The September 11th tragedy: Effects and interventions in the school community

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THE SEPTEMBER 11TH TRAGEDY:

EFFECTS AND INTERVENTIONS IN THE SCHOOL COMMUNITY

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

by

Julia Ellen Westcot

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ABSTRACT

The terrorist attacks to the World Trade Center and the Pentagon on September 11th, 2001 shocked the nation. In the aftermath, uncertainty about the nation’s future and personal safety were predominant in the minds of citizens. This study surveyed the post-traumatic reactions to the tragedy in some of our youngest citizens at local elementary schools. It also explored the variety of interventions used by three schools to help students process the incident.

Significant correlations were found between both the use of interventions and overall attention given to September 11th topics and the overall level of observed symptoms. Also significant was the relation between administrative encouragement and both attention given to the various related topics and the use of interventions. No effect was found for gender nor grade level on observed symptoms.
ACKNOWLEDGMENTS

I would like to thank Dr. Dan Reed, and Dr. David Long, and the schools sampled for their cooperation and participation in this study. I would also like to thank Dr. Rosemary McCaslin, Dr. Matt Riggs and Timothy Thelander for their advisement and support on the study. Finally I would like to express gratitude to Kristin Anthony-Mahler, John Preble, and Dr. Raymond Liles for their encouragement and emotional support.
DEDICATION

This study is dedicated to all the families, friends, and loved ones of the victims of the September 11th tragedy and any related incidents. May all those whose lives have been affected by this tragedy remember the emergent feelings of community and the united spirit that arose from the nation and never feel that they are alone in their sorrow or their healing.
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CHAPTER ONE
INTRODUCTION

The contents of Chapter One present a proposal of a project studying some of the effects of the September 11th Tragedy on elementary school children in Southern California. The significance of the study, policy regarding crisis intervention and counseling in schools, and current social work practice context are discussed followed by the purpose of the study. Finally, the significance of the project for the profession of social work is presented.

Problem Statement

On September 11th, 2001, a frightening series of acts of terrorism were inflicted on America. Terrorists hijacked four airplanes, two of which were flown into the twin towers of the World Trade Center, and one was flown into the Pentagon, all creating mass fire and destruction of the buildings. A fourth, allegedly on course for the White House was crashed into a field in Pennsylvania. These events came to be known as the “September 11th Tragedy”. This national tragedy, combined with the resulting “War on Terror” initiated by President George Bush has brought the ideas of both domestic and
international terrorism, disasters, war, and family and personal safety to the forefront of American awareness. Since then, there have also been sporadic incidents of anthrax infections delivered by mail, indicating that the terrorist attacks may not be over. Though these incidents have been located almost entirely on the east coast, the shadow of terror spreads across the hearts of all Americans, regardless of domicile.

The September 11th Tragedy fits Bell’s definition of a traumatic event. Its occurrence “lies outside the range of usual human experience” and is “capable of overwhelming any person’s normal coping abilities and causing severe stress reactions” (1995). Disaster research suggests that the trauma of the September 11th terrorist acts alone could cause long-lasting effects in the psychological health of Americans, especially more vulnerable children (Shore, et al., 1986; Terr, et al., 1999; Vogel & Verberg, 1993), yet the threats to personal safety and the ominousness of war continues well beyond that historic date.

Some symptoms for traumatic stress include but are not limited to: depression, anxiety, nightmares, irritability, trauma-specific fears, negativistic thoughts of future, regression, sleep disturbance, crying spells,
guilt, increased dependence on parental figures, clinginess or avoidance of being alone, withdrawal, information seeking behaviors, and traumatic play (DiGiovanni, 1999; Klingman and Goldstein, 1994; Shore et al., 1986; Terr, et al., 1999; Vogel & Verberg, 1993; Wright et al., 1989). These responses could negatively affect both the educational process of children and their normal development (Vogel & Verberg, 1993).

Additionally, because the media and government have identified the September 11th attacks as “terrorist” attacks associated with a particular group of people, an additional concern arises regarding a potential increase in prejudice or violence towards or the “scapegoating” of Muslims, Arabs, or Middle Easterners (Levine, 1996). This could result in escalated tensions, fights, and distractions around Southern California’s multi-ethnicity campuses decreasing focus and ultimately affecting schoolwork.

The continued media coverage and the deployment of soldiers to the Middle East has brought the tragedy closer to home for many Southern California residents. Teachers and administrators in the educational systems need to be aware of the current issues, the possible effects on children and their schoolwork, and appropriate ways to
deal with any additional stress reactions possibly resulting from the tragedy. Research further suggests faculty and parents would be more help to children if more aware of their own reactions to the tragedy, coping strategies, and capability and comfort discussing the issues (Pratt, et al., 1985; Reid & Dixon, 1999).

**Policy Context**

Though California Education Codes have historically provided for comprehensive educational counseling programs that include "personal and social counseling" for the purpose of bettering their "academic abilities, careers, vocations, personalities and social skills" (Ed. Code, section 49600-49604), this concerns only individual counseling and not school wide interventions specifically. Furthermore, school mental health programs have traditionally focused efforts on special education students (Brener, et al., 2001).

School wide interventions and programs do include some disaster and trauma issues such as earthquakes (Ed. Code section 35295-35297) and fires (Ed. Code, 32000-32004); however, these are preventative programs and not aimed at dealing with the residual effects of these events.
With the increasing prevalence of school violence, legislation also recognizes the need for programs addressing "techniques and programs to combat crime and violence at school sites" (Ed. Code section, 32228-32254, 35294). However, again there is no specific mandate for crisis intervention after the traumatic experience.

Currently, it seems all educational legislation is focused on the prevention and reduction of trauma at school sites, however, with the increase in school-related violence, combined with the threat of terrorism attacks throughout the United States, perhaps policy should further address the need for mandated programs for post-traumatic reduction of symptoms, and better training of teachers for recognizing and addressing trauma symptoms in students. Though many schools do recognize the need for trauma counseling, no specific mandate addresses the extent of services to be offered.

**Practice Context**

Though virtually all California schools are mandated to provide comprehensive educational counseling, very few have employed onsite social workers. This seems to follow the nationwide trend. Research suggests only 43.9% of public schools have either a part-time or full-time social worker available to the students (Brener, et al., 2001).
In these schools, Social workers were only available for an average of 18.8 hours per week. The bulk of the mental health responsibilities fall on guidance counselors, which are provided by 77.1% schools (averaging 48.9 hours per week) and part-time school psychologists provided by 66% of schools (averaging 14.5 hours per week) (Brener, et al., 2001). The majority of personal therapeutic services require the individual to seek out services at a separate agency.

