transmission, and delineating the impacts of intergenerational trauma. Such detailed exploration is not the focus of this

impacts of intergenerational trauma. Such detailed exploration is not the focus of this chapter; however, an overview of the salient research to date is in order. At its core, intergenerational or cultural trauma is suggested to be a result of a population's identification with the emotional distress and suffering of previous generations (M. Y. H. Brave Heart, 2003, 2007; M. Y. H. Brave Heart et al., 2005). There appear to be common characteristics of the type of events that lead to cultural trauma. Most notably, an "outside" group, whose intent is to subjugate or to cause harm, generally perpetrates the incidents. Although natural disasters have been found to contribute to collective trauma, it is generally the course of human events that seems to breed the greatest devastation. Additionally, events that are experienced by a large number of members of a specific group, for whom the event created significant distress and bereavement, tend to create trauma that is transmitted to future generations (M. Y. H. Brave Heart, 2003, 2007; Brave Heart & DeBruyn, 1998; M. Y. H. Brave Heart et al., 2005; Evans-Campbell, 2008; Whitbeck et al., 2004; Williams, 2018). All too often, these events involve genocide, enslavement, or decimation of marginalized factions of people.

M. Y. H. Brave Heart (2003, 2007) has identified the following symptoms as one example of a sort of historical trauma nosology among indigenous peoples of North America: depression, anxiety, isolation, loss of sleep, anger, discomfort around White people, shame, fear and distrust, loss of concentration, substance abuse, and violence and suicide. In other studies, evidence of generational trauma has been found in the children of Holocaust survivors (Gangi et al., 2009). Wiseman et al. (2006), in their exploration of second-generation Holocaust survivors, have found that these offspring exhibit anger and guilt related to parental overprotectiveness, enmeshment, and expectations. The monumental losses suffered by Holocaust survivors dramatically influence their familial relationships, which often are characterized by an intense need to protect and maintain family cohesion as a survival strategy. Behaviors that are rooted in the trauma of a past violation are an ongoing influence in the actions of the present, and these even may be propagated by third-generation survivors (Scharf, 2007) and beyond. Sotero (2006) states that "a key feature of historical trauma theory is that the psychological and emotional consequences of the trauma experience are transmitted to subsequent generations through physiological, environmental and social [ecological] pathways resulting in an intergenerational cycle of trauma response" (p. 95).

We believe that it may be helpful to offer a real-world example, so that readers can understand the nature of the oppression described here. Although we look to the Hill District, located centrally in the city of Pittsburgh, Pennsylvania, as an apt example, we submit that the Hill shares demographic characteristics with trauma-affected, low-resource communities around the world; we offer field-based examples, about recent work in the Hill District, later in this chapter. The Hill has had a storied and challenging history, one that has been mixed with cultural and economic vibrancy, as well as external and internal factors influencing its decline in the 1960s and encroaching gentrification today. The Hill community is predominantly Black and African American, and historically, this population has experienced collective trauma(s) such as slavery, Jim Crow laws, and institutional racism. Historical trauma theory offers a path toward contextualizing current psychological and emotional distress, as articulated by the term "community trauma." In addition, current research has begun to link historical or transgenerational trauma with racial and ethnic health disparities (Atkinson et al., 2010; Sotero, 2006; Williams et al., 2003).

Sotero's (2006) model emerges from considering the subjugation of a population by a dominant group. Four elements must be present, as parts of the suppression, in order to qualify as subjugation: "(a) overwhelming physical and psychological violence, (b) segregation and/or displacement, (c) economic deprivation, and (d) cultural dispossession" (p. 99). From the primary generation that experienced the subjugation, future generations can be affected by the original trauma through various factors. These factors are by-products of extreme trauma experienced by the primary generation. Sotero states, "Extreme trauma may lead to subsequent impairments in the capacity for parenting. Physical and emotional trauma can impair genetic function and expression, which may in turn affect offspring genetically, through in-utero biological adaptations, or environmentally" (p. 99). In addition to such epigenetic changes, Sotero argues that future generations can experience vicarious

epigenetic changes, Sotero argues that future generations can experience vicarious traumatization through storytelling and oral traditions of the population. Sotero claims that historical trauma theory "creates an emotional and psychological release from blame and guilt about health status, empowers individuals and communities to address the root causes of poor health and allows for capacity building unique to culture, community and social structure" (p. 102).

Historical trauma theory can shed light on the possible underlying factors contributing to mental distress and mental health disparities in racial/ethnic minority populations. It is clear that the responses of individuals are related to the responses of their families, which are, in turn, influenced by the responses of the community as a whole. Although there is considerably more research to be done, we can view cultural trauma as a multisystemic influence that has long-term social manifestations across generations. Additionally, even though the focus of this discussion is on transgenerational and historical trauma, we would be remiss in not at least mentioning an additional strand in this discourse, namely, that of transgenerational resilience. In spite of experiencing horrendous trauma, across generations, affected groups of people have managed to survive and even thrive. This courageous resilience, in the face of egregious acts of violence and hatred, has been referenced in a nascent part of the literature as transgenerational resilience (e.g., Denham, 2008; Kirmayer et al., 2014) and begs further inquiry, along with transgenerational trauma. Due to the ramifications of historical trauma and the reality-based issues that arise in the lives of those affected, it is important to consider the need for situation-specific and culturally sensitive human services. The next section continues the thread from historical trauma theory to the developmental effects of trauma.

Posttraumatic Slave Syndrome

In addition to historical trauma theory, DeGruy's (2005) concept of "Posttraumatic Slave Syndrome" applies historical trauma theory to the Black and African American experience in the United States context. In DeGruy's (2005) *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing*, she provides an historical context for understanding the negative perceptions, images, and behaviors many Black and African Americans experience as a result of slavery. DeGruy traces the historical effects of American chattel slavery on Black and African Americans and how they have adapted their behaviors over the centuries in order to survive the effects of chattel slavery. She proposes the concept of Post Traumatic Slave Syndrome (PTSS) in order to conceptualize how the current lived experience of many African Americans is related to transgenerational adaptations linked to past traumas of slavery and ongoing oppression (p. 13). DeGruy defines PTSS as:

A condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalized racism today. Added to this condition is a belief (real or imagined) that the benefits of the society in which they live are not accessible to them. This, then, is Post Traumatic Slave Syndrome:

Multigenerational trauma together with continued oppression and

Absence of opportunity to access the benefits available in the society leads to ...

Post Traumatic Slave Syndrome. $M + A = P$. (p. 121)

Consequently, she argues that there are resulting common patterns of behaviors associated with PTSS. She identifies three categories: (a) vacant esteem; (b) ever present anger; and (c) racist socialization. The following paragraphs briefly describe the three categories.

Vacant esteem relates to a belief that an individual has little or no worth. This belief of having little or no worth has been influenced by three domains: society, community, and family. Society contributes to vacant esteem in a variety of ways from laws, institutions, and policies, as well as how African Americans are portrayed in the media. African Americans are disproportionally represented in the judicial system (M. Alexander, 2012). Racial bias and lethal force against Black and African Americans in policing is a systemic problem across the United States. To illustrate this point, in 2013, we note that a civil, nonviolent movement, with the hashtag #BlackLivesMatter, was formed after the acquittal of George Zimmerman in the shooting death of Trayvon Martin. The mission of #BlackLivesMatter has been to confront White supremacy by encouraging local communities to intervene in violence targeted at Black

White supremacy by empowering local communities to intervene in violence targeted at Black communities by the state as well as by vigilantes (Black Lives Matter, 2020, "about" section).

#BlackLivesMatter has evolved since 2013 into a global network foundation and includes the United States, United Kingdom, and Canada. We witnessed, in the summer of 2020 in the United States, a tipping point to unwarranted police violence and systemic racism toward Blacks with the killing of George Floyd by a White police officer. George Floyd's death has symbolized the countless deaths of Black and African American individuals by police and the legacy of trauma inflicted by racially unjust systems, particularly racial profiling by police officers. In many ways, the #BlackLivesMatter movement has mitigated the uncritical reinforcement of vacant esteem. Vacant esteem arises and is influenced by the various systems (e.g., as denoted in the Bioecological Model) with which an individual interacts on a daily basis as well as by the historical context. As a result, vacant esteem can be passed down, through generations, in the form of parenting styles. #BlackLivesMatter had demonstrated that this, along with overall systemic racism, no longer is acceptable.

The next category associated with PTSS is "ever present anger," which DeGruy states is the most prominent behavior pattern related with PTSS. She suggests that the anger manifests from ongoing oppression by the dominant group, in which "goals are blocked"; this, then, may result in a fear of failure that often exists within Black and African American communities. An example that DeGruy points to, which she says has perpetuated "blocked goals," is the fallacy that Blacks and African Americans have been fully integrated into the greater society. The year 2020 has marked the 55th anniversary of "Bloody Sunday" and the march over the Edmund Pettus Bridge in Selma, Alabama. The protest (e.g., #BlackLivesMatter) for equality and justice for minority groups has only been partially realized, as evident by the disparities that exist in educational opportunities, healthcare, the judicial system, and bank lending practices in the United States, to name a few.

The last category is racist socialization, which DeGruy considers "the most insidious and pervasive symptom" of PTSS (p. 134). Racist socialization represents the social construction of a value system related to class and race/ethnicity, where "Whiteness" is superior to "Blackness." This is similar to Du Bois' (1903/1965) "double consciousness," which he articulates in *The Souls of Black Folk*. Du Bois suggests that not only do "Black folk" view themselves through their own Black identity, but they also view themselves or their community through White eyes. As a net result of the trauma from chattel slavery, residuals have been passed down through the generations, socializing Black and African Americans that they were inferior "physically, emotionally, spiritually, and intellectually" (DeGruy, 2005, p. 137). For many Black and African American communities, the residuals from transgenerational trauma associated with slavery and DeGruy's conceptualization of PTSS add another dimension and insight into the lived experience of community trauma.

Developmental Effects of Trauma

For the residents of low-resource, often marginalized communities of color that frequently are located in large urban areas, their trauma started when they were children and took on many forms of interpersonal traumas. Examples of these traumas include sexual abuse, physical and verbal violence inside or outside of the home, and being rejected or discriminated against because of skin color. The term "complex trauma" is used in the literature to describe the impact that multiple layers of interpersonal traumatic experiences can have on the development and identity formation of an individual (Courtois & Ford, 2013; Ford & Courtois, 2020). Complex trauma occurs when the stressor event is repeated over time and/or perpetrated by a family member or an authority figure; it usually begins in childhood or adolescence but also can occur in adulthood. Because these experiences usually occur within the child's primary caregiver system, it can affect the child's ability to regulate emotionally, feel safe, trust self and others, and make sense of what is happening to them. The effects of multiple traumatic experiences are related to multiple risk factors, which then can lead to long-term physical and behavioral health problems, as well as to negative coping mechanisms (Courtois & Ford, 2013; Ford & Courtois 2020). In addition to complex trauma relating to repeated individual victimization by primary caregivers, it also can exist within the context of

the community. The following section further explores the role of attachment and the environment in this complex developmental cycle of maltreatment.

Role of Attachment and Environment

The effects of complex trauma are rooted in the nature of the attachment bonds that have formed between child and primary caregivers. Children who live in a secure and safe environment learn to trust their feelings and the world around them. Through the modeling of a primary caregiver, children learn increasingly more intricate vocabulary to describe emotions effectively. This learned emotional vocabulary and a trust in the primary caregiver's ability to restore a sense of control and safety, when a child is distressed, moderates against "trauma-induced terror" (van der Kolk, 2005). The opposite is true in an insecure environment and with primary attachments that have not established a sense of trust and safety in the child. Such children may be in extreme distress, existing in a situation in which no relief from the stress can be found, because either the primary caregiver is the source of the distress or is unable to model emotional regulation or an emotional vocabulary. This, in turn, fosters an environment in which the child lacks the ability to process, integrate, or categorize what is happening. If a child feels helpless and lacks any sense of stability or control, mechanisms of the primal brain can be triggered (i.e., fight/flight/freeze), and the child is not able to learn from the experience (van der Kolk, 2005, 2014).

The inability of the child to process, integrate, or categorize the stressor(s), along with the repetitious nature of complex trauma, can lead to a constant state of being in psychological and biological "survival" mode (Courtois & Ford, 2013). Over time, if the victimization continues or recurs, these survival reactions can be ingrained in the individual's personality as they develop. Survival can become the primary vehicle from which an individual conceptualizes their being in the world, affecting both personal relationships and the ability to self-regulate emotions. As a result of an inability to self-regulate and to maintain relationships, as well as being stuck in survivor mode, many survivors of complex trauma seek other coping mechanisms to self-soothe. Some of these coping mechanisms include alcohol and drug abuse, self-harm, and suicidality (Najavits, 2006; van der Kolk et al., 1991). Survivors of these early life traumas often struggle with anger, alienation, distrust, confusion, grief, low self-esteem, loneliness, shame, and self-loathing (Courtois & Ford, 2013). To examine the potential effects of negative childhood experiences further, the Adverse Childhood Experiences (ACE) study has provided needed context (Chapter 2 offers a brief description of the ACE study, and the reader can refer to the figure of the ACE Pyramid, presented there).

The Adverse Childhood Experiences Study

The ACE study (1995-1997) has been the largest study to date, with more than 17,000 participants, which has linked health risk behavior and disease in adulthood to exposure to emotional, physical, or sexual abuse, and household dysfunction during childhood (Felitti et al., 1998). The study found that nearly two-thirds of all respondents had at least one adverse childhood experience (occurring before the age of 18), and that 12% of the respondents had four or more adverse childhood experiences. The study also found a strong graded relationship to the amount of exposure to abuse or household dysfunction and multiple risk factors associated with some of the leading causes of death in adults. The ACE study found a significant relationship between adverse childhood experiences and alcoholism, drug abuse, sexual promiscuity, sexually transmitted diseases, intimate partner violence, obesity, physical inactivity, depression, suicide attempts, and smoking. Further, the more adverse childhood experiences reported, the more likely it is that a person may develop heart disease, cancer, diabetes, liver disease, stroke, and skeletal fractures.

The original ACE Pyramid graphic included the following, from the base to the top of the pyramid: Adverse Childhood Experiences; disrupted neurodevelopment; social, emotional, and cognitive impairment; adoption of health risk behaviors; disease, disability, and social problems; and early death (Centers for Disease Control and Prevention [CDC], 2020). However, over the last few years, the ACE Pyramid has been updated to include "social

However, over the last few years, the ACE Pyramid has been updated to include “social conditions/local context” and “generational embodiment/historical trauma” at the pyramid base, with the latter at the very bottom. These two blocks, positioned at the base of the pyramid, have underscored the impact that the environment/systems and generational trauma can have over the life-span of an individual. In addition, the ACE study has illustrated that adverse childhood experiences are more common than acknowledged; it shows the impact that these adverse experiences can have on physical and behavioral health later on in life, thus illuminating the need for culturally sensitive preventative interventions.

