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Writing and Rhetoric 101-11

School Shootings and PTSD

On February 14 2018 in Southern Florida, an active shooter in Stoneman Douglas High School opened fire and killed 15 students and two teachers with an AR-15. This massacre was later titled one of the ten deadliest mass shootings in history, affecting students, teachers, and witnesses worldwide. At 2:15 Cruz started shooting into four classrooms, killing twelve students then heading up the east stairwell of a building off the main annex. The school goes on lockdown and the police arrive. The attention of the world is grabbed, even receiving notes from the President. At this point, the gunman flees the premise and the students are packed into buses and sent to a hotel for shelter. The following day, the gunman is identified; an ex-student of Stoneman Douglas, spiteful about his exile from the school seeking revenge by violence. This information was recorded according to law enforcement authorities, school officials and witnesses. (Nicole Chavez, 2018)

Children could have PTSD if they have lived through an event that could have caused them or someone else to be killed or badly hurt. Such events include sexual or physical abuse or other violent crimes. Disasters such as floods, school shootings, car crashes, or fires might also cause PTSD. Other events that can cause PTSD are war, a friend's suicide, or seeing violence in the area they live. Child protection services in the U.S. get around three million reports each year. This involves 5.5 million children. Of the reported cases, there is proof of

abuse in about 30%. From these cases, we have an idea how often different types of abuse occur. (Schwartz, 1991)

Also, three to ten million children witness family violence each year. Around 40% to 60% of those cases involve child physical abuse. (Note: It is thought that two-thirds of child abuse cases are not reported.)

Three factors have been shown to raise the chances that children will get PTSD. These factors are how severe the trauma is, how the parents react to the trauma, and how close or far away the child is from the trauma

Children and teens that go through the most severe traumas tend to have the highest levels of PTSD symptoms. The PTSD symptoms may be less severe if the child has more family support and if the parents are less upset by the trauma. Lastly, children and teens who are farther away from the event report less distress. Other factors can also affect PTSD. Events that involve people hurting other people, such as rape and assault, are more likely to result in PTSD than other types of traumas. Also, the more traumas a child goes through, the higher the risk of getting PTSD. Girls are more likely than boys to get PTSD. It is not clear whether a child's ethnic group may affect PTSD. Some research shows that minorities have higher levels of PTSD symptoms. Other research suggests this may be because minorities may go through more traumas. Another question is whether a child's age at the time of the trauma has an effect on PTSD. Researchers think it may not be that the effects of trauma differ according to the child's age. Rather, it may be that PTSD looks different in children of different ages.

These children may not have flashbacks or problems remembering parts of the trauma, the way adults with PTSD often do. Children, though, might put the events of the trauma in the wrong order. They might also think there were signs that the trauma was going to happen. As a

result, they think that they will see these signs again before another trauma happens. They think that if they pay attention, they can avoid future traumas.

Children of this age might also show signs of PTSD in their play. They might keep repeating a part of the trauma. These games do not make their worry and distress go away. For example, a child might always want to play shooting games after he sees a school shooting. Children may also fit parts of the trauma into their daily lives. For example, a child might carry a gun to school after seeing a school shooting.

Besides PTSD, children that have gone through trauma often have other types of problems.

Much of what we know about the effects of trauma on children comes from the research on child sexual abuse. This research shows that sexually abused children often have problems with fear, worry, sadness, anger, feeling alone and apart from others, feeling as if people are looking down on them, low self-worth, and not being able to trust others, as well as behaviors such as aggression, out-of-place sexual behavior, self-harm, and abuse of drugs or alcohol.

For many children, PTSD symptoms go away on their own after a few months. Yet some children show symptoms for years if they do not get treatment. There are many treatment options, described below:

CBT, or Cognitive Behavioral Therapy, is the most effective approach for treating children. According to the National Service for Disorders and Treatment, one type of CBT is called Trauma-Focused CBT (TF-CBT). In TF-CBT, the child may talk about his or her memory of the trauma. TF-CBT also includes techniques to help lower worry and stress. The child may learn how to assert himself or herself. The therapy may involve learning to change thoughts or beliefs about the trauma that are not correct or true. For example, after a trauma, a child may start thinking, "the world is totally unsafe."

Some may question whether children should be asked to think about and remember events that scared them. However, this type of treatment approach is useful when children are distressed by memories of the trauma. The child can be taught at his or her own pace to relax while they are thinking about the trauma. That way, they learn that they do not have to be afraid of their memories. Research shows that TF-CBT is safe and effective for children with PTSD. CBT often uses training for parents and caregivers as well. It is important for caregivers to understand the effects of PTSD. Parents need to learn coping skills that will help them help their children.

Psychological First Aid (PFA) has been used with school-aged children and teens that have been through violence where they live. PFA can be used in schools and traditional settings. It involves providing comfort and support, and letting children know their reactions are normal. PFA teaches calming and problem solving skills. PFA also helps caregivers deal with changes in the child's feelings and behavior. Children with more severe symptoms may be referred for added treatment. EMDR combines cognitive therapy with directed eye movements. EMDR is effective in treating both children and adults with PTSD, yet studies indicate that the eye movements are not needed to make it work. Play therapy can be used to treat young children with PTSD who are not able to deal with the trauma more directly. The therapist uses games, drawings, and other methods to help children process their traumatic memories. Special treatments may be needed for children who show out-of-place sexual behaviors, extreme behavior problems, or problems with drugs or alcohol.

Reading this fact sheet is a first step toward helping your child. Learn about PTSD and pay attention to how your child is doing. Watch for signs such as sleep problems, anger, and

avoidance of certain people or places; also watch for changes in school performance and problems with friends.

No matter what happens within the depths of violence and terror, the aftermath of these events and how they effect people will always be relevant. Post Traumatic Stress Disorder is a real problem which can effect people of all ages. It's important to know the signs of this disorder, especially in a time where violence is prevalent and inevitable.

Citations:

Bardeen, J. R., Kumpula, M. J., & Orcutt, H. K. (2013). Emotion regulation difficulties as a prospective predictor of posttraumatic stress symptoms following a mass shooting. *Journal of Anxiety*

Schwarz, E. D., & Kowalski, J. M. (1991a). Malignant memories: PTSD in children and adults after a school shooting. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30, 936–944. doi:10.1097/00004583-199111000-00011

Suomalainen, L., Haravuori, H., Berg, N., Kiviruusu, O., & Marttunen, M. (2011). A controlled follow-up study of adolescents exposed to a school shooting—Psychological consequences after four months. *European Psychiatry*, 26, 490–497. doi:10.1016/j.eurpsy.2010.07.007

Reddy, M., Borum, R., Berglund, J., Vossekuil, B., Fein, R., & Modzeleski, W. (2011). Evaluating risk for targeted violence in schools: Comparing risk assessment, threat assessment,

Griffin, M. G., Resick, P. A., Waldrop, A. E., & Mechanic, M. B. (2003). Participation in trauma research: Is there evidence of harm? *Journal of Traumatic Stress*, 16, 221–227. doi:0.1023/A:1023735821900

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., and Ebraugh, J. (1961). An inventory for measuring depression. *Arch. Gen. Psychiatry*, 4: 53-63.

Haan P, Mays L. Children shooting children: school shootings in the United States. *Soc Work Rev.* 2013;4:49–55.