The study also shows that only three-fourths of the schools require guidance counselors to have a Master's degree in counseling. Bell (1995), however, feels that an MSW is the "professional of choice" for trauma debriefing due to their "unique" set of skills, perspective, and training. Unfortunately, the studies suggest too few schools have recognized the benefit of school social workers. Many social workers can only volunteer services or are solicited by the schools to provide only short-term grief and trauma counseling immediately following a traumatic event.

Schools are slow to recognize the growing need for appropriate interventions in traumatic situations, as well as potential benefits of an on-site social worker to provide both preventative as well as posttraumatic
counseling, as well as on a multitude of other social and emotional issues. Nor do they seem to recognize the specific training in referring to other outside resources and services.

Purpose of the Study

The purpose of the study was to record the post-traumatic symptoms resulting from the September 11th tragedy, as observed in students by their teachers and counselors throughout a six-month period. Discussion will also include a description of the types and extent that interventions were utilized by schools in attempts to process the traumatic events. The study will then look at any resulting effect on the early symptoms after a three-month period.

Further, discussion will address the level of encouragement and overall attitudes of the administration and teachers regarding the importance of discussion, counseling, and continued attention to this issue. Based on the findings, and guided by social work theory, interventions will be recommended to participating schools to better serve their students.

The hypothesis is that recognition of the September 11th tragedy as important as demonstrated through
encouragement and attention to September 11th topics will yield more forms of intervention utilized. In addition, a negative correlation between use of interventions and symptoms is anticipated. By comparing schools, it is expected that children in those schools that have directly dealt with the September 11th tragedy and continued threats will show less dramatic symptoms of trauma stress after a three month period, due to their interventions and concerned attitudes of the administration. Regarding overall symptoms, it is hypothesized that there will be a decrease in level of observable symptoms in the later months of January to April, then initially observed from September to December.

Significance of the Project for Social Work

The results of this project will provide social workers with better awareness of the level of need in the community’s children to receive trauma counseling for events of this magnitude. Adding to the research on traumatic symptoms, it can help social workers educate teachers and parents as to what to watch for in their children, and interventions to help alleviate symptoms.

Ultimately, it is hoped that the education system will recognize the growing need for school social workers
on campus daily to assess for and provide services for all types of grief and trauma, as well as counseling services intended to better all areas of social functioning.
CHAPTER TWO
LITERATURE REVIEW

Introduction

Chapter Two consists of a discussion of the relevant literature. Specifically covered are the definitions of trauma and disaster, classification of potential victims, various symptoms of trauma, the theoretical effects of distal exposure to trauma, the researched effects of trauma specific to children, and the social work theories guiding this study.

Disasters and Traumatic Events

Bell (1995) defines a traumatic event as "incidents that lie outside the range the range of usual human experience" and that often cause "severe stress reactions" due to their capability of overwhelming "any person's normal coping abilities". Though the National Institute of Mental Health also recognizes the potential for "long-lasting mental and physical effects" of trauma, they offer a broader definition considering trauma to be anything "emotionally painful, distressful or shocking" (2001). Vogel and Verberg (1993) also recognize trauma as anything "outside of everyday experience" that would be universally distressing.
To be considered a "disaster," they suggest it should be "relatively sudden, highly disruptive, time-limited, and public." The terrorist attacks on the World Trade Center twin towers and the Pentagon, as well as the anthrax incidents fit all these definitions.

Disaster research most often categorizes events as either induced naturally or man-made or technological. The majority of past research has been on natural disasters such as earthquakes, floods, and wildfires. Terrorism is considered a man-made disaster. The advancements in technology have increased the incidence and potential for man-made disasters in the United States, and research is slowly reflecting this. Both Ofman and Mastria (1995) suggest that terrorism or other man-made disasters can be more traumatizing due to the unique uncertainties involved. Though one can reassure oneself that a flood or tornado in the same place is a relatively rare occurrence, a man-made disaster is beyond the scientific explanations of meteorology. One now has to consider the "motivations, logic and psychological make-up of the terrorist" which results in a lot more uncertainty and fear of reoccurrence (1995).
Classification of Potential Victims of Disasters

Many researchers recognize a variety of factors that may affect the psychological effects of a disaster on its victim. One of the most common cited is their personal level of involvement. Those directly impacted by personal injury or personal loss have greater risk for trauma. These are most often referred to as primary victims. However, it is common experience for those with family or friends that were affected, those who work with trauma victims and disaster recovery efforts, as well as those who narrowly escaped disaster to have traumatic symptoms.

A.J. Taylor (1989) categorizes victims in a six level classification system recognizing potential victims that may have had very little actual contact or impact from the disaster. He defines primary victims as those "directly exposed" and where patterns of behavior or well-established relationships are disrupted, or loss of property. A secondary victim would be those who are close to a primary victim and therefore also experience severe grief and feelings of loss. He also recognizes the possibility of guilt reactions. Tertiary victims include civil servants and others whose careers afford them
opportunities to deal with disaster victims or recovery efforts.

This research will mainly be dealing with the idea of a “quarternary victim”. These people are geographically beyond the impact area, and more removed emotionally than secondary or tertiary victims, but nonetheless express their concern and caring for victims in a variety of ways. The fifth and sixth categories include a variety of more removed victims such as people who feel that chance kept them from being primary or secondary victims, those feeling guilty for not revealing an earlier premonitions regarding the tragedy, or those psychopathologically obsessed with the disaster though not originally involved.

According to Taylor, these categories provide a much broader definition of victim to account for apparent trauma symptoms beyond the direct impact of a disaster.

Symptoms Apparent after Traumatic Stress

Research on the after effects of disaster trauma suggests a wide range of symptoms. Bell (1995) categorizes these into physiological, behavioral, cognitive and emotional symptoms. The majority of research widely recognizes cognitive and emotional symptoms such as depression (Bell, 1995; Ofman & Mastria, 1995), confusion
or anxiety (Bell, 1995; Chung, Chung, & Easthope, 2000; DiGiovanni, 1999; Goenjian, et al., 2000; LaMothe, 1999; Ofman & Mastria, 1995; Shore et al., 1986; Vogel & Vernberg, 1993) and grief (Brock, 1998). General worry (Ofman & Mastria, 1995), flat affect and emotional numbing (Bell, 1995; Horowitz et al., 1979; Ofman & Mastria, 1995) were also topics of research.

More specifically related to disasters are feelings of "survivor guilt" that someone else got hurt and guilt for one’s thoughts or actions prior to the event (Assal & Farell, 1992; Bell, 1995; Brock, 1998; DiGiovanni, 1999; Vogel & Vernberg, 1993). Many researchers described the presence of fears that were specifically related to the disaster, such as fire or flying (Chung, Chung, & Easthope, 2000; Pfefferbaum, et al., 1999; Terr, et al., 1997; Terr, et al., 1999; Vogel & Vernberg, 1993). Another prominent effect of disasters were nightmares or flashbacks, rumination of memories or trauma-related thoughts, which were recognized by Assal and Farell (1992); Horowitz, et al., (1979); Ofman & Mastria, (1995); Pfefferbaum, et al. (1999); Miller (1996); Terr et al., (1997,1999); and Wright, et al. (1989). On the other hand, a loss of memory regarding the trauma, as well as problems
with short-term memory functions was also indicated (Ofman & Mastria, 1995).