Community Trauma

In the research literature, community trauma often is associated with the impact that a particular event or events may have on a community. Some examples include chronic community violence, workplace and school violence, natural and manmade disaster, war, genocide, and terrorism (Herman, 1992/1997; Levers & Buck, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Even though individual traumatic events happen within the context of a community, the term “community trauma” may refer to any form of violence that affects a number of people or an entire community. The World Health Organization (WHO) defines “violence” as “the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maltreatment, or deprivation” (Krug et al., 2002, p. 5). This definition of violence is intentionally broad in scope, covering a wide range of violent acts toward an individual or a community, that go beyond typically defined outcomes of injury or death. This definition better illustrates the sometimes hidden acts of violence that the majority of those in our society do not experience or acknowledge, but that many in urban, ethnic/racial, minority communities experience on a daily basis (Alim et al., 2006; Breslau et al., 1998; Liebschutz et al., 2007). Some examples of these hidden acts of violence that may be experienced on a daily basis include racism, low SES, poverty, lack of adequate healthcare, and substandard educational opportunities. Community-based research conducted by Walsh (2015) suggests multidimensional origins that are caused not by one particular event, but rather by multiple contributing factors, including historical trauma that has been passed down through generations.

PUTTING IT ALL TOGETHER: TRAUMA-AFFECTED COMMUNITY

Over the last 20 years, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) has been researching and working on developing a *Trauma-Informed Approach* that can be used across a variety of service sectors as a way to help resolve trauma-related issues. SAMHSA reports that trauma researchers, clinicians, and survivors suggest that non-integrated trauma-specific interventions are insufficient to improve treatment outcomes or healing for trauma survivors. Trauma-specific interventions that primarily are used in specialized clinical settings might only be effective for those who seek treatment, have access, and/or realize that their physical or mental distress may be related to a traumatic experience. As mentioned earlier in this chapter, we explore the Hill District, an area in central Pittsburgh, Pennsylvania, as an illustrative example of a trauma-affected community. Box 19.1 provides a description of the *Neighborhood Resilience Project*, which embodies the work of trauma-informed service provision in a trauma-affected community.

BOX 19.1

Case Illustration From the Field: Neighborhood Resilience Project

The *Neighborhood Resilience Project* (NRP) is a faith-based, nonprofit community agency, located in the Hill District of Pittsburgh, Pennsylvania. As informed by the lived experience of community trauma, at both individual and collective levels, NRP establishes and promotes resilient, healing, and healthy communities so that people can be healthy enough

promotes economic, housing, and healthy communities so that people can be healthy enough to sustain opportunities and to realize their potential. The NRP currently offers an array of psychosocial and medical services to residents of the Hill District, the Greater Pittsburgh area, and surrounding counties. Services include a free medical clinic in the Greater Pittsburgh area that also provides psychiatric services and trauma counseling, food and clothing programs for children and families, and a county-wide trauma response team that responds to homicides as a result of gun violence. This response includes trained trauma responders (primarily volunteers) who bring a mobile unit (fitted RV) to the affected site and remain as long as possible within the first 48 hours.

The NRP works with neighborhoods, block-by-block, or the “micro-community,” depending on the geography of the community, to assess the physical and behavioral health of residents as well as the social health of the block. Such assessments are a part of NRP’s *Trauma Informed Community Development* (TICD) effort, which has gained national and international attention. TICD is a culturally sensitive and context-specific framework that uses grass-roots information from local stakeholders to conduct community-appropriate development. During the course of NRP’s work in the Hill District and in response to demand, NRP now offers an annual *TICD Institute* that draws cohorts of community members from around the country whose agencies or groups are interested in using the TICD framework to advance their own aspirations in their home communities. By formalizing TICD into a national institute, other interested communities have had an opportunity to replicate the framework, with adaptation for local needs. Reports to date are that TICD replications have been successful across communities. NRP is also in the foundational stages of adapting TICD for use in school systems.

For many in the Hill District, trauma and trauma responses have become normalized in the community, which has contributed to non-help-seeking processes. Identifying *trauma-affected communities* is important as an extension of the current paradigm shift in the healthcare delivery system to a trauma-informed approach to development and community building. The following subsections elucidate a framework for working with a trauma-affected community; this framework is based upon our work and research in the Hill District and at the *Neighborhood Resilience Project*.

Environment as Risk or Protective Factor

Working from an ecological framework emphasizes the importance of identifying the protective and risk factors that interact within multiple environments and that influence the lived experience of community members, who have been affected by trauma, as well as of the community itself (e.g., [Bronfenbrenner & Morris, 2006](#); [Lynch & Cicchetti, 1998](#)). In addition, recognizing and identifying the differences between life in affluent communities and life in minority or low-resource communities may lead to more divergent modes of thinking about trauma in the context of the community as a whole. The Reverend Paul Abernathy has stated that “Our community, our children are aware this [trauma] is happening. ... Creating a worldview shaped by this trauma” (as cited in [Walsh, 2015](#)). This statement makes explicit the potential difference between the lived spaces of predominantly low-resourced neighborhoods and the lived space of predominantly high SES neighborhoods.

The framework for working in the Hill District emphasizes that the community’s perceptions of trauma, or what “is” or “is not” happening in their respective neighborhoods, have a direct influence on how individuals in the community generate and sustain a worldview of either safety, security, and control, or a worldview devoid of them ([Courtois & Ford, 2013](#); [Singer, 2004](#); [van der Kolk, 2005, 2014](#)). The trauma literature is consistent in demonstrating the mitigating qualities that environments can have against various types of traumas, including how people make meaning from traumatic experiences; this, then, can facilitate those situations in which an individual feels safe and secure, has some degree of control, and develops healthy attachments ([Park et al., 2008](#); [Singer, 2004](#); [van der Kolk, 2005, 2014](#)). In addition, the indirect impact of residents “hearing about” ([Horowitz et al., 1995](#)) trauma or resilience can perpetuate views about their community as to whether or not

the means are available in the community to keep the residents safe and secure.

Following Bronfenbrenner's (1979) bioecological model, Lynch and Cicchetti (1998) have proposed an ecological-transactional model in which an individual is "nested" within multiple levels or environments that have varying degrees of proximity to the individual. They have posited that transactions take place between the individual and multiple ecologies, and that these transactions are not unidirectional, but rather are bidirectional or multidirectional. This approach to viewing the individual as "nested" postulates that not only do multiple environments influence individual identity formation, but also that the individual can influence the environment. In other words, the relationship between the individual and their multiple environments is reciprocal; the ensuing dynamic is one of reciprocity, and this is useful in thinking about individual and community interactions. In addition, we typically think of inequity as an individual issue, but Radd et al. (2021) emphasize that the construct of inequity operates across historical, structural, and institutional dimensions, as well as spanning individual and interpersonal dimensions, depending upon the context. It would not be a theoretical leap, then, to imagine linking individuals' experiences of complex trauma or "compounded trauma" to a collective "identity of trauma" that influences and is influenced by multiple ecologies. In turn, this would require a paradigm shift, from focusing therapeutic interventions solely upon individuals to focusing interventions on the collective identity of trauma expressed in the community. This shift ultimately would direct the primary intentionality of interventions toward a more inclusive or expansive environment, engaging in a kind of *cultural therapeutics* (e.g., Romanyshyn, 2001).

Trauma-Affected Community: A Working Framework

As previously inferred in this chapter, many people are affected personally by the trauma that occurs within their communities and neighborhoods. We have proposed the following structure for understanding a trauma-affected community:

A framework [is] used to illuminate the complex web of variables present in the environment that can influence identity and worldview formation founded on layers of victimization that exist in an individual and community context and that can be passed down through generations. This framework posits that community meaning-making has been influenced by multidimensional layering of traumas, which act as a conduit to the construction of a community and individual narrative based on negative views of the self and community, including lack of agency, "vacant esteem" (DeGruy, 2005), anger, isolation, and fragmented families and communities (Abernathy et al., 2019, p. 249).

The framework makes explicit the lived experience of traumas, as well as the ensuing meaning-making that emerges, within the context of the community. Such scaffolding illuminates the complex interwoven web of systemic issues and variables that may influence disparities in behavioral health treatment, urban/rural (re)development, and the overall well-being of the community. This framework highlights both the individual and collective experience of "suffering," which has the potential to influence negative meaning-making processes in the self, family, and ultimately in the community.

The framework highlights the centrality of the *culture*. The context for culture used in this framework alludes not only to the experiences of many in the African American community, but a community culture affected by multidimensional layering of traumas. These layers of traumas are interrelated between the individual and community as a shared experience and expression of each. Included in these layers of traumas are types of trauma, lived experiences, meaning-making, ACEs, social determinants, and the residuals from transgenerational or historical trauma. Community trauma, in this context, is not only a singular event or web of multiple events; community trauma can be conceptualized as a continuum of lived experiences of the past and present, which then informs current and future beliefs about one's potential and identity formation. An example of this would be DeGruy's (2005) PTSS. A participant from Walsh's (2015) study stated that "we are born into trauma, we die in trauma, and we live our lives in trauma ... there is not an answer." The community's worldview has been influenced by the multidimensional layering of traumas, which can act as a conduit to the construction of a narrative that is based on negative views of the self. These negative views, as articulated in the prior definition of the framework,

lack of agency, “vacant esteem” (DeGruy, 2005), anger, and fragmented families and communities. Ultimately, a trauma-affected community has an impact on the psychological and physical well-being of the individual and the community.

Walsh’s (2015) study has suggested that the term “community trauma” does not fully capture the multidimensionality of trauma experiences in a trauma-affected community, which can influence not only the individual’s subjective meaning (i.e., identity formation), but the community’s as well. The term “community trauma” often has highlighted what is noticeable to the observer, such as chronic violence; however, it has not made explicit what are the more implicit pervasive experiences of many residents in a trauma-affected community. The framework, which has emerged from Walsh’s inquiry, illuminates the complex web of variables present in the environment that can influence a worldview and identity formation founded on layers of victimization that exist on both individual and community levels and are passed down through generations.

Walsh’s (2015) research findings have elucidated the connection between types of interpersonal traumas and environmental factors that have led to the idea of a “trauma-affected community” as described through the lived experience of key stakeholders. Walsh hypothesized that, due to the collective and overt nature of multiple types of traumas experienced across the life-span, capturing the lived experience of trauma in the Hill District was more fully understood from a community context. Individuals are “nested” within multiple ecologies, and if the social context does not provide access to essential resources for physiological and psychological needs, including safety and security, it can affect growth as well as the motivation for individuals to reach their full potential or to self-actualize (Lynch & Cicchetti, 1998; Maslow et al., 1970; Ryan & Deci, 2000). In low-resourced urban and rural environments, the lack of access to these essential resources or needs, mixed with the residuals from historical trauma, can contribute to the layering effect of traumas, resulting in a “collective traumatization” (Horowitz et al., 1995), or, more fully articulated, the idea of a trauma-affected community.

TRAUMA-INFORMED COMMUNITY DEVELOPMENT

The need for TICD emerged as a salient result in Walsh’s (2015) community-based study in the Hill District. To mitigate the effects of trauma and to promote healing and recovery in trauma-affected communities, the construct of TICD was formalized, and the TICD model was constructed and assessed, as a part of the work of the NRP. The TICD framework uniquely combines five interrelated areas to produce a bio-behavioral change at the micro-community level. These five areas are comprised of the following: (a) bio-behavioral health community organizing; (b) community trauma and associated communal effects, which are distinct from the existing notion of trauma as an individually experienced phenomenon; (c) research strategies that prioritize the indigenous knowledge; (d) social, economic, cultural, and political capital building; and (e) micro-community as the primary unit of change and analysis, which is a new frame within community development research. Details about the TICD model are presented in Box 19.2.

BOX 19.2

Case Illustration From the Field: Trauma-Informed Community Development

Within a year of the first consultative workshop, the essential ingredients were put together to create the TICD framework. Through the direction of the Reverend Paul Abernathy, CEO of NRP, there were six major points that guided the development of TICD from the original research: (a) The plan uses a community-driven behavior health method, employing a holistic approach to well-being; (b) a medical safety net had already been provided through NRP’s Free Health Center in the community, which addresses access issues; (c) NRP, as necessary, may act as a “proxy agency” (Bandura, 2001), thus providing a “safe place” for

narrative sharing to begin and for *consciousness raising* to occur; (d) the community can begin to build and develop healthy micro-communities by using micro-community interventions (MCI) and housing co-ops; (e) the community can employ a trauma-informed approach to promote community development and community healing; and (f) the community can identify and nurture professionals from within the community, as well as to produce local paraprofessionals, in order to implement the strategy in culturally appropriate and culturally sensitive ways. TICD addresses stigma, chronic community violence, racism, negative social determinants, and transgenerational and historical trauma, as well as identifying and building upon existing protective factors and constructing new protective factors as needed. TICD redefines urban (re)development from viewing development as purely “brick and mortar” to an investment in “human development” (Abernathy et al., 2019).

As the community began to embrace the TICD model, critical community-based needs became more apparent and better defined. Walsh’s (2015) original research continued, serving as a catalyst for ongoing monitoring and evaluation of services. The theoretical basis for TICD expanded, additional human resources developed to address community needs, and a major intervention evolved in order to further assess and meet community needs. These are discussed, briefly, in the subsections that follow.

Three Pillars of Trauma-Informed Community Development

The TICD framework states the following: “As informed by the lived experience of trauma, both personal and collective, TICD establishes and promotes resilient, healing communities so that people can be healthy enough to sustain opportunity and realize their potential” (Abernathy et al., 2019, p. 3). There are three pillars that have evolved over the last several years as the TICD framework has been refined: (a) community support, (b) health and well-being, and (c) leadership development. Many functions of the TICD framework brace these three pillars, but much of the work reinforcing the three pillars is carried out by the activity of the behavior health community organizers and within the scope of the micro-community interventions; these are detailed in the text that follows.