Feelings of fear often were more generalized to various phobias such as social phobias, acrophobia, (DiGiovanni, 1999), and even fear of public gatherings (Vogel & Vernberg, 1993). Fearfulness was sometimes related to thoughts of dying and suicide and negative visions of the future, which are described by several researchers (Assal & Farell, 1992, Klingman & Goldstein, 1994, Terr, et al., 1997; Terr, et al., 1999). Assal and Farell (1992) showed an overall increase in the presence of pessimistic thoughts and perceived futures.

Behavioral symptoms are also widely recognized. Crying was reported by multiple researchers (Brock, 1998; Digiovanni, 1999; Goenjian, et al., 2000; Levine, 1996; Lewis & Veneman, 1987; Ofman & Mastria, 1995; Shore et al., 1986; Vogel & Verberg, 1999; Wright et al., 1989). Information seeking behaviors commonly existed with regards to disaster trauma where victims inquired about the safety of others, looked for explanations, and otherwise tried to make meaning of the event (Terr, et al., 1997; Terr, et al., 1999; Wright et al., 1989). In tragedies it is common for those involved to demonstrate blaming behavior and scapegoating of those possibly
responsible (DiGiovanni, 1999; and Levine, 1996). Substance use (DiGiovanni, 1999; Goenjian, et al., 2000), anger and aggression (Bell, 1995; DiGiovanni, 1999 Ladd & Cairns, 1996) were also reported.

Other reactions noted were poor concentration (Ofman & Mastria, 1995) withdrawal, isolation or avoidance behaviors (Bell, 1995; Horowitz et al., 1979) and hypervigilance or heightened fear response (Bell, 1995; Ofman & Mastria, 1995). Sleep disturbances such as insomnia or sleepwalking were also noted by several researchers (Bell, 1995; DiGiovanni, 1999; Ladd & Cairnes, 1996; Miller, 1996; Ofman & Mastria, 1995; Vogel & Vernberg, 1993; and Wright, et al., 1989).

More specific to children were behavioral observations of traumatic play (Assal and Farell, 1992; Vogel & Vernberg, 1993), where children acted out disaster-related themes or drew pictures pertaining to the violence or fear. Also observed were regression and increased dependence on parents (Vogel & Vernberg, 1993). Another type of effect common to trauma is physiological manifestations such as stomach problems and headaches, and other bodily aches (Ladd & Cairns, 1996; Miller, 1996; Tucker & Pfefferbaum, 2000; Wright, et al., 1989). Other
researchers have collected reports of enuresis or diarrhea (Bell, 1995), or loss of appetite (Ofman & Mastria, 1995).

Though the variety and severity of symptoms covers a broad range, some research samples had combinations of and severe enough symptoms to meet qualifications for DSM diagnoses of either Acute Stress Disorder or Post Traumatic Stress Disorder (DiGiovanni, 1999, Goenjian, et al., 2000; Pfefferbaum, et al., 1999; Tucker & Pfefferbaum, 2000; Shore, et al., 1986).

Symptoms of Children

The National Institute of Mental Health (2001) responded to the September 11th Tragedy with a website intended to help children and adolescents cope with this event. Their research summarizes symptoms most often seen in school-age children ages 6-11. They suggest watching for symptoms of depression, anxiety, guilt, irritability, outbursts of anger, fighting, inattentiveness, disruptive behaviors, regressive behaviors, nightmares, sleeping problems, irrational fears, numbing or "flatness" of emotions, bodily symptoms, and refusing to attend school. They recognize the likelihood of this event affecting their ability to stay on task at school and in homework and predict that schoolwork will suffer (2000).
When working with children it is important to keep in mind that their biological age does not always correspond with their emotional maturity. Therefore, it is important to be aware of symptoms affecting other aged children to encompass the full range of possibilities. The NIMH recognizes separation anxiety and clinging behaviors as common in those younger than six. In adolescents they list suicidal thoughts, revenge fantasies, peer problems, substance usage, and anti-social behaviors as additional concerns (2001).

Distal Effects

Though the September 11th Tragedy took place in New York City, previous research suggests that many more than New York residents were effected by the day's events. Though none of the terrorist attacks, anthrax incidents, nor the war efforts thus far have taken place in Southern California, research suggests that even distal violence can have a strong impact on psychological health (Ladd & Cairnes, 1996; Terr, et al., 1999; Wright, et al., 1989). At times of war the indirect affects can be far-reaching beyond the soldiers in combat (Ross, 1991); especially with the help of mass media to relay details to all corners of the United States.
Communications technology has allowed instant dissemination of significant news developments, as they are unfolding, to millions of viewers often worldwide. A 1989 study regarding the Space Shuttle Challenger Explosion in 1986 showed that of those not witnessing the launch in Cape Canaveral, more than half of their sample turned on the television news immediately upon hearing something of the disaster, and that 95% of their sample had viewed videotaped footage of the explosion by the end of the day (Wright et al., 1989). A 1999 study also regarding the Challenger explosion shows long distance effects of the tragedy with students in California experiencing the same types of symptoms as those watching the lift-off in Cape Canaveral (Terr et al., 1999).

Additional trauma research further supports the idea that one does not have to experience an event first hand to develop posttraumatic symptoms. Vogel and Verberg (1993) recognize that direct exposure to a life threat will increase intensity of symptoms, but that distress has potential to be experienced by anyone with knowledge of a public tragedy. Taylor's classification of potential victims supports this idea recognizing a vast potential for extreme emotional involvements to a disaster (1989). DiGiovanni's 1999 work with terrorism suggests that even a
perceived or potential danger, such as an unfounded bomb threat, "hoax" biochemical contamination, or "reports of gas" are enough to trigger what is referred to as psychogenic illness or somatization and psychological impairment in persons that do not work with these agents on a regular basis. Roan, from The LA Times reported that more than 2000 unfounded claims of anthrax contamination resulted from mass hysteria of contamination fears (2001).

Human Behavior in the Social Environment Theories Guiding Conceptualization

Many theories guided the formulation of this study and its discussion of significance. Developmental theory, trauma theory, persons in their environment, systems theory, and social learning theory all suggest that the September 11th Tragedy could have negative effects on social and psychological functioning.

Developmental and Trauma Theories recognize the potential effects that significant life events, especially when occurring at critical stages, can have on normal development and overall social and psychological well-being. Recognition of the events and early intervention may help alleviate developmental delays and maladjustment.
Person in Environment theory reminds us that a child's well-being cannot be assessed by only considering the child himself, but must consider the context of their environment. The state of the nation currently is an environment riddled with confusion, uncertainty, and fear for many people, which can affect proper social interactions.

Systems theory also considers a child's environment proposing that a child plays a role in larger systems outside the family, such as the school community, and more importantly in this case, a national community whose safety is being threatened. Taylor (1989) suggests trauma causes significant changes in the "social fabric" of communities, affecting victims in multiple ways. Consideration of the child's ecosystem would illustrate changes in many different parts of their system, all ultimately impacting the child in some manner.

Finally, Social Learning Theory cautions that children may learn from models around them. The multiple depictions of destruction, violence, and intolerance of difference depicted in the news of the tragedy and the war efforts resulting could negatively influence behaviors in our nation's children.
Summary

Literature defining trauma and disasters and describing potential symptoms is reviewed in Chapter Two. The theoretical rationale for early recognition of potential effects of trauma and distal violence are also discussed.
CHAPTER THREE

METHODS

Introduction

Chapter Three documents the steps to be used in developing this research project. Specifically, it describes the sample and how it was selected, the instruments utilized for measurement, and the methods of analysis.

Study Design

This study investigated the symptoms seen in elementary school children that are resultant from a national tragedy. It also compared the attitudes and beliefs of school administration to the amount of interventions completed with hopes of decreasing symptoms and potential effects on overall functioning.

This study is correlational in nature and consists of both qualitative and quantitative measurements of symptomology and experiences.

Sampling

The study utilized a sample of three local elementary schools in Southern California. Four local school districts were contacted for permission, with only one able to accommodate the time frames and requirements of
the study. The three school samples were assigned by the director of research and measures for the school district based on meeting the requirement of a year round school calendar, and their willingness to participate. The surrounding city has an approximate population of 142,381 (U.S. Census Bureau, 2000), and the three schools have an average enrollment size of 859 students. The schools were fairly similar in their representation of ethnic groups with mean percentages equaling 43.6 percent Hispanic, 27.7 percent African American, 19.4 percent White, five percent Asian, and 1.4 percent "Other".

Participants solicited within the schools were limited to full-time teachers who had taught since September 11th, 2001. The sampled faculty was chosen based on their higher probability of observing the target behaviors in the students. The total sample included 137 teachers and resource specialists.

Data Collection and Instruments

The research utilized an original instrument based primarily upon the Pediatric Emotional Distress Scale or "PEDS" developed by Saylor, and Swenson (1999). This scale was consulted because of its simple language, brevity, and closeness of fit to the "envisioned" instrument for this
study. It also had a similar research base and researched its reliability. The alpha coefficient for the test was .85 with both test-retest reliability and interrater reliability showing significance (Saylor & Swenson, 1999). Also consulted was the Horowitz Impact of Events Scale or IES (Horowitz, 1979).

The original instrument adapted both wording and format to accommodate for a teacher’s observations rather than a parent’s and to maintain language consistent with the synopsis of all previous research consulted (see Appendix A).

It consisted of 40 items and was administered to teachers and counselors. The first four questions pertained to demographic information regarding class size, grade level, years of teaching experience, and gender. Eight questions pertained to the teacher’s experience and attitudes regarding the September 11th Tragedy, and their perceptions of administrative and parental attitudes. The remaining 28 questions addressed the frequency of symptomatic behaviors observed in either female or male students and/or reported by the students or their parents. This section is divided into “early” and “later” symptoms, which are designated by date of occurrence, either between
September 11th and December 11th or between January and April (allowing for school break).

Each section allowed for specific examples of behavior to be described and for comments regarding that section of questions. A final section specifically asked for any suggested interventions for administration to consider implementing in future traumatic events.

Procedures

After obtaining permission from the superintendent of the school district and the director of educational research, each school secretary and principal was contacted by phone to be made aware of the study, and to arrange for the distribution of the instruments. The school secretaries helped with the delivery of the questionnaire by distributing one to each of the teacher’s mailboxes. The questionnaire contained instructions telling the participants that once they have completed the survey, to enclose their responses in the envelope provided, seal it, and drop it off with the school secretary to be collected by the researcher on three different occasions at each school. The envelopes were addressed directly to the researcher to further ensure the privacy of their responses. Also included with the
questionnaire was a raffle ticket enclosed with instructions on how to possibly win one of two prizes valued approximately ten dollars. The raffle was meant as an incentive to increase the response rate and turnover time, as well as a thank you to the participants.

Protection of Human Subjects
For sake of protecting the participants' anonymity and inputting the data, a numbering system was utilized. No participant names were used. Study participants were asked to give informed consent by placing a mark on a form in which they were reminded that their participation is completely voluntary (see Appendix B). The form explained that they could stop at any time during the study. Participants were also given a debriefing statement with the names of the researcher and the advisor along with a phone number to contact the researchers if they have any questions concerning the study (see Appendix C).

Additionally, each participant was provided with an envelope addressed to the researcher in which to enclose his or her response and seal before dropping off to the school secretary. Raffle tickets were collected separately in one envelope held by the secretary to ensure that anonymity of the survey responses.
Data Analysis

The study used uni-variate analysis to look for relationships between the grade level and frequency of early and late symptoms, and between grade level and the interventions used. It also looked for correlations between level of encouragement given by the administration, the use of interventions, and the frequency of symptoms. Finally a comparison of between frequency of symptoms observed soon after the tragedy versus those seen after the Christmas break will be done.

Summary

This section discussed the demographics and method of selection of the sample, the development of the instruments and the measurement procedures. It also discussed the procedures utilized to ensure anonymity and confidentiality of the participants. Finally it looked at the statistics used for analysis and the relationships to consider.
CHAPTER FOUR

RESULTS

Introduction

Chapter Four consists of a presentation of the results. It includes a description of the respondents of the questionnaire. Further, it discusses the mean utilization of interventions, level of encouragement received by the administration, frequency of symptoms observed, and explores correlations between these variables. It also looks for significant differences between outcomes. Lastly, the Chapter concludes with a summary.

Presentation of the Findings

Descriptive Statistics

There were 42 respondents. Of these, 39 were female teachers and 3 were male. Overall, the average years of teaching experience was 13.43 years. Nine were Kindergarten teachers, nine taught first grade, eight taught second grade, seven taught third grade, five taught fourth, and four were included in the category of “other” because they taught a range of grade levels as special education teachers, lab or PE teachers, or resource specialists (see Table 1).
Table 1. Demographics of Participants

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<td>9</td>
</tr>
<tr>
<td>second grade teachers</td>
<td>8</td>
</tr>
<tr>
<td>third grade teachers</td>
<td>7</td>
</tr>
<tr>
<td>fourth grade teachers</td>
<td>5</td>
</tr>
<tr>
<td>other or mixed level teachers</td>
<td>4</td>
</tr>
<tr>
<td>mean years of experience teaching</td>
<td>13.43</td>
</tr>
</tbody>
</table>

The average level of encouragement reported was 5.62; as rated on a scale of one to ten, one being "not at all encouraged" and ten being "very much encouraged" (see Table 2).