Behavior Health Community Organizer

For this strategy to be authentically community driven, the behavior health community organizers (BHCOs) needed to be selected from the local community—in this case, the Hill District. Key stakeholders reported that professionals and paraprofessionals needed to be able to “talk the talk and walk the walk,” building rapport on the “streets.” This would help to ensure that community members do not feel they are merely a part of another academic study, but rather that they are being offered authentic care and support. In addition, a BHCO who is from the neighborhood would build *trust* and improve *buy in* from the community. NRP and university partners worked with key stakeholders to develop a training program for the BHCO. The BHCO program has fostered community building, along with a sense of healing and recovery, and also has assisted in building micro-communities that have an understanding of health and well-being. The second component of the BHCO program has facilitated the establishment of micro-communities through block interventions or MCI.

Micro-Community Intervention

The BHCO serves as the organizer for the block interventions. The MCI aims to establish healthy micro-communities as a first step in defragmenting and reconnecting community members. MCIs employ a 10-step strength-based approach, focusing on human development. Some aspects of MCI include leadership development, well-being planning, place making, and reconnecting person and the community.

TICD seeks to redefine urban and rural community development by incorporating a trauma-informed approach. In the event of rural development in a trauma-affected community, the TICD framework is still applicable, as the MCI can pertain to a city block or a 30 square mile

TICD framework is still applicable, as the MCI can pertain to a city block or a 30 square mile radius. The unit of measure is defined by the community utilizing the TICD framework. Urban communities with similar social and environmental characteristics as the Hill District are at risk for urban (re)development that is based solely on brick-and-mortar improvements. Traditional urban redevelopment often can lead to gentrification or re-gentrification of the neighborhood (Lees, 2008), rather than investing in human development and in healing trauma-affected communities. TICD is a community-driven approach to development and has the potential to heal the residual scars of historical traumas, reduce behavior health disparities in low-resourced populations, and build resilience.

CONCLUSION

In this chapter, we have explored the lived experience of community trauma from a cultural historical context. Historical trauma theory provides an understanding of *how* and *why* certain populations have a greater likelihood of disease and other disparities (Office of Disease Prevention and Health Promotion, 2020). Historical trauma theory traces the psychological and emotional consequences of a preceding oppressed or subjugated population's transmission to subsequent generations through bioecological pathways that can result in intergenerational trauma symptomology. We have explored the impact that psychosocial trauma can have developmentally (e.g., ACEs) as well as the role of attachment as a mitigating or aggravating factor (i.e., complex trauma). We have laid out a trauma-affected framework that expands upon the idea of community trauma to provide a fuller articulation of the elusive and layering nature of community trauma. Finally, we have offered a notable case study of a culturally sensitive community-based intervention, as inaugurated by the *Neighborhood Resilience Project*. TICD is a cultural therapeutic that targets the risk factors associated with trauma-affected communities, while at the same time strengthening protective factors at the individual and community levels, thereby influencing community resilience. We have concluded by offering a online list of practice-based resources.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

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CHAPTER 20

Mass Violence

KENYA JOHNS, TUMANI MALINGA, TAPOLOGO MAUNDENI, AND LISA LÓPEZ LEVERS

CHAPTER OVERVIEW

This chapter focuses on issues related to mass violence and the effects of mass violence on the populace, both in terms of proximal and distal locations of those affected. The increase of mass violence has caused global concern. The effects of mass violence events continue to traumatize those who are affected. This chapter offers insight to help understand the impacts of mass violence on survivors, families, communities, and society.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Define mass violence;
2. Develop awareness about the prevalence of mass violence;
3. Identify specific types of mass violence;
4. Understand the kinds of traumatic responses that people may have in the face of a mass violence event; and,
5. Identify interventions that can help to support those who have experienced mass violence.

INTRODUCTION

Throughout history, there have been different rulers, kingdoms, dynasties, religious beliefs, and ways of living. Dating back to prehistoric times, there has been one constant that has linked all of these periods of history, times which have included Homo sapiens—better known as human beings—and that constant is violence. Humans have acted violently throughout history for various reasons; humans have used violence as a way to achieve power, to acquire wealth, to obtain leadership status, to assert dominance, and even as a form of protest. Although this list is not exhaustive, it illustrates how various societal mechanisms, throughout history, have perpetuated violence. Whether or not the calls for violence have been warranted, human acts of aggression have permutated in ways that sometimes seem to amplify violence, almost as if it were a language that has been a chosen form of expression for human beings.

Although humanity's history of violence spans eons, it was not until the early 20th century that we began to examine the impact of trauma on physical and emotional development, on culture in general, on our views about others, and even on the planet Earth. Violence is not a new problem; however, there is a growing concern regarding the prevalence of violence that has manifested throughout the last century and into the present (Gerlach, 2010; Savelsberg, 2015). With the development of man-made tools, such as guns, bombs, weapons of mass

destruction, poisons, and so forth, there has been an increase in mass violence. This chapter explores the definition of mass violence, the prevalence of mass violence, the traumatic responses experienced after a mass violence event, and ways to support those who have experienced mass violence.

DEFINING MASS VIOLENCE

Mass violence is a term that encompasses a wide range of violent acts and events but that, at surface, gives no indication about the cause of or the motive to commit the violence (Adesola & Anyaduba, 2017; Cilliers, 2018; Parks et al., 2019). Gerlach (2006, 2010) argues that mass violence arises from complex processes within the society, stating that mass violence is “widespread violence against non-combatants, that is, outside of immediate fighting between military or paramilitary personnel, but reaching beyond mass killings” (Gerlach, 2006, p. 455). The Office for Victims of Crime and the American Red Cross offer the following definition of an act of mass violence: “an intentional violent crime ... that results in physical, emotional, or psychological injury to a sufficiently large number of people and significantly increases the burden of victim assistance and compensation for the responding jurisdiction” (as cited in Substance Abuse and Mental Health Services Administration [SAMHSA], 2017, p. 3).

The World Health Assembly declared, in 1996, that violence is a major public health issue (Krug, Mercy et al., 2002). The World Health Organization (WHO) views violence as a universal challenge. The WHO further defines violence as the “intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (WHO, 1996, cited in Krug, Mercy et al., 2002, p. 5). In the Foreword to the *World Report on Violence and Health* (Krug, Dahlberg et al., 2002), Mr. Nelson Mandela stated the following:

The twentieth century will be remembered as a century marked by violence. It burdens us with its legacy of mass destruction, of violence inflicted on a scale never seen and never possible before in human history ... the result of new technology in the service of ideologies of hate. (“Foreword,” p. 1)

For many people, the thought of a mass violence event was once a foreign concept; however, there appears to be a shift or change in the ways that we think about and receive news regarding mass violence events. With mass violence events occurring more frequently, what once felt like an improbable occurrence now feels more plausible. In some ways, it almost seems as if a numbing process has taken hold; we feel “shocked” by each incident, but somehow we no longer seem “surprised.” Use the self-reflection exercise in Box 20.1 to examine your suppositions.

BOX 20.1

Self-Reflection Exercise

When you think of mass violence, what do you think of? Take a minute to reflect on your own thoughts regarding mass violence:

- Did you become anxious?
- Did it have an impact on you (or not)?
- What kind of an impact?

Krug, Mercy et al. (2002) indicate that violence is the leading cause of death worldwide, claiming millions of victims annually. As previously indicated, violence that is committed by an individual or group of individuals, that is deliberate, and that happens across a large group or collective of people has come to be known as “mass violence.” Garbarini and Adjemian (2015) argue that we can conceptualize mass violence in the following way:

Mass violence events also are defined as violent crimes that are committed with the intentional purpose of causing emotional, psychological, or physical harm to a large group of people. In this chapter, we use this definition of mass violence, with an emphasis on the public health concerns associated with mass violence. For the purpose of this chapter, we have reviewed the prevalence and impact of mass violence within the workplace, institutional settings, and university and campuses. This chapter illuminates the importance of developing a disaster plan and the implications for the counseling profession.

Mass violence can happen anywhere and at any time. Within the last century, mass violence in public settings has occurred at an alarming rate; for example, the [Gun Violence Archive \(2021\)](#) has reported 109 mass shootings between January 1 and March 27, 2021. [Figure 20.1](#) provides a breakdown of the mass violence events that have occurred in the United States of America between 2000 and 2018 ([Federal Bureau of Investigation \[FBI\], 2018](#)). Mass violence can emerge in the workplace, in institutional settings, at colleges and universities, and in public venues such as churches, bars, nightclubs, concert arenas, and malls. Although this list is not extensive, it provides some context for the prevalence of mass violence. Mass violence can happen anywhere, but it is preventable. In this section, we discuss the prevalence and impact of mass violence in the following subsections: Work Stress and Workplace Violence, Mass Violence in Institutional Settings, Mass Violence at Universities and Campus Shootings, Known Characteristics of a Mass Violence Perpetrator, and The Necessity of Having a Disaster Plan.

FBI: Quick Look

Source: Federal Bureau of Investigation, 2013.

<https://www.fbi.gov/about/partnerships/office-of-partner->

[engagement/active-shooter-incidents-graphic](#)

Work Stress and Workplace Violence

Engaging in a job and working is an essential part of life for most people. Working provides the financial security needed to sustain a viable living. Although working is essential and necessary for financial stability, it also can be stressful. If a person works 40 hours a week or more, the majority of the individual's time is spent at work. The amount of time devoted to work can create an imbalance of time in a person's life, particularly pertaining to other important and necessary aspects of living, thus causing increased stress. Due to the nature of the work, all varieties of workers may experience a myriad of emotions and reactions, which may lead to differing levels of stress.

Stress in the workplace is common. In fact, according to the results of stress-related research conducted by [ComPsych \(2019\)](#), most stressors experienced by American adults arise from workplace stress. For a large number of employees (61%), stress levels are high enough to cause them to feel fatigued and not in control ([ComPsych, 2019](#)). Key findings of the research indicate that 20% of workers miss more than 6 days of work annually, due to stress, and that 36% of employees identify "people problems" as causing the most stress at work ([ComPsych, 2019](#)). ComPsych's yearly surveys indicate that workplace stress varies for each individual. Workplace stress tends not to end at the completion of the workday, but rather to encroach into other areas of the worker's life. In other words, workplace stress can affect one's personal life as well as one's professional life. Workplace stress that is cumulative and not managed effectively can lead to workplace violence—not necessarily, but given the right combination of personal and environmental stressors, along with idiosyncratic characteristics and life circumstances of a particular individual, it might.

With workers experiencing an increase of stress within the workplace, the risk rises for the occurrence of violence. Workplace violence constitutes a physical, psychological, or emotional assault on a person that, in turn, causes mental or physical harm either intentionally or unintentionally. The Occupational Safety and Health Administration ([OSHA, 2019](#)) reported that more than two million workers a year experience workplace violence. [Turner \(2020\)](#) identifies four types of workplace violence. Type 1 is *criminal intent*. Criminal intent typically implies that someone who has no relationship with the business, or any of that business's employees, commits the act of violence; acts of terrorism and crime also belong in this category. An example of this is the 9/11 terrorist attacks, in which the terrorists hijacked the planes in order to commit other crimes. Type 2 involves the *customer/client*, in which a patron of the workplace commits the violent act. An example of the customer/client type is if a client attacks a counselor during a session. Type 3 is *worker on worker*, in which an employee is threatened, harassed, or physically harmed in the workplace by a past or present employee. For example, an ex-police officer, Christopher Dorner, was fired from his job and went back later to commit acts of violence against other police officers ([Kelly, 2013](#)). Type 4 is a *personal relationship*, in which the perpetrator has an association with an employee at the workplace and not the business. An example of this is the November 2018 Mercy Hospital shooting in Chicago, Illinois, in which a man murdered his ex-fiancée and two other people, who all worked at the hospital.

For the purpose of this section, we emphasize type 3, worker-on-worker workplace violence. This form of violence often is linked to workplace stress. Unbalanced workplace stress can lead to the development of poor social interactions, poor negative relationships with peers, poor production in work, poor mental and physical health, and poor personal relationship outcomes. Not treating workplace stress can compound underlying stress that then can lead to poor work productivity, animosity, anxiety, depression, and even death ([Murray et al., 2020](#)). Although there is a need for more research regarding the correlation between workplace stress and mass violence, it is important to monitor it and to be cognizant of the effects of workplace stress on employees, in order to help prevent mass violence events within the workplace.

Mass Violence in Institutional Settings

Violence in institutional settings continues to grow (e.g., [Cohen et al., 2014](#)). At surface, this has some overlap with the previous section, in that an institution is a work setting for those who work there. Yet we discuss these institutional settings, here, as having the characteristic of being public or semi-public spaces ([Parks et al., 2019](#)), which serve distinct functions, and in which people are not expecting to experience violence while conducting routine activities, for example, shopping at a grocery store, attending a religious service, and listening to music at a concert. We report on several specific incidents in this section, all mass shootings and all relatively recent.

Harvest Music Festival, Las Vegas, Nevada (10/1/2017)

The Harvest Music Festival was one of the deadliest shootings in modern American history. The tragic event left 58 people murdered and more than 850 more injured. The event occurred during a country music festival on the Las Vegas, Nevada strip. The shooting occurred from a high-rise hotel by a lone assailant. This event catapulted fears from many regarding the increasing risk of being involved in a mass shooting. The criminal investigation was unable to identify a motive for this event, leaving many unanswered questions.

Tree of Life Synagogue, Pittsburgh, Pennsylvania (10/27/2018)

The Tree of Life Synagogue massacre was one of the deadliest mass shootings within the Jewish community in American history. The shooting left 11 people dead and six people wounded. The mass shooting occurred at a Jewish synagogue where members were preparing for a baby-naming ceremony. The mass shooting was completed by one individual, who was captured and charged with the murders. After law enforcement officials completed their investigation, it was determined that the mass shooting was inspired by hatred and was classified as a hate crime.

Christchurch, New Zealand Mosque Shootings (3/15/2019)

The Christchurch shooting occurred at two separate mosques in New Zealand, the Al Noor Mosque and the Linwood Islamic Centre. The murders left 51 killed and 40 injured. The initial event was live streamed on the Facebook platform, leaving the world to see this horrific event. The shooter was a lone assailant, who was linked to an alt-right hate group. The assailant was captured and sentenced to life in prison. This event added to the growing fear of safety while worshipping.

JC Kosher Supermarket, Jersey City, New Jersey (12/20/2019)

The JC Kosher Supermarket shooting occurred in Jersey City, New Jersey. The mass shooting left five people dead. Two assailants, who carried out the shooting, were killed during the mass shooting event. Because the shooting occurred at a kosher grocery store, it was investigated as a hate crime.

Multiple Spa Shootings, Atlanta, Georgia (3/16/2021)

On March 16, 2021, a series of mass shootings, which targeted the Asian American population, occurred in Atlanta, Georgia. The mass shootings took place at three separate spas in Atlanta, leaving eight people dead and one other person wounded. At the time of this book being written, it is inconclusive whether these heinous murders occurred as hate crimes or were due to other insidious motives of the lone assailant. At this time, the assailant was captured and charged with eight counts of murder.