Table 2. Encouragement and Attention

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>mean</th>
<th>standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Encouragement</td>
<td>40</td>
<td>5.62</td>
<td>3.27</td>
</tr>
<tr>
<td>Level of Attention by Administration</td>
<td>39</td>
<td>5.76</td>
<td>3.06</td>
</tr>
<tr>
<td>Overall Level of Attention</td>
<td>39</td>
<td>3.01</td>
<td>1.41</td>
</tr>
<tr>
<td>Attn to Sept 11th Events</td>
<td>42</td>
<td>6.9</td>
<td>2.4</td>
</tr>
<tr>
<td>Attn to Anthrax Issue</td>
<td>42</td>
<td>4.40</td>
<td>3.03</td>
</tr>
<tr>
<td>Attn to War Against Terrorism</td>
<td>42</td>
<td>4.17</td>
<td>2.91</td>
</tr>
<tr>
<td>Attn to U.S. Security/Safety Issues</td>
<td>42</td>
<td>4.51</td>
<td>2.86</td>
</tr>
<tr>
<td>Attn to Issues of Prejudice/Racism</td>
<td>42</td>
<td>5.19</td>
<td>3.37</td>
</tr>
</tbody>
</table>

The use of interventions was reported at a 4.6; with a rating of one being "not at all used" and ten being
"very frequently used". The most frequent intervention utilized was informal class discussions (6.41), with optional classroom activities and letters to parents also common (4.19 and 4.07 respectively) [see Table 3].

Table 3. Use of Interventions

<table>
<thead>
<tr>
<th>Overall Use Of Interventions</th>
<th>Use Of Informal Discussion</th>
<th>Use Of Curriculum Lesson</th>
<th>Use Of Optional Activity</th>
<th>Use Of School Assemblies</th>
<th>Use Of Letters Sent To Parents</th>
<th>Use Of Parent/Teacher Conferences</th>
<th>Use Of Teacher Training/In-service</th>
<th>Use Of Referrals To School Counselors</th>
<th>Use Of Referrals To School Psychologists Or Social Workers</th>
<th>Use Of Referrals To Outside Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>3.12</td>
<td>6.41</td>
<td>3.27</td>
<td>4.20</td>
<td>2.27</td>
<td>4.08</td>
<td>1.78</td>
<td>2.07</td>
<td>2.66</td>
<td>1.71</td>
<td>1.88</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.57</td>
<td>2.83</td>
<td>2.69</td>
<td>3.20</td>
<td>2.19</td>
<td>2.96</td>
<td>1.81</td>
<td>2.16</td>
<td>2.60</td>
<td>1.85</td>
<td>1.56</td>
</tr>
</tbody>
</table>

The overall average degree of observable symptoms reported was 4.8; with one being observed in "no boys" or "no girls" and ten being "every boy" or "every girl". The most frequent symptoms observed were tragedy-related conversations and increased compassion for others (Tables 1 and 2).
<table>
<thead>
<tr>
<th>Symptom</th>
<th>September-December</th>
<th>January-April</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying/sadness/depression</td>
<td>41 1.8 1.63</td>
<td>41 1.21 0.6</td>
</tr>
<tr>
<td>Tragedy-related conversations</td>
<td>41 4.78 2.96</td>
<td>41 1.65 1.09</td>
</tr>
<tr>
<td>Drawing of tragedy-related themes</td>
<td>41 3.56 3.18</td>
<td></td>
</tr>
<tr>
<td>Acting out tragedy-related themes in play</td>
<td>41 1.89 1.93</td>
<td>41 1.39 1</td>
</tr>
<tr>
<td>Avoidance of tragedy-related topics</td>
<td>40 1.49 1.17</td>
<td>40 1.2 0.69</td>
</tr>
<tr>
<td>Increased anger/aggression/violence</td>
<td>41 2.31 2.14</td>
<td>41 1.78 1.75</td>
</tr>
<tr>
<td>Isolation/avoidance behaviors</td>
<td>41 1.51 1.03</td>
<td>41 1.29 0.84</td>
</tr>
<tr>
<td>Increased fear of strangers or new situations</td>
<td>41 2.16 2.29</td>
<td>41 1.65 1.37</td>
</tr>
<tr>
<td>Fear of going out in public places or crowds</td>
<td>41 1.46 1.36</td>
<td>41 1.24 0.54</td>
</tr>
<tr>
<td>Fear of flying, fires, or tragedy-related fears</td>
<td>41 2.98 2.82</td>
<td>41 1.76 1.32</td>
</tr>
<tr>
<td>Fear for future safety, family safety</td>
<td>41 3.12 2.98</td>
<td>41 2.23 3.65</td>
</tr>
<tr>
<td>Increased anxiety or worry</td>
<td>41 2.79 2.61</td>
<td>41 1.49 1.05</td>
</tr>
<tr>
<td>Regression/babyish behavior/increased dependence on parents</td>
<td>40 2 1.87</td>
<td>41 1.44 0.9</td>
</tr>
<tr>
<td>Temper tantrums/extreme responses</td>
<td>41 1.49 1.58</td>
<td>41 1.27 0.78</td>
</tr>
<tr>
<td>Heightened startle response/fearyful with no immediate reason</td>
<td>41 2.18 2.43</td>
<td>41 1.33 0.79</td>
</tr>
<tr>
<td>Bodily pains/headaches/other somatic complaints</td>
<td>40 2.33 2.1</td>
<td>40 1.7 1.29</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>40 1.58 1.39</td>
<td>40 1.18 0.84</td>
</tr>
<tr>
<td>Insomnia/intermittent sleep/sleepwalking/won't get out of bed/won't sleep alone</td>
<td>39 1.67 1.72</td>
<td>39 1.28 0.83</td>
</tr>
<tr>
<td>Nightmares/hallucinations</td>
<td>39 1.9 1.83</td>
<td>39 1.26 0.71</td>
</tr>
<tr>
<td>Increased prejudice/scapegoating</td>
<td>40 2.05 2.18</td>
<td>40 1.5 1.2</td>
</tr>
<tr>
<td>Increased focus on topics of death, suicide, or murder</td>
<td>40 2.53 2.37</td>
<td>40 1.43 0.84</td>
</tr>
<tr>
<td>Negative visions of future/pessimism</td>
<td>41 1.78 1.57</td>
<td>41 1.41 1.5</td>
</tr>
<tr>
<td>Increased concern for non-family, compassion</td>
<td>41 3.29 3.29</td>
<td>41 2.12 2.43</td>
</tr>
<tr>
<td>Survivor guilt/overconcern for victims</td>
<td>41 1.93 2.1</td>
<td>41 1.41 1.47</td>
</tr>
<tr>
<td>Obsessive thoughts</td>
<td>40 2.73 2.84</td>
<td>40 1.65 1.92</td>
</tr>
</tbody>
</table>
Table 5. Frequency of Symptoms Observed in Females

<table>
<thead>
<tr>
<th></th>
<th>September-December</th>
<th>January-April</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>mean</td>
</tr>
<tr>
<td>crying/ sadness/ depression</td>
<td>41</td>
<td>1.8</td>
</tr>
<tr>
<td>tragedy-related conversations</td>
<td>41</td>
<td>4.78</td>
</tr>
<tr>
<td>drawing of tragedy-related themes</td>
<td>41</td>
<td>3.56</td>
</tr>
<tr>
<td>acting out tragedy-related themes</td>
<td>41</td>
<td>1.89</td>
</tr>
<tr>
<td>avoidance of tragedy-related topics</td>
<td>40</td>
<td>1.49</td>
</tr>
<tr>
<td>increased anger/ aggression/ violence</td>
<td>41</td>
<td>2.31</td>
</tr>
<tr>
<td>isolation/ avoidance behaviors</td>
<td>41</td>
<td>1.51</td>
</tr>
<tr>
<td>increased fear of strangers or new situations</td>
<td>41</td>
<td>2.16</td>
</tr>
<tr>
<td>fear of going out in public places or crowds</td>
<td>41</td>
<td>1.46</td>
</tr>
<tr>
<td>fear of flying, fires, or tragedy-related fears</td>
<td>41</td>
<td>2.98</td>
</tr>
<tr>
<td>fear for future safety, family safety</td>
<td>41</td>
<td>3.12</td>
</tr>
<tr>
<td>increased anxiety or worry regression/babyish behavior/ increased dependence on parents</td>
<td>41</td>
<td>2.79</td>
</tr>
<tr>
<td>temper tantrums/ extreme responses</td>
<td>41</td>
<td>1.49</td>
</tr>
<tr>
<td>heightened startle response/fearful with no immediate reason</td>
<td>42</td>
<td>2.18</td>
</tr>
<tr>
<td>bodily pains/ headaches/ other somatic complaints</td>
<td>40</td>
<td>2.33</td>
</tr>
<tr>
<td>loss of appetite</td>
<td>40</td>
<td>1.58</td>
</tr>
<tr>
<td>insomnia/ intermittent sleep/ sleepwalking/ won't get out of bed/won't sleep alone</td>
<td>39</td>
<td>1.67</td>
</tr>
<tr>
<td>nightmares/ hallucinations</td>
<td>39</td>
<td>1.9</td>
</tr>
<tr>
<td>increased prejudice/ scapegoating</td>
<td>40</td>
<td>2.05</td>
</tr>
<tr>
<td>increased focus on topics of death, suicide, or murder negative visions for future/ pessimism</td>
<td>41</td>
<td>2.53</td>
</tr>
<tr>
<td>increased concern for non-family, compassion</td>
<td>41</td>
<td>1.78</td>
</tr>
<tr>
<td>survivor guilt/ overconcern for victims</td>
<td>41</td>
<td>3.29</td>
</tr>
<tr>
<td>obsessive thoughts</td>
<td>40</td>
<td>2.73</td>
</tr>
</tbody>
</table>
Statistical Analysis

A factor analysis was used to confirm that all symptoms fit a single factor solution. Also, a $t$-test showed no difference between genders for symptoms ($t = .854; p = .40$). Therefore, the early symptoms of both male and female students were pooled together and the late symptoms of both genders were pooled together to form two new group variables. A $t$-test revealed a decrease in symptoms observed in the early period from January to December compared to the later period of January to April ($t = 4.78, p = .00$; see Figure 1). The observations made in these time frames will be referred to as "early" and "later" symptoms for the remainder of the article and in the figures and tables.

![Comparison of Observance of Early vs. Later Symptoms](image)

Figure 1. Frequency of Observed Symptoms
Correlations were found between level of encouragement and the amount of attention given to September 11th topics ($r = .542$, $p = .00$; see Figure 2), the use of interventions ($r = .611$, $p = .00$; see Figure 3), and the frequency of late symptoms ($r = .371$, $p = .03$; see Figure 4). There was no significance found for early symptoms ($r = .32$, $p = .06$).

![Figure 2. Encouragement and Attention](image-url)
Relation between Encouragement Received and Overall Use of Interventions

Figure 3. Encouragement and Interventions

Relation between Encouragement Received and Frequency of Later Symptoms

Figure 4. Encouragement and Later Symptoms
The amount of attention given to the topics also correlated with the observance of early and late symptoms with an $r$ of .552 ($p = .00$), and .680 ($p = .01$) [see Figure 5].

![Relation between Overall Attention Given to Tragedy Topics and Symptoms](image)

Figure 5. Attention And Frequency Of Symptoms

Also explored was the effect of grade level on the frequency of symptoms. A one-way ANOVA showed no significance for either early or later symptoms ($F = 1.46$, ($5,32); p = .36; F = 1.09$ ($12,24); p = .46; see Figure 6).
In comparing schools, it was found that there were no significant differences in level of symptoms (for early symptoms (see Figure 7) $F = .98 \ (2,35); \ p = .386$; for later symptoms (see Figure 8) $F = .81 \ (2,34); \ p = .45$). As Figure 8 illustrates, there was more variability in the later symptoms for school 3 but no mean differences. There was also no significance found for use of interventions or overall level of attention given to the topics ($F = .45 \ (2,33); \ p = .65$; and $F = 1.79 \ (2,37); \ p = .18$, see Figures 9 and 10 respectively).
Comparison of Early Symptoms
By School

Figure 7. Comparison of Early Symptoms by School

Comparison of Later Symptoms
By School

Figure 8. Comparison of Later Symptoms by School
Comparison of Total Use of Interventions
By School

Figure 9. Comparison of Total use of Interventions by School

Total amount of Attention
As compared by school

Figure 10. Total Amount Attention given as Compared by School
Chapter Four reviewed the results extracted from the project including correlations between level of encouragement and use of interventions, level of encouragement and attention given to the topic, level of attention and use of interventions, and overall use of interventions and symptoms observed.
CHAPTER FIVE

DISCUSSION

Introduction

Included in Chapter Five was a presentation of the conclusions gleamed as a result of completing the project, specifically, consideration of the unexpected outcomes and discussion of the limitations. Further, the recommendations for future research and social work practice are presented. Lastly, the chapter concludes with a summary.

Discussion

While the study supported some of its hypotheses, it also revealed some interesting and unexpected results.

Surprisingly, the use of interventions increased the likelihood of observed symptoms. This may be because the awareness of the issue was heightened in the teachers. Perhaps because of the more predominance of the topic, the symptoms were more readily recognized and remembered.