King Soopers Supermarket, Boulder, Colorado (3/22/2021)

The King Soopers Supermarket shooting in Boulder, Colorado, is one of the most recent mass shootings as of the time of this writing. The King Soopers Supermarket shooting left 10 people dead and an unknown number of people physically injured. The event occurred when a

lone assailant entered into a supermarket and opened fire on the patrons and on law enforcement. The investigation and motive for the shootings are still under review during the time of this chapter being written. The assailant was captured and charged with 10 counts of murder; the court procedures are ongoing.

Mass Violence at Universities and Campus Shootings

As an extension of the previous section, we continue the discussion of mass violence in an institutional setting, but in one that has some unique characteristics—that of the college campus. Unlike other types of institutional settings, in which people come and go freely and for differing reasons, in many ways universities share characteristics of both home and community. Students, and even some faculty members, live on campuses, as they would at home; similarly, while colleges are situated within a larger community, they share many aspects of a self-sufficient community.

Mass violence events may happen in any human-occupied space, including colleges and universities. In fact, we have seen a sharp rise of violence on college campuses ([Voice of America, 2019](#)). Between the years of 2010 and 2020, more than 50 mass violence events have occurred on a university or college campus worldwide ([The Violence Project., 2020](#)). [Shahid and Duzor \(2019\)](#) have reported the following:

On the morning of Aug. 1, 1966, Charles Whitman, a former Marine, stepped out on the observation deck of the University of Texas Tower and aimed his Remington bolt-action rifle at his first victims on the campus below. More than an hour after the shooting began, 15 people were dead and 31 injured. Among those was Claire Wilson, the first target, who was shot in the stomach. Wilson, who was eight months pregnant at the time, lost her unborn child and spent several months recovering in the hospital. The massacre ... wasn't the first mass shooting in modern U.S. history. But at the time, it was the deadliest, and marked a turning point in public awareness of mass shootings and shooters in the era of mass media.

The infamous Virginia Tech shooting, which unfortunately claimed the lives of 33 victims, including that of the perpetrator, was the deadliest college campus shooting in modern history. Seung-Hui Cho entered a residence hall on the campus of the Virginia Polytechnic University on the morning of April 16, 2007, where he shot and killed two students. Several hours later, Cho chained the doors of a classroom building and then opened fire on students and faculty members who were attending classes. By the end of that morning, 33 people were dead and another 17 were injured ([Virginia Tech Review Panel, 2007](#)). Since 2007, we have witnessed a surge in college and university campus shootings.

A recent campus shooting occurred at the University of North Carolina at Charlotte ([Peterson & Densley, 2019](#)) on April 30, 2019. The shooting originally left two people dead and four people injured. Although this latest school shooting is not technically a mass shooting, the event adds to the growing concern about mass shootings in public places. This shooting led to the arrest and conviction of the lone assailant. The assailant was sentenced to life imprisoned without the possibility of parole.

Although the prevalence of shootings at colleges and universities has increased in the last two decades, there is still a low probability that someone attending these institutions will be involved in a mass violence event. For a myriad of reasons, it is less likely for a mass violence event to occur on college and university campuses. One salient reason that this is less likely to happen is due to the policy frameworks at each institution. With the rise of campus shootings, there have been changes in policy on college campuses regarding firearm safety and monitoring on campuses. In addition, there has been more awareness across campuses, which has resulted in more people addressing their concerns to law enforcement to investigate. Also, these institutions have begun to create *disaster plans* in the event that a mass violence event does occur ([Peterson et al., 2015](#); [Weber et al., 2018](#)).

Known Characteristics of a Mass Violence Perpetrator

Understandably, when an incident of mass violence occurs, widespread media coverage underscores the enormity of such events ([Wormwood et al., 2019](#)). Yet the incidents of mass

violence remain relatively rare (Duwe, 2020). Because incidents are relatively rare, the need remains for collecting additional empirical evidence about the perpetrators of mass violence. The following common factors are identified in an American Psychiatric Association publication:

Factors common among individuals who commit mass murder include extreme feelings of anger and revenge, the lack of an accomplice (when the perpetrator is an adult), feelings of social alienation, and planning well in advance of the offense. Many mass murderers do not plan to survive their own attacks and intend to commit suicide or to be killed by police after committing their assaults. However, in a detailed case study of five mass murderers who did survive, a number of common traits and historical factors were found. The subjects had all been bullied or isolated during childhood and subsequently became loners who felt despair over their social alienation. They demonstrated paranoid traits such as suspiciousness and grudge holding. Their worldview suggested a paranoid mind-set; they believed others to be generally rejecting and uncaring. As a result, they spent a great deal of time feeling resentful and ruminating on past humiliations. The ruminations subsequently evolved into fantasies of violent revenge. (Knoll & Annas, 2016, pp. 84–85)

Perpetrators of mass violence certainly use multiple means to carry out their plans, but incidents of mass violence more typically involve guns (Peterson & Densley, 2019; Shahid & Duzor, 2019; The Violence Project, 2020; Voice of America [VOA], 2019). For this reason, we focus the discussion in the remaining part of this subsection on the known characteristics of mass shooters; this is emergent information, and thereby not intended to suggest the existence of a profile—as inferred previously, we do not yet have enough research-based information to formulate a definite perpetrator profile. Unfortunately, a prevalent stereotype of mass shooters as having a mental illness mischaracterizes and obscures the larger picture; a strong and enduring societal stereotype linking violence and mental illness simply is not supported by evidence (Levers, 2001). While some mass shooters may have a history of mental health issues, mental illness is not a singular causation (Shahid & Duzor, 2019). In the previously cited American Psychiatric Association publication, Knoll and Annas (2016) identify common misperceptions and evidence-based facts regarding mass shootings and mental illness. These are presented in Box 20.2.

BOX 20.2

From the Field

Common Misperceptions

- Mass shootings by people with serious mental illness represent the most significant relationship between gun violence and mental illness.
- People with serious mental illness should be considered dangerous.
- Gun laws focusing on people with mental illness or with a psychiatric diagnosis can effectively prevent mass shootings.
- Gun laws focusing on people with mental illness or a psychiatric diagnosis are reasonable, even if they add to the stigma already associated with mental illness.

Evidence-Based Facts

- Mass shootings by people with serious mental illness represent less than 1% of all yearly gun-related homicides. In contrast, deaths by suicide using firearms account for the majority of yearly gun-related deaths.
- The overall contribution of people with serious mental illness to violent crimes is only about 3%. When these crimes are examined in detail, an even smaller percentage of them are found to involve firearms.
- Laws intended to reduce gun violence that focus on a population representing less than 3% of all gun violence will be extremely low yield, ineffective, and wasteful of scarce resources. Perpetrators of mass shootings are unlikely to have a history of involuntary psychiatric hospitalization. Thus, databases intended to restrict access to guns and established by guns laws that broadly target people with mental illness will not capture

established by guns laws that broadly target people with mental illness will not capture this group of individuals.

- Gun restriction laws focusing on people with mental illness perpetuate the myth that mental illness leads to violence, as well as the misperception that gun violence and mental illness are strongly linked. Stigma represents a major barrier to access and treatment of mental illness, which in turn increases the public health burden. (Knoll & Annas, 2016, pp. 81-82)

Once we deconstruct the myths and stereotypes that long have been associated with psychiatric disability and focus on facts and evidence, we begin to see some common characteristics that mass shooters seem to possess. According to [The Violence Project \(2020\)](#), most mass shooters have the following four characteristics in common:

- Early childhood trauma and exposure to violence at a young age
- An identifiable grievance or crisis point
- Have studied the actions of past shooters and seek validation for their methods and motives
- The means to carry out an attack (cited in [Shahid & Duzor, 2019](#), "Mass Shooters (1966-2019)," p. 3)

It would seem that violence prevention and abatement programming, aimed at ending the various cycles of violence in our society, would be far more efficacious and fiscally responsible than continuing to support false narratives about mental illness being the cause of gun violence.

The Necessity of Having a Disaster Plan

Disaster plans are strategic frameworks designed to reduce the harmful and negative effects that occur when a mass violence event happens. Disaster plans represent action-based measures that aim to prevent or mitigate further harm; these practices serve as an action plan that can be carried out logically by first responders and other helpers called to the scene. Having a disaster plan in place helps to provide employees and staff with a blueprint for what to do if they are in a difficult and scary situation, such as a mass violence event. When a person is in a situation marked by high stress and fear, the disaster plan aids the individual in feeling more prepared; a well-crafted disaster plan also increases the likelihood of survival. Additionally, it provides a safe way to account for and locate all of the individuals who may be at risk. While all institutions' disaster plans are unique to their specific environments, the majority of plans include having an exit strategy, a rendezvous place, and a form of communication.

Previously, disaster plans focused on individuals waiting for law enforcement to arrive and to help them out of the situation; however, research has shown this to be ineffective ([Federal Emergency Management Agency \[FEMA\], 2015](#)). Disaster plans include getting out of the dangerous environment and to a safe location as soon as possible; a strong emphasis is rapid mobilization and movement to safety, and not waiting to do so. Having a disaster plan is essential.

TRAUMATIC RESPONSES AFTER A MASS VIOLENCE EVENT

The importance of deploying appropriate response mechanisms as immediately as possible, in the face of a mass violence event, cannot be overstated. During, immediately after, and in the hours and days that follow a mass violence event, effective professional interventions are imperative and can make the difference between a survivor's ability to cope and recover, versus reacting with continued anxiety and creating a greater potential for PTSD. This section focuses on the importance of post-violence debriefing along with the aftermath experiences of those most affected by the violence.

Post-Violence Debriefing

Post-Violence Debriefing

A critical need exists for conducting a post-violence debriefing after a mass shooting occurs. The post-violence debriefing helps to alert the public and law enforcement officials about what has occurred and how the shooting has been resolved. Reporting the accuracy of the mass shooting is integral to addressing the community and families that have been affected by the mass shooting. Debriefing helps by providing a sense of safety to communities and by decreasing the anxiety that people may be experiencing. Debriefing also provides an opportunity to develop a working alliance between law enforcement and citizens.

It is important to note that a post-violence debriefing should be conducted through multiple streams of communication, including text messaging, radio, TV broadcast, social media platforms, and all other available communications, in order to reach the most citizens. The debriefing should include ways to support those who have been affected by the mass shooting and those who are working to support the people affected. Research has found that the most useful debriefing strategies occur when support is provided within the first 24 to 72 hours after the event. The longer a person goes without support, the less likely it is that an intervention can be effective in minimizing long-term effects. Various ways to support those affected are discussed later in this chapter.

When developing a post-violence debriefing, it is important to use already-established community supports. Collaborating with known and familiar community agencies helps to increase recovery and to build resilience. Post-violence debriefing is a collaborative process that should make use of all of the available resources in the community.

Aftermath of Mass Violence

Mass violence affects individuals, families, communities, institutions, nations, and, given the preponderance of media and social media, the world. The impact of mass violence is felt not only by the individuals who suffer severe pain and loss of body parts or even loss of life, but also by other systems in the ecology within which the individuals interact. During the aftermath of mass violence, the plethora of situation-specific actors include the survivors, their family members,

peers, those who witnessed the violence unfolding, the first responders, and hospital staff members dealing with injuries and casualties. Exposure to mass violence might result in anxiety, trauma, depression, and a variety of other mental health symptoms and disorders (de Zulueta, 2007; Murthy, 2007). Thompson et al. (2019) highlight the point that even excessive media exposure to mass violence can cause extreme distress among the viewers/consumers of news.

Mass violence exposes survivors and witnesses to psychologically traumatic events in ways that might disrupt their capacity to share the experience (Gobodo-Madikizela et al., 2014). Langer (1991) reports that traumatic experiences might take on a sense of timelessness, and that they can be relieved in various ways. The traumatic experiences, to which individuals and communities are exposed, may be worsened by the physical, social, and psychological strains of situations involving mass violence (Frazer et al., 2017; Hobfoll et al., 2007) along with the destruction of resources, services, and support which can deprive them of the needed support to cope with the trauma (Hobfoll, 1998). Furthermore, people may be affected by the lack of safety within the area where the mass violence occurred as well as by the loss of a sense of meaning (Hobfoll et al., 2007). The case of Jadyn, presented in Box 20.3, offers an example of how someone may be affected by mass violence.

BOX 20.3

Clinical Vignette: The Case of Jadyn

The client, Jadyn, is a 23-year-old African American male from Chicago, Illinois, who presented for treatment after surviving a mass shooting in the southside of Chicago. The mass shooting event happened while Jadyn was working at a local restaurant. The mass shooting occurred when two assailants with AR-15's drove down the busy street, opening fire on the patrons of the restaurant. The shooting left six people dead and four others injured, including Jadyn's best friend. Although Jadyn was not physically injured during the mass shooting, he expressed excessive worry and anxiety associated with thoughts about the shooting. He reported having nightmares that have caused him to lose sleep. He also has developed anxiety attacks when entering public spaces. He expressed feeling paranoid when leaving his house but also feeling alone due to not engaging with peers anymore.

Reflection Questions:

- What is the client experiencing?
- How has the client's traumatic experiences shaped his thinking?
- What would you do to support the client in recovery?

Because mass violence is unpredictable, survivors feel emotionally distressed; they might present with complaints like anxiety and trouble sleeping, among others, and the distress may be acted out in anger, fear, resentment, and aggression. Such symptoms might manifest weeks or months after the mass violence event occurs. As mass violence is a collectively experienced pain, the suffering and trauma that comes with it might be a barrier to cultural and communal bonds (Gobodo-Madikizela et al., 2014). It is therefore critical that victims and survivors develop some narratives around it, in order "to reconstruct a shattered self, find a voice, reclaim a sense of agency, and construct meaning from traumatic experience" (Gobodo-Madikizela et al., 2014, p. 86).

SUPPORTING THOSE WHO HAVE EXPERIENCED MASS VIOLENCE

Due to the psychological, social, emotional, and physical pain and suffering that mass violence inflicts upon families and communities, there is a need for early psychological intervention to respond to the traumatic event. Early intervention is defined as "any form of psychological intervention delivered within the first four weeks following a major incident or disaster" (Pitkin, 2002, p. 44). Pitkin further states that although the timing of the intervention is critical, the content of the intervention is also important. The intervention should focus on providing emotional support, information, and a sense of control to the survivors. It should also aim to reduce the sense of isolation and help the survivors to connect with others who have experienced similar events. The intervention should be culturally sensitive and take into account the specific needs of the community affected by the violence.

disaster” (Ritchie, 2003, p. 44). Ritchie further argues that the timing and the type of intervention necessitate consideration of several factors, such as:

- The type of event;
- The population affected, including family members, peers, and first responders;
- The environment of the recovery efforts; and,
- The actuality of whether responders are locals or from outside of the affected area.

There is also a need to consider the ways in which some groups will be more vulnerable than other groups. These include wounded victims and those who have lost loved ones in mass violence incidents, and those with psychiatric disorders, as their symptoms might become elevated in response to the mass violence event (Ritchie, 2003). In addition, Dyregrov and Regal (2012) suggest that guidelines need to be followed, in order to ensure that help is tailored to the individuals, families, and groups to whom professionals reach out. Dyregrov (2003) identified the following principles for responding to mass violence: immediacy, proximity, use of expectancy, and flexibility. Response to any mass violence crisis should be timely to the event and to the people affected. Dyregrov (2003) further indicates that several important factors be considered:

- Magnitude of the event: Mass-scale situations, disaster, terrorism or war versus one person event
- Duration of event: Single-event trauma versus cumulative trauma, exposure time
- Type of event: Accident, violence, death, other loss
- Type of exposure: survivor of direct life-threat, bystander, family member, helper, and so forth
- Place of exposure: home, work, street
- Immediate reactions and recovery environment
- Cause: human or natural
- Resources available to help
- Personality, personal history, cultural background, training, resources and social network
- Expressed need for assistance (Dyregrov, 2003, p. 18).

Based upon a scoping review of the relevant research literature, Richins et al. (2020) concluded that early interventions also “support emergency responders following exposure to trauma when these are tailored to the needs of the population, are supported by the host organization, and harness existing social cohesion and peer support processes within a team or unit” (p. 1). Richins et al. (2020) also emphasized the importance of evaluation of early interventions, along with the delivery of emergency response services. In the remaining parts of this section, we offer discussion about relevant neuroscience considerations, multicultural and social justice implications, trauma-informed treatment strategies, and counseling implications.

Relevant Neuroscience Considerations in Mass Violence Events

Recent research has examined the psychological impact that mass violence has on those directly and indirectly involved with the event. Research has shown that the neurological response to mass violence is person specific; however, we can assume that, for most individuals facing danger, the autonomic nervous system (ANS) will engage, with a fight-or-flight response likely. Fear is a strong motivator, and in the event of experiencing and witnessing mass violence, all of the neurobiological mechanisms described in Chapter 2 of this textbook are likely to be engaged. With the ANS engaged, the affected person’s body, in a state of hyper arousal, may experience the release of glucose, rapid heartbeat, increased breathing due to lung dilation, increased blood pressure, increased alertness and sharper senses (due to more oxygen sent to the brain), muscular tension, increased perspiration, and a decrease in digestive activity. This sympathetic nervous system activity makes a fight-or-flight response more probable, and in the panic of trying to remove oneself from danger, the frightened person may not care about shoving another person out of the way. Conversely, if

frightened person may not care about shoving another person out of the way. Conversely, if parasympathetic activity is engaged, the person may shut down or collapse in fear, even fainting in response to the danger.

Any individual who perceives themselves to be in extreme danger is susceptible to a wide range of responses, including but not limited to fear, depression, anxiety, posttraumatic stress disorder (PTSD), increased risk of a substance use concern, problems with sleep, and survivor's guilt. These responses can be exacerbated, depending on the trauma exposure, pre-disaster risk factors, and post-disaster environment. SAMHSA (2017) has categorized the mental and behavioral health responses into three categories:

Acute phase: In this phase, it is critical to develop support and treatment from mental health clinicians. Psychological First Aid (PFA) is the most effective strategy during this stage. In this acute phase, survivors experience the initial stage of shock, disbelief, and denial.

Intermediate phase: This phase includes psychological distress, such as anxiety, depression, fear, inability to focus, panic, sleep disturbances, and feeling the need to retaliate. Although this stage can cause psychological distress and feel harmful, this stage is normal.

Long-term phase: This is a critical phase in which a person begins to develop positive or negative coping strategies that will have an impact on their lives, long-term. In this phase, if the negative effects are not treated, they may manifest into illness or mental health crises.

Ongoing research continues to examine the persistence of mass violence events. As more longitudinal studies are conducted, more long-term impacts can be evaluated. It is important to understand that mass violence has an impact on everyone, collectively and individually. Although there may be shared experiences following a mass shooting, every person may experience these heinous acts differently, depending on a number of individual factors, including but not limited to previous exposure to violence, family history, individual resiliency, and the availability of treatment after the mass violence event.

Multicultural and Social Justice Implications of Mass Violence

It is important to acknowledge and address that mass violence events are documented differently in communities of color. One example of such differential interpretation and documentation is the "Kettling" of peaceful protesters in communities of color (Human Rights Watch, 2020). Gang violence or crimes that are committed in areas with high minority populations are not included in outcomes or treated as areas of mass violence events. In fact, among databases, there is not a clear definition regarding what constitutes a mass violence event (Booty et al., 2019), thus excluding communities that are experiencing gun violence at a disproportionate rate. It is imperative to address gun violence in communities of color, and to ensure that these communities are added to the mass violence count, in order to develop a complete understanding of the impacts that it has on all community members (Frazer et al., 2017).

In the previously cited American Psychiatric Association publication, Knoll and Annas (2016) have emphasized the importance of exploring salient sociocultural factors involved in mass shootings, not the least of which is the narcissism and entitlement often expressed by the perpetrators, both at individual and cultural levels. Knoll and Annas have suggested the following interventions:

- Policies and laws should focus on those individuals whose behaviors identify them as having increased risk for committing gun violence, rather than on broad categories such as mental illness or psychiatric diagnoses.
- Public health educational campaigns should emphasize the need for third-party reporting of intent or concerning warning behaviors to law enforcement.
- Institutions and communities should develop specialized forensic threat assessment teams to evaluate third-party reports of potential dangerousness.
- Resources should be increased to provide enhanced education, beginning in elementary

- Resources should be increased to provide enhanced education, beginning in elementary school, with a focus on constructive coping skills for anger and conflict resolution, mental health, and mental wellness education. (Knoll & Annas, 2016, p. 99)

Trauma-Informed Treatment Strategies for Mass Violence Events

Mass violence continues to be explored, and treatment strategies continue to develop. For those who experience a mass violence event, the response will vary. Most survivors of mass violence events will not need additional support, beyond PFA. In fact, most survivors demonstrate resilience post-event. Early intervention outcomes should promote normal recovery, resiliency, and personal growth (Ritchie, 2003). As much as the focus is on the individual experiencing the trauma, it is critically important also to focus on the contextual component of the event (de Jong, n.d.). As illustrated by the bioecological framework, treatment or intervention can be offered at different levels, including the micro, meso, exo, and macro level systems (Bronfenbrenner, 1979, 1997; Bronfenbrenner & Morris, 1998; Bronfenbrenner et al., 1993). Involving all of the levels of the ecology ensures that all of those affected by mass violence, as well as those with whom they interact, can receive the necessary help (Frazer et al., 2017).

While most survivors develop resiliency, some may not. Further, in order to capture individual psychological vulnerability indicators, such as feeling safe in the present, being forced to move (de Jong et al., 2008), and experiencing a difficult recovery environment (Steel et al., 2009), strengths-based and somatic strategies are proposed. Similarly, Hobfoll et al. (2007) identified empirically supported intervention principles to guide and inform intervention for the survivors and witnesses of mass violence and other disasters. These include promoting the following: (a) a sense of safety, (b) calming, (c) a sense of self- and community efficacy, (d) connectedness, and (e) hope.

Another form of trauma-informed treatment is developing individualized plans that address the immediate needs of the survivor. Trauma-informed treatment focuses on addressing the traumatic event, that is, the mass violence event. PTSD treatment techniques have been found to be effective in addressing the longer-term concerns after a mass violence event. Therapy is a useful technique used to address the event, helping clients to learn skills, acknowledge the situation, and provide support. Eye Movement Desensitization and Reprocessing (EMDR) is a specialized therapeutic technique that is effective in helping to alleviate distress. For those who have severe PTSD symptoms, medication management is an option to help manage symptoms, as is acupuncture (Ding et al., 2020) and medical marijuana (Moss, 2018).

Counseling Implications for Responding to Mass Violence

Counselors play a pivotal role in addressing mass violence. Immediately following a mass violence event, counselors need to be present to assess the mental and physical needs of those involved as well as to assist the first responders. Counselors who are involved in traumatic events, such as mass violence events, should be trained in PFA. This foundational training provides insight into how to assess the situation, address the immediate needs, and be educated on the psychological impact of the event on those involved.

Counselors' assessments can help those involved in the event to navigate these experiences. Providing psychoeducation helps to increase the likelihood of a person affected by the event to develop resiliency. By offering their assistance, counselors can be among the first line of defense. Counselors help to provide effective coping strategies, consultations, support, and resources.

It is important for counselors to be aware of the impact that a mass violence event may have on their own mental health. Counselors have an ethical obligation to be cognizant of their own stress responses and the impact that this mass violence event may be having on them (Tarvydas et al., 2017). Counselors should monitor how much time they are spending at the trauma site, managing their own physical needs, such as food and rest.

CONCLUSION

Violence that is perpetrated by nongovernmental officials, and which is deliberate and happens across a large group or collective of people, is considered to be mass violence. Mass violence is a concern for us all, because it can happen anytime and anywhere. The insidious nature of mass violence is harmful, by definition. Although still rare, mass violence events have increased, exponentially, over the last century. Those who have lived through a mass violence event are at a higher risk of developing mental health concerns, such as PTSD, depression, or anxiety. Even those who have not lived through such an event personally, but have been exposed to the violence through the media, face the possibility of developing the same mental health concerns. It is important to address and to help minimize the potential for a mass violence event to occur. The goal is to not be reactive toward these atrocities, but rather to be proactive in preventing them from ever occurring.

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RESOURCES

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www.ovcttac.gov/videos/dspMV_Response.cfm OR
www.youtube.com/watch?v=5pNslcbJdP0

Center for Victim Research Webinar: Mass Violence and Terrorism Victimization: What Do We Know From Research? (2020; 1:13:44)

www.youtube.com/watch?v=lbtlaju_AOE

A History of Mass Violence: A KXAN Investigative Special (2019; 42:54)

www.youtube.com/watch?v=lx38AS_JVvg

Websites

The National Child Traumatic Stress Network

www.nctsn.org/what-is-child-trauma/trauma-types/terrorism-and-violence/mass-violence

Workplace Violence Toolkit

<https://nursesunions.ca/workplace-violence-toolkit-policies-resources-post-incident-support>

SAMHSA: Incidents of High Violence

www.samhsa.gov/find-help/disaster-distress-helpline/disaster-types/incidents-mass-violence

SAMHSA: Mass Violence and Behavioral Health (research bulletin)

www.samhsa.gov/sites/default/files/dtac/srb-mass-violence-behavioral-health.pdf

U.S. Dept. of Veterans Affairs: *The Impact of Disaster and Mass Violence Events on Mental Health*

www.ptsd.va.gov/professional/treat/type/violence_trauma_effects.asp#:~:text=Those%20affected%20by%20disaster%20and,stress%20disorder%2C%20and%20complicated%20grief

FBI: Active Shooter Incidents

www.fbi.gov/about/partnerships/office-of-partner-engagement/active-shooter-incidents-graphics

American Psychological Association: *What Happens to the Survivors*

www.apa.org/monitor/2018/09/survivors

Victim Connect: *Mass Violence*

[https://victimconnect.org/learn/types-of-crime/mass-](https://victimconnect.org/learn/types-of-crime/mass-violence/#:~:text=A%20mass%20violence%20event%20can,a%20large%20number%20of%20people)

[violence/#:~:text=A%20mass%20violence%20event%20can,a%20large%20number%20of%20people](https://victimconnect.org/learn/types-of-crime/mass-violence/#:~:text=A%20mass%20violence%20event%20can,a%20large%20number%20of%20people)

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www.nctsn.org/what-is-child-trauma/trauma-types/terrorism-and-violence/mass-violence

Workplace Violence Toolkit

<https://nursesunions.ca/workplace-violence-toolkit-policies-resources-post-incident-support>

SAMHSA: Incidents of High Violence

www.samhsa.gov/find-help/disaster-distress-helpline/disaster-types/incidents-mass-violence

SAMHSA: Mass Violence and Behavioral Health (research bulletin)

www.samhsa.gov/sites/default/files/dtac/srb-mass-violence-behavioral-health.pdf

U.S. Dept. of Veterans Affairs: *The Impact of Disaster and Mass Violence Events on Mental Health*

www.ptsd.va.gov/professional/treat/type/violence_trauma_effects.asp#:~:text=Those%20affected%20by%20disaster%20and,stress%20disorder%2C%20and%20complicated%20grief

eu/%20by/%20disaster/%20and,%20stress/%20disorder/%20/%20and/%20complicated/%20grit

FBI: Active Shooter Incidents

www.fbi.gov/about/partnerships/office-of-partner-engagement/active-shooter-incidents-graphics

American Psychological Association: *What Happens to the Survivors*

www.apa.org/monitor/2018/09/survivors

Victim Connect: *Mass Violence*

[https://victimconnect.org/learn/types-of-crime/mass-](https://victimconnect.org/learn/types-of-crime/mass-violence/#:~:text=A%20mass%20violence%20event%20can,a%20large%20number%20of%20people)

[violence/#:~:text=A%20mass%20violence%20event%20can,a%20large%20number%20of%20people](https://victimconnect.org/learn/types-of-crime/mass-violence/#:~:text=A%20mass%20violence%20event%20can,a%20large%20number%20of%20people)

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CHAPTER 21

School Violence and Trauma

AMY E. ALEXANDER AND LISA LÓPEZ LEVERS

CHAPTER OVERVIEW

This chapter examines the history and evolution of violence in schools and presents the various mental health and violence prevention theories and interventions that have developed and continue to emerge in the ever-changing landscape of the spillover of societal violence into spaces historically considered safe, such as American schools. This chapter delves into the

the discrepancies in response time and method, funding, and maintenance of follow-up in districts and communities that have fewer resources. Statistics regarding the occurrence of violence in public and private schools are presented, and strategies aimed at increasing safety are discussed. Brief and long-term counseling approaches are explored, and resources are offered online at Springer Connect.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Understand preventative measures that schools can incorporate, in order to reduce violent acts in school and at school-sponsored events;
2. Identify specific ways an anti-violence culture can be established via district goals and programming into school communities;
3. List agencies that provide information and assistance to schools and communities directly affected by school violence;
4. Identify contributing factors to student and staff feelings of safety within schools and at school-related functions; and
5. Recognize community resources and partnerships that can be engaged within schools to build connections and strengthen relationships.