Despite the positive correlation between utilization of interventions and symptoms observed, regardless of level of attention or interventions employed, the overall incidence of observed symptoms decreased over time as originally hypothesized. This was consistent when analyzed
in both group form and when looking at individual schools with the exception of school 3 with its greater variability.

Limitations

In review, there are many limitations that affect the interpretation of the results of the study. These include recall ability, the limited sample, subjectivity of the rating scales, and social desirability bias.

First of all, the amount of time that past between the September 11th tragedy and the distribution of the surveys was over six months. None of the schools involved were told in advance that they would be asked to recall symptoms or the extent of interventions. Therefore accurate recall is unlikely. Perhaps surveying the teachers immediately after the first three month period and then again at the six-month mark would have yielded more accurate counts.

The study was restricted to one school district, which yielded many limitations. First of all, with one school district came one approach to addressing the September 11th Tragedy. It would have been beneficial to compare different school districts with perhaps different philosophies on how best to handle the incident. The low
level of symptoms overall may have been the result of a modeling effect, as suggested by social learning theory. If the teacher’s are not talking about the incident or reacting in any observable way, the children may follow suit and react according to the socially acceptable way.

Not being able to compare different geographic areas with more varied socio-economic status and environments was also unfortunate. Many of the qualitative comments received pertained to the life situations of their students as being especially difficult including incarcerated parents, poverty, and "bigger" problems and events ringing closer to home for them. With a comparison of additional schools, perhaps more variation would have been seen in observed symptoms.

Likewise, by expanding the sample in other ways such as in the age groups observed could have yielded more variation in symptoms levels as well as the frequency of each type of symptom. Older students with higher levels of abstract thinking and reasoning abilities may have yielded very different symptoms. As some teachers pointed out, the children’s ages limited their ability to fully perceive the impact of the event, as well as limited their attention span of the subject.
Further, in reviewing qualitative comments and inconsistencies within responses, some alterations to the instrument might have eliminated some confusion and effected results in some way. For example, a less subjective quantification of intervention use is a prime example. If actual numbers were used instead of “none” versus “very frequent use” interpretation would have less variation. Additionally, inquiries into a change in the level of attention or use of intervention over time may also have been useful when considering the decrease in overall symptoms.

Finally qualitative comments that were apologetic for not having “much to report” suggest that perhaps there is some social desirability bias occurring. It is natural for one to think that an event of this magnitude should have some effect on children and that someone researching symptoms would want to see some grand effect. Some teachers may have been maximizing symptoms based on what they felt the study was looking for. On the other hand, there appeared to be some evidence of disagreeing with the district policy to “not talk about it” which may have influenced reports of level of attention given, interventions used and symptoms observed in either direction.
Recommendations for Social Work Practice, Policy and Research

As social workers we can use these results to help us reevaluate our work. As therapists we often hold dear to the idea that "talking" about something is the best way to begin deal with something. This study suggests that at some ages, maybe it's better if it is not talked about. However, though the immediate effects may show less traumatic symptoms without an intervention, or at least a forced intervention by teachers or social workers, we still have no way of knowing what the disregard for such a historical event might have in the long run.

Though some of the results were not as anticipated, I still feel that this study supports the utilization of social workers in schools in times of trauma. Qualitative comments given by the teachers suggested that they were not sure how to deal with some of the concerns of their students, especially when the district was stressing silence on the subject.

"Adults had no answers"

"There was little that could be said."

"Told not to do much."

Teachers were surprised by some of the reactions they saw. One student requested "bombing drills"; others
mentioned "nightmares about planes" and many "brought up the subject of safety". Some faces registered "terror" the first time a plane flew overhead after the tragedy. Further, the "worst" students became the "most dignified" during a moment of silence and the calm lasted throughout the period. The longevity of the symptoms was also unexpected by some. One teacher reported "surprise" that a student would "react so strongly" by crying when the subject was mentioned almost 9 months later.

Though the level of traumatic symptoms was low, they still existed, and the idea that "If you don't discuss it...it didn't really happen," does not help those students that are struggling. A social worker available for classroom observance and referrals could have been an asset for many of these classes.

Also, the results show which symptoms were more prevalent, and which interventions were most often used in these schools. This information may help develop a plan of intervention that is supplemental to school-based interventions in any future tragedy.

Conclusions

The conclusions extracted from the project follows.

The use of interventions increased recognition of
traumatic symptoms in students. The more teachers were encouraged by administration, the more likely they were to use interventions. Qualitative comments suggest cognitive dissonance in some of the teachers on how best to handle the situation.
APPENDIX A

QUESTIONNAIRE
The September 11th Tragedy: Effects and Interventions

Section 1- Demographics

How many years teaching experience do you have? ______
Have you been working with this classroom since September 11, 2001? Yes/No
What grade level do you currently teach? K/1/2/3/4/5/6/other
Are you male or female? Male / Female

Section 2- Level of Attention

Please rank the following questions on a scale of 1-10; by circling the number that you feel best describes the level of attention given to the following issues: 1 being not at all addressed and 10 being extremely well addressed.

How well was the September 11th tragedy addressed in your class?

1 2 3 4 5 6 7 8 9 10
Not at all Very well addressed

How well were other September 11th related incidents addressed?

Anthrax?

1 2 3 4 5 6 7 8 9 10
Not at all Very well addressed

War against terrorism?

1 2 3 4 5 6 7 8 9 10
Not at all Very well addressed

National security or safety issues?

1 2 3 4 5 6 7 8 9 10
Not at all Very well addressed

Prejudice towards Muslims or those of Arabian decent?

1 2 3 4 5 6 7 8 9 10
Not at all Very well addressed
Please indicate with a circle what level of encouragement you feel you received from your school's administration in addressing these topics?

1  2  3  4  5  6  7  8  9  10
Not at All Encouraged  Very Much Encouraged

Comments?

How would you rate the school administration's overall level of attention given to these issues, with regards to both students and staff?

1  2  3  4  5  6  7  8  9  10
Not Attention  Very Much Attention

Comments?

How would you describe the administration's overall attitude towards these incidents?

Section 3- Interventions

Please indicate the frequency of use of any of the following interventions that your class participated in regarding the September 11th tragedy and related incidents, on a scale of 1-10, with 1 being not at all, and 10 being very frequently used.

Informal class discussion?

1  2  3  4  5  6  7  8  9  10
Not at all  very frequent use

Curriculum lesson?

1  2  3  4  5  6  7  8  9  10
Not at all  very frequent use

Optional activity such as art activity or journal entries?

1  2  3  4  5  6  7  8  9  10
Not at all  very frequent use
School Assembly?
1 2 3 4 5 6 7 8 9 10
Not at all
very frequent use

Letters to parents?
1 2 3 4 5 6 7 8 9 10
Not at all
very frequent use

Special parent-teacher conferences?
1 2 3 4 5 6 7 8 9 10
Not at all
very frequent use

Teacher in-service or training?
1 2 3 4 5 6 7 8 9 10
Not at all
very frequent use

Referrals to school guidance counselor?
1 2 3 4 5 6 7 8 9 10
Not at all
very frequent use

Referrals to school psychologist or social worker?
1 2 3 4 5 6 7 8 9 10
Not at all
very frequent use

Referrals to outside services?
1 2 3 4 5 6 7 8 9 10
Not at all
very frequent use

Any comments about above interventions?
Please feel free to describe any interventions used including those not listed above. (Continue on back if necessary).

Were there any interventions or actions that you would have liked to have seen happen, or felt would have been beneficial to the staff or students?
This last section is extremely important. We recommend taking a small break before starting it.

Section 4 - Symptoms of traumatic stress

This section requires that you recollect to the best of your ability, any specific behavioral changes in your students that you had observed or that were reported to you by parents that MAY HAVE BEEN as a result of the national tragedies. Please use your best judgment in ruling out any behavioral changes that coincided with or are most likely pertaining to another personal incident in the student's life (family problems, health, etc).

In the first column, labeled Sept-11th - Dec 31st, please indicate to the best of your recollection, approximately how many boys and how many girls demonstrated the following behavioral changes from September 11th until they took their winter break. Please include both those observed by you or those reported to you by parents as one count.

In the second column, labeled Jan 1st - present, please indicate approximately how many students were exhibiting the behaviors from their return to school in January until presently, again considering both observed behaviors or those reported to you by parents between January and the present.

<table>
<thead>
<tr>
<th>FROM Sept 11 - Dec 31</th>
<th>FROM JAN 1 - PRESENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crying/Sadness/Depression:</strong></td>
<td><strong>Crying/Sadness/Depression:</strong></td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>no boys</td>
<td>no boys</td>
</tr>
<tr>
<td>every boy</td>
<td>every boy</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>no girls</td>
<td>no girls</td>
</tr>
<tr>
<td>every girl</td>
<td>every girl</td>
</tr>
<tr>
<td><strong>Tragedy-related Conversations:</strong></td>
<td><strong>Tragedy-related Conversations:</strong></td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>no boys</td>
<td>no boys</td>
</tr>
<tr>
<td>every boy</td>
<td>every boy</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>no girls</td>
<td>no girls</td>
</tr>
<tr>
<td>every girl</td>
<td>every girl</td>
</tr>
<tr>
<td><strong>Drawing of tragedy-related themes:</strong></td>
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Comments about items on this page:
### FROM SEPT 11th - DEC 31st

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<th>Acting out tragedy-related themes in play</th>
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<td><strong>1 2 3 4 5 6 7 8 9 10</strong></td>
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<th>Increased anger/aggression/violence</th>
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<tr>
<th>Increased Fear of strangers</th>
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<tr>
<th>Fear of going out in public</th>
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### Comments about items on this page:
**FROM SEPT 11th - DEC 31st**

Fear of flying, fires, tragedy-related fears
- 1 2 3 4 5 6 7 8 9 10
- no boys every boy
- no girls every girl

Fear for safety, family safety
- 1 2 3 4 5 6 7 8 9 10
- no boys every boy
- no girls every girl

Increased overall anxiety, worry
- 1 2 3 4 5 6 7 8 9 10
- no boys every boy
- no girls every girl

Regression/ babyish behavior/ increased dependence
- 1 2 3 4 5 6 7 8 9 10
- no boys every boy
- no girls every girl

Temper Tantrums/ extreme responses
- 1 2 3 4 5 6 7 8 9 10
- no boys every boy
- no girls every girl

Heightened startle response/ fearful with no immediate reason
- 1 2 3 4 5 6 7 8 9 10
- no boys every boy
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**FROM JAN 1st - PRESENT**

Fear of flying, fires, tragedy-related fears
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**Comments about items on this page:**

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<td><strong>Loss of appetite</strong></td>
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<tr>
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<td><strong>Nightmares/ Hallucinations</strong></td>
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FROM SEPT 11th - DEC 31st

Negative visions of future/
Pessimism

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Increased concern for non-family/
Increased compassion

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Survivor guilt/ Overconcern
for victims

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Obsessive thoughts of tragedy-related themes (fires, bombings, crashes, war, etc.)

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FROM JAN 1st - PRESENT

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Please describe any further behaviors you felt were related to this incident but were not already accounted for above:

Please take a moment to describe at least one of the most memorable behaviors in more detail below and/or on the back of this sheet:
APPENDIX B

INFORMED CONSENT
INFORMED CONSENT

Your participation is being requested in a study designed to investigate the effects of terrorist attacks on children and how schools may help decrease some of their symptoms of traumatic stress. Julia Westcot, an MSW student at CSUSB is conducting this study under the supervision of Dr. Matt Riggs, with the guidance of Dr. Rosemary McCaslin, Coordinator of MSW research. This study has been approved by the Department of Social Work Sub-Committee of the Institutional Review Board of California State University San Bernardino.

In this study you will be asked questions regarding behaviors you have witnessed in your classroom(s) and interventions regarding the terrorist incidents. The questionnaire should take you about 30 minutes to fill out.

Please be assured that your individual responses will be held in strictest confidence by the researcher. A response envelope addressed to the researcher has been provided in which to seal your responses. All data will be summarized and reported in group form in the study results. Your participation is completely voluntary as you may withdraw from the study at any time. At the conclusion of the study you may request a copy of the results. If you agree to these terms, please mark the line below.

I acknowledge that I am over 18 years old and have been informed of, and understand the nature and purpose of this study and freely consent to participate.

Participant’s Mark: __________________________ Date ________________

Your participation is greatly appreciated.

Researcher’s Signature: _________________________

Date ________________________________
APPENDIX C

DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

This research is being conducted to identify the effects that events pertaining to distal violence including terrorism, war, and threats to the national community may have on elementary school children. Research suggests that these events have the potential to produce trauma symptoms in children that affect their social and academic functioning. The information collected will identify the traumatic symptoms observed in classroom behavior and help guide future intervention to reduce those symptoms.

I appreciate your involvement in this study. If you would like refer a student or anyone you know to speak to a counselor for treatment of traumatic symptoms, I have included some referral information at the bottom of this form. If you have any concerns regarding this study, please feel free to contact the Social Work Department at CSUSB. The university's social work research advisor, Dr. Rosemary McCaslin, can be reached at (909) 880-5507 or by email at rmccaslin@csusb.edu.

The results of the study will be available in the Summer of 2002 at Pfau Library, California State University, San Bernardino 5500 University Parkway San Bernardino, Ca 92407.

Youth Service Center of Riverside
Riverside County Mental Health

Youth Service Center in Moreno Valley

National Institute of Mental Health:
http://www.nimh.org
REFERENCES