INTRODUCTION

While school violence often may be perceived as a mass shooting or hostage situation, in which extreme conditions require extreme actions, this typically is not the situation. Often, school violence is comprised of insidious acts such as bullying, harassment, and fighting that weigh on the collective psyche and set the atmosphere of a school community. This chapter addresses some of the ways in which events that are commonly considered the quotidian occurrences of contemporary 21st century school life affect the culture and trauma responses of not only students, but also of teachers and other school personnel, as well as of the surrounding communities. We consider how things have changed regarding school safety and protocol, in light of an increase in mass school shootings and school violence throughout the history of American public education. We also look at what constitutes best practice when considering school evacuation and disaster plans and aftercare of individuals and communities. These aims are accomplished in the following major sections of this chapter: Providing Context: School and Campus Population Numbers, Violence in American Educational Settings, School Environment, Weapons, Emergency and Disaster Planning, and School-Based Interventions,.

PROVIDING CONTEXT: SCHOOL AND CAMPUS POPULATION NUMBERS

In the fall of 2019, approximately 50.8 million students were enrolled in public schools in America. Another 5.8 million were enrolled in America's private schools ([National Center for Education Statistics \[NCES\], 2020](#)). The numbers for public school enrollment and attendance over the next decade are expected to increase to approximately 51.4 million ([NCES, 2020](#)). In the fall of 2019, there were 3.2 million public school teachers and 0.5 million teachers in private schools across America. With the addition of 19.9 million college students during that same period, there were over 70 million students in America. The number of college professors in American institutions of higher learning totaled approximately 1.5 million in 2017 (Institute of Education Services, National Center for Education Statistics, [IES/NCES, 2020](#)). Combining all of these groups together equals over 75 million people engaged in school settings in America every day. These numbers do not include university administrators or service workers such as those engaged in maintenance, food service, medical, and custodial duties. These numbers represent those who potentially could be affected, directly, by some form of school or campus violence each year in America. In the

be affected, directly, by some form of school or campus violence each year in America. In the sections that follow, we flesh out the context for understanding school violence by looking at Violence in American Educational Settings, School Environment, Weapons, and Emergency and Disaster Planning.

VIOLENCE IN AMERICAN EDUCATIONAL SETTINGS

Violence in America is not new; we can identify numerous types of violence, including violence to control, violence to punish, and even violence to entertain. What is alarming about public school violence in particular is the mandatory, universal nature of the physical space. Because school attendance in America is compulsory, the ghoulish nature of any criminal or non-criminal act of violence committed in that setting is even more heinous. Certainly, school violence cannot be linked to one singular cause, as the complexity of our social fabric warrants more in-depth examinations of its roots as well as what sustains it. Even in an attempt to evaluate safer learning spaces for students and school employees, we must consider that there has been no period, in the history of America, in which parents and guardians could send their children to school with confidence in their safety and well-being (Midlarsky & Klain, 2005). Assurances simply have not existed that children never would suffer harm from violence by peers and teachers (Midlarsky & Klain, 2005). Considering the amount of time that learners spend in school and involved in school-related and school-sponsored activities, on average approximately 35 hours per week with 10 to 15 additional hours depending on extracurricular endeavors, parents and guardians should be able to have confidence in the societal systems that are in place and charged with keeping students safe.

Students are not the only demographic affected by school violence. There is a collective response to traumatic events within the entire school community, including teachers, administrators, parents and guardians, school counselors, school social workers, school psychologists, food service workers, bus drivers, custodians, maintenance workers, and security staff. We also must consider the neighborhood community and the greater geographical area. Most school districts employ a significant number of community residents, creating a kind of dual role of trauma response to violence that occurs in schools. This multilayered dynamic calls for a unique and well-thought-out approach to both interventions and postvention treatment.

School violence has other unique factors that have influenced its progression; this phenomenon actually began with the adults. *Teachers* are the originators of violence in schools. The focus on violence in schools typically has been on student behaviors, although "it is important to note that teachers also have long exhibited violent behavior" (Midlarsky & Klain, 2005, p. 46). In fact, the earliest recorded incidents of school violence have involved teacher-to-student violence, framed in what we often refer to as "corporal punishment" (Midlarsky & Klain, 2005, p. 46). Certainly, this form of school violence is not what first comes to mind when discussing violent acts in schools. However, we need to consider the history of human interaction within the school setting. It is necessary to parse out how we have arrived at our current perspective. As of 2005, only 27 states prohibited the use of corporal punishment in schools. Historically, the foundation of public schooling in America has been based on the Puritanical ideals of early colonists; therefore, a teacher's primary objective was to maintain class and societal order via physical discipline. It was believed that teachers were responsible for educating students to read the Word of God, in order to rescue their souls from evil and to ensure their eternal salvation. As society has evolved and become more religiously diverse, so has public education, and fortunately, violence in all forms is now unacceptable in most public learning spaces. Perhaps as we examine the proliferation of violence in schools, and attempt to explore treatment options for victims, we can glean some insights from history and use them to develop interventions that are more effective, along with devising preventative measures.

Where do school districts begin when attempting to establish or extend a climate and a culture of safety within the buildings themselves and at school-sponsored and school-related activities? Students spend most of their day in school. The physical space is where many eat breakfast, lunch, and dinner, in many cases. It is where they see their friends, establish

relationships, study math, and learn how to be a good citizen. School provides the foundation for some of the most memorable, long-lasting relationships with peers, as well as with adults. It is where many Americans grow into themselves and learn who they are apart from their family of origin, religion, and established family cultural norms. American school systems play a substantial role in the life and culture of all Americans; therefore, we need to feel and be safe in those environments. How, then, do school officials create a safe school environment while protecting the individual and collective psyches of stakeholders?

SCHOOL ENVIRONMENT

In 2018, there was, on average, close to one mass shooting in the United States per day (Campisi, 2018). Guns killed or injured more than 2,700 people under the age of 18 by October of that year (Campisi, 2018). In many cases, these deaths and injuries have been associated with a school shooting (Musu et al., 2019). Wherever people gather, public places constitute potential targets, and architects and designers of schools should be ever mindful of the safety concerns and precautions necessary in providing the safest space possible for schoolchildren and staff. Hellman (2015) amplifies the importance of addressing school building safety "by incorporating the principles of crime prevention through environmental design" ("Principles of CPTED," p. 1). There is an obvious correlation between school violence and school environment. The way in which the value or perceived value of the physical space is addressed, along with the environment, culture, and attitudes regarding the idea of education and the people who occupy those spaces together, are key components that contribute to school environment. Both built environment and school climate will be discussed in the text that follows.

Physical Building

Consideration of the physical spaces and structures of school buildings are crucial to being able to prepare for safety. Many school officials deeply believe that the physical environment is critical in keeping schools safe and that there must be a balance between safety and a welcoming calmness in design and layout (Campisi, 2018). The level of care for the physical building also lends to a safer environment. Daniels and Haist (2012, p. 336) have pointed out that, "Buildings that are clean and well cared for generally have lower levels of violence than those that are dirty and cluttered." According to architectural designer Jenine Kotob, who has helped design multiple school building projects in Washington, DC, schools can be designed for safety without feeling cold or like prisons (cited in Cimino, 2018). According to architects who specialize in school design, safe schools should have plenty of both natural and artificial light. Lighted spaces discourage student misbehavior and victimization, as well as provide practical elements needed for hallways, classrooms, computer labs, and other learning spaces. Safe schools should have integrated alarms and a public address system that reaches classrooms, offices, and hallways; safe schools also should have fewer access points. Additionally, parking areas, traffic patterns, and open-space areas, such as playgrounds, sports fields and courts, and other open spaces, should be planned and laid out carefully.

School Climate

The school climate is equally as significant to the school environment as the physical building. School climate generally refers to the social-emotional atmosphere within a physical school structure as well as the attitudes and beliefs of the communities in which the schools geographically exist (Osher & Berg, 2017). Having partnerships with other community stakeholders is paramount to establishing and maintaining a safe and positive school climate. Local police departments can serve as key supporters of positive, safe school climates. When officers have a good relationship with a school, they are more likely to know the campus and individual building layout, safety protocols, the student body, and school staff. Knowing the unique needs of the school district, knowing the students' mindsets, and understanding how they think are intricacies that could be of assistance, should officers need to intervene in

they think are individuals that could be of assistance, should officers need to intervene in occurrences within the school buildings and at other school-related events and activities.

Cohen et al. (2009) not in ref list. have defined "school climate" as "the quality and character of school life" (p. 182). According to the National School Climate Center (n.d., "How Do We Define School Climate?", p. 1), "School climate is based on patterns of students', parents' and school personnel's experience of school life and reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures." Based upon a review of the available research on school safety at the time, Daniels and Bradley (2011) identified dimensions of the social-emotional climate that interrelate with a safe school environment. They asserted that safe schools and communities typically possess the following five factors:

- Skills instruction
- Expected student behaviors
- Engagement with the community
- Student self/other awareness
- Positive adult interactions

Skills instruction is applicable and beneficial to both learners and school employees. Learners receive instruction in such life skills as communication, decision-making, problem-solving, conflict resolution, cooperation, self-control, and interpersonal relating. School employees gain from training in crisis response, quality teaching pedagogy, and other forms of professional development (Daniels & Bradley, 2011). *Expected student behaviors* are those that students are supposed to exhibit while at school and in attendance at school-sponsored functions and activities, often with interventions by school employees. Such behaviors include checks on undesirable behavior, consistent and fair consequences, well-defined guidelines and rules that must be followed, heightened observation and increased supervision, intolerance of disrespectful behavior, establishment and enforcement of clear rules and boundaries, investigating all gossip and acting on it in a timely manner, physical safety, and effective leadership.

The third element related to school safety is *engagement with the community* (Daniels & Bradley, 2011). This component of school safety is key and requires the school to engage, interact, and integrate with the community and other stakeholders, and to recognize the importance of extracurricular activities to unite the community. Outside resources such as think tanks, local organizations, police, and even architectural firms also can be helpful in safeguarding school communities, but it is important to involve the community itself in the move to create a secure school. For example, a significant part of an architect's process can be participatory design, which allows all relevant voices to have the chance to contribute. For instance, teachers typically ask about things like classroom door hardware and other practical aspects of the physical space itself. If the approach to school safety is holistic, various stakeholders are invited to be seated at the discussion table, in order to provide differing insights. Working with community members also means involving students, who can serve as ambassadors to report potential threats, and consultants in creating safety protocol, or another set of "eyes and ears" capable of talking to school officers when they do not feel safe (Musu et al., 2019). Schools often overlook students in the process, yet the insights that they can provide are invaluable.

The fourth component, *student self/other awareness*, relies heavily on understanding one's own and others' emotions, as well as the tenets of social, emotional, and ethical learning, as much as possible. Finally, the fifth component is *positive interactions with adult stakeholders*. This critical piece includes adults displaying genuine warmth and authenticity toward students as well as maintaining interest in the whole learner; serving as positive role models; engaging consistently in equitable treatment for all learners; establishing and reinforcing trusting relationships; breaking the code of silence, including reframing common accusatory language; and treating all with dignity and respect. Additionally, this component entails nurturing connections and relationships with all learners, along with providing emotional and social safety and respecting diversity.

WEAPONS

In incidents of violence in American schools, more people tend to think of firearms or knives as the weapons most often used. Although there are other items that have been reported as being enlisted as weapons in schools, such as scissors, letter openers, and chairs, the most lethal are guns and knives. According to the National Center for Education Statistics:

The percentage of students in grades 9 to 12 who reported being threatened or injured with a weapon on school property during the previous 12 months decreased from 9% in 2001 to 6% in 2017. The percentage also decreased between 2001 and 2017 for both male students (from 12% to 8%) and female students (from 7% to 4%). In each survey year from 2001 to 2017, a lower percentage of female students than of male students reported being threatened or injured with a weapon on school property. For instance, in 2017, approximately 4 percent of female students reported being threatened or injured with a weapon on school property, compared with 8 percent of male students. (NCES, 2019, "Indicator 4," p. 2)

With the proliferation of and easier access to firearms over the last several decades, school-aged youth are able to acquire guns more readily, whether legally or illegally. This more recent phenomenon further serves to complicate matters regarding school safety.

The previous 2017 statistics related to school violence reveal yet another aspect of the school violence discussion, that is, race/ethnicity and gender identity. In the same year, the percentage of students in grades 9 to 12 who reported being threatened or injured with a weapon on school property during the previous 12 months differed by race/ethnicity and grade level. Lower percentages of Asian American students (4%) and White students (5%) than of Black students (8%), students of two or more races (8%), and American Indian/Alaska Native students (14%) reported being threatened or injured with a weapon on school property (Musu et al., 2019). The percentage of Latinx students (6%) who reported being threatened or injured with a weapon on school property was lower than the percentages for African American students and American Indian/Alaska Native students. Lower percentages of 11th- and 12th-graders (5% each) than of 9th- and 10th-graders (7% each) reported being threatened or injured with a weapon on school property (Musu et al., 2019). Through various school surveys and commissions on violence in school, we also recognize that frequently students who bring weapons to school are responding to some sort of treatment they deem threatening, hurtful, or disrespectful in nature. Often, bringing weapons into the schools is a protective factor in the minds of those students who do it.

EMERGENCY AND DISASTER PLANNING

States have played a key role in the safety of schools. According to a *National Institute of Justice Report*, "States carry out a variety of activities to support school safety, including providing training, resources, and guidance to schools and school districts on topics that range from bullying to emergency operations planning" (Carlton et al., 2017, p. 2). However, the United States Government Accountability Office (USGAO, 2016) 2015 survey of 51 state educational agencies indicated that only 32 states required school districts to have an Emergency Operations Plan in place. According to the USGAO survey, a key strategy for schools—and even for businesses—to be able to respond effectively in an emergency entails having a specific plan for doing so. Typically referred to as an Emergency Operations Plan or EOP, this document outlines how a school will prepare for, respond to, and recover from an emergency. One of the earlier steps in developing an EOP is to form a planning committee that includes various school and community stakeholders. Such stakeholders might involve a school's administrators, teachers, counselors, social workers, psychologists, bus drivers, and security officers, as well as including community partners, like first responders, local emergency management staff, public health individuals, and the American Red Cross, as appropriate.

The designated team should establish a regular time to review, evaluate, and update the

school EOP, at least every 2 years, and provide regular training on the school EOP to staff and students. Experts recommend that such a plan should describe contingencies for natural and human-made disasters, such as earthquakes, tornadoes, floods, fires, and chemical spills, as well as for other potential crises (Dorn et al., 2004; Ewton, 2014). The EOP also should include contingencies for acts of violence, including intruders and active shooters (Carlton et al., 2017).

One way to prepare for emergencies is to incorporate real-world scenarios into school safety training. These types of exercises facilitate participant discussions regarding emergency policies and procedures, and their roles and responsibilities before, during, and after an emergency scenario. This helps to improve performance during an actual incident (USGAO, 2016). Schools should reinforce training through drills and other exercises that are appropriate for the school's culture and community. Schools should conduct operations-based drills for staff and faculty along with developmentally appropriate trauma-informed drills for students, in order to test procedures and skills. Schools should mandate at least one operations-based exercise annually and include community partners along with school employees. Afterward, schools should construct an After-Action Report, along with an Improvement Plan, laying out the changes that were made and why (resources are provided online; see end of the chapter for access information). Issues related to the importance of emergency and disaster planning are discussed in the text that follows and detail the following concerns: Treating Students Exposed to Violence, Effects of Violence on Survivors, and Influences of Trauma Response to Violence in Schools.

Treating Students Exposed to Violence

The significance of the methods used to diagnose and treat individuals affected by school violence is of great consequence and should not be minimized during emergency and disaster planning. When trying to determine the most effective and appropriate treatments for children affected by school violence, clinicians should be well versed in childhood and adolescent developmental stages, as well as being aware of the lived experiences, ethnic and religious considerations, and stress and trauma responses of the specific individuals. With regard to adults affected by school violence, clinicians should be professionally competent and keenly aware of ethnic background, religious and spiritual beliefs, any cultural and gender role considerations of the specific survivors in selecting appropriate counseling methods, and theories to incorporate. As we entertain the implications of treatment, we must consider the effects of school violence on whole communities as well as on individuals, risk and protective factors of survivors and other stakeholders, internal and external conditions that have an impact on treatment, and school and community-based intervention and prevention approaches.

Effects of Violence on Survivors

The effects of traumatic events on humans of any ethnic or religious background, gender identity, or age are complex, reflecting human intricacies, diverse lived-experiences, individual traits, and a host of other factors that affect our human journey. Often when we experience trauma in a collective form, the healing processes differ from those that we would undergo as part of an individual journey. Ideas about how humans have internalized and processed trauma events have evolved over the years and continue to evolve. As discussed in Chapter 1, "An Introduction to Counseling Survivors of Trauma: Beginning to Understand the Historical and Psychosocial Implications of Trauma, Stress, Crisis, and Disaster," the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (APA, 1980), was the first iteration of the publication to include trauma-related diagnostic criteria for posttraumatic stress disorder (PTSD). In subsequent versions of the manual, the definitions and criteria have expanded to include broader, more comprehensive scenarios and types of experiences, which extend to a more extensive swath of the population. These more inclusive criteria have resulted in a reduction of shame and embarrassment for those who might be apprehensive about seeking treatment for trauma related to school violence, thereby

apprehensive about seeking treatment for trauma related to school violence, thereby increasing the numbers of survivors who receive timely treatment and are able to begin the healing process.

In the interest of exploring how human development affects trauma responses, Bronfenbrenner's (1979) Bioecological Model of Human Development is enlightening. This model has posited the idea that human development and responses to trauma are influenced by more than our individual experiences, that they are interconnected with and affected by multiple social systems. Such an ecological-transactional perspective has allowed us to "situate the lived experiences of traumatized persons within the time and space of a relevant ecology in order to understand the trauma event as well as personal meaning making" (Levers, 2012, p. 7). According to Bronfenbrenner's (1979) ecological model, not only are our own lived experiences, cultures, religious beliefs, family traditions, and community connections indicative of how we respond to trauma, so is the chronological time frame, as well as the historical lens through which the event(s) has occurred. The most common responses that typically manifest, upon exposure to trauma, are anxiety and stress. Yet, those who experience trauma resulting from school violence are susceptible to adjustment, mood, sleep, and substance-related disorders as well. It then becomes important to explore how different manifestations of trauma emerge, depending on several internal and external factors present in survivors' lives, and how these factors influence responses to school violence.

Influences of Trauma Response to Violence in Schools

Generally speaking, schools are relatively safe spaces. Students are exposed to violence perpetration and victimization more frequently away from school property and events than they are at school (Ewton, 2014; Flannery et al., 2004). Despite this, students still report experiencing violence at school as witnesses more often than as victims; they also report experiencing violence in their neighborhoods and homes, depending on demographics, at a higher level than at school, even considering the high-profile school incidents of mass violence over the last 20 years (Musu et al., 2019). These factors, along with some additional considerations, influence how any individual may internalize traumatic events and what, if any, potential disorders may emerge as a result.

People, particularly younger children, who experience victimization from persistent violence suffer from higher levels of depression, anxiety, and self-doubt. Although there have not been vast amounts of research, historically, that focus on the impact of exposure to violence at school (Flannery et al., 2004), this area of research has expanded in recent years (e.g., National Institute of Justice, 2016). It further can be inferred that much of the existing research regarding violence and trauma reasonably can be applied to school violence as well. Differences in how individuals and groups process responses to violence depend on previous exposure, type of violence, whom the victim is, the victim's relationship to the perpetrator, developmental stage, any risk and protective factors present, and the perceived life threat. Risk and protective factors also are linked to cultural traditions and beliefs within some ethnic groups. Religious and spiritual beliefs, gender roles, value of familial ties, and strength of community connections are all potential risk or protective factors for victims of school violence, depending on the role they play in individuals' lives or collectively to a group.

Unique to the risk and protective factors related to school violence and trauma is the teacher-to-student ratio. Often, students feel physically safer in school spaces and are more likely to seek out adult help from school counselors, teachers, administrators, or other adult school personnel when there is sufficient staffing. The number of adults within a school building has a direct effect on the level and number of violent incidences that occur, thus influencing the intensity of the trauma response. Research also finds that the building size and design play a part in feelings of safety among students (Campisi, 2018; Carlton et al., 2017; Hellman, 2015). This, again, can influence trauma responses and the ability of an individual to heal, as safety concerns affect levels of anxiety and depression. The larger, more populous schools tend to record more violent incidents than smaller schools with fewer students to look after. Another possible risk factor, which operates within schools and is

especially difficult to assess, is the lack of staff members who understand and respect cultural differences. A lack of understanding often is interpreted as a lack of empathy that might interfere with the ability of students and community members to move on from violent events within the school. The myriad factors that influence an individual's or group's trauma response to school violence are also indicators of what treatment interventions could work best in the healing process.

SCHOOL-BASED INTERVENTIONS

School personnel and outside consultants should be cognizant of the impact that exposure to school violence has on student achievement; academic interest and decline; behavior; relationships, particularly those formed and nurtured at school; and on overall mental health. Evaluations of survivors, perpetrators, and witnesses (adults as well as students) should be conducted to determine the level of intervention needed. Once triage is done, more specific treatment plans can be discussed and implemented. Intervention and treatment methods suggested to schools should address the particular needs of witnesses to school violence as well. Witnessing school violence such as fights, sexual assault, and threats also can have negative and severe repercussions, depending on the rates and persistence of exposure. While ethnicity may be a factor in developing and instituting specific culturally sensitive interventions for trauma that results from school violence, research shows that developmental processes, levels of academic achievement, and IQ play substantial roles in intervention outcomes (Flannery et al., 2004; Hellman, 2015). Treatment for the perpetrators or bullies also is paramount, as students who bully peers are shown to have been influenced by violence previously, whether as victims or witnesses (Estévez et al., 2009, p. 478). In this section, we explore the following intervention strategies: debriefing, long-term counseling interventions, and identifying the counseling implications of school violence and trauma.

Debriefing

Incidents of school shootings and hostage takings have become more prevalent in the last 20 years; however, there is still a lacuna of research regarding treatment for survivors exposed to such occurrences. Numerous studies have been conducted on trauma responses to other forms of single-incident violent events such as physical and sexual abuse. It is worth noting that survivors, particularly children, of any violent exposure who develop pathological responses to trauma tend to do so regardless of the type of violence or trauma experienced. Therefore, a number of interventions can be adapted to many types of traumatic exposure. There are two types of debriefing typically implemented with regard to violence exposure in schools: psychological debriefing and critical incident stress debriefing (CISD). Psychological debriefing is a single-session individual psychological intervention that involves reworking, reliving, or recalling the trauma and subsequent emotional reactions (Szumilas et al., 2010). It also can be applied to group formats, and "is designed to prevent negative psychological responses to the traumatic event" (Daniels & Haist, 2012, p. 341). Although CISD was designed for workers in high-risk occupations, such as police officers, disaster workers, and firefighters (Barboza, 2005), it has been adapted to use as a debriefing option in school violence incidents. Because of the sudden and unexpected nature of a critical incident, there are varying ideas about what types of events qualify as critical incidents.

Aucott and Soni (2016, p. 86) describe a critical incident, in part, as "a sudden and unexpected event that has the potential to overwhelm the coping mechanisms of a whole school or members of the school community." The aim of CISD is to reduce initial distress and to prevent the development of more severe psychological responses, including PTSD. The focus of CISD is threefold: (a) promoting emotional processing through allowing individuals to express reactions, (b) preparing individuals for possible experiences following a critical incident, and (c) identifying individuals who may require further intensive intervention (Mitchell & Everly, 1995, as cited in Aucott & Soni, 2016).

CISD is a psycho-educational approach that explores the cognitive and affective domains of an experience. Because CISD was not initially developed to be implemented in schools, there

an experience. Because CISD was not initially developed to be implemented in schools, there is little research either to support or to refute its effectiveness in a school setting. In the absence of empirical evidence, it is helpful to consider the underlying theoretical assumptions of CISD and the extent to which these would deem it an appropriate intervention to use with school staff. Therefore, literature from the general field of bereavement and loss has been drawn upon to give insight into the appropriateness of CISD in this context. Some advance the option of using the practical elements of CISD, such as teaching and re-entry, as they offer support in assisting participants to manage or cope with the critical incident. CISD also promotes a sense of control, encourages social support, and provides information regarding when and how to seek additional support (Morris & Block, 2012, as cited in Aucott & Soni, 2016). For example, support could be requested that equips survivors with additional knowledge and resources needed to help others who may seek their assistance (Aucott & Soni, 2016). It also is worth noting that debriefing of any sort is not therapy. Debriefing is intended to de-escalate any possible progression of symptoms, resulting from a violent exposure, which might spiral into more serious or pathological issues.

Long-Term Counseling Interventions

A certain number of survivors of school violence exposure incidents are likely to need more comprehensive therapy than just debriefing. There are varying options for such individuals,

depending on the severity of any pathological indicators that emerge as a result of the event(s). We also need to consider the survivor's race and ethnicity, religious and spiritual needs, sexual orientation and identity, previous trauma experiences, other mental health concerns and diagnoses, and any additional lived experiences that might affect therapy. Schools can be systems that operate as unifiers and support within communities by providing "insulation" to children from violence, helping to minimize the effects, and teaching nonviolent methods of coping and behaving (Garner, 2014, p. 489). A contributing factor of recovery and maintenance after exposure to violence within schools is either to provide ongoing therapy within the school setting or to support out-of-school interventions.

Various counseling theories have been used with violence-exposed populations including play therapy, solution-focused brief therapy (SFBT), cognitive therapy (CT), rational emotive behavior therapy (REBT), and cognitive behavior therapy (CBT) (Daniels & Haist, 2012; Levers, 2012). Despite which form of therapeutic intervention is used with survivors of school violence, timely delivery of evidence-based treatment (EBT) with "trauma-related mental health sequelae is critical to prevent negative consequences of trauma exposure" (Dorsey et al., 2017). While there are multiple forms of CBT, a more commonly implemented version, when addressing child and adolescent violence exposure trauma, is trauma-focused cognitive behavioral therapy (TF-CBT). This form of therapy facilitates the involvement of parents and guardians in the process and includes some conjoint sessions (Dorsey et al., 2017). Most sessions are separate, incorporating the same therapeutic elements with parent/guardian and child. The elements include psychoeducation regarding violence exposure as trauma, PTSD coping skills, imaginal exposure, in vivo exposure, and safety skills training (Dorsey et al., 2017). Therapeutic elements such as parenting skills are added, eliminated, or limited, based on specific characteristics of the parent(s)/guardian(s) and child such as age and comorbidity. Children, in particular, who had overt exposure to elements of the trauma experience in TF-CBT, via talking about them or confronting triggers, experienced lower levels of fear associated with thinking and talking about their trauma experience (Dorsey et al., 2017).

Risk reduction through family therapy (RRFT) integrates TF-CBT and multisystemic therapy principles with other evidence-based interventions to address comorbid PTSD, substance abuse, and risky sexual behaviors. This form of treatment resulted in lower levels of substance abuse but not in risky sexual behaviors (Dorsey et al., 2017). Although used with only a small sample size, this form of treatment could be considered an option for school violence survivors who also are susceptible to comorbidity. In addition, some headway has been made regarding the use of individual CBT with parent involvement among culturally diverse children and adolescents, thus making it more desirable as a treatment option for those exposed to school violence and resulting trauma.

Cognitive behavioral interventions for trauma in schools (CBITS) is a form of group therapy that is implemented within the school facility and does not extensively include parent/guardian participation. Because CBITS occurs on school grounds and is comprised of other students of the same age range, teachers and other school personnel are included in the psychoeducational aspect of the process, which, in many ways, helps to form a cohesive school community and assists in strengthening the support system and the process of healing. This type of therapeutic process encourages participants to examine their thoughts, concurrent with the event, via a story-like construct called the trauma narrative, which can be written or drawn by the participants or dictated to an adult educator participant. After additional examination of the narrative by the student and educator, the child shares it with a parent or guardian to facilitate future awareness and communication. It is worth noting that CBITS has been tested with culturally and ethnically diverse populations from its inception, providing greater confidence regarding its effectiveness with youth beyond a White, middle-class population.

Jordan (2003) has developed a trauma and recovery model for those affected by a school shooting. She has termed such shootings as "catastrophic," indicating that the focus should be on behavior, cognitive dimensions, and the need to examine the psychological effects on the school, the students, and the needs of those affected. In analyzing the importance of this

model, [Shaughnessy et al. \(2018, p. 7\)](#) have stated that, "Often the impact of a school shooting is not clearly understood and all too often the responses of those impacted are not extensively investigated or recognized or validated." As a relatively new phenomenon, school shootings often are misunderstood and not properly dealt with, and as is so often the case with psychological interventions, Jordan's model was based on a middle-class, White population and cannot necessarily be implemented successfully with more diverse populations ([Daniels & Haist, 2012](#)). Also emblematic of the knowledge gap regarding school violence exposure incidents, there is no prescriptive regarding perpetrators. To date, neither researchers nor clinicians has developed a comprehensive therapeutic intervention designed specifically to address the unique issues surrounding school shooting incidents.

EMDR generally incorporates coping skills, cognitive restructuring, imaginal exposure, and simultaneous bilateral sensory input (eye movement) and is individual in structure ([Dorsey et al., 2017](#)). EMDR has been regarded as similarly effective when compared to CBT. Individual integrated therapy for complex trauma (ITCT-A) amalgamates various theories such as attachment, developmental, family systems, and CBT within a complex trauma framework, which is defined by "cumulative poly-victimization" that is interpersonal in nature and involves "direct harm, exploitation, or neglect/abandonment by caregivers" ([Dorsey et al., 2017, p. 13](#)). Survivors who could benefit from this form of therapeutic intervention typically are considered to have more severe impairment issues and higher psychiatric comorbidity. While there are multiple forms of therapeutic intervention that are considered effective with those exposed to school violence, we remain mindful that all interventions should be geared toward the specific individual or group and should address culture and ethnicity, gender identification and sexual orientation, religious and spiritual issues, and lived experiences. Therapy is a personal experience and not something that can be implemented *en masse*, based on general commonalities.

A few additional therapeutic methods are worth mentioning, as they relate to exposure to school violence. These include individual client centered play therapy, groups creative expressive + CBT, and music therapy. The latter, music therapy, has been used to reduce anxiety, on both psychological and neurobiological levels; it is generally believed to support positive identity formation, and has been used by many ancient cultures for healing ([McFerran & Wöfl, 2015](#)).

Counseling Implications

Considerable evidence regarding the efficacy of psychosocial treatments for youths with mental health symptoms related to trauma exposure provides sufficient verification for CBT as the first-line treatment approach ([Dorsey et al., 2017](#)). However, the lacuna of research on therapeutic interventions appropriate for those who have experienced or will experience school violence exposure reflects the lack of professional options available to clinicians. The literature identifies some common elements across interventions and in the highest evidentiary levels of individual treatment options; these include a psychoeducational component, emotion regulation strategies, imaginal exposure, in vivo exposure, cognitive processing, and problem-solving ([Dorsey et al., 2017](#)).

Counselors and other mental health and education professionals should make themselves familiar with the signs and symptoms of traumatized youth and manifestations of pathology. Keeping in mind that the more prompt the intervention, the more likely students and other school community members with trauma due to violence exposure can recover, therapeutically speaking. The evidence supports a brief intervention for all and a follow-up assessment to determine who would benefit from treatment that is more comprehensive. The school-as-community has been shown to be a helpful perspective in recovery. The "insulation" that the school can provide as a significant piece of the therapeutic puzzle is helpful in reducing anxiety, depression, and other sequelae of violence exposure trauma. As the school is an integral part of culture and is essential to how societies function, it should be a safe space for all who enter its doors. Unfortunately, that is not the reality of our current existence. Therefore, we must prepare and educate ourselves as to how we react to any forms of violence that occur within school walls. Teacher-to-student violence, student-to-student

of violence that occur within school walls. Teacher-to-student violence, student-to-student violence, gun violence, sexual assault violence, bullying violence, and cyber violence are all unacceptable, and educators should be equipped with the proper tools to combat the internal and external factors that influence the onset of violent tendencies where possible. Support systems play an integral role in recovery, and schools provide a stable environment for students for an overwhelming amount of time. Not every student is afforded a safe and stable home environment, and for these students, their teachers, school counselors, food service workers, school bus drivers, administrators, and school resource officers play an even more significant role in everyday life and even more so in the recovery from violence exposure events. [Box 21.1](#) offers a real-world illustration of violence which erupted at one high school; the event was highly publicized, locally, nationally, and even internationally. [Box 21.1](#) is followed by a case analysis and then additional related information from the field in a subsequent box.

BOX 21.1

From the Field: High School Mass Stabbing

In April 2014, a 16-year-old sophomore stabbed and slashed 20 students and a security guard in an incident labeled as a mass stabbing in which 24 people (stabblings and other injuries) were counted among those injured ([National Public Radio \[NPR\], 2014](#)). After hearing of this incident at a nearby public high school, I heard from many of my students, who are demographically just about the polar opposite of those in the predominantly White, middle-class district where the mass stabbing occurred.

Many students with whom I had discussions about this incident, along with other notable instances of school violence, could not absorb how a high school student could attack fellow classmates at school. Many were more emotionally affected than they thought they would be, as they did not know the attacker personally nor any of the victims. Together, we were able to explore the idea of secondary trauma, make sense of our fears, and begin to comprehend how we are affected by trauma that seemingly is unrelated to us. These discussions helped us to understand better that we are all connected in ways that we might not realize until a trauma event occurs.

Reflection Questions:

- How might you begin to think about immediate student response to violence as this played out in the hallways?
- How might you begin to think about teacher response to violence in the present moment?
- How might you begin to conceptualize the chaos that would have been sparked by the initial and then the following stabblings?

Franklin Regional School District, where the event took place, is located in a municipality about 20 miles east of the city of Pittsburgh. The demographics on race breakdown are as follows: White 92% to 95%, African American 0.61% to 1.1%, Asian 3.28% to 5.0%, Native American 0.0% to 0.05%, Latinx of any race, 0.56% to 1.3% ([Sperling's Best Places, n.d.](#)). The racial demographics are included here to illustrate several points on school violence and our perception of it as well as to show the contrast between the district in which the first author of this chapter works and the district where the mass stabbing took place. Such data are germane in assessing the ability of some districts to respond to school violence in any form.

The preventative measures, the therapeutic and law enforcement interventions, and the ability to establish a safe school culture and environment are directly linked to the financial outlook of a community and school district. As with all other aspects of public education, the more affluent a district is, the better is its ability to be proactive in staving off acts of violence as well as to respond with sustained, quality response interventions. For purposes of illustration, we compare the district where the stabblings occurred, the Franklin Regional School District, with another nearby school district. The Penn Hills School District is located in the municipality of the same name, bordering the city of Pittsburgh to the east. Penn Hills

in the municipality of the same name, bordering the city of Pittsburgh to the east. Penn Hills is the second largest municipality in Allegheny County, Pennsylvania, smaller only than Pittsburgh. In stark contrast to Franklin Regional School District, the Penn Hills School District has a student population comprised of 70+% African American and another 2.5% to 3.0% of other ethnic minority students. The reader can recall the variations in services provided when race, gender, and economic status are considered, as these relate to the occurrence of and response to school violence, which vary significantly in comparison to districts that are more financially stable.

Fortunately, the Franklin Regional School District was able to enlist their many resources to help in responding to this tragic event. A few miles away, in the Penn Hills School District, as in most nearby districts and neighborhoods, learners and educators were shaken by the news of what happened at Franklin Regional High School. The incident opened up room for discussions and expressions of fear and some feelings of helplessness. While there is no conclusive data on the causes of school violence, "the level of economic development, as measured by the GDP (gross domestic product) per capita, is reported to be related to school violence" (Diagne, 2009, p. 138). Additionally, GDP has been found to be a major variable that significantly is associated with rates of school violence once national characteristics of schooling have been controlled for. Socioeconomic status (SES), as indicated by students who received free or reduced school meals and by the parents' occupation, also may be related to school violence. Numerous studies citing income inequality have found that countries, states, or neighborhoods that are less equal in wealth have higher rates of violent crime, including homicide. Therefore, it follows that school districts like Franklin Regional are more capable of responding to school violence in ways that are comprehensive and long-term, whether the violence occurs on their own property or in neighboring districts. In [Box 21.2](#), the first author of this chapter discusses her response to the mass stabbing that occurred at the nearby school.

BOX 21.2

From the Field: A School Counselor's Response to School Violence

Much of what was expressed to me reflected a sense of disbelief. As a school counselor, I not only was responding to the fears and feelings of confusion and helplessness from students, but also from other educators, parents and guardians, community members, and a host of other stakeholders around this event. Feelings centered on the following concern: "We don't believe anything like this particular incident would occur in our spaces but, other forms of violence can and does." While our understandings of trauma continue to evolve, the evidence is pretty clear that distal trauma can and does have a serious impact. For example, most of us can think of where we were on September 11, 2001, when a terrorist attack took down the World Trade Center in New York City. Even people who were geographically distant from that area were likely to have been affected deeply by the occurrence. If individuals had no relative or other loved one lost to the events of that day, most still felt the pain and anguish of loss. The same is true of school violence; the fact that an incident did not occur in one's presence or own physical space does not eliminate the possible effects on those individuals or groups.

In the building in which I work, we were able to deconstruct and make meaning of our feelings of vulnerability related to the nearby school violence and then connect them to the real and perceived threats that we face daily and the stress and anxiety that they produce. Aware of risk factors and vulnerabilities, we leaned into the protective factors that we routinely experience, like a strong community and school presence. Mass shootings and stabbings, such as the ones that dominate news coverage, were not the source of my students' main fears. Rather, it was their lived experiences of community, neighborhood, and home violence that emerged as triggers in their quotidian lives.

Reflection Questions:

- If you were a school counselor working with the children described, how might you respond in the immediacy of the school violence?

respond in the immediacy of the school violence?

- If you were a clinical mental health counselor to whom any of the previously described children were referred, how might you begin to think about a longer-term plan for ongoing counseling?
- If you were a marriage and family counselor, and the family of one of the previously described children came to you for counseling, how might you begin to think about addressing the counseling needs of the family?

While not much research exists on the full range of effects of various forms of school violence, other research strongly connects the everyday struggles of pervasive violence to higher incidences of anxiety, depression, inability to concentrate, addiction, predilection for adultification, and other sequelae of economic and cultural disadvantage and marginalization. Essentially, most students in urban and urban-like schools do not fear the mass shootings many associate with school violence in the 21st century. However, those occurrences may cause other trauma-related symptoms to emerge and affect schoolwork, the level of school violence that is acceptable to or normalized by learners as participants and bystanders, and other trauma-related symptoms.

Students have greater access to media and video from all over the world than ever before.

The chance that a majority of them will indeed bear witness to some form of school violence and its repercussions is extremely high. Within schools and their larger communities where violence occurs, everyone experiences manifestations of the trauma in differing ways, forms, and levels of intensity. It is imperative that we, as a nation and as citizens of the world, act preemptively and comprehensively, in all ways possible, to combat school violence in all forms, in all types of schools, and in every kind of manifestation. We need to protect our learners from the ramifications of experiencing such violence and from passing those manifestations on, into the future.

CONCLUSION

We live in a technology-driven society, and it is important to remember that, with the increase in the visibility of violent attacks on school properties, visuals can be sent around the world within moments, for all to see. In addition, interactions initiated via social media can be played out on school grounds, when those involved are gathered in a single physical space, thus increasing the number of possible altercations. In this sense, not only are the specific communities affected where such events take place, but people in other places around the world who are able to see the violence via technology may be as well. While technology may be positive in many cases, it also can increase the number of victims affected by a school violence event—an event that is hundreds or even thousands of miles away from where they actually live. This adds to the burden of school districts and employees of all schools to implement programs that address healthy ways of confronting anger and other feelings that could lead to violence.

As we attempt to develop more therapeutically appropriate interventions that are specific to school violence exposure trauma, we need to be mindful that distal trauma also can be an area for future examination. Additionally, multiple school plans and therapeutic interventions incorporate school counselors and other school staff into the treatment plan without any consideration that those school employees are also members of the school community and could very well be suffering from exposure to school violence events. We must consider the community make-up and norms, including socioeconomic status and ethnic and cultural traditions as well as any other aspects of the community that would have an impact on the types of therapies offered and implemented, in addition to the appropriate trauma- and event-specific interventions. Perhaps most significant in the quest to combat school violence, violence exposure, and the resulting trauma pathologies is comprehensive, district-specific, and appropriate plans to educate students and families about therapeutic interventions prior to violent events. If schools were able to prevent acts of violence and educate citizens about healthier means of dealing with feelings of anger, isolation, and fear, perhaps we would need

healthier means of dealing with feelings of anger, isolation, and fear, perhaps we would need fewer interventions on the other side of violence, because there would be fewer acts of violence.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Ready Kids

www.ready.gov/kids

Federal Emergency Management Agency (Items Related to School Violence)

[https://search.usa.gov/search?](https://search.usa.gov/search?utf8=%E2%9C%93&affiliate=fema&query=school+violence&commit=Search)

[utf8=%E2%9C%93&affiliate=fema&query=school+violence&commit=Search](https://search.usa.gov/search?utf8=%E2%9C%93&affiliate=fema&query=school+violence&commit=Search)

TRIPwire—IED Incident Information-Sharing Portal

www.schoolsafety.gov/resource/tripwire-ied-incident-information-sharing-portal

Department of Homeland Security

School Security and Resilience Video (YouTube video)

www.youtube.com/watch?v=Kz3Gs4hAiBM

Cybersecurity and Infrastructure Security Agency (CISA)

This agency provides information geared toward educators, school resource officers, and school administrators who serve in important roles in safeguarding schools. The following videos are some of the resources that they offer:

CISA Videos:

School Security and Resilience

www.youtube.com/watch?v=Kz3Gs4hAiBM

Active Shooter Emergency Action Plan www.youtube.com/watch?v=8Pjlr2rrEZc

Active Shooter Preparedness and Response Training: The Campus Setting

www.youtube.com/watch?v=yKKW4lywv40

U.S. Department of Education

The U.S. Department of Education offers the *Institutional Resilience and Expanded Postsecondary Opportunity* (IREPO) program, which is designed to help institutions of higher education emerge from the Coronavirus pandemic more resilient and expand educational opportunities for students.

<https://www2.ed.gov/about/offices/list/oep/heerfirepo.html>

Department of Education

This guidance helps teachers and school personnel identify behaviors and other signs that could result in youth violence.

Office of the Ohio Attorney General: Threat Assessment Training Videos

State Agency.

This video training series includes 10 segments with guidance from local, state, and national

experts in law enforcement and education on incorporating threat assessment in schools.
www.ohioattorneygeneral.gov/threatassessment

REMS TA Center Toolkit Training By Request

Department of Education: This website hosted by REMS TA Center offers free training by request for state education agencies, schools, or school districts.
<https://rems.ed.gov/virtual-toolkit/training-by-request.html>

Schoolsafety.gov: This site offers resources to create a safer school.
www.schoolsafety.gov

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